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

PRINTED: 09/09/2019 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER CHERRY POINT BAY NURSING AND REHABILITATION CENTER CHERRY POINT BAY NURSING AND REHABILITATION CENTER MAYELOCK, NC 28532 THE SOULANDARY STATEMENT OF DEFICIENCY SUPPLIES AND PRECINCE (ACC REPOSENCY MUST SEP PRECIDED BY FULL FREGULATION OF USE DESCRIPTION OF PRECIDE AND PROPERTY AND PROVIDERS PLAN OF CORRECTION OF PROPERTY AND PROPERTY AND PROVIDERS PLAN OF CORRECTION OF PROPERTY AND PROPERTY AND PROVIDERS PLAN OF CORRECTION OF PROPERTY AND PROPERTY AND PROVIDERS PLAN OF CORRECTION OF PROPERTY AND PROVIDERS PLAN OF CORRECTION OF PROPERTY AND PROVIDERS PLAN OF CORRECTION OF PROPERTY AND PROPERTY AND PROVIDERS PLAN OF CORRECTION OF PROPERTY AND PROPERTY AND PROVIDERS PLAN OF CORRECTION OF PROPERTY AND P	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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PREFIX TAG					110 MCCOTTER BOULEVARD	•		
The facility was found in compliance with the requirement CFR 483.73 Emergency Preparedness Event ID # RSN011. F 000 INITIAL COMMENTS A recertification survey and complaint investigation survey was conducted on 07/29/2019 fincy 08/1/2019. There were 10 allegations investigated and 10 were unsubstantitated. F 641 Accuracy of Assessments CFR(s): 483.20(g) \$483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS, a tool used for resident assessment) for 1 of 27 resident assessments reviewed. (Resident # 63). The findings included: Resident # 63 was admitted to the facility on 4/11/2019 with diagnosis that included heart failure, hypertension, diabetes, Hyperlipidemia and Non-Alzheimer's dementia Review of the discharge Minimum Data Set (MDS) dated 4/22/2019 indicated Resident # 65 was discharged to acute hospital. Review of the nurse notes dated 4/22/2019 and the medical record indicated Resident # 65 was the medical record indicated Resi	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
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		The assessment muresident's status. This REQUIREMENT by: Based on record refacility failed to accumulate Data Set (MDS, a to assessment) for 1 or reviewed. (Resident The findings include Resident # 63 was a 4/11/2019 with diagrallure, hypertension and Non- Alzheimer Review of the disch (MDS) dated 4/22/2 was discharged to a Review of the nurse	ust accurately reflect the IT is not met as evidenced view and staff interviews, the urately code the Minimum ool used for resident f 27 resident assessments if # 63). ed: admitted to the facility on nosis that included heart n, diabetes, Hyperlipidemia d's dementia arge Minimum Data Set 019 indicated Resident # 65 incute hospital.		Rehabilitation Center acknowle receipt of the Statement of Def and proposes this plan of correextent of findings is factually or in order to maintain compliance applicable rules and provisions of care of residents. The plan correction is submitted as a wrallegation of compliance. Cherry Point Bay's response to Statement of Deficiencies does denote agreement with the State Deficiencies nor does it constit admission that any deficiency in Further, Cherry Point Bay reseright to refute any of the deficiency	edges ficiencies ection to the orrect and e with s of quality of itten o this s not atement of cute an is accurate. erves the encies on		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Electronically Signed

08/14/2019

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	345487		B. WING			C 08/01/2019		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	01/2019	
				11	10 MCCOTTER BOULEVARD			
CHERRY	POINT BAY NURSING AN	ID REHABILITATION CENTER		Н	AVELOCK, NC 28532			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	HOULD BE COMPLETION		
F 641	41 Continued From page 1		F	641				
	discharged to Assisted Living Facility. During the interview on 7/31/2019 at 3:29 PM, Minimum Data set (MDS) nurse reviewed the discharge MDS and confirmed it was inaccurate. The MDS nurse explained it was coded in error as Resident # 63 was discharged to Assisted Living Facility (ALF). During an interview on 7/31/2019 at 3:35 PM with the DON (Director of Nursing), she indicated that discharge to the ALF should have been coded on Resident # 63's MDS dated 4/22/2019. During Further interview with DON, she stated that it is her expectation that the MDS should be coded accurately and she will review the MDS's after they are completed by the MDS nurse.				Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F 641 SS=D Accuracy of Assessments CFR(s): 483.20(g) Resident #63 MDS Section A was reviewed and corrected on 7/31/19 by MDS Nurse. A 100% audit of current resident's mos recent MDS Section A was audited by DON for accuracy on 8/5/19 with no	t		
					further deficiencies noted. On 8/2/19, 100% of staff with MDS responsibilities to include the MDS Nur Social Worker, Certified Dietary Manage Activities Director, DON, and QI Nurse were in-serviced by the Administrator in regards to MDS assessments and Codper the RAI manual with emphasis on completing assessments accurately and completely. Any new employees that a hired with MDS responsibilities will also trained regarding MDS assessments are accuracy upon new employment orientation by the DON or designee. The decision to monitor the accuracy of MDS was made by the Administrator of 8/5/19. An audit of 10% of all current residents MDS Assessments Section A will be completed by the DON or design weekly X4 weeks and monthly X2 mon using the MDS accuracy tool to ensure accurate and complete coding of the M	ger, n ling d re o be nd f n nee ths		

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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
CHERRY	POINT BAY NURSING AN	ID REHABILITATION CENTER		110 MCCOTTER BOULEVARD				
				HAVELOCK, NC 28532				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG				(X5) COMPLETION DATE	
F 641	Continued From page	e 2	F6	to include Section A. All identifice concern will be addressed immer the DON to include retraining of Nurse or other staff completing modifications on the MDS assess. The DON will review and initial that Accuracy Tool weekly X4 weeks monthly X2 months to ensure all of concern have been addressed. The DON will forward the result MDS Accuracy Tool to the Exect Committee monthly X3 months to determine trends and/or issue may need further interventions applace and to determine the need further and/or frequency of months.	ediately the MC ssment. the MDS and ny areas d. s of the utive Q for reviees that put into d for	by DS S S		