DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				O. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY IPLETED
		345487	B. WING		0	C 3/05/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	0.	5/05/2024
				110 MCCOTTER BOULEVARD		
CHERRY	POINT BAY NURSING AN	ID REHABILITATION CENTER		HAVELOCK, NC 28532		
(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 APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 0	00		
	onsite on 2/27/24 with received remotely on surveyor returned to a validate the immediat The removal plans fo unable to be validated that education had be surveyor returned to a the immediate jeopar validated. Therefore, The following intake	the facility on 3/05/24 and dy removal plans were the exit date was 3/05/24. was investigated NC00213273 resulted in				
	CFR 483.25 at tag F6	was identified at: 580 at a scope and severity J 589 at a scope and severity J 726 at a scope and severity J				
	The tag F689 constitu Care.	uted Substandard Quality of				
F 580	removed on 2/03/24 1 F689 and F726. A pa conducted. Notify of Changes (In	began on 2/01/24 and was for F580 and 3/02/24 for artial extended survey was jury/Decline/Room, etc.)	F 5	80		3/6/24
SS=J	§483.10(g)(14) Notific					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE
Electroni	cally Signed					03/18/2024

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.

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 03/22/2024 MAPPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345487	B. WING					C 05/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
CHERRY F	POINT BAY NURSING AN	D REHABILITATION CENTER			10 MCCOTTER BOULEVAR	RD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA		(X5) COMPLETION DATE
	Continued From page consult with the reside consistent with his or representative(s) whe (A) An accident involv results in injury and ha physician intervention (B) A significant change mental, or psychosocid deterioration in health status in either life-thr clinical complications) (C) A need to alter tre a need to discontinue treatment due to advec commence a new form (D) A decision to trans resident from the facil §483.15(c)(1)(ii). (ii) When making notif (14)(i) of this section, all pertinent informatic is available and provide physician. (iii) The facility must a resident and the reside when there is-	SC IDENTIFYING INFORMATION) a 1 ent's physician; and notify, her authority, the resident in there is- ring the resident which as the potential for requiring ; ge in the resident's physical, ial status (that is, a i, mental, or psychosocial eatening conditions or); atment significantly (that is, an existing form of erse consequences, or to m of treatment); or sfer or discharge the ity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the lent representative, if any, or roommate assignment	TAG		CROSS-REFEREN			
	(B) A change in reside State law or regulation (e)(10) of this section. (iv) The facility must r update the address (n phone number of the representative(s). §483.10(g)(15)	ent rights under Federal or ns as specified in paragraph ecord and periodically nailing and email) and						

Facility ID: 955450

If continuation sheet Page 2 of 37

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				M APPROVI D. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
		345487	B. WING		03	C / 05/2024
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
CHERRY F	POINT BAY NURSING AI	ND REHABILITATION CENTER		110 MCCOTTER BOULEVARD HAVELOCK, NC 28532		
				,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETIO DATE
F 580	Continued From page	e 2	F 5	80		
		istinct part (as defined in	10			
		e in its admission agreement				
		tion, including the various				
		se the composite distinct				
		y the policies that apply to				
		en its different locations				
	under §483.15(c)(9).					
	This REQUIREMENT	Γ is not met as evidenced				
	by:					
	Based on record rev	iew and staff, Nurse		Resident #1 continues to	reside in the	
	Practitioner (NP) and	Physician interviews the		facility and remains in sta	ble condition.	
	facility failed to notify	the physician immediately		Notification of the physicia	an was made the	
	when Resident #1 ha	id a fall from the shower bed		morning of 2/1/24 and orc	lers obtained to	
	(a bed utilized for the	provision of personal care		continue neurological che		
		immobile or who have		physician of any changes		
		adfirst to the floor of the		Practitioner (NP) evaluate		
		/24 at approximately 2:50		with no new orders given.		
		tained a small bruise to the		checks were completed fr		
		l an abrasion to her lower		through 10:00am with no		
		t risk for further injury from		At 10:00am, 7 hours post		
	head trauma due to a	-		during neurological check		
		rgical procedure where a		nystagmus (repetitive, un	-	
		is removed) and seizures.		movement) and notified N the facility and who evalua		
		timately 10:00 AM the le in neurological status with		An order was obtained to		
	nystagmus (repetitive	-		Emergency Department (
		I. The NP was notified and		evaluation.		
	ordered for the reside					
		ent (ED) for evaluation. At		On 2/1/2024, the Quality	Assurance (OA)	
		24, the resident had a		nurse completed a 100%	, , , , , , , , , , , , , , , , , , ,	
	-	e. This deficient practice		reports from 1/1/2024 to 2		
	U U	ents reviewed for notification		ensure the provider was in		
	of significant changes			notified of all incidents inc	-	
	- g s e			potential head injury. No o		
	Immediate jeopardv I	began on 2/01/24 when the		concern were identified.		
		diately notify the physician of				
		ne immediate jeopardy was		On 2/1/2024, the QA nurs	e initiated an	
	removed on 2/03/24			inservice with all nurses r		
	···· =· • • • • • • •	eptable credible allegation of		Notification of the Physicia	5 5	1

Facility ID: 955450

If continuation sheet Page 3 of 37

		ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 03/22/20 RM APPROVE IO. 0938-03
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		345487	B. WING			C 03/05/2024	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CHERRY F	POINT BAY NURSING AN	ND REHABILITATION CENTER			0 MCCOTTER BOULEVARD		
				H	AVELOCK, NC 28532		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 580	Continued From page	e 3	F 5	80			
		emoval. The facility remains			emphasis on how to avoid distractior	16	
		a lower scope and severity			and delay in notification of the physic		
		with potential for more than			including (1) immediately notify the		
		not immediate jeopardy) to			physician of all incidents including fa	lls	
		d monitoring systems put into			with a potential head injury (2) if una		
	place are effective.				reach the attending, notifying the on-	call	
					physician and (3) documentation in t	he	
	Findings included:				electronic record following notificatio	n of	
					the physician. Inservice was comple		
		nitted to the facility on			by 2/2/2024. After 2/2/2024, any nur	ses	
	6/04/20 with diagnos				that were not inservices by the Staff		
		lysfunction, seizure disorder,			Development Nurse (SDC) will comp		
	and history of a left h	emicraniectomy.			before working their next scheduled		
	Resident #1's quarter	rly Minimum Data Set dated			Any newly hired nurses will be educa by the SDC during orientation.	aleu	
	-	e was in a chronic vegetative			by the SDC during onentation.		
	state.				The Interdisciplinary team including	the	
					Minimum Data Set (MDS) Nurse, Sta		
	Review of Resident #	1's fall event report dated			Development Nurse, Quality Assurar		
		ompleted by Nurse #1 read,			Nurse, and Director of Nursing will re		
	in part, that the show	er bed hit an uneven area in			all incidents 5x/week x4 weeks then		
	the floor in the showe	er room and when the bed			1x/week x4 weeks then monthly x3		
	-	e bed folded down and the			months to ensure the physician and/		
		oor. The immediate action			on-call physician is immediately notif		
		hat a small bruise was noted			all incidents to include falls with pote		
		small reddened bump to			head injury with documentation in the		
		The notification section			electronic record following the notific		
	at 6:30 AM.	cian was notified on 2/01/24			The MDS Nurse, SDC, QA Nurse, ar Director of Nursing (DON) will addres		
					concerns identified during the audit t		
	An interview with Nur	rse #1 on 2/27/24 at 10:11			include notification of the physician a		
		was on duty and assigned			staff re-training.		
		01/24 at 2:50 AM when the			5		
		shower bed to the shower			The Administrator and/or DON will p	resent	
	room floor. She obse	rved Resident #1 lying face			the findings of the incident audit tools		
	up on the shower floo	or. She stated that she			the Quality Assurance Performance		
		nt and noted an abrasion to			Improvement (QAPI) Committee more		
		and a small bruise to the			for 3 months. QAPI Committee will r		
	back of her head. She	e started neurological			audits to determine trends and/or iss	ues	

Facility ID: 955450

If continuation sheet Page 4 of 37

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/22/2024 M APPROVEI D. 0938-039	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345487	B. WING			C 03/05/2024		
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
CHERRY	POINT BAY NURSING AN	ND REHABILITATION CENTER		н	IAVELOCK, NC 28532			
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 580	checks (a neurologica physical examination affecting your brain, s system) per protocol 30 minutes x 4, every and every 4 hours x 2 Nurse #1 stated she physician until later in had no neurological of shift. She indicated sh when she made the p A progress note dater. Nurse #2 read in part observation for the put (repetitive, uncontroll An interview with Nur revealed that she was Resident #1 on 2/01/2 stated that she receiv #1 that the resident h bed and had no neuro that she continued the protocol. Nurse #2 sta neurological change of and she notified the N requested that the resident hospital. Review of the hospita 2/09/24 indicated Con (CT) scans revealed changes. Discharge the facility. Prior to d observed with a later ability to follow comm breakthrough seizure	al check consists of a to identify signs of disorders spinal cord, and nervous (every 15 minutes x 4, every y hour x 4, every 2 hours x 2, 2, and every shift x 3 shifts). had not called the on-call the morning as the resident changes for the rest of her he received no new orders obysician notification. d 2/01/24 at 10:00 AM by t that the neurological upil check noted nystagmus ed eye movement). rse #2 on 3/04/24 at 9:50 AM s on duty and assigned to 24 day shift (7am-3pm). She ved a shift report from Nurse that Resident #1 had a of nystagmus at 10:00 AM Nurse Practitioner who sident be sent to the al discharge summary dated mputerized Tomography the resident had no acute was recommended back to ischarge, Resident #1 was al gaze and she lost the	F	580	that may need further interventions a the need for additional monitoring.	Ind/or		

Facility ID: 955450

If continuation sheet Page 5 of 37

		D HUMAN SERVICES MEDICAID SERVICES					FORM): 03/22/2024 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		E CONSTRUCTION		(X3) DATE COMF	SURVEY LETED
		345487	B. WING					C 05/2024
NAME OF PI	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STA	TE, ZIP CODE		
CHERRY I	POINT BAY NURSING AN	D REHABILITATION CENTER			10 MCCOTTER BOULEVAR	RD		
				ŀ	HAVELOCK, NC 28532			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page medication was increa day. Resident #1 was medical issues while a discharged back to the An interview with the revealed that she was fall the morning of 2/0 went to the facility. She the resident and requi- hospital. She revealed should have been not resident sent to hospi- due to Resident #1 hi and the resident shis The NP added that the seizures and was on stated that the resident the facility (admission resident had a seizure felt could have been re- her head. An interview with the 10:00 AM revealed the physician should have and sent to the hospit due to her head traum shower bed. She stat- left hemicraniectomy skull on the left side of bleed in 2020. She co Resident #1's seizure not. She stated that i and the nurse should timely notification of the had a fall and hit their	e 5 ased to 1500 mg twice a s noted with unrelated at the hospital. She was e facility on 2/9/24. NP on 2/28/24 at 9:34 AM s notified of Resident #1's 1/24 at 8:30 AM when she he stated that she assessed ested she be sent to the d that the physician on call ified immediately and the tal right away for evaluation tting her head during the fall tory of hemicraniectomy. e resident had a history of antiseizure medication. She ht had not had a seizure at date of 6/4/20). The e at the hospital which she elated to the fall and hitting Physician on 2/28/24 at at she believed the on-call e been notified immediately al after Resident #1's fall ha caused by falling off the ted that the resident had a (missing a portion of her f her head) from a brain build not say whether was related to her fall or t was a bad judgement call have been educated on he physician if the resident head.		580	D			
	not. She stated that i and the nurse should timely notification of th had a fall and hit their	t was a bad judgement call have been educated on ne physician if the resident						

If continuation sheet Page 6 of 37

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345487	B. WING				C 05/2024
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CHERRY F	POINT BAY NURSING AN	ID REHABILITATION CENTER			110 MCCOTTER BOULEVARD HAVELOCK, NC 28532		
(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 580	physician should have of Resident #1's fall. S been immediately edu physician. The Administrator was Jeopardy on 2/28/24 a The facility provided a was not acceptable to The plan did not demo monitoring plan to en- sustained. The facility provided t allegation of Immedia - Identify those recipie are likely to suffer, a s a result of the noncom On 2/1/24 at 02:50 ar Resident #1 to the sh bed. The head of the elevated position, and was not in an elevated the shower room, the the drain in the floor, unsteady and begin to bed jarred, and the he support fell. NA #1 pro from completely tippir resident's body slid of floor. NA #1 called for	at she believed the on-call e been notified immediately She stated that the staff had ucated on when to notify the s notified of Immediate at 11:15 AM. a corrective action plan that o the State Survey Agency. onstrate a sufficient sure compliance was he following credible te Jeopardy removal: ents who have suffered, or serious adverse outcome as npliance: n, Nursing Assistant #1 took ower room via the shower shower bed was in an d the foot of the shower bed d position. While entering wheel of the shower bed hit causing the bed to become o tip to the side. The shower bead of the bed (HOB) evented the shower bed ing to the side. However, the ff the shower bed onto the assistance.	F	580			
	of Resident #1 and no	a head-to-toe assessment oted a hematoma to the a bruise on the lower back.					

If continuation sheet Page 7 of 37

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345487	B. WING			03	C 8/05/2024
NAME OF P	ROVIDER OR SUPPLIER		I	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
CHERRY	POINT BAY NURSING AN	ID REHABILITATION CENTER			110 MCCOTTER BOULEVARD HAVELOCK, NC 28532		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	The resident was ass mechanical lift onto the to the room. Neuro ch 3:00 am to 9:00 am w 8:05 am, the facility N updated on the status orders. At 10:00 am, on nurse noted nystagm eye movement) and r NP assessed the resi- send to the emergence evaluation and treatm the resident had a 2-r and was treated for si- Additionally, the resid persistent vegetative cerebral parenchyma nature, all unrelated to All residents who had injury, had the potent Quality Assurance Nu- residents utilizing an On 2/1/24, a root cau by the Administrator a root cause was detern became distracted an notify the on-call prov facility protocol. On 2/1/2024, a 100% from 1/1/2024 to 2/1/2 Quality Assurance Nu- was immediately notifi falls with a potential h other identified areas	isted up from the floor via he shower bed and returned hecks were completed from with no negative findings. At lurse Practitioner (NP) was a of the resident with no new during a neuro check, the us (repetitive, uncontrolled eported this to the NP. The dent with a new order to cy room for further hent. While at the hospital, minute breakthrough seizure eizure-like activity. ent was admitted for a state, and a small area of I hemorrhage chronic in o the fall. falls, including those with ial to be affected. The urse identified these incident audit tool on 2/1/24. se analysis was completed and Director of Nursing. The mined to be that the nurse of inadvertently failed to ider of the resident's fall per	F	580			

Facility ID: 955450

If continuation sheet Page 8 of 37

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		345487	B. WING	_			C
NAME OF PI	ROVIDER OR SUPPLIER	545467			TREET ADDRESS, CITY, STATE, ZIP CODE	03/	05/2024
CHERRY F	POINT BAY NURSING AN	ID REHABILITATION CENTER			10 MCCOTTER BOULEVARD		
		ATEMENT OF DEFICIENCIES		H	IAVELOCK, NC 28532 PROVIDER'S PLAN OF CORRECTION		(25)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	× 0		-00			
1 300	Continued From page	e o lure to prevent a serious	F:	580			
		n occurring or recurring, and					
	An in-service was init	iated on 2/1/24 by the					
	Quality Assurance nu	rse with all nurses regarding					
		ysician, with emphasis on ons and delay in notification					
	of the physician inclu	ding (1) immediately					
		n of all incidents including lead injury (2) if unable to					
	reach the attending, r						
		umentation in the electronic					
		cation of the physician. eted by 2/2/24. After 2/2/24,					
	The Staff Developme	nt Nurse monitored staff					
	· · ·	urse who had not completed nplete it before working their					
	next scheduled shift.						
	Any newly hired nurse	es will be educated by the					
		urse during orientation					
	regarding Notification emphasis on how to a	of the Physician with avoid distractions and delay					
	in notification of the p	hysician including (1)					
		the physician of all incidents potential head injury (2) if					
	unable to reach the a	ttending, notifying the on-call					
		umentation in the electronic cation of the physician.					
	, and the second s	nt Nurse was notified of this					
		Administrator on 2/1/24.					
	Date of Jeopardy Rer	moval 2/3/24.					
		n of immediate jeopardy					
		on 3/05/24. Interviews were ple of Nurses to verify					
		cted for Nurses regarding					

Event ID: SBYR11

Facility ID: 955450

If continuation sheet Page 9 of 37

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/22/2024 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345487	B. WING				C 105/2024
NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
CHERRY F	POINT BAY NURSING AN	ID REHABILITATION CENTER			I0 MCCOTTER BOULEVARD AVELOCK, NC 28532		
(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 580	Continued From page notification of the phy- in-service records wa	sician. Documentation of	F	580			
F 689 SS=J	Staff Development Co all Nurses had been in procedure to notify the she was responsible f the procedure for noti The facility's immedia 2/03/24 was validated	ards/Supervision/Devices	F	689			3/6/24
	as free of accident ha §483.25(d)(2)Each re supervision and assis accidents. This REQUIREMENT by: Based on record revi Nurse Practitioner (NI the facility failed to fol instructions for the us bed utilized for the pro- residents who are imm mobility) and to provid resident reviewed for accidents. On 2/01/2 transported Resident	are that - sident environment remains izards as is possible; and sident receives adequate stance devices to prevent is not met as evidenced ew, observation, and staff, P), and Physician interviews, llow the manufacturer's e of a mobile shower bed (a povision of personal care for mobile or who have reduced de care safely for 1 of 1 supervision to prevent 24 Nursing Assistant (NA) #1 #1 to the shower room via			Resident #1 continues to reside in the facility and remains in stable condition. Shower bed was immediately taken ou service and sent to Maintenance Direct for evaluation. On 2/1/2024, the Quality Assurance (Conurse completed a 100% audit of incider reports from 1/1/2024 to 2/1/2024 to ensure no incident resulted from falls during shower transport by shower become	t of tor PA) ent	
	resident reviewed for accidents. On 2/01/2 transported Resident the shower bed witho that secured the head	supervision to prevent 24 Nursing Assistant (NA) #1			nurse completed a 100% audit of incide reports from 1/1/2024 to 2/1/2024 to	ent I or	

Event ID: SBYR11

Facility ID: 955450

If continuation sheet Page 10 of 37

		MEDICAID SERVICES				<u> 0938-03</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
			A. BUILDING	3		С
		345487	B. WING			/ 05/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		103/2024
				110 MCCOTTER BOULEVARD		
CHERRY	POINT BAY NURSING AN	ND REHABILITATION CENTER		HAVELOCK, NC 28532		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 689	Continued From page	o 10	E 00	0		
F 009	Continued From page		F 68	9		
		t of the shower bed released to the floor. NA #1 did not		On 2/1/2024, the Staff Dev	velonment	
		She continued to push the		Coordinator (SDC) comple		
		er bed to the shower room.		questionnaires with all ale		
		shower room when the		residents regarding conce		
		eled over the drain in the		shower bed/chair transpor	-	
	floor, the bed became	e unsteady, began to tip to		areas of concern were ide		
	the side and the head	d of the bed released				
	dropping toward the f	floor resulting in the resident		On 2/1/2024, the Maintena	ance Director	
	-	er bed headfirst onto the		completed a 100% audit o		
		istained a small bruise to the		beds to ensure no other sl		
		l an abrasion to her lower		required locking pins. No		
		ent was transported to the		beds were identified. The		
	on 2/02/24, the reside	t 11:01 AM. At the hospital ent had a breakthrough		shower bed was complete service and removed from	-	
	seizure.			On 2/1/2024, the Maintena	ance Director	
	Immediate ieonardy ł	began on 2/01/24 when NA		completed a 100% audit o		
		are safely to Resident #1.		beds and shower chairs to		
		rdy was removed on 3/02/24		repairs were needed to inc		
		ided an acceptable credible		pins and to ensure safe or	-	
		ate jeopardy removal. The		shower beds and shower		
		f compliance at a lower		areas of concern were ide		
	scope and severity of	f D (no actual harm with				
		an minimal harm that is not		On 2/1/2024, the Maintena	ance Director	
		to ensure education and		completed 100% of all sho		
	monitoring systems p	out into place are effective.		ensure no safety hazards		
	Lindings instructure			other areas of concern we	re identified.	
	Findings included:			On 2/1/2024, the Nursing	Home	
	A product website for	purchasing of the shower		Administrator (NHA) decid		
		cility indicated the bed was		shower equipment that red		
	-	nyl chloride) pipe material		pins. NHA completed edu	-	
		t foam pad across the		supply clerk regarding not		
		ea of the platform where an		shower equipment that red		
		It was foldable and mobile.		pins. An order was placed		
		sters (wheels that were		shower beds that do not o		
		t the four corners and that		use of pins.		
	were able to lock into	position). It was 38.5"				

Facility ID: 955450

If continuation sheet Page 11 of 37

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/22/2024 FORM APPROVED OMB NO. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345487	B. WING		C 03/05/2024
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
	OINT BAY NURSING AN	ID REHABILITATION CENTER	1	110 MCCOTTER BOULEVARD	
UNERIG			I	HAVELOCK, NC 28532	
(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 APPR DEFICIENCY)	ULD BE COMPLETION
F 689	To fold the bed, the h of the bed folded dow the center portion of t horizontal plane with 41.5". The operating instruct purpose of this bed w horizontal position an showering. The show end for easy storage on either end until the Resident #1 was adm 6/04/20 with diagnose non-traumatic brain d and history of a left ho procedure where a la removed). Review of Resident # revealed an order dat Levetiracetam (an an twice a day for seizur Resident #1's quarter assessment dated 11	2" diameter x 76.5" length. ead of the bed and the foot vn towards the casters with the bed remaining in a the folded length measuring tions (undated) indicated the vas to transport a person in a d to use as a platform for ver bed folded down at each by unpinning and lifting up e section disengaged. hitted to the facility on es which included lysfunction, seizure disorder, emicraniectomy (surgical rge flap of the skill is et1's physician's orders ted 2/02/23 for tiseizure) 750 milligrams es.	F 689	On 2/2/24, the NHA completed an inservice with the maintenance dir regarding notifying the NHA of any equipment that needs frequent attention/repairs and monitoring of beds/chairs weekly. On 2/1/2024, the SDC initiated ed with all nurses and nursing assista regarding safety hazards and open procedures when transporting resi shower beds/chairs and completed demonstrations. The inservice emphasized 1) inspecting equipment function and missing parts before transport; 2) immediately reporting maintenance staff and/or supervis safety hazards to prevent the risk 3) ensuring the resident is properly positioned in the shower bed/chair using the shower bed/chair if equip not fully functional with all parts; and repairs are needed, red tag the sh transport device and place outsides maintenance office for repairs. Inse was completed on 2/2/2024. Any nursing assistance who did not co the inservice with SDC will be inse- prior to their next scheduled shift.	rector / f shower ucation ants rational idents in d return ent for g to or of falls; y r; 4) not pment is nd 5) if ower e service nurse or mplete erviced
	staff for activities of d prescribed an anticoa Resident #1's care pla revealed a focus area with an intervention for	aily living. She was not agulant. an last revised 5/24/23 a for activities of daily living or total dependence for		hired nurses and nursing assistant be educated by the SDC with return demonstration obtained during original On 3/1/24, the NHA re-inserviced on the responsibility to include bot	ts will rn entation. the SDC
	the head of the bed e	lso an intervention to keep levated. 1's fall event report dated		shower chairs and beds with the education of all newly hired staff. On 3/1/24, the SDC initiated an ins	service

Facility ID: 955450

If continuation sheet Page 12 of 37

	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	O. 0938-03
ATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345487	B. WING			С
	ROVIDER OR SUPPLIER	545467		STREET ADDRESS, CITY, STAT		8/05/2024
VAIVIE OF P	ROVIDER OR SUPPLIER					
CHERRY	POINT BAY NURSING AN	ND REHABILITATION CENTER		110 MCCOTTER BOULEVARD HAVELOCK, NC 28532)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETIC DATE
F 689	Continued From page	o 12	Ге	80		
1 003			F 6			
		ompleted by Nurse #1 read,		with all nurses and n		
		er bed hit an uneven area in		regarding safety haza	•	
		e bed jarred the head of the the resident slid to the floor.		procedures when trai		
					nservice emphasized	
		n taken read, in part, that a ed to the lower back and		1) inspecting equipm missing parts before		
		to the back of the head.		immediately reporting	. ,	
		o to the back of the flead.		staff and/or supervise	-	
	An interview with NA	#1 on 2/27/24 at 3:15 PM		prevent the risk of fal		
		jularly provided care for		resident is properly p	, -	
	Resident #1 and had				not using the shower	
		shower bed. She stated she		bed/chair if equipmer		
		ferred Resident #1 from her		functional with all par	-	
		d via the mechanical lift.		are needed, red tag t	, .	
		he transported Resident #1		device and place out	-	
		vard the shower room. There		-	ervice was completed	
		ch side of the shower bed		by 3/2/24. The SDC		
		ocked in place with locking		completion of the ins		
		side rails were in an upright		any nurse or nursing		
		with the locking pins in		not completed the ins		
		sported Resident #1 down		it before working thei	-	
		d of the shower bed was		shift. The Director of		
	elevated, and the foo	t was not elevated. She		provided oversight of	staff education to	
	stated that the reside	nt care guide intervention		validate staff knowled	dge and	
	was to keep the head	d of the bed elevated at all		understanding of the	education provided.	
	times, so she kept the	e head of the shower bed				
		t of the way down the		The Maintenance Dir		
	-	ion of the shower bed (a			nower beds/chairs for	
		able of folding down toward			veekly x4 weeks then	
		d which caused it to be in a		monthly x3 months to		
	-	ward the ground while the		are needed in showe		
		nained on the horizontal		shower equipment.		
	-	now why this happened.		audits weekly x4 wee	-	
		art of the resident was off the		months to ensure all	concerns are	
		did not believe the resident		addressed.		
	-	ng off of the bed so she		The Administrator an		
		e shower bed towards the		Director will present t	-	
		stated that after she entered		to the Quality Assura		
	the shower room, the	head of the shower bed (a		Improvement (QAPI)	Committee monthly	

Facility ID: 955450

If continuation sheet Page 13 of 37

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	D. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,)	· · · ·	PLETED
						С
		345487	B. WING			/05/2024
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		
				110 MCCOTTER BOULEVARD		
CHERRY	UNI BAY NURSING A	ND REHABILITATION CENTER		HAVELOCK, NC 28532		
(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 TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 689	Continued From page	e 13	F 68	a		
		at was capable of folding	1 00	for 3 months. QAPI Con	omittee will review	
	•	ters) released and fell toward		audits to determine trend		
		dent slid off the shower bed		that may need further int		
		r. The resident was lying		the need for additional m		
		ower room floor. NA #1			5	
	stated she went to th	e shower room door and				
	called for help. The n	urse (Nurse #1) came to				
	assess the resident.	After the resident was				
	-	the mechanical lift to put the				
		er bed and transport her to				
		that she was unaware there				
	• ·	the head and foot of the				
		locking pins for the folding				
		parate from the locking pins				
	she had not been trai	ail securement). She stated				
		ctions were. NA #1 stated				
		received for the shower bed				
		about the locking pins				
		ails in an upright, locked and				
	secured position on e					
		rse #1 on 2/27/24 at 10:11				
		e was on duty and assigned				
		01/24 at 2:50 AM when the				
		shower bed to the shower				
		d that NA #1 had called out				
		She observed Resident #1				
		he shower room floor. She				
	• •	ved the head of the shower				
		. She stated that she				
		nt and noted an abrasion to				
		and a small bruise to the				
		rse #1 stated that they used				
		transfer Resident #1 to the				
		sported her back to her				
	room. She started ne	urological checks (a				1
	neurological check co					

If continuation sheet Page 14 of 37

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345487	B. WING				C 6/05/2024
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CHERRY	POINT BAY NURSING AN	ID REHABILITATION CENTER			110 MCCOTTER BOULEVARD HAVELOCK, NC 28532		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	system) per protocol 30 minutes x 4, every and every 4 hours x 2 Nurse #1 stated that to neurological changes she called the on-call She indicated she red she made the physici A progress note dated Nurse #2 read in part observation for the put (repetitive, uncontrolled An interview with Nur revealed that she was Resident #1 on 2/01/2 stated that she receiv #1 that the resident h bed and had no neuro that she continued the protocol. Nurse #2 sta neurological change of and she notified the N requested that the resident hospital. Review of the hospital 2/09/24 indicated Cor (CT) scans revealed to changes. Discharge the facility. Prior to di observed with a latera ability to follow comm breakthrough seizure Neurology was consu-	binal cord, and nervous (every 15 minutes x 4, every thour x 4, every 2 hours x 2, 2, and every shift x 3 shifts). the resident had no for the rest of her shift, and physician the next morning. weived no new orders when an notification. d 2/01/24 at 10:00 AM by that the neurological upil check noted nystagmus ed eye movement). se #2 on 3/04/24 at 9:50 AM s on duty and assigned to 24 day shift (7am-3pm). She ed a shift report from Nurse ad fallen from the shower ological changes. She stated e neurological checks per ated that Resident #1 had of nystagmus at 10:00 AM Jurse Practitioner who sident be sent to the al discharge summary dated mputerized Tomography the resident had no acute was recommended back to ischarge, Resident #1 was al gaze and she lost the	F	689			

Facility ID: 955450

If continuation sheet Page 15 of 37

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	0: 03/22/2024 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345487	B. WING		_	03/	C 05/2024
NAME OF PI	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				110 MCCOTTER BOULEVA	RD		
CHERRY I	POINT BAY NURSING AN	D REHABILITATION CENTER		HAVELOCK, NC 28532			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / 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 689	Continued From page medical issues while a discharged back to th	at the hospital. She was	F 68	99			
	discharged back to the An interview on 2/27/2 Maintenance Director one shower bed and h in place to regularly cl mechanical safety. He of the locking pins wh the bed from a folded head and foot of the s position. He stated the on the side rails of the an upright position. He checked the shower b locking pins (the side secured the head and preventing them from because the pins "we he had to replace the was out of the facility #1 fell and when he w emergency maintenant Maintenance Director checked the bed after 2/01/24, the locking p the bed were missing had been discarded a no longer in the facility did not have locking p	e facility on 2/9/24. 24 at 1:38 PM with the revealed the facility had be did not have a procedure heck the shower bed for e stated that he was aware ich were used to transition position by securing the shower bed in a horizontal ere were also locking pins a shower bed to hold them in le stated that he usually bed weekly to ensure all the rail pins and the pins that the foot of the shower bed folding down) were in place int missing sometimes" and m. He also stated that he the week before Resident vas out there was only nee coverage. The stated that when he returning to work on ins for the head and foot of . He stated that shower bed fiter the accident and was y and the new shower bed ins on the bottom. Nurse Practitioner (NP) on					
	of Resident #1's fall. S assessed the resident sent to the hospital. S resident had hit her hos transported to the hos	t and requested that she be he also stated that since the ead, she should have been					

Facility ID: 955450

If continuation sheet Page 16 of 37

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345487	B. WING				C 05/2024
NAME OF P	ROVIDER OR SUPPLIER			ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE		
CHERRY	POINT BAY NURSING AN	D REHABILITATION CENTER			110 MCCOTTER BOULEVARD HAVELOCK, NC 28532		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / 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 689	hemicraniectomy. The had a history of seizu medication. She also not had a seizure at th 6/4/20). The resident which she felt could h and hitting her head. An interview with the 10:00 AM revealed th Resident #1 should ha hospital immediately a trauma caused by fall stated that the residen hemicraniectomy (mis on the left side of her 2020. She could not seizure was related to that she did not know caused any negative resident was in a chro An interview with the a 10:54 AM revealed th Resident #1's fall from caused by the showed missing locking pins of bed and the lack of st pins were in place. Sh bed had been removed She indicated they did for training the staff of The Administrator was jeopardy on 2/28/24 a The facility provided a immediate jeopardy re	e NP stated that the resident res and was on antiseizure stated that the resident had he facility (admission date of had a seizure at the hospital ave been related to the fall Physician on 2/28/24 at at she believed that ave been sent to the after her fall due to her head ing off the shower bed. She ht had a left using a portion of her skull head) from a brain bleed in say whether Resident #1's o her fall or not. She stated if the resident's fall had consequences as the onic vegetative state. Administrator on 2/27/24 at at she believed the cause of in the shower bed was bed failure due to the on the head and foot of the aff education to check the ne stated that the shower ed from use immediately. I not have a system in place in the shower bed. Is notified of immediate tt 11:15 AM.	F	689			

If continuation sheet Page 17 of 37

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 03/22/2024 MAPPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345487	B. WING		_		C 05/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				110 MCCOTTER BOULEVA	RD		
CHERRY F	POINT BAY NURSING AN	D REHABILITATION CENTER		HAVELOCK, NC 28532			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / 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 689	plan could not be valid have sufficient eviden completed for staff. M received education. T provide a revised creating jeopardy removal. The facility provided t allegation of immediat - Identify those recipies are likely to suffer, a se a result of the noncom On 2/1/24 at 02:50 an Resident #1 to the shi bed. The head of the elevated position, and was not in an elevated the shower room, the the drain in the floor, a unsteady and begin to bed jarred, and the he support fell. NA #1 pro- from completely tippin resident #1 called for The nurse completed of Resident #1 and no back of the head and The resident was assis mechanical lift onto th to the room. Neuro ch 3:00 am to 9:00 am w 8:05 am, the facility N	ediate jeopardy removal dated as the facility failed to ce that education was Aultiple staff working had not The facility was asked to dible allegation of immediate the following revised credible te jeopardy removal: ents who have suffered, or serious adverse outcome as apliance: n, Nursing Assistant #1 took ower room via the shower shower bed was in an I the foot of the shower bed d position. While entering wheel of the shower bed hit causing the bed to become to tip to the side. The shower ead of the bed (HOB) evented the shower bed of the shower bed and returned a bruise on the lower back. isted up from the floor via te shower bed and returned tecks were completed from ith no negative findings. At urse Practitioner (NP) was	F 68		DEFICIENCY)		
	The resident was ass mechanical lift onto th to the room. Neuro ch 3:00 am to 9:00 am w 8:05 am, the facility N notified of the status of	isted up from the floor via le shower bed and returned lecks were completed from ith no negative findings. At					

Facility ID: 955450

If continuation sheet Page 18 of 37

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345487	B. WING				C / 05/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CHERRY	POINT BAY NURSING AN	ID REHABILITATION CENTER			110 MCCOTTER BOULEVARD HAVELOCK, NC 28532		
(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)	ЗE	(X5) COMPLETION DATE
F 689	nurse noted nystagmi eye movement) and r NP assessed the resi send to the emergence evaluation and treatm the resident had a 2-r and was treated for se Additionally, the resid persistent vegetative cerebral parenchymal nature, all unrelated to All residents who are beds have the potenti Director of Nursing id- utilizing a census she On 2/1/24, a root caus by the Administrator a root cause of the fall w in the up position, and place per the manufact On 2/1/2024, a 100% from 1/1/2024 to 2/1/2 Quality Assurance Nu- incident resulted from transport by gurney o identified areas of cor On 2/1/24, a 100% au Maintenance Director shower beds required no other beds identifie bed was immediately the Maintenance Dire	us (repetitive, uncontrolled eported this to the NP. The dent with a new order to cy room for further nent. While at the hospital, minute breakthrough seizure eizure-like activity. ent was admitted for a state, and a small area of I hemorrhage chronic in o the fall. transported via shower ial to be affected. The entified these residents et on 2/2/24. se analysis was completed and Director of Nursing. The was that the footrest was not d the locking pins were not in cturer's specifications. audit of incident reports 2024 was completed by the urse (QA) to ensure no of falls during shower r chair. There were no other neern.	F	689			

If continuation sheet Page 19 of 37

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE	
		345487	B. WING				C / 05/2024
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
CHERRY	POINT BAY NURSING AN	ID REHABILITATION CENTER			110 MCCOTTER BOULEVARD HAVELOCK, NC 28532		
(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 689	residents regarding or chairs/bed transport. completed on 2/1/24. areas of concern. - Specify the action the process or system fai adverse outcome from when the action will b On 2/1/2024, a 100% beds/chairs was comp Director to ensure no required including loc operations. There were of concern. On 2/1/2024, a 100% was completed by the ensure no safety haza identified concerns. On 2/1/24, the Admini- the shower bed/chairs was completed by the with the supply clerk in shower equipment ree An in-service was cor Administrator with the regarding notifying the equipment that needs and monitoring of sho	oncerns during shower The questionnaires were There were no identified the entity will take to alter the lure to prevent a serious in occurring or recurring, and the complete: audit of all shower pleted by the Maintenance needed repairs were king pins and to ensure safe re no other identified areas audit of all shower rooms the Maintenance Director to ards. There were no other istrator decided to not utilize s with pins. An in-service the Administrator on 2/1/24 regarding not ordering any quiring locking pins. mpleted on 2/2/24 by the the maintenance director to any the frequent attention/repairs over beds/chairs weekly. iated on 2/1/2024 by the urse with all nurses and garding safety hazards and the when transporting	F	689			

Facility ID: 955450

If continuation sheet Page 20 of 37

DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & MI					FORM	03/22/2024 APPROVED 0938-0391
	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	PLE CONSTRUCTION		(X3) DATE S COMPL	SURVEY ETED
	345487	B. WING		_	C 03/0	5/2024
NAME OF PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
CHERRY POINT BAY NURSING AND	REHABILITATION CENTER		110 MCCOTTER BOULEVA HAVELOCK, NC 28532			
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
and missing parts befor immediately reporting to supervisor safety hazar falls, (3) ensuring the re positioned in the shower shower bed if equipmer with all parts and (5) if r tag the shower transpor- maintenance office for r completed by 2/2/2024. Nurse monitored staff c and ensured any nurse completed the in-servic working their next scher An in-service was initial Staff Development Nurse nursing assistants rega operational procedures residents in shower char emphasized (1) inspect and missing parts befor immediately reporting to supervisor safety hazar falls, (3) ensuring the re positioned in the shower shower chair if equipmer with all parts and (5) if r tag the shower transpon maintenance office for r completed by 3/1/2024. Nurse monitored staff c and ensured any nurse completed the in-servic working their next scher	ting equipment for function re transport, (2) o maintenance staff and/or ds to prevent the risk of esident is properly er bed, (4) not using the nt is not fully functional repairs are needed, red rt device and place outside repairs. In-service was . The Staff Development completion of the in-service or nurse aide who had not e will complete it before duled shift. ted on 3/1/2024 by the se with all nurses and rding safety hazards and when transporting airs. This in-service cing equipment for function re transport, (2) o maintenance staff and/or ds to prevent the risk of esident is properly er chair, (4) not using the ent is not fully functional repairs are needed, red rt device and place outside repairs. In-service was . The Staff Development completion of the in-service or nurse aide who had not e will complete it before duled shift.	F 68				

If continuation sheet Page 21 of 37

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345487	B. WING				C 05/2024
NAME OF PI	ROVIDER OR SUPPLIER		•	:	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CHERRY I	POINT BAY NURSING AN	ID REHABILITATION CENTER			110 MCCOTTER BOULEVARD HAVELOCK, NC 28532		
(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 689	be educated by the S during orientation reg procedures during shi The Staff Development responsibility by the A 3/1/24, the Staff Development responsibility to include beds with the education Date of Immediate Jee The credible allegation removal was verified of conducted with a same and Nurses to verify ef Nurses and NAs regates safety. Documentation reviewed. In an interview on 3/0 Maintenance Director received education of place to monitor the st for safety. In an interview on 3/0 Staff Development Co all Nurses and Nursin in-serviced on the sho	education provided. es and nurse assistants will taff Development Nurse arding safe operational ower chair/bed transport. nt Nurse was notified of this administrator on 2/1/24. On elopment Nurse was	F	689			
	new nurses and nursi						

Facility ID: 955450

If continuation sheet Page 22 of 37

	STOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		345487	B. WING		03/05/2024
NAME OF PI	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
CHERRY I	POINT BAY NURSING AN	ID REHABILITATION CENTER		MCCOTTER BOULEVARD	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 689	Continued From page	e 22	F 689		
		shower room revealed the			
		ad no locking pins on the			
		e shower chairs were			
		ed to be in good condition. were observed to be located			
		nall with out of order tags			
	attached to them.				
	The facility's immedia	te jeopardy removal date of			
	3/2/24 was validated.				
F 693 SS=D	Tube Feeding Mgmt/I CFR(s): 483.25(g)(4)	-	F 693		3/6/24
	§483.25(g)(4)-(5) Ent	eral Nutrition			
		c and gastrostomy tubes,			
		ndoscopic gastrostomy and			
	percutaneous endosc enteral fluids). Based	copic jejunostomy, and			
	,	ssment, the facility must			
	ensure that a residen				
	§483.25(g)(4) A resid	ent who has been able to			
	eat enough alone or v	with assistance is not fed by			
		ss the resident's clinical es that enteral feeding was			
		d consented to by the			
	resident; and	5			
	§483.25(g)(5) A resid	ent who is fed by enteral			
	means receives the a	ppropriate treatment and			
		possible, oral eating skills			
		ications of enteral feeding ed to aspiration pneumonia,			
	diarrhea, vomiting, de				
	abnormalities, and na	asal-pharyngeal ulcers.			
		is not met as evidenced			
	by:	ns, record review, and staff		Resident #1 continues to reside in	44

Facility ID: 955450

If continuation sheet Page 23 of 37

							<u>0. 0938-03</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	· · ·	E SURVEY PLETED
			A. BOILDING	<u> </u>			С
		345487	B. WING				/05/2024
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00	
				11(0 MCCOTTER BOULEVARD		
CHERRY	POINT BAY NURSING AN	ID REHABILITATION CENTER		HÆ	AVELOCK, NC 28532		
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETIO DATE
F 693	Continued From page	e 23	F 69	93			
		failed to 1) follow procedure			facility and remains in stable condition	1	
		(g-tube) care by Nurse #2			with no ill affects from 30cc of water b		
		e plunger through the			pushed through the g-tube syringe by	•	
		e and 2) failed to store a			using the plunger.		
		with the plunger separated					
		was for 1 of 1 resident			On 2/27/24, the Director of Nursing		
	reviewed for enteral f	eeding management			educated the Nurse #1 immediately		
	(Resident #1).				regarding administering medication/flushes via g-tube by gravi	tv.	
	Findings included:				flow and on storing the feeding tube	Ly	
					syringe/plunger with plunger removed		
	Resident #1 was adm	nitted to the facility on			from the syringe.		
	6/04/20 with diagnose	es which included					
	cerebrovascular accio	dent and Diabetes Mellitus.			On 2/27/2024, the Quality Assurance	(QA)	
					nurse completed a 100% audit of all		
		ly Minimum Data Set dated			residents who receive nutrition/medica	ation	
		e was dependent on staff for			via g-tube to ensure the tube feeding		
	activities of daily living	y.			syringe was not being stored with the plunger inside the syringe. No other		
	An observation on 2/2	27/24 at 11:38 AM revealed			areas of concern were identified.		
		d 30 cubic centimeters (cc)					
		ube using the plunger			On 2/27/2024, the Staff Development		
		e water to flow in the syringe			Coordinator (SDC) initiated an inservi	ce	
	by gravity through the				with all nurses regarding 1) providing		
		omen and potential damage			medications/flushes through the g-tub		
	-	#2 then placed the syringe			via gravity flow as not to potentially ca		
		e the barrel in the storage			abdominal discomfort or damage to th	е	
	bag.				tube and 2) to store feeding tube syringe/plunger with plunger removed		
	An interview on 2/27/	24 at 11:47 AM with Nurse			from the syringe. Inservice was		
		had been taught to push the			completed on 2/28/2024. Any nurses	who	
		instead of allowing it to flow			did not complete inservice with SDC v		
		o stated that she had been			be inserviced prior to their next sched		
		ringe barrel and plunger			shift. Newly hired nurses will be educ	ated	
		but had not done so due to			by the SDC during orientation.		
	nervousness.				The OA pures (SDC will semplete F		
	Δn interview on 2/27/	24 at 11:54 AM with the			The QA nurse/SDC will complete 5 observations a week x4 weeks then 1	n	
		DON) revealed that she did			observations a week x4 weeks then the observations x1 month to observe nur		

Facility ID: 955450

If continuation sheet Page 24 of 37

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· /	LE CONSTRUCTION	OMB NO. 0938-03
ND PLAN OF	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		345487	B. WING		C 03/05/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
CHERRY	POINT BAY NURSING AI	ND REHABILITATION CENTER		110 MCCOTTER BOULEVARD HAVELOCK, NC 28532	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIC
F 693	not know why Nurse g-tube with the plung	#2 pushed the water into the er instead of allowing it to y she had stored the syringe	F 69	 3 1) providing medications/flushes th the g-tube via gravity flow and 2) st feeding tube with plunger removed the syringe. The Director of Nursin (DON) will review audits weekly x2 The DON will present the findings of audits to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 1 month. Q Committee will review audits to det trends and/or issues that may need further interventions and/or the nee additional monitoring 	oring from g weeks. of API ermine
F 726 SS=J	CFR(s): 483.35(a)(3) §483.35 Nursing Ser The facility must have the appropriate comp provide nursing and n resident safety and a practicable physical, well-being of each re resident assessment and considering the r diagnoses of the faci accordance with the at §483.35(a)(3) The fa licensed nurses have and skill sets necess needs, as identified t assessments, and de §483.35(a)(4) Provid	(4)(c) vices e sufficient nursing staff with betencies and skills sets to related services to assure ttain or maintain the highest mental, and psychosocial sident, as determined by s and individual plans of care number, acuity and lity's resident population in facility assessment required cility must ensure that e the specific competencies ary to care for residents'	F 72	0	3/6/24

Facility ID: 955450

If continuation sheet Page 25 of 37

		MEDICAID SERVICES				NO. 0938-03
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · ·	ATE SURVEY
			A. BUILDING			
		245497	B. WING			С
		345487	B. WING			03/05/2024
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	Ξ	
	OINT BAY NURSING AN	ID REHABILITATION CENTER		110 MCCOTTER BOULEVARD		
				HAVELOCK, NC 28532		
(X4) ID			ID	PROVIDER'S PLAN OF COR		(X5) COMPLETIO
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		DATE
F 726	Continued From page	e 25	F 72	6		
	implementing residen	t care plans and responding				
	to resident's needs.					
	§483.35(c) Proficienc	•				
		ure that nurse aides are able				
	to demonstrate comp	,				
1		/ to care for residents'				
	needs, as identified th	scribed in the plan of care.				
		is not met as evidenced				
	by:	is not met as evidenced				
	-	ns, record review, staff,		Resident #1 continues to resi	de in the	
		P), and Physician interviews		facility and remains in stable of		
		ain Nursing Assistants (NAs)				
		y for the safe operation of a		On 2/1/2024, the Quality Assu	rance (QA)	
	foldable shower bed (a bed utilized for the		nurse initiated questionnaires	with all	
	provision of personal	care for residents who are		nursing staff regarding observ	ations of	
		e reduced mobility) for 1 of 1		any concerns during residents		
		NA #1 was unaware that		bed/chair transports. Question		
	the shower bed requi	01		completed by 2/2/2024. After		
		e head of the bed and the		nurse or nurse aide who did n	•	
	foot of bed to prevent			the questionnaire will complete		
	-	IA #1 transported Resident n via the shower bed without		questionnaire before working the scheduled shift.		
		ns. While transporting the				
	resident to the showe			On 2/1/24, the Staff Developm	nent	
		and dropped toward to the		Coordinator (SDC) initiated re		
		to push the resident in the		demonstrations of shower cha		
		ower room. Once arriving in		transport with all nurses and n		
	the shower room the	shower bed was wheeled		assistants. The purpose of the	ereturn	
	over the drain in the f			demonstration is to ensure sta		
		p to the side and the head of		demonstrate a successful kno	-	
	the bed released drop			safe operational procedures d		
	-	nt falling off of the shower		shower bed/chair transport. Fo	-	
	bed headfirst onto the			identified concerns during the		
		ise to the back of her head		demonstration, staff will be im		
	resident was transpor	er lower back area. The		retrained and only allowed to or shower transport equipment or	-	
			1			1

Facility ID: 955450

If continuation sheet Page 26 of 37

	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345487	B. WING		C 03/05/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•
				110 MCCOTTER BOULEVARD	
CHERRY I	POINT BAY NURSING AN	ND REHABILITATION CENTER		HAVELOCK, NC 28532	
(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 ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLÉTIC
F 726	Continued From page	<u>-</u> 26	F 72	26	
	the resident had a bro		1 72	demonstrations were comple 2/2/2024. After 2/2/24, any nu aide who has not completed	urse or nurse
	failure to train and ve	began on 2/01/24 when the rify competency of NAs to wer bed resulted in Resident ower bed to the floor		demonstration with the SDC it before working their next so shift. Any newly hired nurses assistants will be educated b	will complete heduled and nurse
	headfirst. The immed on 3/02/24 when the acceptable credible a	diate jeopardy was removed		orientation regarding safe op procedures during shower ch transport with the completion demonstration before using the	erational air/bed of a return
	compliance at a lowe (no actual harm with	r scope and severity of D potential for more than not immediate jeopardy) to		On 3/1/24, the SDC initiated	
(I n e		d monitoring systems put into		demonstration of shower cha with all nurses and nursing as The purpose of the return de	ssistants.
	Findings included:			is to ensure staff demonstrate successful knowledge of safe	
	This tag is cross-refe	renced to:		procedures during shower ch For any identified concerns d	
		rd review, observation, staff, d physician interviews, the the manufacturer's		return demonstration, staff wi immediately retrained and on operate shower transport equ	ly allowed to
	instructions for the us bed utilized for the pr	se of a mobile shower bed (a ovision of personal care for mobile or who have reduced		they pass the return demonstrations were c 3/1/24. After 3/1/24, any nurs	ration. The completed by
	mobility) and to provi resident reviewed for	de care safely for 1 of 1 supervision to prevent		aide who has not completed demonstration with the SDC	the return will complete
	transported Resident the shower bed witho	24 Nursing Assistant (NA) #1 #1 to the shower room via put utilizing the locking pins		it before working their next so shift. All newly hired nurses a assistants will be educated by	and nursing y the SDC
	place. While transpor	d and the foot of the bed in ting the resident to the t of the shower bed released		during orientation regarding s operational procedures during chair/bed transport with the c	g shower
	and dropped toward t cease the transport.	to the floor. NA #1 did not She continued to push the er bed to the shower room.		return demonstration prior to equipment. The Director of N (DON) will provide oversight	using the lursing
		shower room when the		education and return demons	

Facility ID: 955450

If continuation sheet Page 27 of 37

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURV COMPLETE	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			D
		345487	B. WING		C 03/05/2	024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CHERRY	POINT BAY NURSING AN	ND REHABILITATION CENTER		110 MCCOTTER BOULEVARD HAVELOCK, NC 28532		
(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 S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE CO	(X5) MPLETIO DATE
F 726	Continued From page	e 27	F 72	3		
	shower bed was whe floor, the bed became the side and the head dropping toward the f falling off of the show floor. The resident su back of her head and back area. The reside hospital on 2/01/24 at on 2/02/24, the reside seizure. An interview on 2/27/ Development Coordin she had been SDC for not provided training shower bed for nursin stated that the skills of training for shower be	eled over the drain in the e unsteady, began to tip to d of the bed released floor resulting in the resident er bed headfirst onto the stained a small bruise to the an abrasion to her lower ent was transported to the t 11:01 AM. At the hospital ent had a breakthrough 24 at 1:13 PM with the Staff nator (SDC) revealed that or about one year and had for the safe operation of the ng assistants or nurses. She checklists do not include		 nurses and nursing assistants to staff knowledge and understandeducation received. The SDC/QA nurse will complete observations of nursing staff pe safety checks on shower bed/ch safely transporting via shower eveckly x4 weeks then monthly 3. The Director of Nursing (DON) a Nursing Home Administrator (N observation audits weekly x4 we monthly x3 months. The DON and/or NHA will audit hired nurses and nursing assist training education weekly x4 we monthly x3 months to ensure st trained during orientation regard operational procedures of show beds/chairs and have provided 	ting of the e 10 rforming nair and quipment k3 months. and/or the HA) review eeks then all newly ants eeks then aff are ding safe er	
	immediate jeopardy r Survey Agency return to validate. The imme plan could not be vali have sufficient evider completed for staff. If received education. provide a revised cree jeopardy removal.	a credible allegation of emoval and the State ned to the facility on 3/01/24 ediate jeopardy removal dated as the facility failed to nee that education was Multiple staff working had not The facility was asked to dible allegation of immediate		demonstrations. The DON and/or NHA will prese findings of the staff observations training record audits to the Qua Assurance Performance Improv (QAPI) Committee monthly for 3 QAPI Committee will review audits/observations to determin and/or issues that may need fur interventions and the need for a monitoring	s and ality rement 3 months. e trends ther	

Facility ID: 955450

If continuation sheet Page 28 of 37

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345487	B. WING				C 105/2024
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CHERRY	POINT BAY NURSING AN	ID REHABILITATION CENTER			10 MCCOTTER BOULEVARD IAVELOCK, NC 28532		
(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 726	a result of the norm On 2/1/24 at 02:50 ar Resident #1 to the sh bed. The head of the elevated position, and was not in an elevated the shower room, the the drain in the floor, unsteady and begin to bed jarred, and the he support fell. NA #1 pro- from completely tippin resident's body slid of floor. NA #1 called for The nurse completed of Resident #1 and no back of the head and The resident was ass mechanical lift onto the to the room. Neuro ch 3:00 am to 9:00 am w 8:05 am, the facility N notified of the status of orders. At 10:00 am, on nurse noted nystagme eye movement) and r NP assessed the resi send to the emergence evaluation and treatment the resident had a 2-r and was treated for so Additionally, the resid persistent vegetative cerebral parenchymal nature, all unrelated to All residents who are	npliance; n, Nursing Assistant #1 took ower room via the shower shower bed was in an d the foot of the shower bed d position. While entering wheel of the shower bed hit causing the bed to become o tip to the side. The shower ead of the bed (HOB) evented the shower bed ng to the side. However, the ff the shower bed onto the assistance. a head-to-toe assessment oted a hematoma to the a bruise on the lower back. isted up from the floor via he shower bed and returned hecks were completed from with no negative findings. At lurse Practitioner (NP) was of the resident with no new during a neuro check, the us (repetitive, uncontrolled eported this to the NP. The dent with a new order to cy room for further hent. While at the hospital, minute breakthrough seizure eizure-like activity. ent was admitted for a state, and a small area of I hemorrhage chronic in	F	726			

If continuation sheet Page 29 of 37

CENTER	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES				FORM OMB NC): 03/22/2024 1 APPROVED 0. 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		345487	B. WING		_		。 05/2024	
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE			
CHERRY I	POINT BAY NURSING AN	ID REHABILITATION CENTER		10 MCCOTTER BOULEVA	NRD			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 726	Continued From page Director of Nursing id utilizing a census she	entified these residents	F 726					
	by the Administrator a root cause of the fall v assistant transported room without being pr	the resident to the shower roperly educated on the safe for using the shower bed						
	process or system fai	e entity will take to alter the lure to prevent a serious n occurring or recurring, and e complete						
	Quality Assurance Nu staff regarding observ during residents' show Questionnaires were After 2/2/24, the Staff monitored staff compl nurse aide who has n	etion and any nurse or ot completed the nplete these before working						
	return demonstrations with all nurses and nu purpose of the return staff demonstrate a su operational procedure transport. For any ide return demonstration, retrained and only allo transport equipment of demonstration. The re	demonstration is to ensure uccessful knowledge of safe						

Facility ID: 955450

If continuation sheet Page 30 of 37

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345487	B. WING				C / 05/2024
NAME OF P	ROVIDER OR SUPPLIER		1	S	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
CHERRY	POINT BAY NURSING AN	ID REHABILITATION CENTER			110 MCCOTTER BOULEVARD HAVELOCK, NC 28532		
(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 726	Development Nurse r and any nurse or nurs completed the return it before working their On 3/1/24, the Staff D return demonstrations with all nurses and nu purpose of the return staff demonstrate a si operational procedure transport. For any ide return demonstration, retrained and only all transport equipment of demonstration. The re completed by 3/1/202 Development Nurse r and any nurse or nurs completed the return it before working their The Director of Nursin the education and ret staff to validate staff fe understanding of edu Any newly hired nurse be educated by the S during orientation reg procedures during sh with the completion o before using the equi Development Nurse v responsibility by the A 3/1/24, the Staff Deve instructed by the Adm responsibility to include	nonitored staff completion se aide who has not demonstration will complete r next scheduled shift. Development Nurse initiated s of shower chair transport ursing assistants. The demonstration is to ensure uccessful knowledge of safe es during shower chair ntified concerns during the staff will be immediately owed to operate shower once they pass the return eturn demonstrations were et. After 3/1/24, the Staff nonitored staff completion se aide who has not demonstration will complete r next scheduled shift. In g will provide oversight of urn demonstrations of all showledge and cation. es and nurse assistants will taff Development Nurse arding safe operational ower chair/bed transport f a return demonstration pment. The Staff vas notified of this administrator on 2/1/24. On elopment Nurse was	F	726			

If continuation sheet Page 31 of 37

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345487	B. WING				C / 05/2024
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CHERRY F	POINT BAY NURSING AN	ID REHABILITATION CENTER			10 MCCOTTER BOULEVARD IAVELOCK, NC 28532		
(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 726 F 867 SS=D	The credible allegation removal was verified of conducted with a same and Nurses to verify ef Nurses and NAs regats safety. Documentation reviewed. In an interview on 3/0 Staff Development Co all Nurses and Nursin in-serviced on the sho She stated that she w new nurses and nursi operational procedure transport and use. The facility's immedia 3/02/24 was validated QAPI/QAA Improvem CFR(s): 483.75(c)(d)(0 §483.75(c) Program ff monitoring. A facility must establis policies and procedur collections systems, a adverse event monito procedures must inclu- following: §483.75(c)(1) Facility systems to obtain and	 hired staff. Removal Date: 3/2/24 n of immediate jeopardy on 3/05/24. Interviews were aple of Nursing Assistants education was conducted for rding shower bed/chair in of in-service records was 5/24 at 10:28 AM with the bordinator, she stated that g Assistants had been ower bed/chair for safety. ras responsible for orienting ing assistants on the safe e during shower bed/chair te jeopardy removal date of l. ent Activities (e)(g)(2)(i)(ii) eedback, data systems and sh and implement written es for feedback, data and monitoring, including 		367			3/6/24
	systems to obtain and	l use of feedback and input					

Facility ID: 955450

If continuation sheet Page 32 of 37

	MENT OF HEALTH AN S FOR MEDICARE & I		FORM APPROVED OMB NO. 0938-0391				
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345487	B. WING				C 05/2024
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CHERRY	POINT BAY NURSING AN	ID REHABILITATION CENTER			10 MCCOTTER BOULEVARD IAVELOCK, NC 28532		
(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 867	information will be use are high risk, high vol opportunities for impr §483.75(c)(2) Facility systems to identify, co information from all do not limited to the facil §483.70(e) and include will be used to develop indicators. §483.75(c)(3) Facility and evaluation of per- including the methode development, monitor §483.75(c)(4) Facility including the methode systematically identify analyze and use data adverse events in the facility will use the da prevent adverse ever §483.75(d) Program s systemic action. §483.75(d)(1) The fac aimed at performance implementing those a and track performance implement policies action	res, including how such ed to identify problems that ume, or problem-prone, and ovement. maintenance of effective oblect, and use data and epartments, including but ity assessment required at ling how such information p and monitor performance development, monitoring, formance indicators, ology and frequency for such ring, and evaluation. adverse event monitoring, s by which the facility will <i>x</i> , report, track, investigate, and information relating to facility, including how the ta to develop activities to its. systematic analysis and cility must take actions e improvement and, after ctions, measure its success, e to ensure that alized and sustained.	F	867			

Facility ID: 955450

If continuation sheet Page 33 of 37

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345487	B. WING				C 05/2024
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	(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 867	determine underlying impacting larger syste (ii) How they will dever will be designed to effi- level to prevent qualit safety problems; and (iii) How the facility wi of its performance impover §483.75(e) Program a §483.75(e)(1) The face performance improve high-risk, high-volume consider the incidence of problems in those a outcomes, resident sa- resident choice, and o §483.75(e)(2) Perform activities must track n resident events, analy implement preventive that include feedback facility. §483.75(e)(3) As part improvement activities distinct performance in number and frequence conducted by the faci and complexity of the available resources, a assessment required Improvement projects annually a project tha	causes of problems ems; elop corrective actions that fect change at the systems y of care, quality of life, or all monitor the effectiveness provement activities to hents are sustained. activities. clility must set priorities for its ment activities that focus on e, or problem-prone areas; e, prevalence, and severity areas; and affect health afety, resident autonomy, quality of care. nance improvement hedical errors and adverse /ze their causes, and actions and mechanisms and learning throughout the of their performance s, the facility must conduct mprovement projects. The y of improvement projects lity must reflect the scope facility's services and as reflected in the facility	F	867	7		

If continuation sheet Page 34 of 37

		D HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		LETED
		345487	B. WING			C 05/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				110 MCCOTTER BOULEVARD		
CHERRIN	OINT BAT NURSING AN	ID REHABILITATION CENTER		HAVELOCK, NC 28532		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 867	 (c) and (d) of this sect §483.75(g) Quality as §483.75(g)(2) The quassurance committee governing body, or defunctioning as a gove activities, including im program required und (e) of this section. The (ii) Develop and impleted to correct ident (iii) Regularly review at data collected under the resulting from drug reavilable data to mak This REQUIREMENT by: Based on record reviper facility's Quality Asset (QAA) committee failed procedures and monit committee put into plate recertification and correct of 4/20/23. This was for free of Accident has (F689) that was subsecturent complaint invertified and surveys of record failure federal surveys of record failure federal surveys of record failure failure 	s described in paragraphs tion. sessment and assurance. ality assessment and reports to the facility's esignated person(s) rning body regarding its oplementation of the QAPI ler paragraphs (a) through e committee must: ement appropriate plans of ified quality deficiencies; and analyze data, including the QAPI program and data gimen reviews, and act on e improvements. is not met as evidenced ew, observation, nurse h, and staff interviews, the ssment and Assurance ed to maintain implemented tor interventions that the ace following the mplaint investigation survey for the deficiency in the area azards/Supervision/Devices equently recited on the estigation survey of 3/05/24.	F 86	On 2/28/2023, The Facility Consultant initiated an audit of previous citations action plans to include F689 Free of Accident Hazards/Supervision/Device ensure the QAPI committee has maintained and monitored interventio that were put into place. Action plans revised and updated and presented to QAPI Committee by QA Nurse for any concerns identified. The Facility Consultant will address all concerns identified during the audit to include b not limited to the education of staff. A was completed by 3/1/2024. On 3/1/2024, the Facility Consultant completed an inservice with the	and es to ns were o the / ut	
	Findings included:			-	DN)	

Event ID: SBYR11

Facility ID: 955450

If continuation sheet Page 35 of 37

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/2 FORM APPR OMB NO. 0938	ROVE
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C	(
		345487	B. WING		03/05/202	24
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CHERRY I	POINT BAY NURSING AN	ID REHABILITATION CENTER		110 MCCOTTER BOULEVARD HAVELOCK, NC 28532		
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPL	(5) LETIO ATE
F 867	Continued From page	2 35	F 86	7		
	This tag is cross-refe			and Quality Assurance (QA) Nu regarding the Quality Assuranc		
	nurse practitioner, an facility failed to follow instructions for the us bed utilized for the pr residents who are imm mobility) and to provid resident reviewed for accidents. On 2/01/2 transported Resident the shower bed without that secured the head place. While transport shower room the foot and dropped toward to cease the transport. resident in the shower Once arriving in the s	ee of a mobile shower bed (a ovision of personal care for mobile or who have reduced de care safely for 1 of 1 supervision to prevent 24 Nursing Assistant (NA) #1 #1 to the shower room via out utilizing the locking pins d and the foot of the bed in ting the resident to the of the shower bed released to the floor. NA #1 did not She continued to push the or bed to the shower room. hower room when the		 process to include implemental Action Plans, Monitoring Tools of time for monitoring, the evaluation the QA process, and modification correction if needed to prevent reoccurrence of deficient practicient include professional standards, also included identifying issues warrant development and estall system to monitor the correction implement changes when the ecoutcome is not achieved and su an effective QA process. All ne Administrator, DON, and QA nu educated during orientation reg QA Process. All data collected for identified and the context of the co	tion of and length uation of on and the ce to . Inservice that blishing a ns and expected ustaining wly hired urse will be garding the	
	floor, the bed became the side and the head dropping toward the f falling off of the show floor. The resident su back of her head and back area. The reside hospital on 2/01/24 at	loor resulting in the resident er bed headfirst onto the stained a small bruise to the an abrasion to her lower ent was transported to the t 11:01 AM. At the hospital ent had a breakthrough		concerns to include F689 Free Hazards/Supervision/ Devices taken to the Quality Assurance Performance Improvement (QA committee for review monthly x then Quarterly x3 quarters by the Assurance Nurse. The QAPI co will review the data and determ plans of correction are being for changes in plans of action are improve outcomes, if further state education is needed, and/or if i monitoring is required. Minutes	will be API) 3 months he Quality ommittee nine if the illowed, if required to aff ncreased	
	investigation survey of cited for failure to pro	of 4/20/23, the facility was vide a safe transfer by lependent resident. The prevent a cognitively n known exit seeking		Quality Assurance Committee documented monthly at each m the QA Nurse. The Facility Nurse Consultant w the QA meeting minutes month	will be neeting by will review	

Facility ID: 955450

If continuation sheet Page 36 of 37

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						PRINTED: 03/22/2024 FORM APPROVED OMB NO. 0938-0391	
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 03/05/2024		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		1 00.00.202		
CHERRY POINT BAY NURSING AND 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 PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E	I SHOULD BE COMPLETION		
F 867	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 867	PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIA			

Facility ID: 955450

If continuation sheet Page 37 of 37