STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345002	A. BUILDING ______ B. WING ______	C 09/17/2020

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CYPRESS POINTE REHABILITATION CENTER	2006 SOUTH 16TH STREET WILMINGTON, NC 28401

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted on-site from 09/08/20 through 09/11/20 and continued through 09/17/20 with remote record review. 4 of 47 complaint allegations were substantiated with deficiency. Event ID #S0Q411.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on physician interview, staff interview, and record review the facility failed to communicate with the discharging hospital about medications to ensure that a resident receiving an anti-Parkinsonian medication did not miss any doses and the timing of the medication was kept consistent and failed to follow a physician order to obtain vital signs for 1 of 14 sampled residents (Resident #12) whose physician orders were reviewed. Findings included: 1. Record review revealed Resident #12 was admitted to the facility on 08/25/20. The resident's documented diagnoses included Parkinson's disease, dementia with Lewy bodies, atrial fibrillation, diabetes, and atherosclerotic heart disease. a. Resident #12's 08/22/20 hospital History and Physical (H & P) documented, " ...Presents to the hospital as a transfer from ED (emergency department) with progressively worsening	F 658	Cypress Pointe Nursing and Rehabilitation Center wishes to point out to any person who reviews this document that we do not necessarily agree with this citation in which we were cited. However the law requires us to prepare a plan of correction for the citations regardless of whether we agree with them. Thus, we have prepared such a plan as outlined below. Please note, though that this plan does not constitute an admission that the citations are either legally or factually correct. This plan of correction is not meant to establish any standard of care, contract, obligation or position and Cypress Pointe reserves the rights to raise all possible contentions and defense in any civil or criminal claim, action or proceeding. Please accept September 18th as our date of compliance with the noted deficiencies.	9/18/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 09/23/2020

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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F 658 Continued From page 1

dizziness, speech changes, and mild confusion. Patient has a history of Lewy body dementia ...and Parkinson's disease. (Has) been noted that he has speech changes with his providers in the past. Likely attributed to his Parkinson's disease. He reports that it is just rapidly progressing (and) is concerned about his home safety ....Assessment and Plan: Continue home medications (Sinemet three times daily was one of those documented medications)."

A 08/25/20 Hospital Discharge Summary documented, "Continue these medications which have not changed: carbidopa-levodopa 25-100 milligrams (mg) one tablet three times daily (TID), Sinemet controlled release (CR)....Discharge Diagnoses: 1. Progression of Parkinsonian symptoms." The summary did not document the last time the resident received Sinemet at the hospital or the administration times of the medication in the hospital.

Review of Resident #12's hospital Medication Administration Record (MAR), which did not accompany the resident to the receiving nursing home, documented the last time the resident received Sinemet in the hospital was at 8:56 AM on 08/25/20. The MAR documented the resident's next dose of Sinemet was due at 3:00 PM on 08/25/20 (but he did not receive this dose at the hospital).

Review of the resident's nursing home admission assessments revealed the facility began them at 4:45 PM on 08/25/20.

Review of Resident #12's nursing home August 2020 (MAR) revealed he did not receive any Sinemet in the facility on 08/25/20, but received a

F 658

F658 Services Provided Meet Professional Standards

1. Resident #12 was discharged and no longer resides at Cypress Pointe.

2. Like Residents (Admissions) were audited and no similar findings were observed.

3. The Admissions Director was educated to obtain a current and accurate MAR prior to admission to Cypress Pointe. The charge nurses were provided with education by the DON to ensure documentation supported the MAR had been received and reviewed from the discharging entity. The Charge nurses were educated by the DON on appropriately obtaining and recording vital signs on new admissions.

4. The DON/designee will conduct audits on all new admissions to the center daily for a minimum of eight weeks to ensure the MAR was obtained from the discharging hospital and administered medications are clear at the time of admission and vital signs were documented according to MD order.

5. Corrective actions have been implemented as of September 18, 2020. The QA team will review, analyze and report the results at the monthly performance improvement committee meetings as well as daily QA meetings to validate compliance is achieved and sustained. Subsequent plans of correction will be implemented as deemed necessary/appropriate by this committee.

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F 658	Continued From page 2	F 658		

morning dose of Sinemet on 08/26/20. The administration times documented on the facility MAR for the resident's Sinemet were 8:00 AM, 12 noon, and 4:00 PM on 08/25/20 and 08/26/20. The administration times were changed to 8:00 AM, 2:00 PM, and 8:00 PM starting on 08/27/20.

According to LexiComp (a comprehensive on-line drug database), "Intervals between doses of Sinemet CR should be 4 - 8 hours while awake. Take (Sinemet) at the same time every day. Space doses evenly over the waking hours."

The resident's 08/28/20 5-day Medicare assessment documented his cognition was severely impaired, he exhibited no behaviors including rejection of care, and he was independent to requiring extensive assistance from a staff member with his activities of daily living (ADLs).

During a telephone interview with the facility's Consultant Pharmacist on 09/11/20 at 9:54 AM she stated Sinemet should be given at the same time daily, and for the best results in controlling abnormal movements, there should not be missed doses of the medication.

During a telephone interview with the facility's Pharmacy Manager on 09/11/20 at 10:03 AM she stated on 08/25/20 the pharmacy did not receive medication orders for Resident #12 until 7:42 PM. Therefore, she explained the next time the facility could send out the resident's medications was at 12 noon on 08/26/20. She reported the facility obtained Resident #12's first two doses of Sinemet on 08/26/20 from the Omnicell (a machine system used to store, dispense, and track medications). She reported according to

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F 658	Continued From page 3	F 658		

pharmacy records on 08/26/20 Sinemet was withdrawn from the Omincell at the facility at 10:16 AM and 1:07 PM.

During a telephone interview with the Director of Nursing (DON) on 09/11/20 at 10:09 AM she stated sometimes the resident arrived at the facility before their orders since the hospital was right across the street. She reported that for TID medication orders the facility's medication system pre-populated administration times of 8:00 AM, 12 noon, and 4:00 PM. She commented the facility could input its own administration times only if the order was written for administration every eight hours. She stated when the resident's medication orders were reviewed with the primary physician on 08/27/20 he changed the TID administration times. After reviewing Resident #12's August 2020 MAR, she commented the resident did not receive any Sinemet from the facility on 08/25/20, and the morning dose on 08/26/20 was administered late. According to the DON, it was recommended to give Sinemet at about the same time every day.

During a follow-up telephone interview with the facility's DON on 09/11/20 at 1:57 PM she stated Resident #12's primary physician was still in the building on 08/26/20, and was informed that the resident's Sinemet was administered late with a scheduled time of 8:00 AM and actual administration time of after 10:16 AM on 08/26/20. She reported the physician just advised the staff to provide the other two doses of Sinemet that day per orders that accompanied the resident from the hospital.

During a telephone interview with Resident #12's primary physician on 09/16/20 at 11:06 AM he

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F 658	Continued From page 4	F 658		

stated Resident #12 was on a low, starting dose of Sinemet so he did not think two missed doses, followed by late administration of the medication the next morning would have caused the resident any long-lasting harm. However, he reported there could have been better communication between the nursing home and hospital to have promoted continuity of the Sinemet dosing because once the most effective administration times were established for a resident the medication needed to be provided at about the same time every day without any missed doses.

b. A 08/26/20 physician order was implemented for Resident #12 at 3:00 PM for vital signs each shift x 7 days, then daily.

Review of vital signs and progress notes revealed the following blood pressure readings for Resident #12: 08/25/20 at 4:50 PM 122/58 lying, 08/27/20 at 5:34 AM 160/108 lying, 08/27/20 at 1:45 PM 148/80 lying, 08/28/20 11:40 PM 141/64 lying, 08/29/20 2:26 AM 115/52 lying, 08/29/20 2:17 PM 136/86 sitting, 08/30/20 12:34 AM 136/84 other, 08/30/20 1:18 PM 127/68 lying, and 08/31/20 12:41 AM 126/68 other. (A blood pressure was not obtained for Resident #12 on second shift 08/26/20, on second and third shift 08/27/20, on first shift 08/28/20, on second shift 08/29/20, on second shift 8/30/20, and any shifts on 09/01/20 before the resident was discharged home against medical advice).

During a telephone interview with Nurse #6 on 09/14/20 at 11:37 AM she stated that all residents admitted to the facility had the vital sign protocol order, and vital signs were documented each shift on the MAR for the first seven days in the facility and then daily thereafter. She reported blood

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F 658	Continued From page 5	F 658		

pressure readings were part of the vital sign protocol. She explained if nursing assistants (NAs) obtained the vital signs then the nurse was supposed to transpose them onto the MAR.

During a telephone interview with Resident #12's primary physician on 09/16/20 at 11:06 AM he stated residents with Parkinson's disease often had accompanying autonomic dysfunction which involved experiencing erratic blood pressures. He explained Parkinson patients with autonomic dysfunction often registered elevated blood pressure readings when they were in the supine position (laying down), but the blood pressure frequently normalized when the residents were asked to sit or stand. He reported Resident #12 experienced autonomic dysfunction when he was alerted about a blood pressure of 160/108 in the early morning of 08/27/20. According to the physician, frequent monitoring of the blood pressure was a good practice for residents with Parkinsonian-associated autonomic dysfunction.

During a telephone interview with the Director of Nursing (DON) on 09/16/20 at 12:13 PM she stated the physician order for vitals every shift x seven days after admission was a facility protocol designed to gather as much information as possible about the resident to establish baseline health status and monitor the resident during adjustment to the nursing home environment. The DON reported the vital sign information should be collected as documented in the order so the facility would have the maximum data to utilize in making decisions about resident care and quality of life.