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 06/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS POINTE REHABILITATION CENTER	2006 SOUTH 16TH STREET WILMINGTON, NC 28401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments The survey team entered the facility on 06/21/21 to conduct a Recertification and Complaint Investigation survey. The survey team was onsite 06/21/21-06/24/21. Additional information was obtained offsite on 06/25/21. Therefore, the exit date was 06/25/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# FPLQ11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 06/21/21-06/24/21 to conduct an unannounced Recertification and Complaint Investigation. Additional information was obtained offsite on 06/25/21. Therefore, the exit date was 06/25/21. 0 of the 16 complaint allegations were substantiated. Event ID# FPLQ11.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to accurately code the dental status of a resident for 1 of 2 residents reviewed for dental care (Resident #3). Findings included: Resident #3 was admitted to the facility on 6/30/17. Resident #3's dental care visit documentation dated 8/14/19 revealed the resident was	F 641	F641 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	6/30/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/30/2021

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F 641	Continued From page 1 assessed by the dental hygienist to have no teeth. Resident #3's minimum data set assessment dated 3/18/21 revealed the resident was coded "no" for the question if the resident had, "no natural teeth or tooth fragment(s) (edentulous)." During observation on 6/22/21 at 11:43 AM Resident #3's mouth was observed to not have teeth. During an interview on 6/22/21 at 11:52 AM MDS Nurse #1 stated the minimum data set assessment dated 3/18/21 for Resident #3 was incorrect and the resident did not have any teeth. During an interview on 6/22/21 at 12:25 PM the Administrator stated the minimum data set should accurately reflect resident dental status.	F 641	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 June 30, 2021 as our allegation of compliance. HOW WILL THE CORRECTIVE ACTION ME ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? 1. Resident #3 had a corrected assessment submitted June 22, 2021 following identification of the clerical error. Resident #3 did not have a negative outcome as a result of this finding. 2. Root Cause: A clerical error occurred when completing the assessment for Resident #3. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE? 3. An audit was conducted by the DON/Designee June 22, 2021 following identification. There were no similar findings as a result of this audit. WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES	

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F 641	Continued From page 2	F 641	MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR? 4. The DON/Designee will conducted re-education with the MDS nurses on June 29,2020. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR? 5. Audits will be conducted three times a week for eight weeks by the center DON or Designee regarding accurate coding of Edentulous Residents. The QA team will review, analyze and report the results at the monthly performance improvement committee meetings to validate compliance is achieved and sustained and implement any changes to this auditing/monitoring if recommended/appropriate. Subsequent plans of correction will be implemented as deemed necessary/appropriate by this committee.	