

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  <b>345002</b>	MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	DATE SURVEY COMPLETE:  <b>9/1/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CYPRESS POINTE REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2006 S 16TH STREET WILMINGTON, NC</b>
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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<b>F 157</b>	<p><b>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</b></p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e) (2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, family and staff interviews the facility failed to notify the Responsible Party of falls for 2 of 3 residents reviewed (Resident #27 and #53). The findings included: 1a. Resident #27 was admitted to the facility on 12/30/14 and had a diagnosis of Dementia. The Quarterly Minimum Data Set Assessment dated 7/7/15 revealed the resident had severe cognitive impairment. Review of an incident report dated 8/9/15 at 12:08AM revealed the resident was found on the floor in the room by the bed. The report revealed there was no injury as a result of the fall. Under the section titled " Agencies/People Notified Agency/Person " read: " No notifications found. " Review of the nurse ' s notes dated 8/9/15 revealed no information that the Responsible Party (RP) was notified of the fall. The nurse that documented the incident report was not available for an interview. On 9/1/15 at 5:00PM the Director of Nursing (DON) was observed to review the incident report and the nurse ' s notes for Resident #7. The DON stated she did not see where the RP was notified. The DON stated when a resident falls, it was expected the RP be notified and the information documented. 1b. Resident #27 was admitted to the facility on 12/30/14 and had a diagnosis of Dementia. The Quarterly Minimum Data Set Assessment dated 7/7/15 revealed the resident had severe cognitive impairment. Review of an incident report dated 8/9/15 at 6:50AM revealed the resident was found on the floor beside the bed. The report revealed there was no injury as a result of the fall. Under the section titled " Agencies/People Notified Agency/Person " read: " No notifications found. " Review of the nurse ' s notes dated 8/9/15 revealed no information that the Responsible Party (RP) was notified of the fall. The nurse that documented the incident report was not available for an interview. On 9/1/15 at 5:00PM the Director of Nursing (DON) was observed to review the incident report and the nurse</p>
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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

The above isolated deficiencies pose no actual harm to the residents

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<b>F 157</b>	<p>Continued From Page 1</p> <p>'s notes for Resident #7. The DON stated she did not see where the RP was notified. The DON stated when a resident falls, it was expected the RP be notified and the information documented.</p> <p>2. Resident #53 was admitted to the facility on 6/5/15 and had a diagnosis of Senile Dementia. The Admission Minimum Data Set Assessment dated 6/12/15 revealed the resident had short and long term memory loss and cognitive abilities were moderately impaired.</p> <p>Review of the incident report revealed the resident had a fall on 8/25/15 at 4:00PM. Under the section " Agencies/People Notified Agency/Person ", there was no information documented to indicate the Responsible Party (RP) was notified. Review of the nurse 's notes for the resident dated 8/25/15 revealed no information that the RP was notified of the fall.</p> <p>In an interview on 8/31/15 at 11:40AM the Responsible Party (RP) stated she called the facility to see how the resident was doing and was told the resident had fallen. The RP stated no one from the facility notified her of the fall.</p> <p>On 9/1/15 at 12:45PM an interview was conducted with Nurse #2 who completed the incident report for the resident 's fall on 8/25/15. Nurse #2 stated when she got in the room the staff had already gotten the resident back to bed and the Day Shift Supervisor told her she had it taken care of.</p> <p>The Day Shift Supervisor stated in an interview on 9/1/15 at 2:10PM she did not notify the RP of the resident 's fall.</p> <p>The Director of Nursing stated in an interview on 9/1/15 at 5:00PM when a resident had a fall she expected the RP to be notified and the information documented.</p>		