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 05/09/2019

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 An unannounced Recertification/Complaint investigation survey was conducted on 05/06/19 through 05/09/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 80HM11.	E 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to provide feeding assistance to 1 of 1 residents sampled (Resident #76) who required extensive one-person assistance with eating. Resident # 76 was admitted to the facility on 4/10/19 with active diagnoses that included, left arm fracture, muscle weakness, dysphagia, urinary tract infection, diabetes, and dementia. A review of the most recent Minimum Data Set (MDS) dated 5/1/19 and coded as a change of therapy assessment indicated Resident #76 had moderately impaired cognition and required extensive one-person physical assistance with activities of daily living including eating. A review of the care plan dated 4/12/19 revealed Resident #76 had increased risk for nutrition and dehydration due to a therapeutic diet with altered	F 558	Preparation and execution of this plan of correction, does not constitute admission or agreement of the alleged facts set fourth in this statement of deficiency. The plan of correction is prepared and or executed due to Federal and State requirements. F558 Reasonable accommodations of needs 1. Resident #76□s intake records were reviewed with the physician and IDT to determine if additional interventions were required. 2. Root cause: The staff failed to document the efforts to provide adequate attempt in providing nourishment to Resident #76. 3. An audit was conducted on other residents residing in the facility on 5-20-2019 to ensure that all residents	5/28/19

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

Electronically Signed | 05/21/2019

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F 558	Continued From page 1 texture, and diagnoses. The goal was the Resident would consume 75% of meals and fluids. Interventions in part were to assist with meals as needed, observe diet intolerance and adjust as needed, dietary screening as needed, encourage fluid intake, encourage and monitor meal intake, and weekly weights. A review of the weekly weights recorded from 4/10/19 through 5/8/19 revealed a 10-pound weight loss, or 6.43% in less than one month. A review of the Nutrition Comprehensive Evaluation Risk Screen dated 4/23/19 documented Resident #76 had inadequate meal intake and needed assistance with eating. An observation was conducted on 5/7/19 at 12:45 PM. Resident #76 was lying in bed sleeping, and easily aroused. Her lunch tray with pureed foods of chicken, vegetables, and mashed potatoes were on the bedside table untouched. An unopened carton of the nutritional supplement was on her meal tray. The nurse aide who removed the meal tray from the room stated it looked as though the resident had not eaten anything. On 5/7/19 at 12:45 PM, Resident #76 stated she did not know if she had eaten anything for breakfast or lunch. An interview was conducted on 5/8/19 at 12:38 PM with nurse aide #4. She stated Resident #76 received meal tray set up, and stated nurse aides would provide feeding assistance with meals at times if the resident needed it. An observation of Resident #76 was conducted	F 558	requiring extensive assistance with eating were provided with appropriate support for this ADL. An audit was conducted to ensure appropriate education was provided to line staff. The DON/designee will conduct re-education with nursing staff by 5/28/2019 on providing assistance to Residents requiring extensive assistance with eating. Audits will be conducted 3 times a week for 4 weeks to ensure that Residents requiring extensive assistance with eating receive the support needed. 4. The QA team will review, analyze and report the results at the monthly performance improvement committee 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 558	Continued From page 2	F 558		

on 5/9/19 at 8:40 AM. She was sleeping and would mumble when aroused. Her breakfast tray on the bedside table with lid covered appeared untouched.

An interview was conducted with Nurse #7 on 5/9/19 at 8:57 AM. She stated she was not sure how much breakfast Resident #76 had eaten and stated she did not see any nurse aides in her room during the breakfast meal to assist with her feeding.

An interview was conducted on 5/9/19 at 11:30 AM with nurse aide #3. She stated Resident #76 was disoriented most of the time and eats less than 25% of meals. She stated the aides provided meal tray set up for the resident or would assist with her feeding if needed.

An interview was conducted on 5/9/19 at 1:44 PM with the facility Speech Therapist. She stated Resident #76 had a significant cognitive decline since her admission to the facility. She stated the resident was pleasantly confused and did exhibit behaviors such a s yelling out at times. She agreed that the resident should be receiving staff assistance with her feeding for all meals.

An interview was conducted on 5/9/19 at 9:56 AM with the facility physician. He stated he was aware of Resident #76 ' s weight loss, her appetite was poor, and that she received nutritional supplements. He stated she did exhibit behaviors at times such as yelling out. He agreed that she did require extensive assistance with feeding.

An interview was conducted on 5/9/19 at 2:00 PM with the Director of Nursing. She stated its her

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F 558	Continued From page 3 expectation that staff are providing assistance with feeding for residents that require extensive assistance with eating.	F 558		
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 record review and staff interviews the facility failed to accurately code insulin on a Minimum Data Set (MDS) for 1 of 5 residents (Resident #79) reviewed for unnecessary medications. Findings included: Resident #79 was admitted to the facility on 10/06/17 and had diagnoses of diabetes, dementia, and anxiety disorder. Review of the quarterly MDS dated 04/30/19 revealed Resident #79 received one insulin injection during the seven day look back period. Review of the physician orders revealed insulin had not been ordered for Resident #79. However, Trulicity (a non-insulin GLP-1 receptor agonist) had been ordered to be injected weekly for diabetes. In an interview on 05/09/19 at 10:50 AM the MDS Nurse stated that when she filled out the medication section of the MDS she gathered the information from the Medication Administration Record (MAR). She stated that she thought Trulicity was an insulin and that was why she entered it that way. She indicated that it was a	F 641	F641 Accuracy of Assessments 1. Upon identification Resident #79 MDS was corrected to reflect the accurate medication class of Trulicity. (a non-insulin GLP-1 receptor agonist). There were no negative outcomes as a result of this documentation error. 2. Root Cause: MDS nurse was not aware Trulicity was not an insulin medication. 3. An audit was conducted by the facility MDS nurse following notification to ensure there were no similar findings. The DON/Designee conducted education to MDS staff regarding Trulicity and its medication actions/class. 4. The DON/Designee will conduct re-education to MDS staff regarding accuracy of assessments on or before 5/28/2019. Audits will be conducted 3 times a week for 4 weeks to ensure that medications are recorded in the appropriate medication class. 5. The QA team will review, analyze and report the results at the monthly performance improvement committee meetings to validate compliance is	5/28/19

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F 641	Continued From page 4 mistake and that she would correct it. In an interview on 05/09/19 at 2:26 PM the Director of Nursing (DON) indicated that she expected the information on the MDS to be recorded accurately so that the condition of the resident during the look back period reflected the correct status of the resident at that time.	F 641	achieved and sustained. Subsequent plans of correction will be implemented as deemed necessary/appropriate by this committee.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to ensure it was free of medication error rates greater than 5% as evidenced by 2 medication errors out of 25 opportunities, resulting in a medication error rate of 8% for 2 of 4 residents (Resident #27 and Resident #60) observed during medication administration. Findings included: During a medication administration observation on 05/08/19 at 10:40 AM Nurse #3 produced a packaged scored tablet of pramipexole 1.0 mg (milligram). The expiration date on the package was 12/14/18. Nurse #3 indicated she had removed the medication from the omnicell (a machine that provides a secure electronic system for managing medications) for administration to Resident #27. Nurse #3 broke the tablet in half explaining that the dose ordered was for 0.5 mg by mouth as a one-time dose. Nurse #3 turned to	F 759	F759 Medication error rates 1. Resident #27 did not receive an expired medication following notification. The medication was administered per Physicians order. Resident #60 received a one time order for the dose administered. There were no negative outcomes as a result of these findings. 2. Root cause: The charge nurse/s did not follow medication check process before administering medications. 3. An audit was conducted to ensure that all expired medications stored in the medication carts and omnicell's were not out of date. The DON/Designee will conduct re-education with nursing staff by 5/28/2019 regarding the facility policy on medication administration. Audits will be	5/28/19

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F 759	Continued From page 5 enter Resident #27's room and indicated she was ready to administer the medication. Nurse #3 was stopped at that time. In an interview on 05/08/19 at 10:43 AM Nurse #3 checked the packaging on the pramipexole and verified that the expiration date was 12/14/18. She indicated that a resident should never be administered an expired medication because it may not be as effective and that she had not realized that the medication had expired. During a medication administration observation on 05/09/19 at 9:20 AM Nurse #4 removed an Ativan 1.0 mg tablet from the locked narcotic drawer and administered the tablet to Resident #60. During a medication reconciliation on 05/09/19 at 9:35 AM Resident #60's May 2019 Medication Administration Record (MAR) revealed an order for Ativan 1.0 mg give 0.5mg by mouth every 12 hours as needed for anxiety. In an interview on 05/09/19 at 9:40 AM Nurse #4 was asked to review the order for the Ativan. After reading the order she verified that she should have administered 0.5 mg of Ativan to Resident #60 and not 1.0 mg. She stated she did not read through the complete order which caused her to administer the wrong dose of medication to Resident #60. In an interview on 05/09/19 at 2:26 PM the Director of Nursing (DON) stated that nurses should never give expired medications to residents as they might not work as well. She indicated that nurses should always read through the entire order prior to administering a	F 759	conducted 3 times a week for, four weeks to ensure medication error rates are below 5%. 4. The QA team will review, analyze and report the results at the monthly performance improvement committee 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 759	Continued From page 6 medication to make sure the correct dose of medication was administered. The DON indicated that the facility medication error rate should be less than 5% and that she would like for the rate to be zero.	F 759		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to discard expired medications stored in 1 of 1 omnicells (a machine system	F 761	F761 Label/store drugs and biologicals 1. Resident #27 did not receive an expired medication following notification. The	5/28/19

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F 761	Continued From page 7 used to store, dispense and track medications) and failed to keep unattended medications secured by leaving them on top of a medication cart for 1 of 4 medication carts observed. Findings included: 1. Review of the Omnicell Maintenance Visits report dated 03/18/19 by the Pharmacy Technician revealed that a partial audit of the Omnicell had been performed on drawers three, five, and seven. The report indicated that medication expiration dates were not being entered correctly into the Omnicell and were also not being updated correctly. The report revealed that the former Assistant Director of Nursing (ADON) and the Director of Nursing (DON) were present when the report was gone over by the Pharmacy Technician. In an observation and interview on 05/08/19 at approximately 10:45 AM Nurse #3 accessed the Station 2 Omnicell to remove pramipexole 1.0 mg (milligrams) from the machine. The storage drawer opened and multiple storage compartments with different medications and doses of medications were visualized. There were two doses of pramipexole 1.0 mg with the expiration date of 12/14/18 and two doses with the expiration date of 03/05/20 in the storage drawer compartment for that medication. The expiration dates were verified by Nurse #3 who proceeded to hand the expired medications to the Director of Nursing (DON). The DON stated that the pharmacist was responsible for checking the Omnicell for expired medications and removing them if they were expired. In a telephone interview on 05/08/19 at 12:07 PM the Pharmacist stated that the nurses were	F 761	medication was administered per Physicians order. 2. Root Cause: Nurse #3 failed to follow facility policy regarding medication administration 3. An audit was conducted to ensure that all expired mediation (which are medications that are repacked with expiration dates preceding expiration dates from the manufacturer) had been appropriately removed from the center. The DON/Designee will conduct re-education with nursing staff by 5/28/2019 regarding the procedure for restocking the omnicell. The DON/Designee will conduct audits 3 times a week for, four weeks to ensure that medications delivered to the omnicell are loaded correctly with the expiration date listed of the medication first to expire. 4. The QA team will review, analyze and report the results at the monthly performance improvement committee 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 761	Continued From page 8	F 761		

responsible for restocking the Omnicell when the medications were delivered from the pharmacy and that the pharmacists did not check the Omnicell. She indicated that she felt that the expiration dates were being entered incorrectly by the nurses and that this had caused there to be expired medications in the Omnicell.

In an observation and interview on 05/08/19 at 4:45 PM an audit of drawer #6 in the Station 2 Omnicell was conducted with the DON. Of the 279 medications in the multiple storage compartment drawer, 29 of the medications were expired. The amount of expired medications was confirmed by the DON. The DON indicated that when the nurse received a medication from the pharmacy that needed to go into the Omnicell it was scanned into the machine and the quantity was added. The nurse was then supposed to check the medication in the storage drawer compartment for the expiration dates on those medications and enter the expiration date that was closest to the present date as those would be the medications that would be expiring first. She indicated that the expiration dates were not being entered correctly.

In a telephone interview on 05/08/19 at 11:31 PM Nurse #5 stated she was the nurse who usually put the medications in the Omnicell when they came in from the pharmacy. She indicated that the process was that medications would come in about 3:30 AM and she would scan them into the Omnicell. She would then input the expiration date of the new medication that was going into the Omnicell and not the expiration date of the medication that would be expiring first from the storage drawer compartment.

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In an interview on 05/09/19 at 1:47 PM the Pharmacy Technician stated she was the one who checked the Omnicell, not the pharmacist. She indicated a 100% review was done annually and a quarterly spot check had been performed in March 2019. The Pharmacy Technician stated that the nurses were supposed to sign the medications into the Omnicell, update the quantity, and input the expiration date of the medication in the storage drawer compartment that would be expiring first. She stated that entering the expiration date of the medication that had just been delivered would update the expiration date and the Omnicell would not recognize that a medication that was already in the drawer would expire before the new medication. She indicated that this practice would cause expired medications to be found in the Omnicell.

In an interview on 05/09/19 at 2:26 PM the DON stated that there should never be expired medications in the Omnicell. She indicated that she thought a 100% audit of the Omnicell was performed each time the Pharmacy Technician came into the facility and not just annually. She indicated she was unaware that only partial audits were done the rest of the year. The DON stated that the nurses had been entering the expiration dates into the Omnicell incorrectly and that had caused there to be expired medications in the Omnicell. She stated that although the Maintenance Visit report showed her name, she had been busy with a resident and the ADON who was no longer employed at the facility, had gone over the report with the Pharmacy Technician. The DON stated if she had been aware of the report, training could have been done and there would not have been expired medications in the

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F 761	Continued From page 10 Omnicell. 2. In an observation on 05/07/19 at 10:59 AM an attended medication cart was seen outside the door of room 22. There were two bubble packs of medications on top of the cart. Xifacan (an antibiotic that fights infections only in the intestines) 550 mg 21 tablets and propranolol (a beta blocker which relaxes blood vessels, slows the heart rate, and decreases blood pressure) 10 mg 24 tablets. Nurse #6 approached the cart from around the corner of the hallway within approximately two minutes. During the time the cart was unattended two staff members were seen walking past the cart. In an interview on 05/07/19 at 11:01 AM Nurse #6 confirmed she was the nurse that was assigned to that medication cart. She indicated she was in the middle of something and that was why she left the medication unattended on top of the cart. She stated she knew she was not supposed to leave medications unattended on top of the cart because the facility had wandering residents and they could have taken the medications. Nurse #6 indicated that medications should be kept locked in the medication cart. In an interview on 05/09/19 at 2:26 PM the DON indicated that medications should be locked in the medication cart and not left unattended on top of the cart. She stated that if left on top of the cart, anyone could take the medications and the facility would not know about it.	F 761		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance.	F 867		5/28/19

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F 867	Continued From page 11 §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review the facility's quality assurance (QA) program failed to prevent the reoccurrence of deficient practice related to the medication administration process by having a medication error rate of 8% which resulted in a repeat deficiency at F759. The re-citing of F759 during the last year of federal survey history showed a pattern of the facility's inability to sustain an effective QA program. Findings included: This tag is cross-referenced to: F759: Medication Administration: Based on observation, record review and staff interviews the facility failed to ensure it was free of medication error rates greater than 5% as evidenced by 2 medication errors out of 25 opportunities, resulting in a medication error rate of 8% for 2 of 4 residents (Resident #27 and Resident #60) observed during medication administration. Findings included: Review of the facility's survey history revealed F759 was cited during the facility's 05/25/18 annual recertification/complaint investigation survey for a medication error rate greater than 5%. The facility was re-cited during the current 05/09/19 annual recertification/complaint investigation survey for the same issue of a medication error rate greater than 5% at F759.	F 867	F867 QAPI/QAA Improvement activities 1. No negative outcomes were noted as a result of this finding. 2. Root Cause: Center nursing staff did not appropriately follow the center policy for medication administration. 3. The DON/designee will conduct re-education with nursing staff by 5/28/2019 on following facility policy regarding mediation pass. Audits will be conducted 4 times a week for, eight weeks to ensure the center medication administration policy is followed and an error rate at or below 5% is maintained. The center medical director was consulted on the deficient practice and suggested ongoing auditing with on the spot education if/when errors are identified. 4. The QA team will review, analyze and report the results at the monthly performance improvement committee meetings to validate compliance is achieved and sustained. Subsequent plans of correction will be implemented as deemed necessary/appropriate by this committee.	

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 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 12 In an interview on 05/09/19 at 3:53 PM the Administrator stated that there had been a lot of changes in the facility and that this may have caused the nurses to feel the need to hurry through the medication administration in order to be able to manage other assessment and documentation requirements. She indicated that the multiple changes may have caused the failure of the QA process.	F 867		