STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345487	A. BUILDING _____ B. WING _____	C 08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments The facility was found in compliance with the requirement CFR 483.73 Emergency Preparedness Event ID # RSN011.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation survey was conducted on 07/29/2019 through 08/1/2019, There were 10 allegations investigated and 10 were unsubstantitated.	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 record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS, a tool used for resident assessment) for 1 of 27 resident assessments reviewed. (Resident # 63). The findings included: Resident # 63 was admitted to the facility on 4/11/2019 with diagnosis that included heart failure, hypertension, diabetes, Hyperlipidemia and Non- Alzheimer's dementia Review of the discharge Minimum Data Set (MDS) dated 4/22/2019 indicated Resident # 65 was discharged to acute hospital. Review of the nurse notes dated 4/22/2019 and the medical record indicated Resident # 65 was	F 641	Cherry Point Bay Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance. Cherry Point Bay's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Cherry Point Bay reserves the right to refute any of the deficiencies on this Statement of Deficiencies through	8/5/19

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

Electronically Signed | 08/14/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345487	A. BUILDING _____ B. WING _____	C 08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 1 discharged to Assisted Living Facility. During the interview on 7/31/2019 at 3:29 PM, Minimum Data set (MDS) nurse reviewed the discharge MDS and confirmed it was inaccurate. The MDS nurse explained it was coded in error as Resident # 63 was discharged to Assisted Living Facility (ALF). During an interview on 7/31/2019 at 3:35 PM with the DON (Director of Nursing), she indicated that discharge to the ALF should have been coded on Resident # 63's MDS dated 4/22/2019. During Further interview with DON, she stated that it is her expectation that the MDS should be coded accurately and she will review the MDS's after they are completed by the MDS nurse.	F 641	Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F 641 SS=D Accuracy of Assessments CFR(s): 483.20(g) Resident #63 MDS Section A was reviewed and corrected on 7/31/19 by the MDS Nurse. A 100% audit of current resident's most recent MDS Section A was audited by the DON for accuracy on 8/5/19 with no further deficiencies noted. On 8/2/19, 100% of staff with MDS responsibilities to include the MDS Nurse, Social Worker, Certified Dietary Manager, Activities Director, DON, and QI Nurse were in-serviced by the Administrator in regards to MDS assessments and Coding per the RAI manual with emphasis on completing assessments accurately and completely. Any new employees that are hired with MDS responsibilities will also be trained regarding MDS assessments and accuracy upon new employment orientation by the DON or designee. The decision to monitor the accuracy of MDS was made by the Administrator on 8/5/19. An audit of 10% of all current residents MDS Assessments Section A will be completed by the DON or designee weekly X4 weeks and monthly X2 months using the MDS accuracy tool to ensure accurate and complete coding of the MDS	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345487	A. BUILDING _____ B. WING _____	C 08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 2	F 641	to include Section A. All identified areas of concern will be addressed immediately by the DON to include retraining of the MDS Nurse or other staff completing modifications on the MDS assessment. The DON will review and initial the MDS Accuracy Tool weekly X4 weeks and monthly X2 months to ensure any areas of concern have been addressed. The DON will forward the results of the MDS Accuracy Tool to the Executive QA Committee monthly X3 months for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	