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 09/15/2022

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

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E 000	Initial Comments An unannounced Recertification survey and complaint investigation were conducted on 09/12/22 through 09/15/22. The facility was found to be in compliance with CFR §483.73, Emergency Preparedness. Event ID #EV3411.	E 000		
F 000	INITIAL COMMENTS An unannounced Recertification survey and complaint investigation were conducted on 09/12/22 through 09/15/22. Event ID# EV3411. The following intakes were investigated: NC001189836, NC00190927, NC00191412, NC00186425, NC00184754, NC00192382, and NC00189965. 1 of the 17 complaint allegations was substantiated resulting in a deficiency.	F 000		
F 656 SS=B	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		9/19/22

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

Electronically Signed | 09/26/2022

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F 656	Continued From page 1 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and Nurse Practitioner interview the facility failed to implement a specific plan of care for tube feeding management to check for tube placement every shift, prior to medication administration, and free water flushes for 1 of 1 residents observed for tube feeding management (Resident #14). Findings included: Resident #14 was admitted to the facility on 06/08/21 with diagnoses that included gastrostomy status (feeding tube placement) following a stroke.	F 656	F656 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	

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F 656	Continued From page 2 A quarterly Minimum Data Set assessment dated 06/15/22 documented Resident #14 was rarely or never understood with short and long term memory problems. He was dependent for all activities of daily living including eating. He received 51% or more of his daily calories from a tube feeding. Review of the care plan dated 06/29/22 for Resident #14 revealed the following focus area: At risk for aspiration related to family occasionally provides pleasure food although resident is NPO (nothing by mouth) status with 100% of nutritional needs provided by a feeding tube. One of the goals was for Resident #14 to remain free from complications related to aspiration through the next review date. An intervention was to check for tube placement and gastric contents/residual volume as ordered. Review of a physician order initiated 05/11/22 documented: Enteral feed: check tube for placement every shift before medication administration and before flushes. An observation of tube feeding management was made on 09/15/22 at 12:35 PM with Nurse #8. It was observed Nurse #8 had not brought a stethoscope to check placement of the feeding tube prior to administering a free water flush through the tube. Nurse #8 stated she had checked the placement of the tube at the beginning of the shift, and this was the only time she ever checked tube placement. She reiterated she did not check tube placement each time she used the feeding tube but would on this occasion. She retrieved her stethoscope (needed to check placement of the tube) from the	F 656	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 19, 2022 as our allegation of compliance. HOW WILL THE CORRECTIVE ACTION BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? 1. Resident #14□s medical provider was notified following this occurrence. Resident #14 did not have a negative outcome as a result of this finding. 2. Root Cause: The care plan was not followed as a result of the nurse not following MD orders. 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 Director Of Nursing/Designee On September 15 to ensure that care plans were established and followed for similar Residents. WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES	

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F 656	Continued From page 3 medication cart. She explained to Resident #14 that she was going to flush his tube. He nodded understanding by moving his head up and down. Nurse #14 pushed air through the feeding tube and auscultated with her stethoscope to confirm proper tube placement. She administered 210 ML (Milliliters) of free water through the tube using gravity. The tube was patent and flushed easily. No sign of resident discomfort was observed. In an interview with the Director of Nursing on 09/15/22 at 12:40 PM she stated she expected nurses to check placement of feeding tubes prior to the administration of medication or water. In an interview with the facility Nurse Practitioner on 09/15/22 at 1:55 PM she stated if there was an order for the nurse to check placement of the tube prior to giving a water flush she would expect the nurse to follow the physician's order. She added Resident #14 had a feeding tube that was well established and the risk for his tube to be out of place was low in comparison to a newly placed tube which was more susceptible to dislodgement. She concluded if a dislodged tube was used without first checking for placement, it could lead to infection or resident discomfort.	F 656	MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR? 4. The Director Of Nursing/Designee will conduct re-education with the licensed nurses on or before September 19, 2022 regarding verification of peg tube placement. 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 four weeks by the center Director Of Nursing or Designee regarding verifying placement of Enteral tubes before administration of a flush or medication. 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.	
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and	F 693		9/19/22

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F 693	Continued From page 4 percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and Nurse Practitioner interview the facility failed to provide tube feeding management by failing to check for tube placement prior to the administration of a water flush for 1 of 1 residents observed for tube feeding management (Resident #14). Findings included: Resident #14 was admitted to the facility on 06/08/21 with diagnoses that included gastrostomy status (feeding tube placement) following a stroke. A quarterly Minimum Data Set assessment dated 06/15/22 documented Resident #14 was rarely or never understood with short and long term	F 693	F693 HOW WILL THE CORRECTIVE ACTION BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? 1.Resident #14's medical provider was notified following this occurrence. Resident #14 did not have a negative outcome as a result of this finding. 2.Root Cause: The care plan was not followed as a result of the nurse not following MD orders. HOW WILL THE FACILITY IDENTIFY	

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F 693	Continued From page 5 memory problems. He was dependent for all activities of daily living including eating. He received 51% or more of his daily calories from a tube feeding. Review of the care plan dated 06/29/22 for Resident #14 revealed the following focus area: At risk for aspiration related to family occasionally provides pleasure food although resident is NPO (nothing by mouth) status with 100% of nutritional needs provided by a feeding tube. One of the goals was for Resident #14 to remain free from complications related to aspiration through the next review date. An intervention was to check for tube placement and gastric contents/residual volume as ordered. Review of a physician order initiated 05/11/22 documented: Enteral feed: check tube for placement every shift before medication administration and before flushes. An observation of tube feeding management was made on 09/15/22 at 12:35 PM with Nurse #8. It was observed Nurse #8 had not brought a stethoscope to check placement of the feeding tube prior to administering a free water flush through the tube. Nurse #8 stated she had checked the placement of the tube at the beginning of the shift, and this was the only time she ever checked tube placement. She reiterated she did not check tube placement each time she used the feeding tube but would on this occasion. She retrieved her stethoscope (needed to check placement of the tube) from the medication cart. She explained to Resident #14 that she was going to flush his tube. He nodded understanding by moving his head up and down. Nurse #14 pushed air through the feeding tube	F 693	OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE? 3. An audit was conducted by the DON/Designee On September 15 to ensure that care plans were established and followed for similar Residents. WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR? 4. The Director Of Nursing/Designee will conduct re-education with the licensed nurses on or before September 19, 2022 regarding verification of peg tube placement. 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 four weeks by the center Director Of Nursing or Designee regarding verifying placement of Enteral tubes before administration of a flush or medication. 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	

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F 693	Continued From page 6 and auscultated with her stethoscope to confirm proper tube placement. She administered 210 ML (Milliliters) of free water through the tube using gravity. The tube was patent and flushed easily. No sign of resident discomfort was observed. In an interview with the Director of Nursing on 09/15/22 at 12:40 PM she stated she expected nurses to check placement of feeding tubes prior to the administration of medication or water. In an interview with the facility Nurse Practitioner on 09/15/22 at 1:55 PM she stated if there was an order for the nurse to check placement of the tube prior to giving a water flush she would expect the nurse to follow the physician's order. She added Resident #14 had a feeding tube that was well established and the risk for his tube to be out of place was low in comparison to a newly placed tube which was more susceptible to dislodgement. She concluded if a dislodged tube was used without first checking for placement, it could lead to infection or resident discomfort.	F 693	recommended/appropriate. Subsequent plans of correction will be implemented as deemed necessary/appropriate by this committee.	
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.	F 727		9/19/22

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F 727	Continued From page 7 §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews the facility failed to prevent the Director of Nursing (DON) from serving as a charge nurse and having a resident care assignment including working on the medication cart with a facility census of greater than 60 residents on 2 of 2 occasions (08/22/22 and 08/25/22). Findings included. During an interview with the DON on 09/15/22 at 12:45 PM she stated the facility was actively hiring nursing staff. She stated on a few occasions during the month of August 2022 she had to take an assignment because there were no nurses available to pick up the shift and stated the facility was not currently utilizing agency staff. She stated she was not aware of the federal regulation that prevented the DON from taking a resident care assignment with a facility census of greater than 60. She indicated that she made the schedules for the nursing staff and stated there was not an available nurse to cover the shift on those occasions and she had to take care of the residents. A review of the daily staffing sheet dated 08/22/22 revealed the DON was the assigned nurse for the evening shift from 2:45 PM - 11:15 PM. The daily staff posting on 08/22/22 revealed a facility census of 79 residents. A review of the daily staffing sheet dated 08/25/22 revealed the DON was the assigned nurse for the	F 727	F727 HOW WILL THE CORRECTIVE ACTION BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? 1. The Director Of Nursing completed responsibilities in accordance with the regulations for serving as a full time Director Of Nursing at least 30 hours per week M-F. She also served as a floor nurse while the center was in an outbreak status. 2.Root Cause: The center was in outbreak status and did not have agency to use. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE? 3. The DON was educated that she is not able to serve as a nurse on the floor even if/when requirements to fulfill the full time Director of Nursing position has been met. WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT	

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F 727	Continued From page 8 night shift from 10:45 PM - 07:15 AM. The daily staff posting on 08/25/22 revealed a facility census of 85 residents. An interview was conducted with the Administrator on 09/15/22 at 4:45 PM. She stated she recently informed the DON that she could not work other shifts and that she would have to start mandating or scheduling overtime. She indicated the facility census was greater than 60 during the month of August 2022. She stated her expectation was that the DON would utilize other nursing staff to cover the shifts and should not act as charge nurse when the census is greater than 60.	F 727	RECUR? 4. The DON/Designee was re-educated by the facility Administrator 9/15/2022 that she may not serve as a floor nurse. This education included during times of crisis staffing or outbreak staffing. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR? 5. Audits will be conducted seven times a week for four weeks by the center Administrator or Designee to validate the Director Of Nursing is not working the floor. 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.	