STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345002	A. BUILDING _____ B. WING _____	09/17/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on physician interview, staff interview, and record review the facility failed to communicate with the discharging hospital about medications to ensure that a resident receiving an anti-Parkinsonian medication did not miss any doses and the timing of the medication was kept consistent and failed to follow a physician order [REDACTED].#12) whose physician orders [REDACTED]. Record review revealed Resident #12 was admitted to the facility on [DATE]. The resident's documented [DIAGNOSES REDACTED]. a. Resident #12's 08/22/20 hospital History and Physical (H & P) documented, .Presents to the hospital as a transfer from ED (emergency department) with progressively worsening dizziness, speech changes, and mild confusion. Patient has a history of [DIAGNOSES REDACTED] .and [MEDICAL CONDITION]. (Has) been noted that he has speech changes with his providers in the past. Likely attributed to his [MEDICAL CONDITION]. He reports that it is just rapidly progressing (and) is concerned about his home safety Assessment and Plan: Continue home medications ([MEDICATION NAME] three times daily was one of those documented medications). A 08/25/20 Hospital Discharge Summary documented, Continue these medications which have not changed: [MEDICATION NAME]-[MEDICATION NAME] 25-100 milligrams (mg) one tablet three times daily (TID), [MEDICATION NAME] controlled release (CR) Discharge Diagnoses: [REDACTED]. The summary did not document the last time the resident received [MEDICATION NAME] at the hospital or the administration times of the medication in the hospital. Review of Resident #12's hospital Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. Review of the resident's nursing home admission assessments revealed the facility began them at 4:45 PM on 08/25/20. Review of Resident #12's nursing home August 2020 (MAR) revealed he did not receive any [MEDICATION NAME] in the facility on 08/25/20, but received a morning dose of [MEDICATION NAME] on 08/26/20. The administration times documented on the facility MAR for the resident's [MEDICATION NAME] were 8:00 AM, 12 noon, and 4:00 PM on 08/25/20 and 08/26/20. The administration times were changed to 8:00 AM, 2:00 PM, and 8:00 PM starting on 08/27/20. According to LexiComp (a comprehensive on-line drug database), Intervals between doses of [MEDICATION NAME] CR should be 4 - 8 hours while awake. Take ([MEDICATION NAME]) at the same time every day. Space doses evenly over the waking hours. The resident's 08/28/20 5-day Medicare assessment documented his cognition was severely impaired, he exhibited no behaviors including rejection of care, and he was independent to requiring extensive assistance from a staff member with his activities of daily living (ADLs). During a telephone interview with the facility's Consultant Pharmacist on 09/11/20 at 9:54 AM she stated [MEDICATION NAME] should be given at the same time daily, and for the best results in controlling abnormal movements, there should not be missed doses of the medication. During a telephone interview with the facility's Pharmacy Manager on 09/11/20 at 10:03 AM she stated on 08/25/20 the pharmacy did not receive MEDICATION ORDERS FOR [REDACTED]. Therefore, she explained the next time the facility could send out the resident's medications was at 12 noon on 08/26/20. She reported the facility obtained Resident #12's first two doses of [MEDICATION NAME] on 08/26/20 from the Omnicell (a machine system used to store, dispense, and track medications). She reported according to pharmacy records on 08/26/20 [MEDICATION NAME] was withdrawn from the Omincell at the facility at 10:16 AM and 1:07 PM. During a telephone interview with the Director of Nursing (DON) on 09/11/20 at 10:09 AM she stated sometimes the resident arrived at the facility before their orders since the hospital was right across the street. She reported that for TID medication orders the facility's medication system pre-populated administration times of 8:00 AM, 12 noon, and 4:00 PM. She commented the facility could input its own administration times only if the order was written for administration every eight hours. She stated when the resident's medication orders were reviewed with the primary physician on 08/27/20 he changed the TID administration times. After reviewing Resident #12's August 2020 MAR, she commented the resident did not receive any [MEDICATION NAME] from the facility on 08/25/20, and the morning dose on 08/26/20 was administered late. According to the DON, it was recommended to give [MEDICATION NAME] at about the same time every day. During a follow-up telephone interview with the facility's DON on 09/11/20 at 1:57 PM she stated Resident #12's primary physician was still in the building on 08/26/20, and was informed that the resident's [MEDICATION NAME] was administered late with a scheduled time of 8:00 AM and actual administration time of after 10:16 AM on 08/26/20. She reported the physician just advised the staff to provide the other two doses of [MEDICATION NAME] that day per orders that accompanied the resident from the hospital. During a telephone interview with Resident #12's primary physician on 09/16/20 at 11:06 AM he stated Resident #12 was on a low, starting dose of [MEDICATION NAME] so he did not think two missed doses, followed by late administration of the medication the next morning would have caused the resident any long-[MEDICATION NAME] harm. However, he reported there could have been better communication between the nursing home and hospital to have promoted continuity of the [MEDICATION NAME] dosing because once the most effective administration times were established for a resident the medication needed to be provided at about the same time every day without any missed doses. b. A 08/26/20 physician order [REDACTED].#12 at 3:00 PM for vital signs each shift x 7 days, then daily. Review of vital signs and progress notes revealed the following blood pressure readings for Resident #12: 08/25/20 at 4:50 PM 122/58 lying, 08/27/20 at 5:34 AM 160/108 lying, 08/27/20 at 1:45 PM 148/80 lying, 08/28/20 11:40 PM 141/64 lying, 08/29/20 2:26 AM 115/52 lying, 08/29/20 2:17 PM 136/86 sitting, 08/30/20 12:34 AM 136/84 other, 08/30/20 1:18 PM 127/68 lying, and 08/31/20 12:41 AM 126/68 other. (A blood pressure was not obtained for Resident #12 on second shift 08/26/20, on second and third shift 08/27/20, on first shift 08/28/20, on second shift 08/29/20, on second shift 8/30/20, and any shifts on 09/01/20 before the resident was discharged home against medical advice). During a telephone interview with Nurse #6 on 09/14/20 at 11:37 AM she stated that all residents admitted to the facility had the vital sign protocol order, and vital signs were documented each shift on the MAR for the first seven days in the facility and then daily thereafter. She reported blood pressure readings were part of the vital sign protocol. She explained if nursing assistants (NAs) obtained the vital signs then the nurse was supposed to transpose them onto the MAR. During a telephone interview with Resident #12's primary physician on 09/16/20 at 11:06 AM he stated residents with [MEDICAL CONDITION] often had accompanying autonomic dysfunction which involved experiencing erratic blood pressures. He explained Parkinson patients with autonomic dysfunction often registered elevated blood pressure readings when they were in the supine position (laying down), but the blood pressure frequently normalized when the residents were asked to sit or stand. He reported Resident #12 experienced autonomic dysfunction when he was alerted about a blood pressure of 160/108 in the early morning of 08/27/20. According to the physician, frequent monitoring of the blood pressure was a good practice for residents with Parkinsonian-associated autonomic dysfunction. During a telephone interview with the Director of Nursing (DON) on 09/16/20 at 12:13 PM she stated the physician order [REDACTED].

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