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	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40044 Based on record review, and staff and Physician interviews, the facility failed to maintain complete medical records by not documenting a reweight following a significant increase in the weekly weights that were obtained for a resident admitted with acute congestive heart failure. Resident #72 experienced no significant outcome. This occurred for 1 of 1 resident reviewed for weight management (Resident #72). Findings included. Resident #72 was admitted to the facility on [DATE] with diagnoses including congestive heart failure and fluid overload. A physician's order dated 2/27/25 for Resident #72 revealed to obtain weekly weights. Review of Resident #72's electronic medical record revealed the following weights: 2/25/25 at 5:28 PM the admission weight was 154.0 lbs. documented by Nurse #3. 3/03/25 at 9:26 AM the weight was 166 lbs. documented by Nurse #2. 3/15/25 at 3:57 PM the weight was 181 lbs. (pounds) documented by Nurse #1. Review of Resident #72's electronic medical record revealed no documentation that Resident #72 was reweighed on 3/3/25 or 3/15/25 to determine if the weights were accurate. During an interview on 3/20/25 at 4:22 PM Nurse #2 stated she checked Resident #72's weight on 3/3/25 and saw the increase and rechecked the weight but did not document the reweight that was obtained. She stated she verbally reported the weight to the Physician that day and the Physician assessed Resident #72 that day. During an interview on 3/20/25 at 12:20 PM Nurse #1 stated she checked Resident #72's weekly weight on Saturday 3/15/25 and it was up but he was not symptomatic. She reported that she weighed Resident #72 again on Sunday 3/16/25 and his weight was the same and he remained asymptomatic. She stated she did not think to document the reweight that was obtained. She notified the Nurse Practitioner of the weight increase on Monday morning 3/17/25. (continued on next page)

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 correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's note dated 3/3/25 at 10:26 AM revealed Resident #72 was seen at the bedside today. He reported he was doing better. He denied any lower extremity edema or shortness of breath. A physician's order dated 3/5/25 for Resident #72 revealed a new order to obtain weekly weights due to congestive heart failure. A nursing progress note dated 3/15/25 at 1:09 PM documented by Nurse #1 revealed Resident #72's vital signs were within normal limits. There was no documentation that a reweight was obtained. A physician's note dated 3/17/25 at 10:32 AM revealed Resident #72 was seen at the bedside today. He reported doing well and without acute concerns. His weight was up but he feels well. During an interview on 3/20/25 at 10:00 AM the Physician stated that he was in the facility daily Monday through Friday. He stated that Resident #72 was admitted recently with congestive heart failure and weekly weights were ordered. He indicated that when a weight was significantly up from the previous weight, then a reweigh should occur to determine accuracy, and the weight should be documented in the medical record. During an interview on 03/20/25 at 4:05 PM the Director of Nursing (DON) stated the Physician was in the facility Monday through Friday and the nurses verbally reported to him daily. She indicated that both nurses should have documented the reweight that was obtained following the significant increase in Resident #72's weight on 3/3/25 and 3/15/25. Reweights were obtained to determine accuracy. She stated education would be provided.