STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495234	A. Building B. Wing	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cypress Pointe Rehabilitation and Nursing	5580 Daniel Smith Road Virginia Beach, VA 23462

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49455 Based on resident interview, staff interview, facility documentation review, and clinical record review, the facility staff failed to administer pain medication to a resident who experienced pain and requested pain medication for one (1) of eight (8) residents in the survey sample, Resident #7. The findings include: For Resident #7 the facility staff failed to give pain medication when requested. The resident went without pain medication for approximately 38 hours. Resident #7 was admitted to the facility on [DATE] with diagnoses included but are not limited to left leg pain, peripheral vascular disease (PVD), right below the knee amputation (BKA), left heel unstageable pressure ulcer, and a stage three (3) sacrum pressure ulcer. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/8/23 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible score of 15 which indicated Resident #7 was cognitively intact. Section J Health Conditions/Pain Management was not assessed on the MDS. Resident #7 care plan dated 12/21/2023 included a focus on the risk for alteration in comfort related to PVD, left second toe amputation, right BKA, and pressure ulcers. Resident #7 order summary includes an order dated 12/29/23 for Oxycodone (oxycontin) 10mg every four (4) hours as needed for pain. An interview was conducted with Family Member (FM) #1 over the phone on 7/3/24 at approximately 4:15 PM. FM #1 shared that Resident #7 called her on 1/24/24 at approximately 1:00 AM and shared that he had been asking for pain medication for hours and that the nursing staff kept telling him that he was given medication already and that he was not due to get another dose. During this call FM #1 said she could hear staff in the background saying that Resident #7 was given Percocet (oxycodone/acetaminophen). FM #1 said that she informed nursing staff that Resident #7 was allergic to Percocet. FM #1 shared that after the nursing staff checked the medical records, they realized that it was another resident that received pain medication and not Resident #7. An interview was conducted with Resident #7 over the phone on 7/3/24 at approximately 4:25 PM. Resident #7 said that he suffered in pain for hours and that his pain on a scale of 0-10, with 10 being the worse was a 15. (continued on next page)

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

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted over the phone with Licensed Practical Nurse (LPN) #5 on 7/3/24 at approximately 10:35 AM. LPN #5 shared that she was supervising on 1/24/24 and that Resident #7's daughter called and asked why her father could not get pain medication. LPN #5 said that she did not remember everything, but she remembers there being some confusion about Resident #7 getting pain medication and that the primary nurse had mixed up her residents. Progress note dated 1/24/24 at 1:57 AM written by LPN #4 indicated, Resident #7 requested pain medication and when the medication administration record (MAR) and narcotic book was checked she thought it noted that Resident #7 received pain pills at 12:00 AM. This note also indicates, the 3-11 PM nurse reported that Resident #7 received medication on previous shift and will receive next dose in 4 hours as ordered. The progress note read, Resident #7 insisted that he did not receive his pain medication and called daughter. The nursing supervisor visited the resident and explained to the resident and daughter that she would follow up on the administration time. The nursing supervisor and LPN #4 double checked the narcotic book and realized that the medication was not given to the resident. LPN #4 and the nursing supervisor apologized for the miscommunication. LPN #4 looked at the wrong charting in the narcotic book. LPN #4 administered pain medication to Resident #7 as prescribed. Progress note dated 1/24/24 at 1:58 AM written by the nursing supervisor supported the note written by LPN #4. Review of Resident #7's January MAR indicates prior to Resident #7 calling FM #1 due to pain on 1/24/24 at approximately 1:00 PM, his last dose of Oxycodone was on 1/22/24 at 11:46 AM. After nursing staff recognized their mistake Resident #7 was administered Oxycodone 10mg on 1/24/24 at 1:52 AM, 6:23 AM, 11:52 AM, and 4:56 PM. Review of the facilities Pain Management policy, reviewed and revised on 12/13/23 read, .The facility must ensure that pain management is provided to residents who require such services . An interview was conducted with the Director of Nursing (DON) on 7/8/2024 at approximately 11:30 AM. The DON shared that the expectation is that staff do a pain assessment on every resident every shift at least. The DON indicated that the electronic medical record (EMR) does not populate a pain assessment column if the provider does not order pain assessments. The DON said that the staff had to document their pain assessments otherwise manually. The above findings were shared with the Administrator, Corporate Nurse #1, DON, and Assistant Director of Nursing (ADON) on 7/8/2024 at approximately 5:22 PM. No further information was provided prior to the conclusion of the survey.

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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** 40711 49455 Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to document administered controlled medication on the medication administration record (MAR) for one (1) of eight (8) residents in the survey sample, Resident #7. The findings include: For Resident #7 the facility staff failed to document 50 doses of oxycodone on the Medication Administration Record (MAR) that were signed out on the medication monitoring control records for December 2023 and January 2024. Resident #7 was admitted to the facility on [DATE] with diagnoses included but are not limited to left leg pain, peripheral vascular disease (PVD), right below the knee amputation (BKA), left heel unstageable pressure ulcer, and a stage three (3) sacrum pressure ulcer. Resident #7 care plan dated 12/21/2023 included a focus on the risk for alteration in comfort related to PVD, left second toe amputation, right BKA, and pressure ulcers. Review of Resident #7's medication monitoring control records for the months December 2023 and January 2024 reflect oxycodone being signed out but not documented on the December 2023 and January 2024 MARs for the following dates and times: 12/12/23 at 9 PM, 12/13/23 at 6 PM, 12/13/23 at 11 PM, 12/18/23 at 7 AM, 12/18/23 at 6 PM, 12/19/23 at 6 PM, 12/20/23 at 5 PM, 12/21/23 at 6:30 AM, 12/21/23 at 6 PM, 12/22/23 at 5 AM, 12/22/23 at 1:40 PM, 12/22/23 at 8:40 PM, 12/23/23 at 4:30 PM, 12/25/23 at 2:15 AM, 12/26/23 at 9 AM, 12/27/23 at 10:30 AM , 12/28/23 at 7 PM, 12/29/23 at 6 AM, 12/29/23 at 4:56 PM, 12/30/23 at 6 AM, 12/30/23 at 10:00 AM, 12/31/23 at 3 AM, 1/1/24 at 4 PM, 1/1/24 at 10 PM, 1/3/24 at 7 PM, 1/5/24 at 4:30 AM, 1/6/24 at 6:30 PM, 1/15/24 at 5 PM, 1/15/24 at 10 PM, 1/20/24 at 5:30 PM, 1/20/24 at 11 PM, 1/21/24 at 11 AM, 1/21/24 at 3 PM, 1/21/24 at 7 PM, 1/21/24 at 11 PM, 1/22/24 at 7:15 AM, 1/22/24 at 11:15 AM, 1/22/24 at 6 PM, 1/22/24 at 11:46 PM, 1/24/24 at 11 PM, 1/25/24 at 6 AM, 1/25/24 at 10:45 AM, 1/25/24 at 4 PM, 1/25/24 at 10 PM, 1/26/24 at 3:03 PM, 1/27/24 at 4:15 AM, 1/27/24 at 9 AM, 1/27/24 at 4:15 PM, 1/27/24 at 11:45 PM, 1/28/24 at 9 AM, and 1/26/24 at 10 PM. An interview was conducted with the Director of Nursing (DON) on 7/8/2024 at approximately 11:30 AM. The DON shared that when administering a controlled as needed medication, staff should check the order, dispensed medication, sign it off on the narcotic sheet, and document it on the MAR. The DON shared that they did not have a process in place for auditing the controlled sheets but will be developing a process moving forward. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Licensed Practical Nurse (LPN) #3 on 7/8/24 at approximately 12:00 PM. LPN #3 shared that she developed a bad habit of not always documenting her controlled medication in residents MAR because of feeling rushed at times and the fast-paced flow of her shifts. LPN #3 shared that she was educated on 6/5/24 by the Director of Nursing (DON) of the expectation of complete documentation of administered medications. The above findings were shared with the Administrator, Corporate Nurse #1, DON, and ADON on 7/8/2024 at approximately 5:22 PM. No further information was provided prior to the conclusion of the survey.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 34306 Based on information acquired while reviewing infections acquires in the facility and staff interviews the facility staff failed to have a qualified individual to perform the role of an Infection preventionist (IP). The findings included; On 7/3/24 at approximately 1:05 PM, an interview was conducted with the Registered Nurse identified as the IP. As the documentation was reviewed regarding urinary tract infections (UTI) for residents over a six month period two residents were identified with multiple UTIs. The IP stated staff education was provided without providing documentation of the curriculum. During the interview, the IP also stated that she had completed the training to become a qualified IP but, she did not have the certification because she had not completed the competency test. The IP stated based on information obtained from Human Resources the last qualified IP employed separated from the facility on 12/22/23 and currently she was wearing thehat as the current IP. On 7/8/24 at approximately 1:00 PM, a final interview was conducted with the Administrator, Director of Nursing and Regional Nurse Consultant. They had no comments and voiced no concerns regarding the above information.