STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345505	A. BUILDING _____ B. WING _____	C 07/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA REHAB CENTER OF CUMBERLAND	**4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306**

(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 000	INITIAL COMMENTS On 07/13/2015 through 07/17/2015 and on 07/22/2015 a complaint investigation survey was conducted. On 07/16/2015 through 07/17/2015 an extended survey was conducted. 483.10 (F157) at a scope and severity (J) 483.20 (F309) at a scope and severity (J) 483.25 (F323) at a scope and severity (J) The Immediate Jeopardy began on 06/13/2015 when Nurse #1 discovered Resident #1 undressed in her bed with her tracheostomy dislodged completely from her neck, and the efforts to resuscitate her at that time were unsuccessful. The Immediate Jeopardy was removed on 07/17/2015 at 4:05 PM when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity of no actual harm with the potential of no more than minimal harm that is not immediate jeopardy (D). The facility was in the process of full implementation of corrective action at that time. The Administrator was informed of Immediate Jeopardy on 07/16/2015 at 4:48 PM and Immediate Jeopardy was abated 07/17/2015 at 4:05 PM when the facility implemented a credible allegation of compliance. The facility remained out of compliance at the lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective.	F 000		
F 157 SS=J	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	F 157		8/10/15

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

Electronically Signed | 08/06/2015

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.

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F 157	Continued From page 1 A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and physician interview, the facility staff did not notify the physician about adverse behavioral symptoms, including pulling at her tracheostomy	F 157	The Statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is	

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F 157	Continued From page 2 tubes that jeopardized the safety of one of four residents who had tracheostomies, Resident #1. The Immediate Jeopardy began on 06/13/2015 when Nurse #1 found Resident #1 undressed with her tracheostomy tube dislodged completely from her neck, and the efforts to resuscitate her at that time were unsuccessful. The Immediate Jeopardy was removed on 07/17/2015 at 4:05 PM when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity of no actual harm with the potential of no more than minimal harm that is not immediate jeopardy (D). The facility was in the process of full implementation of corrective action at that time. Findings included: Resident #1's Discharge Summary from a specialty hospital to the facility dated 06/10/2015 indicated that Resident #1 had a discharge diagnosis of respiratory failure, with a tracheostomy tube placed on 04/29/2015. The same Discharge Summary further indicated that the resident had encephalopathy, and that as a result, her mental status waxed and waned. A review of the admission paperwork which accompanied Resident #1 from the hospital included a Medicaid FL2 Form dated 06/10/2015 which revealed Resident #1 had a tracheostomy with 28% oxygen therapy, and that the resident wore mittens due to her pulling at the tracheostomy tube. An Interdisciplinary Plan of Care Discharge and Barrier Update from the hospital listed a goal to	F 157	completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: ¿ On 6/13/2015 Resident # 1 at approximately 12:45 p.m. was found to be unresponsive and not breathing by staff. CPR was attempted by facility staff and 911 was called. Upon arrival, EMS team continued CPR efforts and later pronounced dead at the facility. ¿ The Resident had mittens in place that she could remove and were therefore not considered a restraint. Staff reports that resident frequently took off mittens and attempted to dislodge trach. ¿ All LPNs and RNs were in-serviced on 7/16/2015 regarding physician notification, interventions for trach patients to protect airways, and tracheostomy care. ¿ How corrective action will be accomplished for those resident having potential to be affected by the same deficient practice: ¿ All Licensed Practical Nurses and Registered Nurses were in-serviced on 7/17/2015 regarding the following policies: 1. Documentation and Notification, which states the Charge Nurse is responsible for notifying the Physician and	

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F 157	Continued From page 3 remove Resident #1's mittens without her dislodging her tubes or lines, and that a barrier to this goal was that Resident #1 had a tracheostomy. A review of the facility's Nursing Admission Assessment dated 06/10/2015 revealed Resident #1 was admitted to the facility on 06/10/2015 with a diagnosis of respiratory failure and that her level of cognition was could not be determined because the resident was nonverbal. In addition, the same assessment revealed Resident #1 was totally dependent upon staff assistance for locomotion, dressing, eating, toilet use, personal hygiene, and bathing. Under the category of "Extremities," the assessment indicated that right and left arm reflexes were within normal limits. In an interview with the Minimum Data Set (MDS) nurse on 07/15/2015 at 3:35 PM, she stated that from the time of admission on 06/10/2015, Resident #1 was known to have restless behaviors and that she pulled at her tracheostomy. In addition, she stated that her restless behaviors was discussed in detail in an interdisciplinary meeting and also on daily rounds. The MDS nurse stated she could not recall the exact date and time of the interdisciplinary meeting, but that usually the meetings were held on Thursday mornings, and that Thursday fell on 06/11/2015. She further explained that it was "common knowledge" that Resident #1 pulled off her mittens frequently, and that there was discussion about contacting the physician about getting a medication for agitation control. The MDS nurse stated the resident was admitted to the facility wearing the mittens she had from the hospital, and the facility did not have any access to restraints, including mittens, in the facility	F 157	or the Responsible Party whenever there is a change related to the care of the patient. Included in the in-service was emphasis that anxiety and agitation is reportable to the physician. 2. All Licensed Practical Nurses and Registered Nurses not scheduled on 07/17/2015 will be in-serviced prior to returning to work. 3. The care plans for the three remaining tracheostomy patients were reviewed by the Corporate Quality Improvement Monitor for accuracy and completeness. 4. On 7/16/2015, all Certified Nurses Assistants were in-serviced on notifying the charge nurse of change in resident condition, using the clinical alerts in the electronic medical record system and verbally. Any Certified Nurses Assistants not scheduled on 07/16/2015 will be in-serviced prior to returning to work. Measures put into place to ensure that the deficient practice will not occur: 1. DON and/or designee will daily Monday-Friday X (4) four weeks will audit the Change in Condition and Transfer Assessment notification documentation and the Communication Progress Notes for completion for all Tracheostomy patients. 2. DON and/or designee will daily Monday-Friday X (4) four weeks audit Behavior and Progress note documentation on Tracheostomy patients for reporting, notification, and updated	

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F 157	Continued From page 4 because the facility was restraint-free. In an interview with Resident #1's physician on 07/16/2015 at 2:00 PM, he stated that in his History and Physical he completed on 06/11/2015, he did not record any combative or restless behavioral problems related to her tracheostomy, such as pulling at her tracheostomy tubing or device, because Resident #1 did not exhibit such behaviors at the time when he examined her, and he had not received reports of such behavior. The physician stated that he knew that the resident wore mittens upon admission to the facility due to her history of her pulling at the tracheostomy, and that he wrote an order for the mittens on 06/11/2015. The physician stated he did not recall getting a call from a staff member regarding the resident pulling at her tracheostomy, but that he did receive a call after Resident #1 had expired on 06/13/2015 around mid-afternoon. A review of the progress notes revealed a note dated 06/12/2015 at 11:56 PM indicated that mittens continued to be used for tracheostomy safety for Resident #1. This progress note was signed by Nurse #2. An interview was conducted with one of Resident #1's nurses, Nurse #2, on 07/15/2015 at 2:37 PM. Nurse #2 stated that Resident #1 had tried to get out of bed when she was assigned to her during the first day of her stay in the facility, so she kept the resident up in her chair in the day room across from the nurse ' s station so that she could be monitored. Nurse #2 explained that when the resident was around other people, she did not try to get up or exhibit restless behaviors. She stated that she had seen Resident #1 pull at her	F 157	interventions to prevent de-cannulation How the facility plans to monitor and ensure correction is achieved and sustained ¿ The Director of Nursing will report the results of the audits weekly x (3) months in the Weekly Quality Assurance Risk Meeting for problem resolution. ¿ The Administrator will report the results of the audits to the quarterly Quality Assurance meeting X (1) quarter for tracking and trending of compliance and further problem resolution.	

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oxygen tubing before, but never had seen her actually pull on her tracheostomy tube. In addition, Nurse #2 stated that she wasn ' t sure that the mittens were a helpful intervention for Resident #1 because she was very alert and capable of removing them herself.

Per the Minimum Data Set (MDS) 5-Day assessment dated 06/13/2015, Resident #1 had no range of motion impairment.

Another progress note dated 06/13/2015 at 12:37 AM documented that Resident #1 was observed several times during the shift removing her mittens and grabbing at her tracheostomy. This note was signed by Nurse #7.

In a telephone interview with Nurse #7 on 07/22/2015 at 2:22 PM, she stated that she could not recall many details about what she documented in the progress note on 06/13/2015, but stated if she documented that the resident was observed pulling on her tracheostomy tube, then it happened. Nurse #7 stated that she worked the 3:00 PM to 11:00 PM shift on 06/12/2015 and that her progress note was written late, after her shift was over. Nurse #7 stated that when the resident was observed pulling off her mittens and pulling at her tracheostomy tube, it occurred right after her daughter left from a visit. Nurse #7 stated that Resident #1 became fidgety and upset when she left. She added that when she became upset, she removed her mittens and pulled at her tracheostomy, so she (Nurse #7) went to her and replaced her mittens, and explained to her why she had to wear them. Nurse #7 explained that she felt no need to contact the resident ' s physician because the resident seemed to calm

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down after she explained the need for the mittens. She stated that she was uncertain whether the resident had been known to remove her mittens or pull at her tracheostomy tube before then. In addition, she stated that it was not her idea to keep the resident in the day room for observation and that the resident was already in the day room when she came onto her shift at 3:00 PM on 06/12/2015.

A progress noted dated 06/13/2015 at 1:51 AM documented, "...trach care provided. Resd (resident) wearing mittens on bilat (bilateral) upper extremities d/t (due to) resident attempting to remove trach. (tracheostomy tube) ...will continue to monitor." This note was signed by Nurse # 3.

In an interview with Resident #1's nursing assistant on 07/15/2015 at 2:40 PM, she stated that when she went to check on Resident #1 on 06/13/2015 between 8:00 AM and 9:00 AM, she found that Resident #1 was not wearing her mittens. She explained she then went to ask the nurse, Nurse #1, if the resident needed to wear the mittens all the time. The nursing assistant stated that Nurse #1 told her the resident needed to wear mittens all the time to keep her from pulling at her tracheostomy tube, so she returned to the resident's room and applied the mittens per the nurse's direction.

A progress note which documented dated 06/13/2015 at 8:32 PM revealed the following:

"Situation: res (resident) found in bed lying still, not moving or breathing. Background: She continuously pulls her mitts (mittens) off and pulls at O2 (oxygen) hookup and trach (tracheostomy.)CNA (certified nursing assistant) and I had to put mits (mittens) back on mid-shift today and redirect her not to pull at trach

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(tracheostomy). She stated, "I don ' t need it." Assessment: Found laying in bed not breathing, no response to verbal cue or sternal rub. Charge nurse was brought into room along with crash cart, chest compressions and CPR (cardiopulmonary resuscitation) were began. 911 was called and continued to stay on phone until EMS (emergency medical service) arrived. Chest compressions and CPR was performed until EMS arrived. All 3 family members on the responsible party list were called and not reached. [Family member] Ms. [xxxx] called back and I spoke with her about the situation. The other two kids showed up shortly thereafter." This note was signed by Nurse #1.

In an interview with Nurse #1 on 07/16/2015 at 11:27 AM, Nurse #1 stated that she was assigned to Resident #1 for just one day on 06/13/2015 on the day shift from 3:00 PM to 11:00 PM, and that she received a report from the previous shift ' s nurse who informed her that the resident needed the mittens to keep her from pulling at her tracheostomy site. Nurse #1 explained there were no other interventions to keep Resident #1 from pulling at her tracheostomy tube other than checking on her frequently, at least every 2 hours.

On 07/16/2015 at 1:40 PM, an interview was conducted with Nurse #3, the nurse who was acting as the charge nurse on 06/13/2015. (Nurse #3 worked the 7:00 to 3:00 PM shift on 06/13/2015.) Nurse #3 stated that if a resident with a tracheostomy was exhibiting adverse behaviors, such as pulling at her tracheostomy, she would keep the resident in the day room for close monitoring for safety. She also stated that if this intervention was not successful, she would contact the physician to report her behavior.

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In a second interview with Nurse #1 on 07/17/2015 at 12:33 PM, she stated that the nurse who previously cared for Resident #1 on the night shift reported to her that the resident had tried to pull at her tracheostomy but did not have a suggestions as to how to keep them on her. Nurse #1 stated that the facility was restraint-free, and that with that in mind, there was not much she could do to keep the resident from pulling off her mittens or pulling at her tracheostomy, and that she would not have contacted the physician about her restless adverse behaviors.

On 07/16/2015 at 9:45 AM, an interview was conducted with the unit manager from the unit where Resident #1 resided. The unit manager stated that she was not working on the date when Resident #1 pulled out her tracheostomy tube, but stated that it would be her expectation that if a resident displayed restless or adverse behaviors which could potentially harm him/her, the assigned nurse should contact the physician to receive guidance. In addition, she stated that if a nurse was unfamiliar with a resident, she should receive a report from the previous shift nurse, and she should review progress notes, the history and physical notes, the discharge summary information from the hospital in order to understand the resident ' s needs and possible behaviors.

The administrator, the acting Director of Nursing, and the facility's consultant nurse were notified of the immediate jeopardy in a meeting on 07/16/2015 at 2:40 PM.

The facility provided the following credible

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F 157	Continued From page 9 allegation on 07/17/2015 at 1:09 PM. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 6/13/15 Nurses documented resident #1 made two attempts to remove tracheostomy. On 6/13/2015 at approximately 2:00 p.m., based on interview with the nurse and CNA on duty on at the time, Resident #1 was found to be unresponsive and not breathing. CPR was attempted by facility staff and 911 was called. Upon arrival, EMS team continued CPR efforts and later Resident #1 was pronounced dead at the facility. Nurses notes do not reflect MD notification. All LPNs and RNs were in-serviced on 7/16/2015 regarding physician notification. How corrective action will be accomplished for those resident having potential to be affected by the same deficient practice: All Licensed Practical Nurses and Registered Nurses were in-serviced on 7/17/2015 regarding the following policies: 1. Documentation and Notification, which states the Charge Nurse is responsible for notifying the Physician and or the Responsible Party whenever there is a change related to the care of the patient. Included in the in-service was emphasis that anxiety and agitation is reportable to the physician. 2. All Licensed Practical Nurses and Registered Nurses not scheduled on 07/17/2015 will be in-serviced prior to returning to work. 3. The care plans for the three remaining tracheostomy patients were reviewed by the Corporate Quality Improvement Monitor for	F 157		

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F 157	Continued From page 10 accuracy and completeness.On 7/16/2015, all Certified Nurses Assistants were in-serviced on notifying the charge nurse of change in resident condition, using the clinical alerts in the electronic medical record system and verbally. Any Certified Nurses Assistants not scheduled on 07/16/2015 will be in-serviced prior to returning to work. On 07/17/2015 at 3:20 PM, verification of the credible allegation was evidenced via interviews with unit managers, supervising nurses, and other licensed staff who stated they received in-service education regarding the notification of the physician regarding behavioral changes or other adverse behaviors such as pulling at the tracheostomy which could impact the resident's safety. Interviews with nursing assistants revealed that they had been provided in-service education about the importance of monitoring residents frequently, especially those who exhibited behavioral issues such as removing mittens, and reporting such behaviors to the nurse immediately. The nursing assistants also stated they received in-service education about the importance of keeping resident from harming themselves.	F 157		
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		8/10/15

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F 309	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on physician interview, staff interviews, visitor interview, and record review, the facility failed to develop an interim care plan to address the tracheostomy needs and adverse behavioral symptoms related to tracheostomy safety for one of one resident who was found unresponsive after pulling out her tracheostomy, Resident #1. The Immediate Jeopardy began on 06/13/2015 when Nurse #1 discovered Resident #1 undressed in her bed with her tracheostomy dislodged completely from her neck, and the efforts to resuscitate her at that time were unsuccessful. The Immediate Jeopardy was removed on 07/17/2015 at 4:05 PM when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity of no actual harm with the potential of no more than minimal harm that is not immediate jeopardy (D). The facility was in the process of full implementation of corrective action at that time. Findings included: Resident #1's Discharge Summary from a specialty hospital to the facility dated 06/10/2015 indicated that Resident #1 had a discharge diagnosis of respiratory failure, with a tracheostomy placed on 04/29/2015. The same Discharge Summary further indicated that the resident had encephalopathy, and that as a result, her mental status waxed and waned. A review of the admission paperwork which accompanied Resident #1 from the hospital	F 309	The Statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The initial care plan being developed did not fully address the specialized care needs for the Tracheostomy. On 07/16/15, The MDS nurse conducted an audit of the current (3) three tracheostomy residents to ensure the Care Plan objectives, care needs, and special needs for tracheostomy and mittens was accurate and completed. At the time of the audit, there were no new admissions with tracheostomy needs. How the correct action will be accomplished for those residents having a potential to be affected by the same deficient practice. On 07/16/15, the MDS Nurse conducted an audit to validate the presence of an accurate current Care Plan for the current (3) three tracheostomy residents which addressed medical and nursing objectives and	

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F 309	Continued From page 12 included a Medicaid FL2 Form dated 06/10/2015 which revealed Resident #1 had a tracheostomy with 28% oxygen therapy, and that the resident wore mittens due to her pulling at the tracheostomy tube. An Interdisciplinary Plan of Care Discharge and Barrier Update from the hospital listed a goal to remove Resident #1's mittens without her dislodging her tubes or lines, and that a barrier to this goal was that Resident #1 had a tracheostomy. A review of the facility's Nursing Admission Assessment dated 06/10/2015 revealed Resident #1 was admitted to the facility on 06/10/2015 with a diagnosis of respiratory failure and that her level of cognition was unable to be determined because the resident was nonverbal. In addition, the same assessment revealed Resident #1 was totally dependent upon staff assistance for locomotion, dressing, eating, toilet use, personal hygiene, and bathing. Under the category of "Skin" the comment box documented, " trach (tracheostomy) midline, clean. " Under the " Motor Control " section of the assessment, the resident was documented as having an unsteady gait and poor balance. A review of the facility's Device Assessment dated 06/10/2015 revealed that "Mittens" were not marked as present on the assessment. Review of the progress notes revealed there was a note made upon admission on 06/10/2015 at 2:32 PM which stated, "O2 (oxygen) at 4 LPM (liters per minute) via trach (tracheostomy) collar. Breathing even, unlabored. Skin warm and dry. Resident able to stand with assist x 1 (with the	F 309	interventions for tracheostomy and special needs. On 07/16/15, the MDS Nurse, Director of Nursing, Unit Manager, and House Supervisors received education by the Staff Development Coordinator on the following Procedure points: the Care Plan will be activated upon admission, the Comprehensive Care plan will be completed within 7 days of the completion of the Comprehensive Assessment, the Care Plan will be updated by each discipline on an ongoing basis as changes in the patient occur and reviewed quarterly, On 07/16/15, all Licensed Nursing staff were educated by the Staff Development Coordinator on the Care Plan process, objectives, and interventions for patients with tracheostomy and mittens. All Licensed Nursing staff not scheduled on 07/16/15 will be in-serviced by the Staff Development Coordinator prior to returning to work. Measures put into place to ensure that the deficient practice will not occur: The Director of Nursing and or designee will audit the 24 hour Chart review using the eMAR documentation and Order Listing Reports daily X 4 weeks Monday-Friday to ensure accurate and updated Care Plan objectives and interventions for all tracheostomy patients. Don and/or designee will daily Monday ¿ Friday X 4 weeks will audit the Change in Condition and Transfer assessment notification documentation and the Communication Progress Notes to ensure	

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F 309	Continued From page 13 assistance of one staff member.) Ambulates with assist x 1 (with the assistance of one staff member.) Admitted with mittens on both hands ... " This progress note was signed by Nurse #2. An interview was conducted with Nurse #2 on 07/15/2015 at 2:37 PM. Nurse #2 stated that she was the nurse who worked with Resident #1 on the day she was admitted to the facility on 06/10/2015, and that the resident was wearing her mittens which had been given to her by the hospital. Nurse #2 stated that right after admission, while she was on duty, Resident #1 tried to get out of bed. She explained that she kept Resident #1 in the day room during the day because when she was around other people, she did not try to get out of bed. Nurse #2 also stated that she was monitored by more staff members when she was in her geri-chair in the day room. Nurse #2 stated that she had seen the resident with her mittens off before, but she had not ever seen the resident pull at the tracheostomy strap. Nurse #2 also stated that she was not even sure that the mittens were helpful in preventing the resident from pulling at her tracheostomy because the resident was very alert and capable of removing the mittens. She stated the mittens were a soft cotton-like material on the palm of the hand and that there was a Velcro fastener around the wrist to help keep them in place. A review of the medical record revealed there was no interim care plan to address Resident #1's tracheostomy care or her behavioral tendencies of pulling at the tracheostomy device or tubing. In an interview with the Minimum Data Set (MDS) nurse (nurse responsible for writing care plans)	F 309	accurate and updated Care Plan objectives and interventions for all Tracheostomy patients. New MDS Nurse, Director of Nursing, Unit Manager, and House Supervisors will receive education during orientation by the Staff Development Coordinator on the following Procedure points: the Care Plan will be activated upon admission, the Comprehensive Care plan will be completed within 7 days of the completion of the Comprehensive Assessment, the Care Plan will be updated by each discipline on an ongoing basis as changes in the patient occur and reviewed quarterly for all tracheostomy patients. How the facility plans to monitor and ensure correction is achieved and sustained: The Director of Nurses will report the results of the audits to the weekly Quality Assurance Risk Meeting for further problem resolution for one (3) month. The Administrator will report the results of the audits to the QA committee quarterly for tracking and trending, and further problem resolution.	

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F 309	Continued From page 14 on 07/15/2015 at 3:35 PM, she stated that from the time of admission on 06/10/2015, Resident #1 was known to have restless behaviors and that she pulled at her tracheostomy. The MDS nurse explained that an interim care plan to address her tracheostomy needs and her restless behaviors should have been initiated immediately upon admission after her nursing facility admission assessment. The MDS Nurse stated that the interim care plan would be completed by any of the nurses who were taking care of Resident #1 would have been responsible for completing an interim care plan based upon her diagnoses and her tracheostomy needs. The MDS nurse added that there were three MDS nurses who wrote care plans, and that Resident #1 was not in the facility long enough to have a formal nursing care plan written within 14 days of her admission. She stated that the interim care plan was supposed to be in place to address her care needs regarding the tracheostomy, including her behavior of pulling at her tracheostomy, until the formal care plan could be initiated. In addition, she stated that there was a concern among the nursing staff regarding Resident #1 ' s restless behavior and attempts to pull out her tracheostomy, and that this was discussed in detail in an interdisciplinary meeting and also on daily rounds. The MDS nurse stated she could not recall the exact date and time of the interdisciplinary meeting, but that usually the meetings were held on Thursday mornings, and that Thursday fell on 06/11/2015. She further explained that it was "common knowledge" that Resident #1 pulled off her mittens frequently, and that there was discussion about contacting the physician about getting a medication for agitation control. The MDS nurse stated the resident was admitted to the facility wearing the mittens she had from the hospital,	F 309		

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and the facility did not have any access to restraints, including mittens, in the facility because the facility was restraint-free.

A review of the physician's orders revealed an order dated 06/11/2015 for "mittens to both hands for stability of trach " (tracheostomy.) There were no other orders regarding the tracheostomy care for Resident #1.

In an interview with Resident #1's physician on 07/16/2015 at 2:00 PM, he stated that in his History and Physical dated 06/11/2015, he did not record any combative behavioral problems related to her tracheostomy, such as pulling at her tracheostomy tubing or device, because she did not exhibit such behaviors at that time and he had not received reports of such behavior. The physician stated that he knew that the resident wore mittens upon admission to the facility due to her history of her pulling at the tracheostomy, and that he wrote an order for the mittens on 06/11/2015. The physician stated he did not recall getting a call from a staff member regarding the resident pulling at her tracheostomy, but that he did receive a call after Resident #1 had expired on 06/13/2015 around mid-afternoon.

Per the Minimum Data Set (MDS) 5-Day assessment dated 06/13/2015, Resident #1 had a partial list of diagnoses including hypertension, respiratory failure, muscle weakness, dysphagia, symbolic dysfunction, and adult failure to thrive. In addition, the same assessment indicated the resident was receiving tracheostomy care and was not receiving respiratory therapy. The MDS assessment also there were no behavioral symptoms exhibited, no rejection of care, and no wandering behaviors. There was no range of

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motion functional impairment for Resident #1, and there were no restraints checked for the resident.

A progress note dated 06/13/2015 at 12:37 AM documented, "Resident able to verbalize needs to staff, resident was observed several times during shift removing mittens and grabbing at trach (tracheostomy). Resident alert x 2 (oriented to person and place), confusion noted." This note was signed by Nurse #7.

In a telephone interview with Nurse #7 on 07/22/2015 at 2:22 PM, she stated that she actually worked on the 3:00 PM to 11:00 PM shift on 06/12/2015, but that she stayed after her shift was over in order to document in the progress notes. She stated that she could not recall many details about what she documented in the progress note on 06/13/2015, but stated if she documented that the resident was observed pulling on her tracheostomy tube, then it happened. Nurse #7 stated that when she observed Resident #1 pulling off her mittens and pulling at her tracheostomy tube, it occurred right after her family member left from a visit. Nurse #7 stated that Resident #1 became fidgety and upset when her family member left that day. Nurse #7 stated she went to her and replaced her mittens and explained to her why she had to wear them. She stated that she was uncertain whether the resident had been known to remove her mittens or pull at her tracheostomy tube before then. In addition, she stated she was not aware of any other interventions in place to address restless behavior or pulling at the tracheostomy tube.

A progress noted dated 06/13/2015 at 1:51 AM

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documented ... "trach care provided. Resd (resident) wearing mittens on bilat (bilateral) upper extremities d/t (due to) resident attempting to remove trach. (tracheostomy) ...will continue to monitor." This note was signed by Nurse # 3.

In an interview with Nurse #1 on 07/16/2015 at 11:27 AM, Nurse #1 stated that she was assigned to Resident #1 for just one day on 06/13/2015 and that she received a report from the previous shift's nurse who informed her that the resident needed the mittens to keep her from pulling at her tracheostomy site. Nurse #1 explained she had no knowledge of any other interventions being used to keep Resident #1 from pulling at her tracheostomy other than checking on her frequently, at least every 2 hours. She added that no one reported to her that the resident should be kept in the day room near the nurse ' s station.

An interview was conducted on 07/15/2015 at 11:03 AM with the visitor who discovered Resident #1 undressed on 06/13/2015. During the interview, she stated that she came to visit the resident on 06/13/2015 shortly after 2:00 PM. The visitor stated that when she started to enter the resident ' s room, she noted the resident was wearing no gown or other clothing. She stated that she had not stayed in the entrance of the resident ' s room long enough to determine whether she was breathing and she just assumed the resident was asleep. The visitor stated that she did not want to embarrass the resident, so she backed out of the room and went to report to a staff member that the resident needed to be dressed. The visitor stated that when she went to the nurse's station to notify a staff member that Resident #1 needed to be dressed, there was no one at the nurse's station, so she found a staff

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member in the hall and reported it to her. She explained that the staff member then went into another resident ' s room for a brief moment, then came back out of that resident's room and got another nursing assistant to assist her with dressing Resident #1. She stated that after the nursing assistants entered the room, they stayed for a few minutes, then one of the nursing assistants came out of the room and ran to get another nurse.

An interview was conducted on 07/15/2015 at 2:40 PM with the nursing assistant (NA #1) who was assigned to Resident #1. During the interview, she stated that the last time she saw the resident with her tracheostomy intact was between 12:35 and 12:40 PM when she heard the resident cough. She explained that she went into the resident ' s room to make certain she was okay, and Resident #1 was breathing without difficulty. NA #1 stated she went back into Resident #1's room after a visitor had reported that she needed to be dressed. She stated that she and another nursing assistant (NA #2) entered Resident #1's room and discovered that the tracheostomy tube was not present on the resident throat area, and that the mask that covered the tracheostomy site was "off to the side." She further stated that the resident had one mitten completely off, and that the other was partially in place on her left hand. NA #1 stated the resident had blood on both of her hands, but that the right hand had the most blood present. NA #1 stated she then realized Resident #1 was not breathing, and that she and NA #2 attempted to arouse the resident by tapping on her feet, checking for a pulse, and providing a sternal rub. She stated that she then left the room to get a nurse. NA #1 also stated that the nurse did not

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tell her how often she should check on Resident #1 during the shift, but that she usually made her rounds every 2 hours.

In an interview with the nurse who was in charge on 06/13/2015, Nurse #3, on 07/16/2015 at 1:40 PM, she stated that the resident was cool to touch when she entered the resident ' s room and started CPR. Nurse #3 stated that if she had a resident with a tracheostomy who had restless or agitated behaviors, she would keep the resident in the day room for close monitoring.

A progress note dated 06/13/2015 at 8:32 PM which was signed by Nurse #1 documented the following: (Note: This progress note was not documented as a "Late Entry.")

"Situation: res (resident) found in bed lying still, not moving or breathing. Background: She
continuously pulls her mitts (mittens) off and pulls at O2 (oxygen) hookup and trach (tracheostomy.) CNA (certified nursing assistant) and I had to put mits (mittens) back on
mid-shift today and redirect her not to pull at trach (tracheostomy). She stated, "I don ' t
need it." Assessment: Found laying in bed not breathing, no response to verbal cue or sternal rub. Charge nurse was brought into room along with crash cart, chest compressions and CPR (cardiopulmonary resuscitation) were began. 911 was called and continued to stay on phone
until EMS (emergency medical service) arrived. Chest compressions and CPR was performed until EMS arrived ... "

A review of the local police department Event Log dated 06/13/2015 revealed that Resident #1's

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F 309	Continued From page 20 death occurred at 2:41 PM and that the resident ' s body was released to the mortuary at 3:15 PM on 06/13/2015. In an interview with the acting Director of Nursing on 07/16/2015 at 8:50 AM, she stated that she was not acting as the Director of Nursing when Resident #1 pulled out her tracheostomy and died on 06/13/2015, but it was an expectation that residents have a care plan to provide direction for nursing care with residents with special needs. The Administrator, acting Director of Nursing, and the facility's consultant nurse were notified of the immediate jeopardy in a meeting on 07/16/2015 at 2:40 PM. The facility provided the following credible allegation on 07/17/2015 at 1:09 PM: Credible Allegation of Compliance for F 309: This allegation of compliance is submitted in compliance with applicable law and regulation. To demonstrate continuing compliance with applicable law, the center has taken or will take the actions set forth in the following allegation of compliance. The following credible allegations constitutes the center's allegation of compliance. All alleged deficiencies have been or will be resolved by the dates indicated. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: The initial care plan being developed did not fully address the specialized care needs for the Tracheostomy.	F 309		

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F 309	Continued From page 21 On 07/16/15, The MDS nurse conducted an audit of the current (3) three tracheostomy residents to ensure the Care Plan objectives, care needs, and special needs for tracheostomy and mittens was accurate and completed. At the time of the audit, there were no new admissions with tracheostomy needs. How corrective action will be accomplished for those resident having potential to be affected by the same deficient practice: On 07/16/15, the MDS Nurse conducted an audit to validate the presence of an accurate current Care Plan for the current (3) three tracheostomy residents which addressed medical and nursing objectives and interventions for tracheostomy and special needs. On 07/16/15, the MDS Nurse, Director of Nursing, Unit Manager, and House Supervisors received education by the Staff Development Coordinator on the following Procedure points: the Care Plan will be activated upon admission, the Comprehensive Care plan will be completed within 7 days of the completion of the Comprehensive Assessment, the Care Plan will be updated by each discipline on an ongoing basis as changes in the patient occur and reviewed quarterly. On 07/16/15, all Licensed Nursing staff were educated by the Staff Development Coordinator on the Care Plan process, objectives, and interventions for patients with tracheostomy and mittens. All Licensed Nursing staff not scheduled on 07/16/15 will be in-serviced by the Staff Development Coordinator prior to returning to work. On 07/17/2015 at 3:20 PM, verification of the	F 309		

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F 309	Continued From page 22 credible allegation was evidenced via interviews with unit managers, supervising nurses and other licensed staff who stated they received in-service education regarding the importance of interim care plans and the initiation of interventions to provide safety for residents, as well as the importance of assessing residents for changes in condition.	F 309		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on physician interview, visitor interview, staff interviews, and record review, the facility failed to implement effective interventions necessary to prevent one of four residents who had a tracheostomy, Resident #1, from dislodging and removing the tracheostomy tube. The Immediate Jeopardy began on 06/13/2015 when Nurse #1 found Resident #1 undressed with her tracheostomy dislodged completely from her neck, and the efforts to resuscitate her at that time were unsuccessful. The Immediate Jeopardy was removed on 07/17/2015 at 4:05 PM when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity of no	F 323	The Statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: ¿ Based on documentation, after attempts by resident #1 to remove	9/15/15

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CAROLINA REHAB CENTER OF CUMBERLAND	4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306

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F 323	Continued From page 23 actual harm with the potential of no more than minimal harm that is not immediate jeopardy (D). The facility was in the process of full implementation of corrective action at that time. Findings included: Resident #1's Discharge Summary from a specialty hospital to the facility dated 06/10/2015 indicated that Resident #1 had a discharge diagnosis of respiratory failure, with a tracheostomy placed on 04/29/2015. The same Discharge Summary further indicated that the resident had encephalopathy, and that as a result, her mental status waxed and waned. A review of the admission paperwork which accompanied Resident #1 from the hospital included a Medicaid FL2 Form dated 06/10/2015 which revealed Resident #1 had a tracheostomy with 28% oxygen therapy, and that the resident wore mittens due to her pulling at the tracheostomy tube. An Interdisciplinary Plan of Care Discharge and Barrier Update from the hospital listed a goal to remove Resident #1's mittens without her dislodging her tubes or lines, and that a barrier to this goal was that Resident #1 had a tracheostomy. A review of the facility's Nursing Admission Assessment dated 06/10/2015 revealed Resident #1 was admitted to the facility on 06/10/2015 with a diagnosis of respiratory failure and that her level of cognition was unable to be determined because the resident was nonverbal. In addition, the same assessment revealed Resident #1 was totally dependent upon staff assistance for	F 323	tracheostomy, no changes in interventions were made. ¿ On 6/13/2015 at approximately 2:15 p.m., based on interview with the nurse and CNA on duty on at the time, Resident #1 was found to be unresponsive and not breathing. CPR was attempted by facility staff and 911 was called. Upon arrival, EMS team continued CPR efforts and later pronounced at the facility. ¿ All LPNs and RNs were in-serviced on 7/17/2015 regarding Change in Condition and Physician Notification utilizing the eINTERACT Model. This model encompasses recognizing a change, reviewing background to clarify change occurred, denoting assessment and/or observation and notifying physician of changes to notify of interventions put in place and further orders the physician may order. How the corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice ¿ All Licensed Practical Nurses and Registered Nurses were in-serviced on 7/17/2015 regarding the following eINTERACT bullets: 1) Recognizing a change in patient status and/or behaviors. 2) Reviewing patient background to verify change. 3) Documenting observation and assessing the patient to identify possible causes of changes. 4) Notification of Physician to inform of interventions put in place and receive new	

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F 323	Continued From page 24 locomotion, dressing, eating, toilet use, personal hygiene, and bathing. Under the category of "Skin" the comment box documented, "trach (tracheostomy) midline, clean." Under the "Motor Control" section of the assessment, the resident was documented as having an unsteady gait and poor balance. A review of the facility's Device Assessment dated 06/10/2015 revealed that "Mittens" were not marked as present on the assessment. Review of the progress notes revealed there was a note made upon admission on 06/10/2015 at 2:32 PM which stated, "O2 (oxygen) at 4 LPM (liters per minute) via trach (tracheostomy) collar. Breathing even, unlabored. Skin warm and dry. Resident able to stand with assist x 1 (with the assistance of one staff member.) Ambulates with assist x 1 (with the assistance of one staff member.) Admitted with mittens on both hands ... " This progress note was signed by Nurse #2. An interview was conducted with Nurse #2 on 07/15/2015 at 2:37 PM. Nurse #2 stated that she was the nurse who worked with Resident #1 on the day she was admitted to the facility on 06/10/2015, and that the resident was wearing her mittens which had been given to her by the hospital. Nurse #2 stated that right after admission while she was on duty, Resident #1 tried to get out of bed. She explained that she kept Resident #1 in the day room during the day after that incident because when she was around other people, she did not try to get up unassisted. Nurse #2 also stated that she was monitored by more staff members when she was in her geri-chair in the day room. Nurse #2 stated that she had seen the resident without her mittens on	F 323	orders if Physician deems appropriate. ¿ On 7/16/2015, all residents in house on this date with a tracheostomy (3 residents with tracheostomies) were reviewed for trach care orders, care plans, and interventions by the Staff Development Coordinator and Unit Managers. All were validated and in place. ¿ MDS Coordinators and Unit Managers were in-serviced by the Staff Development Coordinator 7/17/2015 on initiating the care plan at admission. As a routine practice, the Director of Nursing, Staff Development Coordinator and/or Unit Managers will review all new admissions with tracheostomies and/or mittens on the next business day to ensure that the trach and/or mittens have been care planned and that all special needs have been addressed. Care plans of the remaining three tracheostomy patients were reviewed and updated to reflect, the medical and nursing objectives for tracheostomies. ¿ All Licensed Practical Nurses and Registered Nurses were in-serviced on 7/16/2015 regarding the Documentation and Notification policy, which states the Charge Nurse is responsible for notifying the Physician and or the Responsible Party whenever there is a change related to the care of the patient with a tracheostomy exhibiting intolerance for the tracheostomy tube. All Licensed Practical Nurses and Registered Nurses not scheduled on 07/16/2015 will be in-serviced prior to	

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F 323	Continued From page 25 at times, but she had not ever seen the resident pull at the tracheostomy strap. Nurse #2 also stated that she was not even sure that the mittens were helpful in preventing the resident from pulling at her tracheostomy because the resident was very alert and capable of removing the mittens. In an interview with the Minimum Data Set (MDS) nurse (nurse responsible for writing care plans) on 07/15/2015 at 3:35 PM, she stated that from the time of admission on 06/10/2015, Resident #1 was known to have restless behaviors and that she pulled at her tracheostomy. In addition, she stated that there was a concern among the nursing staff regarding Resident #1's restless behavior and attempts to pull out her tracheostomy, and that this was discussed in detail in an interdisciplinary meeting and also on daily rounds. The MDS nurse stated she could not recall the exact date and time of the interdisciplinary meeting, but that usually the meetings were held on Thursday mornings, and that Thursday fell on 06/11/2015. She further explained that it was "common knowledge" that Resident #1 pulled off her mittens frequently, and that there was discussion about contacting the physician about getting a medication for agitation control. A review of the physician's orders revealed an order dated 06/11/2015 for "mittens to both hands for stability of trach" (tracheostomy.) There were no other physician orders regarding the tracheostomy or for restlessness or agitation. In an interview with Resident #1's physician on 07/16/2015 at 2:00 PM, he stated that in his History and Physical dated 06/11/2015, he did not	F 323	returning to work. ¿ On 7/16/2015, all Certified Nurses Assistants were in-serviced on notifying the charge nurse of change in resident condition, using the clinical alerts in the electronic medical record system and verbally. Any Certified Nurses Assistants not scheduled on 07/16/2015 will be in-serviced prior to returning to work. Measures put into place to ensure that the deficient practice will not occur: Daily Monday-Friday X (4) weeks and weekly X 4 weeks the Director of Nursing and or designee will conduct an audit of Behavior and Progress note documentation on tracheostomy patients for reporting, notification, and updated interventions to prevent de-cannulation. Director of Nursing and or designee will conduct daily Monday through Friday audits X (4) four weeks of the Point of Care documentation Change in Condition alerts for tracheostomy patients for reporting, notification, and updated interventions to prevent de-cannulation. Director of Nursing and or designee will conduct daily Monday through Friday (4) four CNA interviews X (4) four weeks to ensure understanding and documentation of eInteract Change in Condition alerts entry. New hire Licensed nurses will be in-serviced during orientation regarding the Documentation and Notification policy, which states the Charge Nurse is responsible for notifying the Physician and or the Responsible Party whenever there	

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F 323	Continued From page 26 record any combative behavioral problems related to her tracheostomy, such as pulling at her tracheostomy tubing or device, because she did not exhibit such behaviors at that time and he had not received reports of such behavior. The physician stated that he knew that the resident wore mittens upon admission to the facility due to her history of her pulling at the tracheostomy, and that he wrote an order for the mittens on 06/11/2015. The physician stated he did not recall getting a call from a staff member regarding any restless behaviors such as pulling at her tracheostomy or trying to get out of bed. The physician also stated that he did receive a call from a staff member after Resident #1 had expired on 06/13/2015 around mid-afternoon. Per the Minimum Data Set (MDS) 5-Day assessment dated 06/13/2015, Resident #1 displayed no behavioral symptoms, no rejection of care, and no wandering behaviors. There was no range of motion functional impairment for Resident #1, and there were no restraints checked for the resident. A progress note dated 06/13/2015 at 12:37 AM documented, "Resident able to verbalize needs to staff, resident was observed several times during shift removing mittens and grabbing at trach (tracheostomy). Resident alert x 2 (oriented to person and place), confusion noted." This note was signed by Nurse #7. In a telephone interview with Nurse #7 on 07/22/2015 at 2:22 PM, she stated that she actually worked on the 3:00 PM to 11:00 PM shift on 06/12/2015, but that she stayed after her shift was over in order to document in the progress notes. She stated that she could not recall many	F 323	is a change related to the care of the patient with a tracheostomy exhibiting intolerance for the tracheostomy tube. New hire Certified Nurses Assistants will be in-serviced during orientation on notifying the charge nurse of change in resident condition, using the clinical alerts in the electronic medical record system and verbally. Medical Facilities of North Carolina, Inc., with the assistance of Eldercare MB Consultants shall conduct a root cause analysis regarding the facilities survey history beginning July 1, 2011. The root cause analysis shall specify the systemic changes needed to foster sustained compliance rather than cyclic compliance with the Requirements of Participation. A copy of the root cause analysis shall be provided to CMS and the State by September 21st, 2015. A written report of the systemic changes initiated in the facility to foster a culture of quality and safety with a particular focus on resident centered care shall be provided to CMS and the State monthly for six months. The Director of Nursing will be responsible and accountable for the provision of quality care, treatment and services. How the facility plans to monitor and ensure correction is achieved and sustained The Director of Nursing will report the results of the audits weekly x (3) months in the Weekly Quality assurance Risk Meeting for problem resolution. The Administrator will report the results of the audits to the quarterly Quality	

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F 323	Continued From page 27 details about what she documented in the progress note on 06/13/2015, but stated if she documented that the resident was observed pulling on her tracheostomy tube, then it happened. Nurse #7 stated Resident #1 was sitting in the day room when she came on to work her 3:00 PM to 11:00 PM shift, and that she received a report from the day nurse regarding the resident ' s needs. She explained that she kept Resident #1 seated in the day room to visit with her family member and to frequently monitor her. Nurse #7 stated that when she observed Resident #1 pulling off her mittens and pulling at her tracheostomy tube, it occurred right after her family member left from a visit. Nurse #7 stated that Resident #1 became fidgety and upset when her family member left that day. Nurse #7 stated she went to her and replaced her mittens and explained to her why she had to wear them. Nurse #7 explained that the resident seemed to calm down after she explained the need for the mittens to her. She stated that she was uncertain whether the resident had been known to remove her mittens or pull at her tracheostomy tube before then. In addition, she stated she was not aware of any other interventions in place to address restless behavior or pulling at the tracheostomy tube. A progress noted dated 06/13/2015 at 1:51 AM documented ... "trach care provided. Resd (resident) wearing mittens on bilat (bilateral) upper extremities d/t (due to) resident attempting to remove trach. (tracheostomy) ...will continue to monitor." This progress note was signed by Nurse # 3. In an interview with Nurse #1 on 07/16/2015 at 11:27 AM, Nurse #1 stated that she was assigned	F 323	Assurance meeting X (2) quarter for tracking and trending of compliance. Medical Facilities of North Carolina, Inc., with the assistance of RS Connection, Inc shall conduct a root cause analysis regarding the facilities survey history beginning July 1, 2011. The root cause analysis shall specify the systemic changes needed to foster sustained compliance rather than cyclic compliance with the Requirements of Participation. A copy of the root cause analysis shall be proved to CMS and the State. A written report of the systemic changes initiated in the facility to foster a culture of quality and safety with a particular focus on resident centered care. Reports will be provided to CMS and the State monthly for six months. The Director of Nursing will be responsible and accountable for the provision of quality care, treatment and services.	

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to Resident #1 for just one day on 06/13/2015 and that she received a report from the previous shift ' s nurse who informed her that the resident needed the mittens to keep her from pulling at her tracheostomy site. Nurse #1 explained she had no knowledge of any other interventions being used to keep Resident #1 from pulling at her tracheostomy other than checking on her frequently, at least every 2 hours.

In an interview with the facility's consultant nurse on 07/16/2015 at 3:20 PM, she stated that Resident #1 had demonstrated that she was fully capable of removing her mittens and that the mittens were not considered to be a restraint. She added that the facility strived to be restraint-free facility, and that physical or chemical restraints were used only in special circumstances for a short period of time.

An interview was conducted on 07/15/2015 at 11:03 AM with the visitor who discovered Resident #1 undressed on 06/13/2015. During the interview, she stated that she came to visit the resident on 06/13/2015 shortly after 2:00 PM. The visitor stated that when she started to enter the resident's room, she noted the resident was wearing no gown or other clothing. She stated that she had not stayed in the entrance of the resident's room long enough to determine whether she was breathing and she just assumed the resident was asleep. The visitor stated that she did not want to embarrass the resident, so she backed out of the room and went to report to a staff member that the resident needed to be dressed. The visitor stated that when she went to the nurse's station to notify a staff member that Resident #1 needed to be dressed, there was no one at the nurse's station, so she found a staff

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member in the hall and reported it to her. She explained that the staff member then went into another resident's room for a brief moment, then came back out of that resident ' s room and got another nursing assistant to assist her with dressing Resident #1. She stated that after the nursing assistants entered the room, they stayed for a few minutes, then one of the nursing assistants came out of the room and ran to get another nurse.

In an interview with Resident #1's nursing assistant (NA #1) on 07/15/2015 at 2:40 PM, she stated that when she went to check on Resident #1 on 06/13/2015 between 8:00 Am and 9:00 AM, she found that Resident #1 was not wearing her mittens. She explained she then went to ask the nurse, Nurse #1, if the resident needed to wear the mittens all the time. The nursing assistant stated that Nurse #1 told her the resident needed to wear the mittens all the time to keep her from pulling at her tracheostomy tube, so she returned to the resident's room and applied the mittens per the nurse's direction. During the interview, she stated that the last time she saw the resident with her tracheostomy intact was between 12:35 and 12:40 PM when she heard the resident cough. She explained that she went into the resident ' s room to make certain she was okay, and Resident #1 was breathing without difficulty. NA #1 stated she went back into Resident #1 ' s room after a visitor had reported that she was unclothed and needed to be dressed. She stated that she and another nursing assistant (NA #2) entered Resident #1's room and discovered that the tracheostomy tube was not present on the resident throat area, and that the mask that covered the tracheostomy site was "off to the side." She further stated that the resident had

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one mitten completely off, and that the other was partially in place on her left hand. NA #1 stated the resident had blood on both of her hands, but that the right hand had the most blood present. NA #1 stated she then realized Resident #1 was not breathing, and that she and NA #2 attempted to arouse the resident by tapping on her feet, checking for a pulse, and providing a sternal rub. She stated that she then left the room to get a nurse. NA #1 also stated that the nurse did not tell her how often she should check on Resident #1 during the shift, but that she usually made her rounds every 2 hours.

In an interview with the nurse who was in charge on 06/13/2015, Nurse #3, on 07/16/2015 at 1:40 PM, she stated that the resident was cool to touch when she entered the resident's room and started CPR. Nurse #3 stated that if she had a resident with a tracheostomy who had restless or agitated behaviors, she would keep the resident in the day room for close monitoring. She also stated that if the restless behaviors or pulling at the tracheostomy tubing could not be controlled effectively, she would contact the physician to consider a possible medication to assist with preventing self-harm.

In an interview with Nurse #3 on 07/16/2015 at 1:40 PM, she stated that if a resident displayed restless behaviors or pulled at her tracheostomy tube, she would keep the resident in sight, perhaps in the day room next to the nurse's station. Nurse #3 also stated that if the restless behaviors or pulling at the tracheostomy tubing could not be controlled effectively, she would contact the physician to consider a possible medication to assist with preventing self-harm.

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A progress note dated 06/13/2015 at 8:32 PM which was signed by Nurse #1 documented the following: (Note: This progress note was not was not indicated as a "Late Entry.")

"Situation: res (resident) found in bed lying still, not moving or breathing. Background: She
continuously pulls her mitts (mittens) off and pulls at O2 (oxygen) hookup and trach (tracheostomy.)CNA (certified nursing assistant) and I had to put mits (mittens) back on
mid-shift today and redirect her not to pull at trach (tracheostomy). She stated, "I don't
need it." Assessment: Found laying in bed not breathing, no response to verbal cue or sternal rub. Charge nurse was brought into room along with crash cart, chest compressions and CPR (cardiopulmonary resuscitation) were began. 911 was called and continued to stay on phone
until EMS (emergency medical service) arrived. Chest compressions and CPR was performed until EMS arrived ... "

A review of the local police department's Event Log dated 06/13/2015 revealed that Resident #1's death occurred at 2:41 PM and that the resident's body was released to the mortuary at 3:15 PM on 06/13/2015.

The Administrator, acting Director of Nursing, and the facility's consultant nurse were notified of the immediate jeopardy in a meeting on 07/16/2015 at 2:40 PM.

The facility provided the following credible allegation on 07/17/2015 at 1:40 PM:

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F 323	Continued From page 32 This allegation of compliance is submitted in compliance with applicable law and regulation. To demonstrate continuing compliance with applicable law, the center has taken or will take the actions set forth in the following allegation of compliance. The following credible allegations constitutes the center's allegation of compliance. All alleged deficiencies have been or will be resolved by the dates indicated. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: · Based on documentation, after attempts by resident #1 to remove tracheostomy, no changes in interventions were made. · On 6/13/2015 at approximately 2:15 p.m., based on interview with the nurse and CNA on duty on at the time, Resident #1 was found to be unresponsive and not breathing. CPR was attempted by facility staff and 911 was called. Upon arrival, EMS team continued CPR efforts and later pronounced at the facility. · All LPNs and RNs were in-serviced on 7/17/2015 regarding Change in Condition and Physician Notification utilizing the eINTERACT Model. This model encompasses recognizing a change, reviewing background to clarify change occurred, denoting assessment and/or observation and notifying physician of changes to notify of interventions put in place and further orders the physician may order. · How corrective action will be accomplished for those resident having potential to be affected by the same deficient practice: · On 7/16/2015, all residents in house on this date with a tracheostomy (3 residents with trachs)	F 323		

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F 323	Continued From page 33 were reviewed for trach care orders, care plans, and interventions by the Staff Development Coordinator and Unit Managers. All were validated and in place. · MDS Coordinators and Unit Managers were in-serviced by the Staff Development Coordinator 7/17/2015 on initiating the care plan at admission. As a routine practice, the Director of Nursing, Staff Development Coordinator and/or Unit Managers will review all new admissions with trachs and/or mittens on the next business day to ensure that the trach and/or mittens have been care planned and that all special needs have been addressed. · All Licensed Practical Nurses and Registered Nurses were in-serviced on 7/16/2015 regarding the Documentation and Notification policy, which states the Charge Nurse is responsible for notifying the Physician and or the Responsible Party whenever there is a change related to the care of the patient. All Licensed Practical Nurses and Registered Nurses not scheduled on 07/16/2015 will be in-serviced prior to returning to work. · On 7/16/2015, all Certified Nurses Assistants were in-serviced on notifying the charge nurse of change in resident condition, using the clinical alerts in the electronic medical record system and verbally. Any Certified Nurses Assistants not scheduled on 07/16/2015 will be in-serviced prior to returning to work. On 07/17/2015 at 3:20 PM, verification of the credible allegation was evidenced via interviews with unit managers, supervising nurses and other licensed staff who stated they received in-service education regarding the importance of initiation of interventions to provide safety for residents to	F 323		

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	345505	A. BUILDING _____ B. WING _____	C 07/22/2015

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CAROLINA REHAB CENTER OF CUMBERLAND	4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306

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F 323	Continued From page 34 prevent accidents for residents with tracheostomies, such as frequent monitoring and notification of the physician as needed for other interventions.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to connect continuous oxygen into a continuous positive airway pressure (CPAP) machine which resulted in low oxygen saturation rates for 1 of 6 sampled residents (Resident #6) receiving respiratory care. Findings included: A 07/08/15 hospital discharge summary documented Resident #6's principle diagnoses on discharge were "acute on chronic respiratory failure, multifactorial, secondary to chronic heart failure and history of lung cancer, and right- sided pneumonia." The summary also documented, "He is on 2 liters (oxygen) via nasal cannula....He was started on intravenous antibiotics for possible pneumonia ....He was requiring bilevel positive	F 328	The Statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #6 no longer resides at Carolina	8/10/15

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F 328	Continued From page 35 airway pressure (BiPAP) at night. During the day he did not require BiPAP ....I talked to the respiratory therapist and the patient can use continuous positive airway pressure (CPAP) at night." 07/08/15 hospital discharge instructions documented, "CPAP at night." Resident #6 was admitted to the facility on 07/09/15. His documented diagnoses included lung cancer, chronic obstructive pulmonary disease (COPD), and pneumonia. A 07/09/15 Nursing Admission Assessment documented Resident #6 was alert and oriented to person, place, time, and situation, and his cognition was intact. The assessment also documented the resident experienced shortness of breath upon exertion, and fine crackles were heard in the bilateral lower lobes of his lungs. Resident #6's admitting orders to the facility on 07/09/15 included use of CPAP at night and 2 liters of continuous oxygen via nasal cannula. A 07/09/15 2:40 PM progress note documented Resident #6 was alert and oriented to person/place/time, and was verbal with clear speech. His respirations were documented as even with shortness of breath upon exertion or exercise. The resident was educated on lip pursed breathing, and his oxygen saturation was 97% on two liters of oxygen per minute. In a 07/09/15 progress note Nurse #4 documented at 10:00 PM a nursing assistant (NA) informed her that she (the NA) placed Resident #6 on the CPAP per family request since she (the nurse) was involved in completing	F 328	Rehab Center of Cumberland. How corrective action will be accomplished for those resident having potential to be affected by the same deficient practice: Licensed nurses were in-serviced on Nursing Policies and Procedures #2701, Respiratory Care, Respiratory/Oxygen Equipment, which states,¿ Licensed nurses will administer and maintain respiratory equipment, oxygen administration, and oxygen equipment per physician¿s order and in accordance with standards of practice¿. Measures put into place to ensure that the deficient practice will not occur: Daily Monday-Friday X (2) two weeks and weekly X 2 weeks the Director of Nursing and or designee will conduct audits of with CPAP Oxygen connection to validate proper oxygenation per physician¿s order and in accordance with stands of practice. New hire Licensed Nurses will receive education during orientation on Nursing Policies and Procedures #2701, Respiratory Care, Respiratory/Oxygen Equipment, which states,¿ Licensed nurses will administer and maintain respiratory equipment, oxygen administration, and oxygen equipment per physician¿s order and in accordance with standards of practice. How the facility plans to monitor and ensure correction is achieved and sustained:	

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F 328	Continued From page 36 a wound treatment. At 10:15 PM Nurse #4 documented a family member reported Resident #6 was short of breath, and the resident's oxygen saturation was 78% with the CPAP running. She reported she removed the CPAP, and began oxygen via the nasal cannula, with the resident's oxygen saturation climbing to 93 - 95%. According to Nurse #4, the family member questioned why the oxygen was not hooked into the CPAP. The NA stated connecting oxygen into the resident's CPAP was not necessary for proper oxygenation. Nurse #4 documented she was not familiar with the specific type of CPAP machine being utilized for Resident #6 so she located the instruction manual, and discovered that a "T-connector" was to be used to feed the continuous oxygen into the CPAP. Once the oxygen was connected to the CPAP via the "T-connector" the nurse documented the resident's oxygen saturation rates were 93 - 96 %. A 07/10/15 2:40 AM progress note documented Resident #6's oxygen saturation was 93% with oxygen and the CPAP in place. On 07/10/15 Resident #6's care plan identified "The resident has altered respiratory status/difficulty breathing r/t (in regard to) COPD" as a problem. Goals for the problem included, "The resident will have no s/sx (signs or symptoms) of poor oxygen absorption through the review date. The resident will maintain normal breathing pattern as evidenced by normal respirations, normal skin color, and regular respiratory rate/pattern through the review date. The resident will have no complications related to SOB (shortness of breath) through the review date." Interventions to the problem included	F 328	The Director of Nursing will report the results of the audits weekly x (1) month in the Weekly Risk Meeting for problem resolution. The Administrator will report the results of the audits to the quarterly Quality Assurance Meeting X (1) quarter for tracking and trending of compliance.	

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"Correct CPAP usage" and "Monitor/document changes in orientation, increased restless, anxiety, and air hunger."

A late-entry progress note for 7/10/15 at 8:40 PM documented Nurse #5 found Resident #6's oxygen saturation rate to be 64% after family complained of the resident being extremely short of breath. The CPAP mask was found on the pillow next to the resident's face. A nebulizer treatment was provided to help oxygen flow and the CPAP was applied, with the oxygen saturation gradually reaching 87%. According to the note, the family complained that the CPAP was not applied correctly, and Nurse #6 intervened. Upon the family's departure the resident's oxygen saturation was up to 92%.

A 07/11/15 12:39 PM progress note documented Nurse #3, a unit manager, was approached by members of Resident #6's family who did not feel comfortable keeping the resident in the facility since the resident's oxygen saturation rates ran very low the past two nights. The note documented the resident's was discharged from the nursing home at 11:00 AM on 07/11/15.

At 2:10 PM on 07/16/15 Nurse #3 stated she interviewed the second shift nurses who cared for Resident #6 on 07/09/15 and 07/10/15 after the resident was discharged from the facility on 07/11/15 with complaints that staff did not know how to feed oxygen into the resident's CPAP. She reported Nurse #4 commented she had not worked with continuous oxygen in conjunction with CPAP usage before, and had to consult the instruction manual for direction. Nurse #5 reported she had worked with the combination before, and it was not necessary for the oxygen to

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feed into the CPAP. According to Nurse #3, she informed Nurse #5 that she was incorrect, and referred her to the CPAP instruction manual. Nurse #3 stated not using the "T-connector" to feed oxygen into Resident #6's CPAP on the nights of 07/09/15 and 07/10/15 contributed to the resident's low oxygen saturation rates. According to Nurse #3, she was not aware of any facility-wide education about utilizing continuous oxygen in conjunction with CPAP therapy.

At 4:50 PM on 07/16/15 the administrator stated Nurse #5 was no longer employed by the facility, and multiple attempts to reach her by phone were unsuccessful.

At 5:25 PM on 07/16/15 Nurse #4 stated a nurse was supposed to apply the CPAP, but on the night of 07/09/15 the NA applied Resident #6's CPAP because she (the NA) was trying to help out the nurse (Nurse #4) who was already multi-tasking. According to Nurse #4, she also realized when reviewing Resident #6's oxygen and CPAP connection that the dial which the staff thought controlled the liters of oxygen on the concentrator actually controlled the humidification level. This nurse stated that she and the NA working on 07/09/15 gained clarification about the way Resident #6's oxygen fed into his CPAP, but there was no in-servicing following this incident which informed the rest of the staff about how to achieve maximum oxygenation when a resident was receiving continuous oxygen and CPAP services.

At 9:38 AM on 07/17/15 the interim director of nursing (DON) and staff development coordinator (SDC) stated there was no facility-wide in-servicing about CPAP/oxygen usage as of yet,

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F 328	Continued From page 39 but there were no residents currently in the building utilizing a CPAP machine. At 9:52 AM on 07/17/15, during a telephone interview, Nurse #6 stated on 07/10/15 she intervened to help Nurse #5 resolve grievances from the family of Resident #6. She reported the family was upset, saying this was the second evening in a row that the resident's oxygen saturation was very low. They alleged the staff did not know how to keep the resident oxygenated while on his CPAP. Nurse #6 explained that Nurse #5 was saying she did not think the resident's oxygen fed into the CPAP, and the family reported instructions were read the night before which specified that continuous oxygen was fed into the CPAP using a "T-connector". According to Nurse #6, the family alleged Resident #6's lips and mouth were blue when they found him on 07/10/15, but she commented when she observed the resident after intervening on 07/10/15 the resident was verbal, and his lips were pink. Once Resident #6's oxygen was connected to the C-PAP on 07/10/15, the nurse reported the resident's oxygen saturation was up around the low 90s. Nurse #6 stated there had been no facility-wide in-servicing about how to keep resident's properly oxygenated when they were on continuous oxygen and a CPAP machine.	F 328		