DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	D. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		345380	B. WING				C 13/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1	601 PURDUE DRIVE		
	AB AND HC CTR AT VILL	AGE GR		F	AYETTEVILLE, NC 28304		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 164 SS=D	PRIVACY/CONFIDER	PERSONAL NTIALITY OF RECORDS right to personal privacy and or her personal and clinical	F 1	164			4/10/17
	records. Personal privacy inclumedical treatment, we communications, person meetings of family and does not require the f room for each resider Except as provided in section, the resident of release of personal a individual outside the The resident's right to and clinical records d resident is transferred institution; or record of The facility must keep contained in the resident the form or storage m release is required by	udes accommodations, ritten and telephone sonal care, visits, and d resident groups, but this acility to provide a private nt. a paragraph (e)(3) of this may approve or refuse the nd clinical records to any facility. b refuse release of personal oes not apply when the d to another health care elease is required by law. c confidential all information lent's records, regardless of bethods, except when r transfer to another law; third party payment					
	by: Based on medical re Party (RP) interview a facility failed to honor by transferring medic for 1 of 1 sampled res	· · ·			F 164: 483.10(e), 483.75(l) (4) □ PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 1) Actions taken for Residents #3: A. With regards to resident #3, no		
I ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	F		TITLE		(X6) DATE

Electronically Signed

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.

03/28/2017

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/31/201 FORM APPROVEI OMB NO. 0938-039
STATEMENT OF DEFICIENCIES (2 AND PLAN OF CORRECTION				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345380	B. WING		03/13/2017
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATI	E, ZIP CODE
THE REHAB AND HC CTR AT VILLAGE GR				1601 PURDUE DRIVE FAYETTEVILLE, NC 28304	4
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCE	LAN OF CORRECTION (X5) VE ACTION SHOULD BE COMPLETION ED TO THE APPROPRIATE DATE FICIENCY)
F 164	Continued From page	e 1	F 16	4	
	 9/29/2015 with diagned Cerebrovascular, Muthypertension. The Midated 1/13/2017 indices severely cognitively in During the interview of Services on 3/13/2017 the RP did not speak regarding the transfer another facility. She fispoke to Nurse # 1 all the resident to another facility. During the interview of at 11:30 AM, she repeating the interview of 11:45 AM, he reported consent to the facility records to another facility records to another facility. 	REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 indings included: Resident # 3 was admitted to the facility on /29/2015 with diagnosis of Hemiplegia, Cerebrovascular, Muscle weakness, Dysphagia, Rypertension. The Minimum Data Set (MDS) ated 1/13/2017 indicated the resident was everely cognitively impaired. Ouring the interview with the director of Social fervices on 3/13/2017 at 10:55 AM. She reported the RP did not speak with her personally egarding the transfer of the medical records to nother facility. She further reported the RP poke to Nurse # 1 about looking into transferring he resident to another facility. Ouring the interview with Nurse # 1 on 3/13/2017 t 11:30 AM, she reported she did not document nywhere in the records regarding the RP giving onsent to transfer the medical records to nother facility.		 corrective action coul resident information h disseminated. We di resident #3 and the F 2) Actions taken for the potential for being A. On 3/28/2017 the staff were in-serviced Worker regarding: (1) The importance of resident or RP has re- information to be sen prior to the dissemina- information. 3) Actions taken to recurrence: A. Social Worker, o all requests for inform of the facility 2X weel proper documentation B. Following Step 3 designee, will conduct audits X 2 months, fo 2 quarters, and as ne with documentation of resident information. 4) Monitoring for ou established plan and facility QAA/QAPI con A. Social Worker, d results of audits to ma team meeting for revi- weeks. B. Results of all audition of the set of all audition of the set of all audition of the set of all audition of the set of all audition of the set of all audition of the set of the set of all audition of the set of the set of the set	had already been d apologize to RP for the error. r all residents due to g affected: e appropriate facility by the Social of documenting that a equested for resident t outside the facility ation of the prevent further r designee, will audit hation to be sent out k for 4 weeks for n of such request. eX, Social Worker, et random monthly blowed by quarterly X beded for compliance of all requests for utcomes of involvement of mmittee: lesignee, will bring orning administrative iew, weekly X 4
				the facility QAA meet Worker, designee, an QAA committee mont quarterly X 2 quarters C. Any non-complia	nd reviewed by the thly X 2 months, s, and as needed.

Event ID: XUVJ11

Facility ID: 943524

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CENTER	-	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	FORM APPRON OMB NO. 0938-03 (X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		B. WING		C 03/13/2017	
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•
THE REH	AB AND HC CTR AT VILL	AGE GR		601 PURDUE DRIVE AYETTEVILLE, NC 28304	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETI
F 164 F 250 SS=D	Continued From page 2 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.		F 164 F 250	 plan will reviewed by the QAA/QAPI committee for root cause and interventions implemented as needed and/or established plan revised. D. Discussion, interventions, and/or revisions to established plan will be included in the meeting minutes. E. Any adjustment to the established plan, through revision and/or intervent for non-compliance will require re-in servicing of the applicable staff by the Social Worker, or appropriate designe F. Any revision to the established plaw will require the monitoring to begin aga at Step 4A and continue as outlined. 	ions e. an
	by: Based on medical re Party (RP) interview a facility failed to acqui transferring medical r 1 of 1 sampled reside Findings included: Resident # 3 was adr 9/29/2015 with diagne	ecords to another facility for ent.(Resident # 3) nitted to the facility on		F 250: 483.15(g) (1), □ PROVISION (MEDICALLY RELATED SOCIAL SERVICE 1) Actions taken for Residents #3: A. With regards to resident #3, no corrective action could be taken since resident information had already been disseminated. We did apologize to resident #3 and the RP for the error. 2) Actions taken for all residents due the potential for being affected:	the

Event ID: XUVJ11

Facility ID: 943524

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345380 B. WING 03/13/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1601 PURDUE DRIVE** THE REHAB AND HC CTR AT VILLAGE GR FAYETTEVILLE, NC 28304 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 250 Continued From page 3 F 250 Hypertension. The Minimum Data Set (MDS) A. On 3/28/2017 the appropriate facility dated 1/13/2017 indicated the resident was staff were in-serviced by the Social Worker regarding: severely cognitively impaired. (1) The importance of documenting that a During the interview with the director of Social resident or RP has requested for resident Services on 3/13/2017 at 10:55 AM. She reported information to be sent outside the facility the RP did not speak with her personally prior to the dissemination of the regarding the transfer of the medical records to information. another facility. She further reported the RP 3) Actions taken to prevent further spoke to Nurse # 1 about looking into transferring recurrence: the resident to another facility. A. Social Worker, or designee, will audit all requests for information to be sent out During the interview with Nurse # 1 on 3/13/2017 of the facility 2X week for 4 weeks for at 11:30 AM, she reported she did not document proper documentation of such request. anywhere in the records regarding the RP giving B. Following Step 3A, Social Worker, consent to transfer the medical records to designee, will conduct random monthly another facility. audits X 2 months, followed by guarterly X 2 guarters, and as needed for compliance During the interview with the RP on 3/13/2017 at with documentation of all requests for 11:45 AM, he reported he did not give any resident information. consent to the facility's staff to transfer medical 4) Monitoring for outcomes of records to another facility. established plan and involvement of facility QAA/QAPI committee: During the interview with Administrator on A. Social Worker, designee, will bring 3/13/2017 at 3:00 PM, he reported he expected results of audits to morning administrative the staff to have document the conversation with team meeting for review, weekly X 4 the RP regarding consent to transfer the medical weeks. records to another facility. Results of all audits will be brought to B the facility QAA meeting by the Social Worker, designee, and reviewed by the QAA committee monthly X 2 months, guarterly X 2 guarters, and as needed. C. Any non-compliance with established plan will reviewed by the QAA/QAPI committee for root cause and interventions implemented as needed and/or established plan revised. D. Discussion, interventions, and/or revisions to established plan will be

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 943524

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/31/2017 MAPPROVED D. 0938-0391
		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED	
345380			B. WING	B. WING			C / 13/2017
NAME OF PROVIDER OR SUPPLIER				ST	REET ADDRESS, CITY, STATE, ZIP CODE		
THE REHAB AND HC CTR AT VILLAGE GR					01 PURDUE DRIVE AYETTEVILLE, NC 28304		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 250	Continued From page		F 2		included in the meeting minutes. E. Any adjustment to the established plan, through revision and/or interventie for non-compliance will require re-in servicing of the applicable staff by the Social Worker, or appropriate designed F. Any revision to the established pla will require the monitoring to begin aga at Step 4A and continue as outlined.	e. n	
F 278 SS=D	483.20(g) - (j) ASSES ACCURACY/COORD The assessment mus resident's status.		F 2	278			4/10/17
	each assessment with participation of health						
	assessment is complete Each individual who control assessment must sign that portion of the asses Under Medicare and I willfully and knowingly false statement in a re- subject to a civil mone \$1,000 for each asses willfully and knowingly to certify a material and	eted. completes a portion of the n and certify the accuracy of					
	penalty of not more the assessment.						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345380	B. WING				C 13/2017	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	10/2011	
THE REH	AB AND HC CTR AT VILL	AGE GR			601 PURDUE DRIVE AYETTEVILLE, NC 28304			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 278	material and false sta This REQUIREMENT by: Based on record revif facility failed to accura limitation in range of m minimum Data Set (N Annual Comprehension of five (5) sampled revised The findings are: Resident # 1 was addred diagnosis of Hyperter Disease, Diabetes Mereview of the resident staff had assessed the extremity impairment assessment dated 1/2 Comprehensive Annua 05/03/2016. During an interview of MDS coordinator ack must have been missible because Resident (# impairment. During an interview of Administrator and the	tement. T is not met as evidenced ew and staff interviews, the ately assess the functional motion for the quarterly IDS) assessment and the ve Assessment for one (1) sidents. (Resident #1) nitted to the facility with asion, Peripheral Vascular ellitus, and Dementia. A 's medical record revealed e resident's as no upper in the Quarter MDS 26/17 and the al MDS Assessment dated n 3/13/17 at 3:12 PM, the nowledged the assessment ed or was overlooked, 1) has upper extremity n 3/13/17 at 3:25 PM, the Director of Nursing (DON) ations of MDS Staff was to	F	278	 F 278: 483.20(g) □ (j) ASSESSMENT ACCURACY/COORDINATION/CERTIF D 1) Actions taken for Residents #1: A. With regards to resident #1, the M was immediately corrected to accurate reflect that the resident has upper extremity impairment. 2) Actions taken for all residents due the potential for being affected: A. On/before 4/10/2017, the MDS Coordinator, appropriate designee, will visually assess all residents for upper of lower extremity impairment. The MDS Coordinator, appropriate designee, will then compare all assessments to the MDS to ensure accurate coding. B. On 3/28/2017 all MDS nursing sta were in-serviced by the ADON regardir (1) The importance of capturing extreat impairment coding properly for MDS/C Planning. 3) Actions taken to prevent further recurrence: A. MDS Coordinator, or designee, wi audit all Initial MDS Assessment Sheet 2X week for 4 weeks for proper extremt impairment coding. B. Following Step 3A, MDS Coordinated designee, will conduct random monthly audits X 2 months, followed by quarter 	FIE DS ly to pr ff ng: mity are II ss ity ttor, / ly X		
					2 quarters, and as needed for complian with extremity impairment coding in the MDS Any non-compliance will be			

Event ID: XUVJ11

Facility ID: 943524

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DEPARTMENT OF HE						FORM	D: 03/31/201 MAPPROVEI D. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345380				(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED	
		B. WING	C 1 3/2017					
NAME OF PROVIDER OR SUPPLIER			I	ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
THE REHAB AND HC CT	THE REHAB AND HC CTR AT VILLAGE GR			1601 PURDUE DRIVE				
				F/	AYETTEVILLE, NC 28304			
PREFIX (EACH	DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 278 Continued F	rom page 6	5	F	278	 addressed by the MDS Coordinator, designee, as soon as practical. 4) Monitoring for outcomes of established plan and involvement of facility QAA/QAPI committee: A. MDS Coordinator, designee, will the results of audits to morning administrate team meeting for review, weekly X 4 weeks. B. Results of all audits will be brough the facility QAA meeting by the MDS Coordinator, designee, and reviewed the QAA committee monthly X 2 mon quarterly X 2 quarters, and as needed C. Any non-compliance with establis plan will reviewed by the QAA/QAPI committee for root cause and interventions implemented as needed and/or established plan revised. D. Discussion, interventions, and/or revisions to established plan will be included in the meeting minutes. E. Any adjustment to the established plan, through revision and/or intervent for non-compliance will require re-in servicing of the applicable staff by the ADON, or appropriate designee. F. Any revision to the established plan will require the monitoring to begin aga at Step 4A and continue as outlined. 	tive nt to oy ths, hed ions		

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