STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 04/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION 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 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews, the facility failed to administer topical medications as ordered by the physician for 1 of 1 resident reviewed for receiving care according to professional standards (Resident #4). Findings Included: Resident #4 was admitted to the facility on 04/24/14 with diagnoses which included diabetes mellitus and multiple furuncles (bumps under the skin caused by infected and inflamed hair follicles). A review of Resident #4's Minimum Data Set (MDS), dated 03/03/18, revealed Resident #4 to be cognitively intact and required total assistance with her Activities of Daily Living. The MDS indicated Resident #4 had open lesions other than ulcers, rashes and cuts. A review of Resident #4's Care Plan, last updated 10/10/17, revealed Resident #4 had been care planned for potential or actual skin integrity related to the diagnosis of multiple furuncles with a goal of Resident #4's furuncles to be healed by the completion of antibiotic therapy. Interventions included medications and treatment as ordered.	F 658	F 658 The process that led to the deficiency is assigned hall nurses failed to administer resident # 4 topical medications as ordered by the physician. Resident # 4 was administered topical medications as ordered by the physician on 4/24/2018 by the assigned nurse with oversight by the Facility nurse consultant. 100 % Medication Pass audit was initiated on 4-17-2018 by the Facility Consultant and Staff Facilitator (SF) utilizing a Medication Pass Audit Tool with all licensed nurses to include agency staff and medication aides to ensure that orders were being followed as transcribed on the Medication Administration Record (MAR) to include resident # 3 topical medications to be completed by 5/3/2018. Licensed nurse to include agency staff or medication aide will be re-educated during Medication Pass audit for any identified areas of concern by the Facility Consultant and Staff Facilitator. 100 % in-servicing was initiated on 4/17/2018 by the Staff Facilitator with all licensed nurses to include agency staff and medication aides in regards to medications are to be administered as	5/3/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/03/2018

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F 658	Continued From page 1 A review of Resident #4's April 2018 Medication Administration Record (MAR) indicated Resident #4 had physician orders for Hibiclens Liquid (a topical antiseptic cleanser) to be used as a daily body wash to her groin, buttocks and underarms. The MAR indicated Resident #4 had physician orders for Clindamycin Solution 1% (a topical antibiotic solution) to be applied to her groin, buttocks and bilateral axillae (underarms) twice daily. The Hibiclens Liquid had been signed off on the MAR by Nurse #2 as having been administered at 8:00 a.m. on 04/16/17 and 04/17/17 as ordered. The Clindamycin Solution had been signed off on the MAR by Nurse #2 as having been administered on 04/16/17 at 8:00 a.m. and 4:00 p.m. as ordered and on 04/17/18 at 8:00 a.m. as ordered. During an interview with Resident #4 on 04/17/18 at 10:50 a.m., Resident #4 stated her skin had not been treated with the Hibiclens Liquid or Clindamycin Solution on 04/16/18 or 04/17/18 and stated the staff had barely ever treated her skin with either topical medication from the time they had been ordered. During an interview with Nurse #2 on 04/17/18 at 11:00 a.m., Nurse #2 stated her initials on the MAR indicated she had administered a medication as ordered. When asked about her initials on 04/16/18 and 04/17/18 for the Hibiclens Liquid and Clindamycin Solution, Nurse #2 stated she had not administered these medications. When asked why she had signed them off as having been administered, Nurse #2 stated the Nursing Assistants were supposed to administer those medications. During an interview with the Administrator of	F 658	transcribed on the MAR to include topical medications. Initials are to be documented on the MAR under the correct date and next to the correct medication after administration to be completed on 5/3/2018. All newly hired licensed nurses to include agency staff and medication aides will be in-serviced during orientation in regards to medications are to be administered as transcribed on the MAR to include topical medications. Initials are to be documented on the MAR under the correct date and next to the correct medication after administration. 10 % of licensed nurse to include agency staff and medication aides will be audited by the Staff Facilitator and or Director of Nursing (DON) weekly X 8 weeks and monthly X 1 month utilizing a Medication Pass Audit tool to ensure that orders were being followed as transcribed on the Medication Administration Record (MAR) to include resident # 3 topical medications. The Staff Facilitator/Director of Nursing will re-educate the licensed nurse to include agency staff or medication aide during the medication pass audit for any identified areas of concerns. The DON will review and initial the Medication Pass audit tools weekly X 8 weeks and Monthly X 1 month for completion and to ensure that all areas of concerns have been addressed. The Director of Nursing will forward the results of the Medication Pass Audit tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Medication Pass Audit tool to	

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F 658	Continued From page 2 04/17/18 at 12:20 p.m., the Administrator stated it was her expectation nursing staff administer medications as ordered.	F 658	determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews, the facility failed to provide showers as scheduled for 1 of 1 resident reviewed (Resident #3). Findings Included: Resident #3 was admitted to the facility on 02/20/18 with diagnoses which included quadriplegia. A review of Resident #3's Minimum Data Set (MDS), dated 02/27/18, revealed Resident #3 was cognitively intact and required total dependence on staff for his Activities of Daily Living. The MDS indicated Resident #3 felt it was very important for him to be able to choose between a tub bath, shower, bed bath or sponge bath. A review of Resident #3's Care Plan, last updated on 02/13/18, indicated Resident #3 required total dependence on staff for bathing and personal hygiene related to impaired mobility, impaired balance, physical limitations and the diagnosis of	F 677	The process that led to the deficiency was that the assigned hall nursing assistant failed to provide resident # 3 a shower per the shower schedule. Resident # 3 was offered and given a shower on 4/17/2018 by the assigned hall nursing assistant with oversight by the assigned hall nurse. A 100% audit will be completed by 5/3/2018 by the Staff Facilitator to include resident # 3 to ensure residents receive a shower according to the shower schedule. Any negative findings will be addressed immediately by the Staff Facilitator/Quality Improvement nurse during the time of the audit. 100% in-servicing initiated by Staff Facilitator/Quality Improvement Nurse on 4/17/2018 for all nursing assistants to include agency staff, related to Cleaning and bathing your residents. Both of these task are a daily requirement unless resident prefers otherwise. Showers to be given by shower schedule unless resident prefers otherwise. If care cannot be	5/3/18

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F 677	Continued From page 3 quadriplegia. During an interview with Resident #3 on 04/16/18 at 10:40 a.m., Resident #3 stated he had not had a shower since he had been admitted to the facility. Resident #3 stated he had voiced his desire for a shower to the Social Worker on two separate occasions and still had not received a shower. A review of the Nursing Assistant (NA) documentation of bathing for Resident #3 indicated Resident #3 had received full or partial bed baths but no showers since having been admitted to the facility. A review of the facility's shower schedule indicated Resident #3 had been scheduled to receive a shower on the 11 pm - 7 am shift on Tuesdays and Saturdays. During an interview with the Social Worker (SW) on 04/17/18 at 9:35 a.m., the SW stated she did not recall having had a conversation with Resident #3 about his desire to have a shower. During an interview with NA #2 on 04/17/18 at 12:58 p.m., NA #2 stated he worked on the 11p - 7a shift at the facility and had never given Resident #3 a shower on his scheduled shower nights. NA #2 stated typically, when he entered Resident #3's room, Resident #3 requested to be put to bed. When asked if he had ever offered Resident #3 a shower, NA #2 stated Resident #3 had been able to make his needs known and if he had wanted a shower, he would have asked for it. During an interview with NA #3 on 04/17/18 at 1:15 p.m., NA #3 stated she worked on the 11p -	F 677	performed for any reason or performed timely, the nurse must be notified. The nurse must ensure that the care needed is provided for the resident in a timely and accurate manner. Nursing assistants must notify the nurse about all refusals of care so that nurse can document in progress note to include notification of Resident Representative of the care being refused to be completed by 5/3/2018. All newly hires nursing assistants, to include agency staff will be in-serviced on Cleaning and bathing your residents. Both of these task are a daily requirement unless resident prefers otherwise. Showers to be given by shower schedule unless resident prefers otherwise. If care cannot be performed for any reason or performed timely, the nurse must be notified. The nurse must ensure that the care needed is provided for the resident in a timely and accurate manner. Nursing assistants must notify the nurse about all refusals of care so that nurse can document in progress note to include notification of Resident Representative of the care being refused during orientation by 5/3/2018. Staff Facilitator/Quality improvement nurse will monitor 10% of all residents to include resident # 3 to ensure showers are being provide per the shower schedule utilizing a Shower audit tool weekly for 8 weeks and monthly for 1 month. The assigned nursing assistant will be immediately retrained during the audit by Staff Facilitator/Quality Improvement nurse for any identified areas of concern. The DON will review and initial the Shower audit tools weekly	

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F 677	Continued From page 4 7a shift at the facility and had never given Resident #3 a shower on his scheduled shower nights. NA #3 stated she had offered him a shower one time and Resident #3 had refused. NA #3 stated she had spoken with a day shift NA who had told her not to worry about it because Resident #3 got a good bed bath on day shift. During an interview with the Administrator on 04/17/18 at 12:20 p.m., the Administrator stated it was her expectation nursing staff provide showers to residents as scheduled.	F 677	for 8 weeks and monthly for 1 month for completion and to ensure all areas of concerns were addressed. The Director of Nursing will forward the results of the Shower Audit tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Shower Audit tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility's quality assurance (QA) process failed to implement, monitor and revise as needed the action plan developed for the revisit survey dated 9/27/17 in order to achieve and sustain compliance. This was for one recited deficiency on complaint survey on 4/17/18. The deficiency was in the area of professional standards at CFR 483.21. The continued failure during two federal surveys of record showed a pattern of the facility's inability to sustain an effective quality assurance program. The findings included:	F 867	F 867 The Administrator, DON and QI Nurse were educated by the Corporate Consultant on the QI process, to include implementation of Action Plans, Monitoring Tools, the Evaluation of the QI process, and modification and correction if needed to prevent the reoccurrence of deficient practice to include professional standards on administering medications. The Administrator, DON and QI Nurse were educated by corporate consultant on the QA process to include identifying issues that warrant development and	5/3/18

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F 867	Continued From page 5 This tag is cross referenced to: CFR 483.21 (F658) - Based on observations, record review and resident and staff interviews the facility failed to administer topical medications as ordered by the physician for 1 of 1 residents reviewed for receiving care according to professional standards (Resident #4). During the revisit survey on 9/27/17 the facility was cited for failure to administer and document the administration of medications for three residents (Residents #135, #97, and #175) of three sampled residents reviewed for medications. During an interview with the Administrator on 4/17/18 at 2:15 PM she reported the facility's Quality Assessment and Assurance program may have failed due to the continued change in staff including the Director of Nursing position. She state they had a system in place and had completed the monitoring on the medication pass deficiency previously cited. She added she had already started a plan of correction for this complaint survey.	F 867	establish a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA program on administering medications. The Administrator/Facility Nurse consultant completed 100% audit of previous citations and action plans within the past year to include professional standards on administering medications and offering showers to ensure that the QI committee has maintained and monitored interventions that were put into place. Action plans were revised and updated and presented to the QI Committee by Administrator on 4/26/2018 for any concerns identified. All data collected for identified areas of concerns to include professional standards on administering medications and offering showers will be taken to the Quality Assurance committee for review monthly x 6 months by the Quality Improvement Nurse. The Quality Assurance committee will review the data and determine if plan of corrections are being followed, if changes in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by Quality Improvement Nurse/Administrator. The Corporate Consultant will ensure the facility is maintaining an effect QA program by reviewing and initialing the Executive committee Quarterly meeting minutes and ensuring implemented	

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F 867	Continued From page 6	F 867	procedures and monitoring practices to address interventions, to include promoting dignity and offering showers and all current citations and QI plans are followed and maintained Quarterly x2. The Facility Consultant will immediately retrain the Administrator, DON and QI nurse for any identified areas of concern. The results of the Monthly Quality Assurance meeting minutes will be presented by the Administrator and/or DON to the Executive Committee Quarterly x 2 for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		5/3/18

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F 880	Continued From page 7	F 880		

providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.

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F 880	Continued From page 8 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to dispose of personal protective equipment (PPE) prior to exiting an isolation room (Room 242) for 1 of 1 rooms posted for contact isolation precautions (Vancomycin Resistant Enterococcus in a wound). Findings included: Review of the facility policy dated August 2005 revealed under "Points to Remember- Personal protective equipment should be used once and properly disposed of in the trash before leaving the room." Review of the posted Contact Precautions sign on the door of room 242 revealed gowns were to be worn if clothing could become contaminated. In an observation on 04/17/18 at 5:58 AM Nursing Assistant (NA) #1 was seen walking down the hallway carrying dirty linen in a plastic bag. A yellow isolation gown was hanging unbagged from her arm. She walked approximately 20 feet down the hallway and deposited the gown and bagged linen into a bin in the dirty utility room. In an interview on 04/17/18 at 6:00 AM NA #1 confirmed that she had just exited room 242 after providing care. She indicated she had placed the soiled linens in a plastic bag but did not have	F 880	F880 The process that led to this deficiency was Nursing Assistant (NA) failed to dispose of Personal Protective Equipment (PPE) prior to exiting an isolation room. Nursing Assistant (NA) #1 was in-serviced on properly disposing of PPE equipment prior to exiting an isolation room per the facility policy on disposing of PPE equipment prior to exiting an isolation room on 4/17/2018 by the Staff Facilitator. A return demonstration was given by Nursing Assistant #1 on properly disposing of PPE equipment prior to exiting an isolation room to the Staff Facilitator on 4/17/2018 after receiving the re-education with no identified areas of concerns. A 100% audit of all nursing assistants (NA) to include NA #1 will be observed by the Staff Facilitator/Director of nursing disposing of PPE equipment prior to exiting an isolation room to ensure the facility policy is being followed utilizing a Resident Care Audit Tool to be completed by 5/3/2018. The nursing assistant will be immediately retrained during the observation by the staff Facilitator for any identified areas of concern.	

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F 880	Continued From page 9 another bag to place the PPE in so she just carried it out of the room. She stated she knew she should have placed the PPE in a bag before bringing it out of the room for disposal. In an interview on 04/17/18 at 6:10 AM Nurse #1 stated it was her expectation that used PPE be bagged before being carried out of an isolation room. She indicated the aide should have made sure she collected all the supplies she needed prior to entering the isolation room to provide care which would include bags to contain the soiled linens and used PPE. In an interview on 04/17/18 at 6:25 AM the Director of Nursing (DON) indicated she expected staff to understand the importance of isolation and the containment of infectious organisms. She stated she expected facility policy to be followed with no shortcuts. The DON indicated NA #1 should have placed any used PPE in a receptacle in the isolation room before exiting the room with it. She stated it was unacceptable that the aide had carried soiled PPE out into the hallway without being contained.	F 880	100% in-service was initiated on 4/17/2018 by the Staff Facilitator with all nursing assistants to include NA # 1 regarding the facility policy on disposing of PPE equipment before exiting an isolation room by the Staff Facilitator to be completed by 5/3/2017. All newly hired nursing assistants will receive the education during orientation by the Staff Facilitator regarding the facility policy on disposing of PPE equipment before exiting an isolation room. 10% of all nursing assistants to include Nursing Assistant # 1 will be observed by the Staff Facilitator/quality improvement nurse to ensure the facility policy on disposing of PPE equipment before exiting an isolation room is being followed utilizing a Resident Care Audit tool weekly x 8 weeks then monthly x 1 month. The Staff Facilitator/Quality improvement nurse will immediately retrain the nursing assistant for any identified concerns during the audit. The Director of Nursing will review and initial the results of the Resident Care Audit Tools weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concerns were addressed. The Director of Nursing will forward the results of the Resident Care Audit tools to the Executive Committee monthly X 3 months. The Executive committee will meet monthly and review the Resident Care Audit tools and address any issues, concerns and\or trends to make changes as needed, to include continued frequency of monitoring x 3 months.	