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 05/04/2018

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 000	INITIAL COMMENTS The surveyor entered the facility on 5/2/18 to conduct a complaint survey and exited on 5/3/18. Additional information was obtained on 5/4/18. Therefore, the exit date was changed to 5/4/18. A new tag was cited as a result of the complaint investigation survey that was conducted. The facility is still out of compliance.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews for one (Resident # 2) of six sampled residents, the facility failed to investigate a facial bruise which was of unknown origin and assure the administrator was aware of the bruise. The following month, the resident sustained an incident of second facial bruising, and the facility failed to investigate any possible correlations between the two incidents. The findings included: Review of the facility's 11/2013 policy entitled, "Guidelines for investigating allegations of	F 607	Cumberland Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Cumberland Nursing and Rehabilitation Center's response to this Statement of	5/23/18

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

Electronically Signed | 05/18/2018

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F 607	Continued From page 1 resident abuse, neglect, or misappropriation of property," revealed all injuries of unknown origin were to be reported to the administrator, assessed, investigated, and documented. The policy also directed that trends in injuries should be investigated, and employee assignments should be reviewed in relation to other identified injuries. Record review revealed Resident # 2 was admitted to the facility on 9/22/10. The resident had multiple diagnoses which included both a history of mental illness with behavioral problems and dementia. Review of the resident's quarterly minimum data set (MDS) assessment, dated 2/14/18, revealed the following information. The resident was rarely understood. She exhibited symptoms of being short tempered, easily annoyed, and had trouble concentrating. The resident needed extensive assistance with bed mobility. She required total staff assistance with her hygiene, bathing, and eating needs. The resident was not assessed to have any falls since the previous last quarterly MDS assessment. Review of the resident's care plan, last reviewed on 4/27/18, revealed staff identified the resident would yell, scream, talk to herself, cry, spit at others, and had a history of combative behavior to the point that she had caused an injury to a staff member. According to the care plan, staff were to monitor and document the resident's behaviors. Review of the resident's medication regimen revealed she did not receive anticoagulants.	F 607	Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Cumberland Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. The process that lead to the alleged deficiency was based on observation, record reviews and staff interviews for one resident (Resident #2) of six sampled residents, the facility failed to investigate a facial bruise which was of unknown origin and assure that the administrator was aware of the bruise. The following month, the resident sustained an incident of second facial bruising, and the facility failed to investigate any possible correlations between the two incidents. A 100% audit of all residents progress notes, to include resident #2, were reviewed by the Facility Consultant on 5/4/18 for the past 30 days, 4/1/18 to 5/4/18 for documentation for possible injuries of unknown origin, to include bruises, and to review progress notes that may have been stuck out, to ensure that the administrator was aware of possible injuries of unknown origins and that an investigation was initiated per policy. There were no negative findings noted on the review.	

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F 607	Continued From page 2 Review of nursing notes revealed the following information. The resident had no documented falls or accidents since her last MDS assessment of 2/14/18. On 3/6/18 the resident had lab work drawn. A nursing entry on 3/9/18 at 2:16 PM was entered into the computerized record and a line had been drawn through it. There was a notation at the beginning of this note which read, "Incomplete documentation." The crossed out documentation contained information that the resident had three bruises to her right hand with no complaints of pain. A nursing entry on 3/11/18 at 12:45 PM was entered into the computerized record and a line had been drawn through it. There was a notation at the beginning of the note which read, "Incomplete documentation." The crossed out documentation contained information that the resident had bruising to her right hand, and that the resident had a history of striking staff, the side rails, and the wall. A nursing entry on 3/19/18 at 3:58 AM was entered into the computerized record and had a line drawn through it. The note was labeled "incomplete documentation." The crossed out documentation contained information that the nurse had been called into the room when it was found the resident had a "light purple bruise to the outer left side of face around eye." The nurse noted the resident was assessed and no other areas of concern were found other than the old bruises already noted.	F 607	SDC began in serving 100% of staff, 4/19/18, on Action checklist for injury of unknown origin, questionnaire for injury of unknown origin and definition of abuse. 10% of current residents, to include resident #2, progress notes will be reviewed for documentation for possible injuries of unknown origin, to include bruises, and to review progress notes that may have been stuck out, to ensure that the administrator was aware of possible injuries of unknown origins and that an investigation was initiated per policy by the DON, SCD, QI nurse and MDS nurse 5 times per week for 4 weeks, then weekly for 4 weeks and then monthly for 1 month using a Progress Note Review QI tool. The DON will review and initial the Progress Note Review QI tool to ensure all areas of concern have been addressed weekly for 8 weeks and then monthly for 1 month. The Executive QI committee will meet monthly and review Progress Note Review QI tool address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x 3 months. The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	

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On 4/19/18 at 2:25 PM a nursing entry was made in the record and had not been struck from the record. This entry noted the resident had a purplish discoloration to the resident's left upper and lower eye and left side of her chin. Prior to this entry there were no nursing notes in the month of April, 2018 noting the resident had been combative.

According to facility investigative records, the police department, the resident's physician, and the responsible party were notified in relation to the April bruising.

According to the medical record, on 4/20/18 the resident's responsible party requested the resident be sent to the hospital. The physician noted the resident had sustained bruising to her left eye, left jaw, and right tongue. The cause of the bruising was not determined.

On 5/2/18 at 9:45 AM the resident was observed in her private room. The resident was in a bed lowered to the floor. The bed had side rails. The resident also had a curved wing mattress. The curvature of the mattress extended up to cover the inner part of the rails. The resident was constantly talking to herself, and when addressed by name would scream loudly but not talk coherently.

On 5/2/18 at 12:15 PM the facility administrator presented the facility's investigation into the resident's 4/19/18 facial bruising. The investigation contained statements and information related to the 4/19/18 bruises. The facility was not able to determine the cause following their investigation. The investigative file

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did not contain evidence the facility had investigated similar staffing trends between the two incidents of facial bruising. The administrator reviewed the resident's nursing notes with the surveyor and was interviewed regarding the 3/19/18 notation being struck from the record. The administrator did not know why the March, 2018 notes had been struck from the record, and stated the notes might have been for a different resident. She was not aware the resident had a bruise near her eye in March, 2018.

A follow up interview with the administrator on 5/3/18 at 1:15 PM revealed the March, 2018 entries, which had been struck from the record, had been for Resident # 2. The administrator had not been able to determine why they had been struck from the record, and stated it could have been a computer documentation error. The administrator had no other investigative information into the March, 2018 bruising.

The treatment aide, who had found the bruising on 3/19/18, was interviewed on 5/3/18 at 10:40 AM. The treatment aide reported the following. She was doing a wound treatment during the evening shift of 3/19/18 when she noted there was a purple area to the resident's outer left eye. She reported it to Resident # 2's nurse. The treatment aide did not know how the resident had sustained the bruise. The treatment aide stated at times the resident would grab her head with her hands or turn her head back and forth.

NA # 1 had been assigned to care for Resident #2 on the 3/19/18 evening shift. NA # 1 was interviewed on 5/3/18 at 4:35 PM. The NA could not recall anything about bruises in March, 2018 for the resident.

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NA # 2 had been assigned to care for Resident # 2 on the night shift which began on 3/19/18 at 11 PM. NA # 2 was interviewed on 5/3/18 at 4:45 PM and reported the following. She did recall the bruise on 3/19/18, but did not know how the resident had sustained the bruise. The NA stated she had always commented how pretty the resident's skin was, and she had never known the resident to have bruises prior to March, 2018. The NA stated she had never witnessed the resident grab her head, and that the resident could sit up some but not completely get up by herself. When she found the bruise on her shift, it had not been reported to her by the previous NA and therefore she told Nurse # 1 about it. It was a "little bit bigger than a quarter" and was blackish in color around her eye. The NA reported the resident had her wing mattress at the time which covered the rails. The NA stated, "It could not have been the rails."

Nurse # 1 had cared for the resident on both the evening shift and the night shift of 3/19/18. Nurse # 1 was interviewed on 5/4/18 at 1:50 PM. Nurse # 1 reported the following. On 3/19/18 the resident had some older bruises on her hand which had been reported to be from her blood draw, but the eye bruise was something different. Therefore when she referred to "other bruises" in her 3/19/18 nursing notation, she was referring to the blood draw bruises. The nurse did not know how she had sustained the bruise near her eye. She stated it looked like she had bumped against something. According to the nurse she had completed facility records per the facility process so there would be administrative follow up on the facial bruise. She had not marked through her nursing entry of 3/19/18, and she did not know

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why the entry had been struck from the record. The nurse reported the resident could be combative and therefore a challenge to care for at times. She also reported there were times she would yell out during the night and upset other residents who were trying to rest. The nurse stated she had not witnessed other residents enter Resident # 2's room and be aggressive towards her, but the resident's location on the hallway was a spot which was harder to watch and monitor if someone were to enter the room.

During an interview with the administrator on 5/3/18 at 3:30 PM, the administrator stated there had been a different director of nursing at the time of the March, 2018 incident. According to the administrator, the staff may have attributed the resident's eye bruise to her combative behavior in March and therefore not have categorized it as "an injury of unknown origin" and alerted her so that she could completely investigate it. According to the administrator, when the resident sustained the 4/19/18 bruising, the nursing entry was read aloud before administrative staff and the investigation immediately begun. During the April, 2018 investigation, she had not looked back into the March, 2018 nursing notes to see that the resident had recently sustained another facial bruise.