PRINTED: 10/15/2012 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION OCT 2 6 2012 (X3) DATE COME					
		345376	B. WNG		1	C)2/2012			
	ROVIDER OR SUPPLIER	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2461 LEGION ROAD FAYETTEVILLE, NC 28306						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE					
F 279 SS=G	A facility must use the to develop, review an comprehensive plan of the facility must develop an for each resident objectives and timetal medical, nursing, and needs that are identificant assessment. The care plan must do to be furnished to attain highest practicable propsychosocial well-being \$483.25; and any sender equired under \$48 due to the resident's each of the sender o	e results of the assessment d revise the resident's of care. elop a comprehensive care that includes measurable bles to meet a resident's mental and psychosocial ed in the comprehensive escribe the services that are in or maintain the resident's sysical, mental, and	F 279	Cumberland Nursing & 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					
	by: Based on record reviefacility failed to revise one (1)cognitively impidentified as being a high findings include: Resident # 1 was adm 1/23/2012 with diagno	ses of Depressive Disorder, alls, Hypothyroidism, End-		and Rehabilitation Center's response to the Statement of deficiencies does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further Cumberland Nursing					

Can dice Bhown - Baldwin. R. A. ANHA

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 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.

		MEDICAID SERVICES				OMB	NO. 0938-03	91
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUi		PLE CONSTRUCTION	(X3) DATE COMPI	SURVEY	
			B. WN	IG.			C	
		345376	D. VIII			10	0/02/2012	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				_
CUMBER	LAND NURSING AND RE	HABILITATION CENTER			481 LEGION ROAD			
				F	AYETTEVILLE, NC 28306			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	ILD BE	(X5) COMPLETION DATE	:
E 070				and Rehabilitation				
F 279			F:	279	Center reserves the			
	Hypertension, Diabete	es Mellitus, Paralysis,			right to refute any			
	Parkinson Disease an	d Cerebrovascular Accident			of the deficiencies			
	(CVA). The most curre Set) dated 8/9/2012 re		ĺ	on this statement				
6)	cognition as severely							
	extensive assistance v			through informal			İ	
	and walking in corridor. MDS further indicated the resident also as totally dependent on staff for				dispute resolution,			
				-	formal appeal			
	locomotion on unit and	I toileting use. MDS also			procedure, and or			
	indicated the resident	as not steady with moving			any other			ł
	from seated to standin MDS further revealed	g position and walking.			administrative			
	impairment on one sid				legal proceedings.			
	impairment on one side	e lower extremity.			_			
	Review of Resident # 1	i's current care guide dated						
	2/29/2012 revealed the	resident was non-	F 279	,	Resident #1 is no			ı
	ambulatory, needed a	mechanical lift for			longer in the facility			
	transfers, used a diape	r for incontinence and			•			
İ	used a bed alarm.				4.4000/ · · · · · · · · ·			١
	CAA (Care Area Asses	sments) worksheet dated			A 100% audit of		10/08/12	1
	6/7/2012 indicated the	resident "flagged for		ĺ	all residents to			
		ia due to a BIMS (Brief			include residents			
		atus) score of less than	1		that are identified			١
1	13. The resident presen	ts with noted confusion-			at high risk for falls,			l
	she will at time make si	mple decisions regarding			care plans and			
	her wants/needs, but fo	r the most part, staff			care guides, were			
	anticipates and provide	for her care as needed.			reviewed by the DON,			l
	requires frequent monit	ired safety awareness and			ADON, Staff Facilitator,			
,	worksheet also indicate	d the resident "is at			MDS Nurses, and			
l i	increased risk for falls/in	jury secondary to right			QI Nurse on 10/08/12			1
] :	sided blindness." The A	ADLs (Activity of Daily			·			
	Living) 'CAA documente	ed resident requires			for accuracy of appropriate			ĺ
["	'extensive assistance w	ith bed mobility,			interventions to include			
	ocomotion on and off u	nit, dressing, eating,			mats, bed alarms and			
į t	oileting, personal hygie	ne, bathing and		1	low hade All Identified			1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345376					C 02/2012
	ROVIDER OR SUPPLIER	HABILITATION CENTER		24	EET ADDRESS, CITY, STATE, ZIP CODE IS1 LEGION ROAD AYETTEVILLE, NC 28306	10/0) <u>2/2</u> 012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X6) COMPLETION DATE
F 279	transfers." The Fall C "requires extensive al mobility needs. Resid falls- she demonstrate awareness secondary increase 's her risk fo transfer resident via tt Review of Resident # 6/7/2012 documented 19 which indicated the falls. The fall risk eva the resident was total fall in the past 30 day was severely impaire also documented the bed alarm. Mat on the low bed." Review of the Reside dated 8/15/2012 documented score of 15 which ind high risk for falls. The	cAA indicated the resident sistance from staff for all lent does have a history of es decreased safety to impaired cognition that in fall/injury. Staff currently he lift." 1's fall risk evaluation dated if the resident had a score of eresident was a high risk for luation further documented assist with transport with a sand the resident 's vision d. The fall risk assessment resident "currently has a effoor beside her bed and a light of the resident had a light of the resident had a light of the resident was at	F	279	areas of concerns related to care plans and care guides were immediately addressed by the MDS Nurses. The MDS Nurses were Educated on 10/16/12 by the Administrator on the utilization of assessment data for accurate care plan development for all residents to include residents that were identified as high risk for falls, formulating care plans, updating		10/16/12
	Resident #1's care plated documented the resident transferring from one to her physical limitati documented the following can weight bear, media safety awareness." Todocumented the "resident characterized by historijury, multiple risk fact process: Blindness, ir balance, impaired mointerventions were "a	an dated 8/17/2012 lent required assistance with position to another related on. The care plan wing intervention: "Resident hanical lift and Monitor for the care plan further ident was at risk for falls ory of falls/ actual, falls, ctors related to: Disease acontinence, impaired			the care plan, and including implementation of new preventative interventions to include low beds, mats, and bed alarms. The MDS Nurses were Educated on 10/17/12 via video training module the MDS 3.0 care area assessment process and care planning.		10/17/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
		345376	B. WING		10/	C 02/2012
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	2	REET ADDRESS, CITY, STATE, ZIP CODE 461 LEGION ROAD FAYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF THE PROVIDER (CROSS-REFERENCE)	ULD BE	(X5) COMPLETION DATE
	risk protocol and Me of the care plan date revealed it was not alarm and floor mat Fall Risk evaluation. Nurse's note dated "Patient did yell and and was found lying Resident was broug (Nurse Assistant), (revealed to get some was slightly swollen, not assessed." Review of the incide 9/22/2012 document was yelling and holle was found lying on fewas in lowest position unplugged. No floor Patient was brought reapplied." The Incident was brought reapplied." The Incident was brought reapplied." The Incident was decreased mobility, process and reachin with altered mental sawareness, psychos status, mental illness. Review of the hospit documented the resi femur fracture. The it documented the resi of bed today and had emergency department.	echanical lift." Further review ed 6/7/2012 and 8/17/2012 updated to include a bed as indicated in the resident 's dated 6/7/2012. 8/22/2012 documented scream at 6:45 this morning on the floor besides her bed. ht back to bed with NA esident) stated she wanted to ster. On inspection, left hip	F 279	An in-service was initiated for all licensed nurses on 10/22/12 by the Staff Facilitator regarding notifying the MDS Nurses of changes in preventative interventions; to include bed alarms, low beds, and mats; by submitting a copy of the updated resident care guide of any changes to the MDS Nurses. All newly hired licensed nurses will be in serviced regarding notifying the MDS Nurses of changes and preventative interventions to include bed alarms, low beds and mats by submitting a copy of the updated resident care guide of any changes to the MDS Nurses during the orientation process by the Staff Facilitator.		10/22/12

PRINTED: 10/15/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPI	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUII	A. BUILDING			С
		345376	B, WING			10/02/2012	
MANE OF DR	OVIDER OR SUPPLIER	<u> </u>		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
					161 LEGION ROAD		
CUMBERI	AND NURSING AND I	REHABILITATION CENTER		F	AYETTEVILLE, NC 28306		
	O: BILLADV	STATEMENT OF DEFICIENCIES	ID	1	PROVIDER'S PLAN OF CORRECTI	ION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREF TAG	1	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETION DATE
					An in-service was		10/22/12
F 279	Continued From page 4			279	Initiated on 10/22/12		
	department physici	an and found to have a			by the DON with		
	fracture of the femur. Patient has significant dementia and is unable to provide any history." The hospital record further documented "A-9 point review of systems was reviewed with her daughter. It is negative with the exception of				the MDS Nurses		
					regarding the		
					completion of care		
					plans for all residents		
	musculoskeletal. W	hich is significant for left			to include residents		+
	femur pain." The h	ospital record also			that are identified		
	documented "The	x- rays of the left femur reveal			as being at high		
	a fracture of the fer	noral shaft in the upper			·		
	one-third. There is	displacement and shortening."			risk for falls through		
	The hospital record	I further documented "we will			the RAI process on		
	take her this evening for intramedullary nail fixation. I have explained to the daughter the risks				admission, quarterly,		
	and henefits of sur			annually,or with any			
	bleeding infection.	nefits of surgery. The risks include g, infection, damage to nerves or blood			significant change.		
	vessels, failure of t			Licensed Nurses			
	more surgery, hear	more surgery, heart attack, stroke, and death."			will notify the MDS		
		40,000 A 40,00 PM	,		Nurses of changes		
	During the interviev	y on 10/2/2012 at 12:30 PM,			And preventative		ļ
	NA#1 reported that	she took care of Resident # 1 2/2012. NA#1 stated that she			interventions		
	checked the reside	nt at 11:00 PM, 1:00 AM and			to include bed		
	5:00 AM. NA #1 ful	ther added that she did not	-				
	see the bed alarm	on the Resident # 1's bed			alarms,		
	during the times the	at she checked on her. NA#1			low beds and		
	further reported that	nt Resident # 1's Care guide			mats as approplate		
		esident should have a bed			by submitting		
		ot see one on the day she sident on 9/22/2012.			a copy of the updated		
	took care of the les	DUGIL VII JIEMEV IE.			resident care guide		
	During the phone is	nterview on 10/2/2012 at 1:45			with any changes to		
	PM. day Nurse # 3	reported she had a loud voice			the MDS Nurses.		
	coming from Resid	ent # 1's room in the morning					
	of 9/22/2012. The	resident was yelling and was					
	on the floor.Nurse	# 1 added Resident #1 had just					
	fallen from her bed	.Nurse # 1further reported the					
	bed alarm did not g	go off before or after the	1				

Facility ID: 953074

On the market of the state of t		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	DENTIFICATION NOMBER.	A. BUII	DING		С		
		345376	B. WN	G			2/2012	
	OVIDER OR SUPPLIER	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2461 LEGION ROAD FAYETTEVILLE, NC 28306					
					PROVIDER'S PLAN OF CORRECT	CORRECTION		
(X4) ID PREFIX TAG	/FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG	1	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	COMPLETION DATE	
F 279	resident fell on the floor. Nurse # 1 also reported she found out the bed alarm cable was not connected all the way while attached beside the bed. Nurse # 1 further added her normal routine was to check the residents bed alarms at the facility to make sure they were functioning correctly at the beginning of her shift. She added she did not check Resident # 1's bed alarm at the beginning of the shift on the night of 9/22/2012. During the interview on 10/2/2012 at 2:30 PM, MDS nurse #1 reported she was responsible for completing the annual assessments at the facility. She added she completed the annual fall risk assessment for Resident # 1 on 6/7/2012 and the resident scored as high risk on her annual fall risk assessment. MDS nurse #1 also added she could not explain why the annual care plan dated 6/7/2012 for Resident # 1 was not updated to include bed alarm, floor mat and a low bed. MDS nurse #1 further reported that she was not responsible for completing the quarterly updates on the care plans at the facility so she could not explain why the quarterly careplan for Resident # 1 dated 8/17/2012 did not include bed alarm, floor			279	The MDS Nurses will revise the care plan for all residents upon the receipt of the revised resident care guide. with identified changes and/or new preventative interventions to include low beds, alarms, and mats. The DON or ADON will review the care plans of all residents with new preventative interventions and/or changes to ensure care plans have been revised by utilization of the care plan interventions			
F 323 SS=G	1 dated 8/17/2012 did not include bed alarm, floor mattress and low bed. During the interview on 10/2/2012 at 3:30 PM, MDS nurse # 2 reported she was responsible for completing the residents quarterly assessments at the facility. MDS nurse # 2 was asked why the current careplan for Resident # 1 was not updated with the use of bed alarm and floor matress. MDS nurse # 2 answered it was an oversight. 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident				QI tool 5 times per week for 4 weeks, 3 times per week for 4 weeks, 2 times a week for 4 weeks, weekly for 4 weeks, Then monthly times 2 months. The DON or ADON will follow up immediate upon identication of any potential concern.	ely		
SS=G	The facility must en				1 '			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X	(X3) DATE SURVEY COMPLETED		
		345376	B. WING	3	_	C 10/02/2012		
CUMBER	ROVIDER OR SUPPLIER LAND NURSING AND RE			STREET ADDRESS, CITY, STATE, ZIP CODE 2461 LEGION ROAD FAYETTEVILLE, NC 28306				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRI DEFICIENCY)	BE COMPLETIO	ON	
	as is possible; and ea adequate supervision prevent accidents. This REQUIREMENT by: Based on record revie facility failed to implem one (1) of three (3) cog who were assessed as (Resident # 1) Findings include: Resident # 1 was adm 1/23/2012 with diagnos Personal History of Fal Disease, Hypertension Paralysis, Parkinson D Cerebrovascular Accid current MDS (Minimum revealed the resident 'impaired; she needed a bed mobility, transfer a MDS further indicated to dependent on staff for I toileting use. MDS also not steady with moving position and walking. Moresident had impairmed extremity and impairmed extremity. The MDS revent coded for side rails	is not met as evidenced ews and staff interviews, the tent fall interventions for gnitively impaired residents, being at risk for falls. itted to the facility on tess of Depressive Disorder, lis, End- Stage Renal to Diabetes Mellitus, tisease and tent (CVA). The most to data Set) dated 8/9/2012 to cognition as severely textensive assistance with and walking in corridor. The resident also as totally to comotion on unit and to indicated the resident as from seated to standing to surper text on one side lower	F323	The findings of the Preventative Intervention QI audit tools will be forwarded to the QI committee for review quarter for the identificati of trends, developm of action plans as indicated, and to determine frequent of continued QI monitoring. Resident #1 no long resides at the facility A 100% audit was a On 9/22/12 by the Ensure preventative Interventions for a residents identified at high risk for falls were in place and functional per the resident care guide to include low beds alarms, and mats. All identified areas concerns were immediately addressed by the D	ly fon ment ncy ger ty. completed DON to re II d	9/22/12		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345376	B. WN	G		10/0	C 02/2012
	ROVIDER OR SUPPLIER LAND NURSING AND R	EHABILITATION CENTER		24	EET ADDRESS, CITY, STATE, ZIP CODE 161 LEGION ROAD AYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	- 1	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFIGIENCY)	LO BE	(X5) COMPLETION DATE
F 323	CAA (Care Area As 6/7/2012 indicated til Cognitive loss/ Dem Interview for Mental 13. The resident presshe will at time make her wants/needs, but anticipates and prove Resident displays imprequires frequent more worksheet also indicincreased risk for fall sided blindness." The Living) 'CAA docum "extensive assistance locomotion on and of tolleting, personal hy transfers." The Fall "requires extensive a mobility needs. Residently needs. Residently needs. Residently needs. Residently needs awareness secondarincrease's her risk for transfer resident via the Review of Resident dated 6/7/2012 documented the residently has a bed and a low be Review of the Residently 12012 documented 8/15/2012 docume	sessments) worksheet dated the resident "flagged for entia due to a BIMS (Brief Status) score of less than sents with noted confusionate simple decisions regarding at for the most part, staff ide for her care as needed. Spaired safety awareness and politoring of staff. "CAA atted the resident " is at assinjury secondary to right the ADLs (Activity of Daily mented resident requires the with bed mobility, and the sessift of all dent does have a history of the decreased safety to impaired cognition that a fall/injury. Staff currently the lift." # 1's fall risk evaluation mented the resident was a fall risk evaluation further dent was total assist with the past 30 days and the ses severely impaired. "The fall adocumented the resident " larm. Mat on the floor beside d." ent # 1's fall risk evaluation umented the resident had a icated the resident was at	F	323	An in service was initiated on 10/19/12 by the Staff Facilitator with Certified Nursing Assistants regarding checking the resident care guide, for all residents to include residents identified for high risk for falls to ensure that all preventative interventions toinclude mats, alarms, and low beds are in place and functioning prior to rendering care. All newly hired Certified Nursing Assistants will be trained on checking the resident care guide to ensure all preventative interventions to include mats, alarms, and low beds are in place and functioning prior to rendering care all preventative interventions to include mats, alarms, and low beds are in place and functioning prior to rendering care during orientation by Staff Facilitator.		10/19/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING	(X3) DATE SURVEY COMPLETED
345376 B. WNG	C
NAME OF DECAMPER OF CHORDER	10/02/2012
CUMBERLAND NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, 2461 LEGION ROAD FAYETTEVILLE, NO	,
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CO	DER'S PLAN OF CORRECTION PRECTIVE ACTION SHOULD BE COMPLETION DEFICIENCY) COMPLETION DATE DATE
Resident #1 to be on "fall risk precaution." Resident #1's care plan dated 8/17/2012 documented the resident required assistance with transferring from one position to another related to her physical limitation. The care plan documented the following intervention: "Resident can weight bear, mechanical lift and Monitor for safety awareness." The care plan further documented the resident was at risk for falls characterized by history of falls/ actual, falls, injury, multiple risk factors related to: Disease process: Blindness, incontinence, impaired balance, impaired mobility and pain." The interventions were "assist during transfer and mobility, Ensure environment is free of clutter, fall risk protocol and Mechanical lift." Further review of the care plan dated 6/7/2012 and 8/17/2012 revealed it was not updated to include a bed alarm and floor mattress as indicated in the resident's Fall Risk evaluation dated 6/7/2012. Nurse's note dated 9/22/2012 documented "Patient did yell and scream at 6:45 this morning and was found lying on the floor besides her bed. Resident was brought back to bed with NA (Nurse Assistant), (resident) stated she wanted to walk to get some water. On inspection, left hip slightly swollen, no bruises or bleeding assessed." Review of the incident and accident report dated 9/22/2012 documented "On 9/22/2012 patient was yelling and hollering at 6:50 AM in her room, was found lying on floor besides her bed. Bed was in lowest position. Cable to bed alarm was unplugged. No floor mattress was in place. Patient was brought back to bed and alarm was reapplied." The Incident report further revealed the resident had "Muscle weakness, impaired standing balance, decreased functional status,	at was by the DON clicensed are of ntions residents lents that iii be laced t the ation ends

STATEMENT OF DEFICIENCIES (X1) PROV		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i i	(X2) MULTIPLE CONSTRUCTION A. BUILDING			URVEY ETED
		345376	B. WIN	lG		10.	C (02/2012
	ROVIDER OR SUPPLIER	SHABILITATION CENTER		2	REET ADDRESS, CITY, STATE, ZIP CODE 461 LEGION ROAD FAYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	decreased mobility, for process and reaching with altered mental stawareness, psychosis status, mental illness. Review of the hospit documented the reside femur fracture. The hospit documented the reside of bed today and had emergency department lower extremity. She will department physician fracture of the femur. dementia and is unabout the hospital record fur point review of system family member. It is not musculoskeletal. We femur pain." The hospital record fur point review of the femore one-third. There is districted to the femore one-third. There is districted blood vessels, failure of for more surgery, hear Review of the hospital for more surgery, hear Review of the more for more surgery, hear Review of the hospital for more surgery, hear Review of the hospital for more surgery, hear Review of the hospital for more surgery, hear Review of the hospital for more surgery hear Review of the hospital for more surgery hear Review of the hospital for more surgery hear Review of the hospital for more surgery hear Review of the hospital for more surgery hear Review of the hospital for more surgery hear Review of	atigue secondary to disease of for objects, acute episode status, Decreased safety is, and decline in mental and diabetes mellitus." all record dated 9/22/2012 dent was admitted due to left ospital record further lent "apparently climbed out a fall. She presented to the int with deformity of the left was seen by emergency and found to have a Patient has significant le to provide any history." In the documented "A-9 is was reviewed with the egative with the exception which is significant for left poital record also rays of the left femur reveal rall shaft in the upper placement and shortening." In the documented "we will for intramedullary nail led to the family member of surgery. The risks stion, damage to nerves or of the fracture to heal, need to attack, stroke, and death."	F	323	An in service was initiated on 10/22/12 by the Staff Facilitator regarding utilizing the preventative intervention check list during their shift to ensure preventative interventions are in place and functioning properly. All newly hired Licensed Nurses will be inserviced regarding utilizing the preventative intervention check list during their shift to ensure preventative interventions are in place and functioning properly during orientation		10/22/12

<u> </u>	COT OTT MEDIOTIVE C	MEDIONID OLIVACEO				OMB NO. 0938-039	
l.	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE COMPI	
		345376	B. WN	IG		10	C 0/ 02/2012
	ROVIDER OR SUPPLIER LAND NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2461 LEGION ROAD FAYETTEVILLE, NC 28306			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	record revealed the re hospital after the surging Review of the hospital dated 10/1/2012 document admitted to hospital or was found to have a lewas immediately evaluservices and admitted open reduction and intintramedullary nail place fracture after discussion review of the Discharger resident was discharge another long term care Review of Resident #1 the resident had not be facility. Review of Resident #1 2/29/2012 revealed the ambulatory, needed a stransfers, and used a be Review of the facility is 9/24/2012 for day Nursiwith Resident #1 on 9/#1 was disciplined for Director of Nursing that and sustained an injury sent to the hospital in a found on floor at 6:45 A 10:00AM due to unable Doctor) per employee. Resident care Guide duoccurred 9/22/2012." Review of the facility is 9/25/2012 for night Nurwas disciplined due to intervention provided for the facility of the facility is 9/25/2012 for night Nurwas disciplined due to intervention provided for the facility is provided for the faci	sident was admitted at the ery on 9/23/2012. 's Discharge Summary mented "the resident was a 9/22/2012, after patient of femur fracture. Patient stated by orthopedic to their services and had ernal fixation and had an exement of the left femur on with family." Further es Summary revealed the ed from the hospital to a facility on 10/1/2012 I's medical record revealed ern readmitted back to the exemption of the left for each was non-mechanical lift for ed alarm. disciplinary warning dated e #1 who was working 22/2012 revealed Nurse "failure to notify (DON) a resident fell out of bed a resident fell out of bed a resident to have resident timely manner. Resident timely manner. Resident and aring rounds. This disciplinary warning dated se #2 revealed Nurse #2 Failure to ensure a safety in place and	F		The Staff Nurse will ensure all preventative interventions are in place and functioning to include mats, low beds and alarms during every shift utilizing the preventative intervention checklist. The DON and/or ADON will review the preventative intervention checklist for completion 5 times per week for 4 weeks, 3 times per week for 4 weeks, 2 times a week for 4 weeks, then monthly times 2. The DON or ADON will follow up mmediately upon dentification of any potential concern.		
7.	ntervention provided for safety in place and unctioning properly. Resident fell out of bed and						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345376	B. WIN	IG	700	C 10/02/2012	
	ROVIDER OR SUPPLIER LAND NURSING AND RE	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2461 LEGION ROAD FAYETTEVILLE, NC 28306				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIEMENCY)	ULD BE	(X5) COMPLETION DATE
	alarm wasn't connected beside the bed. Reside not implemented." During the interview or NA#1 reported that shon the night of 9/22/20 checked the resident a 5:00 AM. NA #1 furthe see the bed alarm on the during the times that should find the reported that Resident alarm but she did not shook care of the resident alarm but she did not shook care of the resident puring a phone interview PM, NA#2 reported should be properly added the before or after Resident #1 on 9/22/20 Nurse #1 to assist in lift floor. NA #2 added the before or after Resident added, the bed alarm of During the interview on the floor. Na#3 was asknown as required to have a bed was required to check to of her shift to make surproperly. NA#3 was asknown as the floor of the resident that she has besides the resident the property of 9/22/2012. The resident the floor. Nurse #1 and the floor. Nurse #1 and the floor. Nurse #1 and the floor. Nurse #1 and the floor. Nurse #1 and the floor. Nurse #1 and the floor. Nurse #1 and the floor. Nurse #1 and the floor. Nurse #1 and the floor. Nurse #1 and the floor. Nurse #1 and the floor. Nurse #1 and the floor. Nurse #1 and the floor. Nurse #1 and the floor. Nurse #1 and the floor. Nurse #1 and the floor. Nurse #1 and the floor. Nurse #1 and the floor. Nurse #1 and the floor.	al fracture. The resident's and nor was a floor mat ent care Guide Intervention in 10/2/2012 at 12:30 PM, so took care of Resident # 1 12. NA#1 stated that she at 11:00 PM, 1:00 AM and readed that she did not the Resident # 's bed the checked on her. NA#1 esident # 1's Care guide tent should have a bed see one on the day she ent on 9/22/2012. Sew on 10/2/2012 at 1:00 es was not assigned to 012 but she was asked by fing the resident from the est bed alarm did not go off at #1 fell on the floor. She cord was disconnected. In 10/2/2012 at 1:30 PM, NA ent # 1 was a fall risk per dided the resident was alarm which she (NA#3) every day at the beginning set was functioning sed whether the resident loor beside her bed. NA# d not seen a mattress	F	323	Findings of the preventative Interventions checklist audits will be forwarded to The QI committee for review quarterly for the identification of trends, development of action plans as indicated, and to determine frequency of continued QI monitoring.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDING	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
					С	
	345376 B. WING		1	10/02/2012		
NAME OF PROVIDER OR SUPPLIER CUMBERLAND NURSING AND REHA		2 F	REET ADDRESS, CITY, STATE, ZIP COD 461 LEGION ROAD AYETTEVILLE, NC 28306	PE	0022012	
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES AUST BE PRECEDED BY FULL DIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X6) COMPLETION DATE	
she found out the bed a connected all the way w bed. Nurse # 1 further a was to check the resider facility to make sure they correctly at the beginning she did not check Resid beginning of the shift on Nurse #1 added she did bed alarm to make sure properly at the beginning was busy with other reside During the interview on Nurse # 3 reported that Frisk and she had a bed a 3 added at the beginning practice was to check the alarm to make sure it was Nurse # 3 further reported seeing a fall mattress beto During the interview on MDS nurse #1 reported seeing a fall mattress beto puring the interview on MDS nurse #1 reported seeing a fall mattress beto puring the interview on MDS nurse #1 reported seeing a fall mattress beto puring the interview on MDS nurse #1 reported seeing a fall mattress beto puring the interview on MDS nurse #1 reported seeing a fall mattress beto puring the interview on MDS nurse #1 reported seeing a fall mattress beto puring the interview on MDS nurse #1 reported seeing a fall mattress beto puring the interview on MDS nurse #1 reported seeing a fall mattress beto puring the interview on MDS nurse #1 reported seeing a fall mattress beto puring the interview on MDS nurse #1 reported seeing a fall mattress beto puring the interview on MDS nurse #1 reported seeing a fall mattress beto puring the interview on MDS nurse #1 reported seeing a fall mattress beto puring the interview on MDS nurse #1 reported seeing a fall mattress beto puring the interview on MDS nurse #1 reported seeing a fall mattress beto puring the interview on MDS nurse #1 reported seeing a fall mattress beto puring the interview on MDS nurse #1 reported seeing a fall mattress beto puring the interview on MDS nurse #1 reported seeing a fall mattress beto puring the interview on matter a fall mattress beto puring the interview on fall mattress beto puring the interview on fall mattress beto puring the interview on fall mattress beto puring the interview on fall mattress beto puring the interview on fall mattress beto puring the int	off before or after the Nurse # 1 also reported larm cable was not thile attached beside the dded her normal routine ints' bed alarms at the y were functioning g of her shift. She added ent # 1's bed alarm at the the night of 9/22/2012. not check Resident #1's it was functioning g of the shift because she dents. 10/2/2012 at 2:01PM, Resident #1 was a fall larm on her bed. Nurse # of the shift her usual as functioning properly. It is functioning properly. It is she did not recall side Resident # 1's bed. 10/2/2012 at 2:30 PM, whe was responsible for issessments at the facility. It is annual fall risk # 1 on 6/7/2012 and the isk on her annual fall risk # 1 also added she could all care plan dated was not updated to nat and a low bed. MDS that she was not g the quarterly updates acility so she could not care plan for Resident #	F 323	Education Training Module: "Mobility and safe Movement of the Elderly, Improving Your Skills to Prevent Injuries and reduce Falls With Teepa Snow,MS, OTR/L,FAOTA. Dementia Care & Training Specialist Positive Approach, LLC. Falls Prevention DVD Was presented to all facility staff members to include all CNAs, Licensed Nurses, Activity Department, Medical Records, Dietary Staff,Social Services, Plant Operations, Therapy Department, Housekeeping staff, Hospice staff and Administrator this DVD was initiated on 10/16/12 and completed on 10/19/12.		10/16/12	

PRINTED: 10/15/2012 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 AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C B. WNG 345376 10/02/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2461 LEGION ROAD **CUMBERLAND NURSING AND REHABILITATION CENTER FAYETTEVILLE, NC 28306** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRFFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 323 Continued From page 13 F 323 During the interview on 10/2/2012 at 3:30 PM. MDS nurse # 2 reported she was responsible for completing the residents ' quarterly assessments at the facility. MDS nurse # 2 was asked why the current care plan for Resident # 1 was not updated with the use of bed alarm, low bed and floor mattress. MDS nurse # 2 answered it was an oversight," During a phone interview on 10/2/2012 at 3:45 PM, night Nurse # 2 who was assigned to Resident # 1 on third shift the day the resident fell reported that she did not witness Resident # 1's fall on 9/22/2012. She added the resident had a quiet night. Nurse # 2 added she saw the bed alarm on the resident bed at the beginning of the shift but she did not check to make sure it was functioning properly at the beginning of the shift. Nurse # 2 added the resident had her own private bed which her family member brought from home. She (Nurse # 2) also reported the bed had side rails which did not prevent Resident # 1 from getting out of bed. Nurse #2 reported the rails were not on the resident's way whenever she tried to get out of bed. She further added the rails

were on one side of the bed and the other side of the bed was against the wall. Nurse # 2 further added the resident was normally very confused and she (Resident # 1) thought she could walk. She (Nurse # 4) added she regularly reminded

During the interview with DON on 10/2/2012 at 4:00 PM, she reported her expectation of her staff was to check the residents ' bed alarms at the facility at the beginning of the shift to make sure they were functioning properly. DON further added she expected the third and first shift nurses to have checked Resident #1's bed alarm to make sure it was functioning properly at the

the resident that she could not walk.

DEPAR	TMENT OF HEALTH A	ND HUMAN SERVICES				PRINT	ED: 10/15/2012	
						FOR	RM APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345376		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		B. WING			С			
NAME OF PROVIDER OR SUPPLIER						10/	02/2012	
		HABILITATION CENTER	i	2461	T ADDRESS, CITY, STATE, ZIP CODE LEGION ROAD 'ETTEVILLE, NC 28308			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETED C 10/02/2012	
1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	REGULATORY OR LSC IDENTIFYING INFORMATION)		F	323				