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Skin conditions; Activity pursuit; Medications; Special treatments and Discharge potential; Documentation of sum the additional assessm areas triggered by the Data Set (MDS); and	d health conditions;		and Rehabilitation Center reserves		
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Medications; Special treatments and Discharge potential; Documentation of sum the additional assessmareas triggered by the Data Set (MDS); and			Right to refute any of the deficience		
Special treatments and Discharge potential; Documentation of sum the additional assessmareas triggered by the Data Set (MDS); and			on this statement through informa		ĺ
Discharge potential; Documentation of sum the additional assessm areas triggered by the Data Set (MDS); and	d procedures:		dispute resolution, formal appeal		Í
the additional assessmareas triggered by the Data Set (MDS); and	- p. 000aa.00,		procedure and or any other		-
the additional assessmareas triggered by the Data Set (MDS); and	nmary information regarding		administrative legal proceedings.		
Data Set (MDS); and	ment performed on the care		F 272		
	completion of the Minimum		On 1/25/13 Resident #39		
bootinontation of parti	liaination in account		was assessed for proper oral care		•
	icipation in assessment.		by the Director of Nursing with the	NA	
			staff. Resident #39 was provided		
	A CONTRACTOR OF THE PROPERTY O		with proper oral care immediately		•
			upon assessment by the Nursing		
1			Assistant.		
RATORY DIRECTOR'S OR PROVIDERISE	UPPLIER REPRESENTATIVE'S SIGNATURE				
/ /	M		TITLE	(	(X6) DATE
	11		excused from correcting providing it is determine	$\mathfrak{Q}/\mathfrak{Q}$	20/13

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

ram participation.

Event ID: Z6Q211

Facility ID: 953074

If continuation sheet Page 1 of 25

#### PRINTED: 02/13/2013 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA TATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** ND PLAN OF CORRECTION A. BUILDING C B. WNG 02/08/2013 345376 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2461 LEGION ROAD **CUMBERLAND NURSING AND REHABILITATION CENTER FAYETTEVILLE, NC 28306** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) 1D (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) The Care Plan and F 272 Care Guide of Resident #39 was F 272 Continued From page 1 updated 1/25/13 by the MDS nurse with specific This REQUIREMENT is not met as evidenced interventions for oral care. On 1/28/13 a 100% audit was conducted by: Based on observation, staff interviews and by the Director of Nursing, Assistant Director record review, the facility failed to assess the of Nursing, QI Nurse, MDS Nurses, and need for frequent oral care for 1 of 1 resident Staff Facilitator for all dependant (resident # 39) not allowed anything by mouth residents in regards to oral care to include with a gastrostomy tube and required total assistance of her oral care. Findings include: residents with nothing by mouth with a gastrostomy tube .Oral care was Resident # 39 was admitted 1/22/09 diagnosis of provided to all dependant cerebral vascular accident, dementia, dysphagia. residents upon identification of any potential and seizures. This required resident #39 to need concern by the nursing assistants. a gastorstomy tube for her nutrition. A 100% audit was conducted Her quarterly minimum data set dated 12/20/12 on 02/07/13 for accuracy of appropriate indicated that she had severe cognitive interventions relating to oral care for impairment and required extensive to total assist with activities of daily living (ADL's). She was all dependent residents coded total assistance for her personal hygiene by the Director of Nursing, which included oral care. Assistant Director of Nursing, Staff Facilitator, MDS Nurses, A review of her ADL care plan indicated that and Quality Improvement Nurse. resident #39 required assistance with bathing. There was no mention of oral care or the All identified areas of concerns specialized need for oral care for a resident with a related to care plans and care guides gastrostomy tube who was not allowed and food were corrected by MDS Nurse on 1/25/13.

resistance with her ADL care.

A review of medical record dental history report dated 9/15/12 stated that oral hygiene was poor with heavy plague and calculus with evidence of periodontitis. The report also indicated that she did not have the ability to clean them herself.

or fluids by mouth. Resident #39 was also care

planned for combativeness during medical exam. but there was no mention of combativeness or

The MDS Nurses were educated on

on admission, quarterly, annually, significant changes, and as needed

interventions on 2/15/13

by the MDS Nurses

updating all care plans by the RAI process

toinclude new implementationof new

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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There we being as months.  On 1/23 be resting coopera substan whitish is moist. It tongue we substan observation products. In an interest at 10:10 updated that she complete assessing coordinate the Resi reflect the the Resi reflect the individual unable to plan did # 39 becalso was regarding the control of the text o	ssessed by de state of the rade and another another and another and another and another anothe	found that resident # 39 was ental services every 6  n, resident # 39 was noted to en asked to smile, she was as a noted pale yellowish the gums of teeth and a dry ne mucus membranes were debris in her mouth but her ith a pale yellowish to the back of her mouth. An orn revealed no oral care  IDS coordinator on 1/24/13 ed she generated and as needed. She also stated person were responsible for rehensive and quarterly residents. The MDS es was responsible to ensure aide were accurate and The MDS coordinator stated aide should be updated to ad for each resident 's MDS coordinator was replanation as to why the care equent oral care for resident othing by mouth status. She after an explanation directive for the NA 's on ide regarding the need for	F 272	The MDS Nurses was Re-Educion 02/15/13 via video trainir odule the MDS 3.0 Care Area Process And Care Planning. An in-service was initiated for all licensed nurses on 02/07/13 by the Staff Facilitator regard quarterly, annually, significant changes, and as needed to include new implementation of new interventions on 2/15, by the MDS Nurses The MDS Nurses was Re-Educated on 02/15/13 via video training module the MDS 3.0 Care Area Assessment Process And Care Planning. An in-service was initiated for all licensed nurses on 02/07/13 by the Staff Facilitator regard notifying the MDS Nurse of changes in care; to include frequent oral care; by submitting a copy of the updated resident care guide of any	ng m Assessment  ing /13	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SU COMPLET		
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F 272	of the comprehens for all of the reside responsible to upda nurse and hall nurse the Resident Care made.  On 1/24/13 at 1:35 up in a reclining chalso in the room. Rupon request. Her were covered with substance. Her ton yellowish substance mouth.  On 1/24/13 at 1:50 assigned resident from off when she stated she used the sponges damped vwas already in the On 1/24/13 at 2:00 located inside the cresident # 39 was required assisted von 1/25/13 at 8:45 observed sitting up teeth appeared to I less of the pale yel front teeth and the tongue was withou	ive and quarterly assessments nts. The MDS nurse was ate the care plan and the MDS ses were responsible to update Guides when changes are  pm, resident # 39 was sitting air. Her responsible party was desident # 39 opened mouth lips appeared dry. Her teeth a pale yellowish colored ague was coated with a pale extending to the back of her pm, NA #9 stated she was #39 and she did provided her ne stuff in her mouth does not be cleaned her mouth. She is green colored toothette with water and the toothpaste swab.  pm, the Resident Care Guide closet door indicated that not allowed anything my mouth nothing indicating the she	F	272	All newly hired licensed nurses will be in serviced regarding notifying the MDS nurse of changes in resident assessement to include frequent oral care by submitting a copy of the updated resident care guide of any changes to the MDS Nurse during the Orientation process by the Staff Facilitator.  All Licensed Nurses were educated on how to notify the MDS Nurse of changes in assessment for the need for frequent oral care by submitting a copy of the updated resident care guide with any changes to the MDS Nurses			

STATEMENT OF DEFICIENCIES  (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED		
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F 279 SS=D	provided by NA # 9 cooperative and approcess. An inspect the bottom teeth revitoward the front bott quickly subsided. The yellowish substance the top teeth and the stated she provided cooperative then as 483.20(d), 483.20(k). COMPREHENSIVE A facility must use the top teeth and the stated she provided cooperative then as 483.20(d), 483.20(k). The facility must use the top develop, review a comprehensive plan. The facility must deep plan for each reside objectives and timel medical, nursing, an needs that are identically assessment.  The care plan must to be furnished to an highest practicable psychosocial well-be \$483.25; and any seeds the required under \$ due to the resident's due to the residen	was done. Resident # 39 was beared to understand the ion of the swab used to clean realed no debris. The gums from teeth began to bleed but here was noted a pale on the swab after cleaning a roof of her mouth. NA # 9 oral care earlier and she was well.  (1) DEVELOP CARE PLANS  The results of the assessment and revise the resident's a of care.  Welop a comprehensive care not that includes measurable tables to meet a resident's and mental and psychosocial diffied in the comprehensive  describe the services that are defain or maintain the resident's polysical, mental, and being as required under ervices that would otherwise 483.25 but are not provided as exercise of rights under the right to refuse treatment		272	On 2/1/13 a QI tool was put into place by the Director of Nursing to ensure that oral care is provided frequently throughout the day and to monitor oral care for all dependant residents to include Resident #39. The Director of Nursing along with the QI nurses will review the QI to on a five times a week x 4 weeks three times a week x 4 weeks, the weekly X 4 weeks then monthly x Follow up will occur by the Director of Nursing upon the identification any potential concern.  The results of the oral care for dependent residents audits will be forwarded to the Exceutive QI Committee monthly for the identification of trends, development of action plans as indicated, and to determine frequency of continued QI monitors.	ol hen n 2 months or n of	
	by:	IT is not met as evidenced ion, staff interviews and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 279	need for frequent oral (resident # 39) not all with a gastrostomy turn assistance of her oral. Resident # 39 was adderebral vascular account seizures. This red a gastorstomy tube for the quarterly minimur indicated that she had impairment and require with activities of daily coded total assistance which included oral can assistance which included oral can assistance with a seizure and for compative or fluids by mouth. Replanned for combative but there was no men resistance with her AI. A review of medical redated 9/15/12 stated to with heavy plague and periodontitis. The report of the was evidence for being assessed by demonths.	ility failed to care plan the care for 1 of 1 resident owed anything by mouth be and required total care. Findings include:  mitted 1/22/09 diagnosis of ident, dementia, dysphagia, quired resident #39 to need in her nutrition.  In data set dated 12/20/12 if severe cognitive red extensive to total assist living (ADL's). She was refor her personal hygiene inc.  are plan indicated that assistance with bathing. In of oral care or the ral care for a resident with a rewas not allowed and food sident #39 was also care the resident with a resident #39 was also care that oral hygiene was poor it calculus with evidence of our also indicated that she is to clean them herself. The count that resident #39 was also was also indicated that she is to clean them herself.	F 2		Care plan was reviewed and revised as necessary by the MDS nurse to it the provision of frequent oral care related to being nothing by mouth a The MDS Nurse revised the care plans for all resident changes to include frequent oral care for residents with nothing by mouth wit gastrostomy feeding tubes on 2/7/13.  The DON or ADON will review the care Plans of all residents with nothing by mouth gastrostomy feeding tubes to ensure care plans have been revised by utilization of the Care plan interventions QI tool 3 times per week for 4 Weeks, 2 times per week for 4 Weeks, and monthly thereafter. Immediate follow up will be taken by the DON or ADON upon the ident of any potential concerns.	nclude and th h with e		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 279	be resting in bed. Wit cooperative. There we substance bordering whitish substance. The moist. There was no tongue was coated we substance extending observation of the roproducts out in view.  In an interview with we at 10:10 am, she state updated the care plancoordinator stated shall the Resident Care Governed to effect the care need individual needs. The unable to offer and explandid not include the also was not able to regarding the lack of the Resident Care Governed to regarding the lack of the Resident Care Governed to a to regarding the lack of the Resident Care Governed to a to regarding the lack of the Resident Care Governed to a to regarding the lack of the Resident Care Governed to update the Resident Care Governed to a to regarding the lack of the Resident Care Governed to update the Resident Care Governed to update the Resident Care Governed to the Res	nen asked to smile, she was ras a noted pale yellowish the gums of teeth and a dry he mucus membranes were debris in her mouth but her rith a pale yellowish to the back of her mouth. An om revealed no oral care  ADS coordinator on 1/24/13 ted she generated and h as needed. The MDS he was responsible to ensure uide were accurate and The MDS coordinator stated uide should be updated to hed for each resident's he MDS coordinator was explanation as to why the care requent oral care for resident hothing by mouth status. She offer an explanation directive for the NA's on hide regarding the need for hated to resident #39's https:  ham, the director of nursing he coordinator was he the care plan and the MDS he were responsible to update hides when changes are	F 279	The MDS Nurse was educated on 02/15/13 by the MDS Nurse Consultant on the utilization of assessment data for accurate care plan development for all residents to include residents that were identified as dependent for oral care. The MDS Nurses were educated on updating all care plans by the RAI process on admission, quarterly, annually, significant changes, and as needed to include new implementation of new interventions. The MDS Nurse was Re-Educated on 02/15/13 via video training module the MDS 3.0 Care Area Assessment Process And Care Planning.		
	up in a reclining chai	m, resident # 39 was sitting r. Her responsible party was sident # 39 opened mouth				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 279	upon request. Her lips were covered with a psubstance. Her tonguyellowish substance emouth.  On 1/24/13 at 1:50pm assigned resident #39 oral care but that the come off when she clestated she used the gsponges damped with was already in the sw.  On 1/24/13 at 2:00 pm located inside the clost resident #39 was not (NPO). There was not required assisted with On 1/25/13 at 8:45am observed sitting up in teeth appeared to hav less of the pale yellow front teeth and the bactongue was without deform to the bottom teeth reveat operative and appear process. An inspection the bottom teeth reveat toward the front bottom	s appeared dry. Her teeth vale yellowish colored e was coated with a pale extending to the back of her oxtending to the teeth oxtending to the teeth oxtending to the teeth oxtending the she her oral care.  The resident # 39 was the reclining chair. Her e been cleaned. There was the reclining chair. Her e been cleaned. There was the teeth oxtending the teeth. Her obris and appeared moist.  The standing the she her oxide to the top oxide		An in-service was initiated by the Staff Facilitator for all licensed nurses on 02/07/13 by the Staff Facilitator regarding notifying the MDS Nurse of changes in care; to include frequent oral care; by submitting a copy of the updated resident care guide of any changes to the MDS Nurse. All newly hired licensed nurses will be in serviced regarding notifying the MDS nurse of changes in resident assessment to include frequent oral care by submitting a copy of the updated resident care guide of any changes to the MDS Nurse during the Orientation process by the Staff Facilitator. The findings of the QI monitoring audits will be forwarded to the QI committee by the DON or QI	Nurse
quickly subsided. There was noted a pale yellowish substance on the swab after cleaning the top teeth and the roof of her mouth. NA # 9 stated she provided oral care earlier and she was cooperative then as well.		i 1	for review quarterly for the identification of trends, development of action plans as indicated, and to determine frequency of continued OI monitori	ng.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		PLE CONSTRUCTION	(X3) DATE SU COMPLET	
		345376	B. WNG				С
NAME OF PE	ROVIDER OR SUPPLIER	040010		eto.	EET ADDOPOG OTT OTATE TO CODE	02/0	8/2013
CUMBER	LAND NURSING AND RE	HABILITATION CENTER		24	EET ADDRESS, CITY, STATE, ZIP CODE 461 LEGION ROAD AYETTEVILLE, NC 28306		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 281 SS=D	PROFESSIONAL STA	d or arranged by the facility al standards of quality.	F2	281	The Medication Administration Record was updated for resident #48 immediately Upon notification by charge nurse on 1/25/13.		
	by: Based on record revifacility failed to follow daily blood glucose mediates with diabete included:	ew and staff interviews, the the physician's orders for onitoring for 1 of 5 sampled is (Resident #48). Findings			A 100% audit was conducted on 1/25/13 by the Staff Facilitator of all diabetic residents. All diabetic residents charts were reviewed and compared to the MAR	4	
	7/24/12 with multiple of diabetes.  Review of the residen physician orders date. Novolog (insulin), disc times daily, start fastir morning, and notify th	t's clinical record revealed d 1/16/13 to discontinue continue accuchecks four ng accuchecks every e physician if results were lL (milligram/deciliter). ed no other orders for			for accuracy with no issues identified 100% in servicing of all Licensed Nur Personnel regarding proper transcription and correct procedure to intiate orders was completed on 2-7-13 by the Staff Facilitator.		
THE TAXABLE PROPERTY OF THE PR	monitoring is conducted finger for a blood same a strip. The strip goes reads the blood sugar.  Review of the resident administration record centry for fasting accuratify MD if accuracy.	ck blood sugar (FSBS) ed by sticking the resident's ple, which is then placed on sinto a glucometer that level.  's January 2013 medication (MAR) revealed an undated heck every morning and s is greater than 200 mg/dL. MAR was blocked off for		***************************************	All newly hired Licensed Nurses will receive education during orientation by the Staff Facilitator on proper transcription of orders and correct procedure to initiate orders		

PRINTED: 02/13/2013 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  CUMBERLAND NURSING AND REHABILITATION CENTER  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 281  Continued From page 9 weekly accucheck monitoring instead of daily monitoring. Review of the MAR revealed accucheck results of 81 mg/dl at 6AM on 1/24/13.  Review of the resident's Blood Glucose (FSBS) Monitoring Sheet revealed no documentation of daily accuchecks. Review revealed results of 81 mg/dl on 1/17/13 and 96 mg/dl on 1/24/13.  Record review of the resident's nursing notes revealed no documentation of daily accuchecks.  B. WING   STREET ADDRESS, CITY, STATE, ZIP CODE 2461 LEGION ROAD FAYETTEVILLE, NC 28306  PROVIDER'S PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PREFIX TAG  F 281  Continued From page 9 weekly accucheck monitoring instead of daily monitoring. Review of the MAR revealed accucheck monitoring instead of daily were initiated on 2/1/13 by the Director of Nursing to verify that orders were transcribed to MARs correctly by 11-7 nursing staff.  Nurse Supervisors/Quality Improvement Nurses will audit orders daily to ensure they are correctly placed on MAR.			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  CUMBERLAND NURSING AND REHABILITATION CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE 2461 LEGION ROAD FAYETTEVILLE, NC 28306  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 281  Continued From page 9  weekly accucheck monitoring instead of daily monitoring. Review of the MAR revealed accucheck results of 81 mg/dl at 6AM on 1/24/13.  Review of the resident's Blood Glucose (FSBS) Monitoring Sheet revealed no documentation of daily accuchecks. Review revealed results of 81 mg/dl on 1/17/13 and 96 mg/dl on 1/24/13.  Record review of the resident's nursing notes revealed no documentation of daily accuchecks.  Record review of the resident's nursing notes revealed no documentation of daily accuchecks.  Record review of the resident's nursing notes revealed no documentation of daily accuchecks.							(	c
CUMBERLAND NURSING AND REHABILITATION CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE 2461 LEGION ROAD FAYETTEVILLE, NC 28306  (X4) ID PREFIX TAG  CONTINUED FOR USCIDENTIFYING INFORMATION)  F 281  Continued From page 9 weekly accucheck monitoring instead of daily monitoring. Review of the Resident's Blood Glucose (FSBS) Monitoring Sheet revealed no documentation of daily accuchecks. Review revealed results of 81 mg/dl on 1/17/13 and 96 mg/dl on 1/24/13.  Record review of the resident's nursing notes revealed no documentation of daily accuchecks.  STREET ADDRESS, CITY, STATE, ZIP CODE 2461 LEGION ROAD FAYETTEVILLE, NC 28306  PROVIDERS PLAN OF CORRECTION (X9) PREFIX TAG  PROVIDERS PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 281  4 Hour Chart Checks were initiated on 2/1/13 by the Director of Nursing to verify that orders were transcribed to MARS correctly by 11-7 nursing staff.  Nurse Supervisors/Quality Improvement Nurses will audit orders daily to ensure they are correctly placed on MAR.			345376	B. WIN	G			
F 281 Continued From page 9 weekly accucheck monitoring. Review of the MAR revealed accucheck results of 81 mg/dl at 6AM on 1/24/13. Review of the resident's Blood Glucose (FSBS) Monitoring Sheet revealed no documentation of daily accuchecks. Review of the resident's nursing notes revealed no documentation of daily accuchecks of the resident's nursing notes revealed no documentation of daily accuchecks.  Record review of the resident's nursing notes revealed no documentation of daily accuchecks.  Record review of the resident's nursing notes revealed no documentation of daily accuchecks.  Record review of the resident's nursing notes revealed no documentation of daily accuchecks.			HABILITATION CENTER		24	461 LEGION ROAD		
weekly accucheck monitoring instead of daily monitoring. Review of the MAR revealed accucheck results of 81 mg/dl at 6AM on 1/17/13 and 96 mg/dl at 6AM on 1/24/13.  Review of the resident's Blood Glucose (FSBS) Monitoring Sheet revealed no documentation of daily accuchecks. Review revealed results of 81 mg/dl on 1/17/13 and 96 mg/dl on 1/24/13.  Record review of the resident's nursing notes revealed no documentation of daily accuchecks.  Record review of the resident's nursing notes revealed no documentation of daily accuchecks.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.D BE	COMPLETION
In an interview on 1/25/13 at 12:42AM, Nurse #3 examined the MAR and acknowledged the accuchecks for Resident #48 should have been completed daily as ordered by the physician. Nurse #3 stated she transcribed the order to the MAR but the third shift nurse blocked off the MAR to indicate weekly accucheck monitoring. The third shift nurse was responsible for completing FSBS monitoring at 6AM. Nurse #3 stated one copy of the order remained in the resident's chart, one copy was sent to the physician to sign, and one copy, the pink copy, was filled at the nursing station. The administrative nurses collected the pink copies daily to be sure the staff followed through on new orders or order changes.  In an interview on 1/25/13 at 1:06PM, the Director of Nursing (DON) stated when the nurses received new orders, they updated the MAR immediately. One copy of the order remained on the chart, one copy went to the pharmacy, and the pink copy went to the Quality Assurance (QA) nurse. After the morning staff meetings, the QA nurse checked all new orders against the MARS for accuracy. The DON examined Resident #48's  In an interview on 1/25/13 at 1:06PM, the Director of Nursing (DON) stated when the nurses received new orders, they updated the MAR immediately. One copy of the order remained on the chart, one copy went to the Quality Assurance (QA) nurse. After the morning staff meetings, the QA nurse checked all new orders against the MARS for accuracy. The DON examined Resident #48's	F 281	weekly accucheck memonitoring. Review of accucheck results of and 96 mg/dl at 6AM Review of the resider Monitoring Sheet revidally accuchecks. Remg/dl on 1/17/13 and Record review of the revealed no documer.  In an interview on 1/2 examined the MAR accuchecks for Resid completed daily as or Nurse #3 stated she to MAR but the third shift to indicate weekly act third shift nurse was resident from the copy of the order remone copy was sent to one copy, the pink costation. The administ pink copies daily to be through on new order. In an interview on 1/2 of Nursing (DON) stated received new orders, immediately. One copy the chart, one copy went to nurse. After the morn nurse checked all new	onitoring instead of daily of the MAR revealed 81 mg/dl at 6AM on 1/17/13 on 1/24/13.  It's Blood Glucose (FSBS) ealed no documentation of eview revealed results of 81 96 mg/dl on 1/24/13.  It's nursing notes station of daily accuchecks.  5/13 at 12:42AM, Nurse #3 and acknowledged the ent #48 should have been dered by the physician. ranscribed the order to the ft nurse blocked off the MAR cucheck monitoring. The esponsible for completing AM. Nurse #3 stated one ained in the resident's chart, the physician to sign, and py, was filed at the nursing rative nurses collected the es sure the staff followed is or order changes.  5/13 at 1:06PM, the Director ed when the nurses they updated the MAR by of the order remained on ent to the pharmacy, and the Quality Assurance (QA) ing staff meetings, the QA orders against the MARS	F	281	were initiated on 2/1/13 by the Director of Nursing to verify that orders were transcribed to MARs correctly by 11-7 nursing staff.  Nurse Supervisors/Quality Improved Nurses will audit orders daily to ensure they are correctly placed on MAR.  Monitoring will be done on 12 selected residents to include Resident # 48, 3 x week for 4 weeks 2x week for 4 weeks and weekly thereafter by QI nurses. Follow up action will be taken upon identification of any potential concern by the Nurse Supervisors and/or QI Nurse Supervisors and/or QI Nurse The results of the Audits will be forwarded to the Executive QI Committee by the QI Nurse monthly for review for follow up action As deemed appropriate, evaluation of the effectiveness of the Plan, and to determine the frequent	s Ition Irse y	

Facility ID: 953074

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. WNG			1	C /08/2013	
	OVIDER OR SUPPLIER	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CO 2461 LEGION ROAD FAYETTEVILLE, NC 28306		161 LEGION ROAD	<u> </u>	·
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	MAR and stated the have blocked the acceptation was transcribed correctly stated the error shou QA nurse and every  The QA nurse and the unavailable for interverse.	third shift nurse should not cucheck order as weekly. for all orders to be to the MARS. The DON ld have been caught by the nurse that read the order. ird shift nurse were lew.  IRE PROVIDED FOR		312	On 1/25/13 Resident #39		
33-0	DEPENDENT RESIDENTS  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.				was assessed for proper oral care by the Director of Nursing with the NA staff member. Resident #39 was provided with proper oral care immediately upon assessment by the NA staff member.		
	by: . Based on observation review, the facility fail care for 1 of 1 resides not allowed any by marketsident # 39 was accerebral vascular acc	is not met as evidenced in, interview and record led to provide needed oral int (resident # 39) who was iouth. Findings include: idmitted 1/22/09 with a of ident, dementia, dysphagia, int #39 used gastrostomy			On 1/25/13 a 100% audit was Conducted by the Assistant Director of Nursing for all dependant residents in regards to oral care to include resi with nothing by mouth with a gast tube. Oral care was provided to all dependant residents upon identification of any potential conby the nursing assistants.	rostomy I	
	indicated that she ha impairment and requi with activities of daily	red extensive to total assist living (ADL's). She was e for her personal hygiene			All nursing staff members were reeducated in regards to proper oral care on 1/25/13 by the Staff F	acilitator	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  2461 LEGION ROAD  FAYETTEVILLE, NC 28306				
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F 312	A review of her ADL resident # 39 require There was no mentic specialized need for gastrostomy tube white fluids by mouth. Resplanned for combative but there was no me resistance during he A review of medical dated 9/15/12 stated with heavy plaque arperiodontitis. The regidness of the ability herself.  On 1/22/13 at 11:20 responsible party, shout cleaning her moures ident #39's mouth substance in the corresident #39's mouth substance in the corresponsible party. There we substance in the corresponsible to the corresponsible to the corresponsible party in the teeth.  On 1/23/13 at 3:17pm be resting in bed. When the corresponsible with a pale yeth to the back of her more content with a pale yeth the back	care plan indicated that d assistance with bathing. on of oral care or the oral care for a resident with a o was not allowed food or ident # 39 was also care reness during medical exam, ntion of combativeness or		312	On 2/1/13 a QI tool was put into place by the Director of Nursing to ensure that oral care is provided frequently throughout the day and to monitor oral care for all dependences to include Resident #39. The QI tool will be monitored daily by the Staff Nurse. Follow up occur by the Director of Nursing up identification of any potential condition of the QI monitoring tool will be forwarded to the QI committee for review quarterly for the identification of trends, develor of action plans as indicated, and to determine frequency of continued QI monitoring.	d dant will pon cern. r ppment	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER	EHABILITATION CENTER	s	TREET ADDRESS, CITY, STATE, ZIP CO 2461 LEGION ROAD FAYETTEVILLE, NC 28306		
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F 312	were covered with a substance. Her tong yellowish substance mouth.  On 1/24/13 at 1:45 pstated that resident anything by mouth a tube. NA # 8 stated resident # 39 but sha a gastrostomy tube.  On 1/24/13 at 1:50p assigned resident # but that the stuff in high when she tries to clearly care for all resident greateding residents.  On 1/24/13 at 2:10p nursing stated her ereoral care for all resideding residents.  On 1/24/13 at 3:00 pstated she ereoral care for all residents, but feeding resident, but feeding resident, but feeding resident was known on 1/25/13 at 8:45a observed sitting up teeth appeared to his corners of her mout was clean and appeared on 1/25/13 at 9:00a	pale yellowish colored the was coated with a pale extending to the back of her own, nursing assistant # 8 (NA) # 39 was not allowed and she had a gastrostomy she was not assigned e knew that any resident with required frequent oral care.  In NA #9 stated she was 39 and she did her oral care her mouth does not come off ean her mouth.  In the assistant director of ean her mouth be frequent dents ' especially tube  In the director of nursing expected oral care be done for a three that the responsible she had mentioned her estated that the responsible she had mentioned her to resist care.  In the reclining chair. Her are been cleaned. The had were clean and the tongue	F 31	2		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	HABILITATION CENTER	s	TREET ADDRESS, CITY, STATE, ZIP COD 2461 LEGION ROAD FAYETTEVILLE, NC 28306			
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F 312 F 323 SS=G	cooperative and apper process. An inspection the bottom teeth reversion to bottom teeth reversion to bottom teeth and the yellowish substance of the top teeth and the stated she provided of cooperative then as we 483.25(h) FREE OF A HAZARDS/SUPERVITTHE facility must ensure environment remains as is possible; and earlies the bottom teeth and the stated she provided to cooperative then as we will be to be the stated she provided to cooperative then as we will be the stated she provided to the stated she are the stated she	eared to understand the n of the swab used to clean aled no debris. The gums m teeth began to bleed but are was noted a pale on the swab after cleaning roof of her mouth. NA # 9 aral care earlier and she was well.  ACCIDENT SION/DEVICES  are that the resident as free of accident hazards	F 31				
	This REQUIREMENT by: Based on record revifacility failed to use a transfer 1 of 3 sample extensive assistance left distal femur fracture Findings included: Resident # 27 was ad 2/13/2012 with diagnor Cognitive communicate coordination and Oste Minimum Data Set (Mineyealed the resident)	is not met as evidenced ews and staff interviews, the mechanical lift to ad residents who needed with transfer, resulting in a re. (Resident # 27).  mitted to the facility on uses of Muscle weakness; tion Deficit; Lack of eoporosis. The most current EDS) dated 10/1/2012 s cognition as moderately extensive assistance with		Past noncompliance: no pl correction required.	an of		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER  AND NURSING AND F	REHABILITATION CENTER		24	EET ADDRESS, CITY, STATE, ZIP CODE 461 LEGION ROAD AYETTEVILLE, NC 28306		
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F 323	Continued From pa	ge 14	F	323			
	worksheet dated 4 "Flagged for falls C during transitions, i. seated to standing surface transfers. (I requires the use of times will need a (n weakness. Staff cu (Resident # 27)'s n needed."  Resident # 27's car documented the re- transferring from or to physical limitatio the following interve for constant superv mechanical aid at a weight bear, Use m  Review of Resident 10/10/2012 indicate mechanical lift to be On 10/29/2012 a n 10/29/2012 docum- leg seem to be mor placed to PA (Phys given to transfer re- evaluation. EMT (E arrived and resident On 10/29/2012 a ne-	re Area Assessment ( CAA) //11/2012 documented AA due to balance problems .e.(example) moving from a position and surface to Resident #27) currently (mechanical lift # 1), but at nechanical lift # 2) due to rrently anticipates all of eeds and provide care as  re plan dated 10/23/2012 sident required assistance for ne position to another related n. The care plan documented entions: "Provide two persons ision/ physical assist with all times, Resident cannot nechanical lift."  If #27's "Care Guide" dated and the resident needed a large a used for transfers.  Lurse's note at 1:41 AM on ented "Observed resident left are swollen and shorten. Call sician Assistant). An order was sident to (hospital) for imergency Medical Technician) at was sent out to (hospital)."  Lurse's note at 7:25 AM dent returned from hospital.					
	Transported back t	dent returned from hospital. o facility by EMS (Emergency on stretcher. Alert with					

	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING	CONSTRUCTION	COMPLE		
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	OVIDER 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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	on 10/29/2012 a nur documented "Swelling or warmth. Without to Able to move leg and On 10/31/2012 a nur documented "called Assistant) #8. Upon noted to thigh that wa 10/29/2012. Residen (Emergency Departn uses Doppler effect to came back negative. notified and an order and femur."  On 10/31/2012 a nur documented "Result received. Oblique fra order received for co Percocet 5/325 mg (Inhours as needed for On 10/31/2012 a nur documented "Reside medicated for pain of applied to left knee pappointment on 11/1 for positioning and retime."  Review of the facility 10/31/2012 documents welling and pain on	knee remains edematous, ow up the doctor."  se's note at 10:41 AM ng to left thigh. No redness enderness when leg moved. It toes at will."  se's note at 10:45 AM in to room by NA (Nurse assessment hematoma as noted previously on thad gone to ED nent) for Doppler (Radar that o measure velocity) which PA (Physician Assistant) received for X- ray of left hip se's note at 2:44 PM lits of X- ray to left thigh cture noted. PA notified and nsult with orthopedic. Also milligram) to be given every 4	F 323				

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ł	LDING	PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
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	ROVIDER OR SUPPLIER LAND NURSING AND RI	EHABILITATION CENTER		24	EET ADDRESS, CITY, STATE, ZIP CODE 461 LEGION ROAD AYETTEVILLE, NC 28306		0/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	(hospital) that all test Resident obtained ar showed left distal fra facility's investigation	ving nurse given report from results were negative.  In x- ray on 10/31/2012 that cture. "Further review of the report revealed the staff at ined on safe movement and	F	323			
	"Resident alert and a to left thigh noted, rei needed Percocet give bed this shift, will con Nurse's note dated 1 "Resident had an app	1/2/2012 documented of with the (Orthopedic ing) order to keep knee					
	Personnel Registry (had 11/1/2012 and a 5 daren Review of a second dated 11/6/2012 reversing (ADON) conducted the family allegation from the family allegation (assigned to the resides shift (assigned to the related to violation of Review of the "Discip	ubmitted to Health Care HCPR) a 24 hour report on y report on 11/5/2012.  facility's 24 hour report aled the Assistant Director inducted an investigation ging neglect related to left ther revealed NA # 11 ent on 10/28/2012 second /2012 second shift (3-11) employment on 11/8/2012 facility policy.					
	dated 11/8/2012 reve						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		345376	B. WI	IG		02/08	3/2013
	OVIDER OR SUPPLIER  AND NURSING AND RE	HABILITATION 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	ΙX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	Assistant) who was a 10/28/2012 second sit (3-11) whe facility due to "formovement and hand!  Nurse's note dated 1 "Resident sent to (Horequest for femur fraction of the hospital dated 11/7/2012 door initially evaluated on fracture and was reconstructed the facility and discomfamily wishes that shows noted to have in increased deformity of prominent time bone side of the distal femulation.  Review of Resident for summary dated 11/1/1 reason for hospitalization in the left thigh. Left of Further review of the documented "after fapatient had ORIF (Or Fixation). Overall the improvement in her parent and hand in the provement in her parent and some side of the distal femulation."	assigned to Resident # 27 on hift (3-11) and 10/29/2012 as terminated from work at allure to follow safe ing policy."  1/7/2012 documented aspital) per family member cture."  al's History and Physical umented "The patient 10/29/2012 for the femurommended closed on was performed and ed to a local nursing facility. If the patient and the elebeseen again. The patient creased swelling with an moted. On presentation to the my, the patient was noted to a inches of shortening with the left femur with a fragments along the lateral ur with skin that is intact."  127's hospital's discharge 4/2012 documented the ation as "Pain and deformity distal femur fracture."	F	323			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SURV	D
		345376	B. WIN	G		1	/2013
	OVIDER OR SUPPLIER	REHABILITATION CENTER		246	ET ADDRESS, CITY, STATE, ZIP CODE 61 LEGION ROAD LYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLO BE	(X5) COMPLETION DATE
F 323	elected a different will be transferred  During the intervie Nursing) on 1/24/2 she initiated an intervience of possibly not using The DON also state of osteoporosis at on 10/31/2012 incher left distal feminad been in -servuse of mechanica facility and was infound out that she	skilled nursing facility and she	F	323			
	The SDC (Staff Direported she in-safter the incident policy in the use on Resident # 27 transferred Resident mechanical lift. Staff the facility were mechanical lift with the types of the the residents' cathe care guide all required when us	ew on 1/24/2013 at 3:00 PM, revelopment Coordinator) erviced the staff at the facility of failure to use the facility's of the mechanical lift by NA #11. SDC reported that the NA # 11 lent # 27 without using a She added the nurse's aides at equired to use a correct type of a men transferring the residents. lifts to be used were recorded on re guide. SDC further stated that so indicated number of staff sing a mechanical lift to transfer two many staff is required to assist					

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DPLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345376	B. WNG		02	C /08/2013
	OVIDER OR SUPPLIER  AND NURSING AND RE	HABILITATION CENTER	s	STREET ADDRESS, CITY, STATE, ZIP C 2461 LEGION ROAD FAYETTEVILLE, NC 28306	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 323	NA # 11 had been to the mechanical lift or extensive assistance Resident # 27 withou further stated the en- been in-serviced in r mechanical lift on the	anical lift. SDC also stated alined before on the use of a residents who needed with transfer but chose to lift at the use of the lift. SDC life staff at the facility had beforence to the use of the	F 32	23		
	the administrator rep working at facility 3 of reported that his exp they should follow the residents who require transfer using a mediadded that he was a had been put in place found with a fracture staff at the facility had of the mechanical life completed for resided been injured and modin place to make sur happen again. He and Assurance) Committed	corted that he had just started days before the interview. He sectation of his staff was that he policy regarding lifting of the extensive assistance with chanical lift. The administrator had been interventions that he after Resident # 27 was he. He further stated that the had been in-serviced in the use the tast and the had been here who could had potential contioring tools had been, put the the incident does not had discussed the had discussed the ling the problem from the had the committee will continue				
	without the use of the unavailable for inter	cused of lifting Resident # 27 ne mechanical lift was view. She (NA #11) was ployment on 10/8/2012.				

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	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION NOF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345376	B. WIN	3		02	C /08/2013
	OVIDER OR SUPPLIER  AND NURSING AND R	EHABILITATION CENTER	:	2461 L	ADDRESS, CITY, STATE, ZIP CODE EGION ROAD TTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	The corrective action dated 10/31/2012 in 1. A 100 % body aur that there were no a edema and pain wa ADON, DON, SDC a completed the audit 2.100% in-service was completed by 1 training with the nur 3. A lift transfer aud X 4 weeks and completed by 11/13 service with the nur 5.100% in-service completed by 11/13 service with the nur 5.100% in-service completed by 11/6/2 service with the lice nurses and Registe 6. QI (Quality Improrelated to pain/eder 11/8/2012 daily 5x/ week x 4 weeks the then weekly x4 week will be completed 4 7. Monitoring of the 16, 2013 then moniquarterly through C	n for past non-compliance cluded: dit on all residents to ensure cute changes in regards to a completed by 10/31/2012- and facility 's consultant as. No concerns were found.  with return demonstration of lift 1/2/2012- SDC completed the ses aides  it was to be completed weekly pleted by 11/29/2012  will be completed related to ent movement policy and 1/2012 - SDC completed the in se's aides.  signs/symptoms of fracture 2012- SDC completed the in se's aides.  signs/symptoms of fracture 2012- SDC completed the in sed staff (Licensed practical red nurses)  evement) of acute changes may to be implemented on week x 4 weeks then 3 times/ and 2 times per week x 4 weeks then 3 times/ and 2 times per week x 4 weeks then monthly x 2 months 1/18/2013  system will occur on January they for 90 days and then the (Quality Assurance) system will be monitored and	F	323			

Event ID: Z6Q211

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	• •	A. BUILDING	S	COMPLETED	
		345376	B. WNG		C 02/08/2013
	OVIDER OR SUPPLIER	EHABILITATION CENTER	2	REET ADDRESS, CITY, STATE, ZIP CODE 461 LEGION ROAD FAYETTEVILLE, NC 28306	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 323	the entire plan of co including re-education of the use of a lift traff of the use of a lift traff of the nurse aides a aware of proper use the transfer of the results in the re	tion process on 1/25/2013, rrection was reviewed on of staff and observations ansfer on residents (Resident £ 57) at the facility. Interviews and nurses revealed they were age of the mechanical lift for esidents at the facility.  e aides also revealed they esidents who require the cooking at the care guides and of the mechanical lift required. Autoring tools revealed that the end the 100 % in-service of the lift and return demonstration of RUG RECORDS, UGS & BIOLOGICALS  Apploy or obtain the services of its who establishes a system at and disposition of all sufficient detail to enable an iton; and determines that drug and that an account of all maintained and periodically als used in the facility must be acce with currently accepted les, and include the	F 323		when eted g ses

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` '	LE CONSTRUCTION	(X3) DATE SUR COMPLET		
			A. BUILDING			
		345376	B. WNG	· · · · · · · · · · · · · · · · · · ·	ı	8/2013
	ROVIDER OR SUPPLIER LAND NURSING AND F	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2461 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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 431	The facility must proper permanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except when package drug distril	t only authorized personnel to keys.  Divide separately locked, compartments for storage of ed in Schedule II of the ag Abuse Prevention and and other drugs subject to the facility uses single unit bution systems in which the inimal and a missing dose can	F 431	100% Inservice of Licensed Nur Staff on 2/7/13 by the Staff Facilitator was conducted on medication storage to include locking themedication cart when nurses not in attendance.  Monitoring for proper storage of to include locking of the med can nurse not in attendance utilizing a QI tool will be completed 3 x week	n of medications	
	by: Based on observatinterviews, the facility insulin in 1 of 5 med medication pass. F  The facility's policy undated, read in paperscription biologic carts or medication  Observation on 1/2-revealed Nurse #2 to administer medic multiple vials of insultray on top of the mixials were not in vie in resident #49's roof.	titled Medication Storage, rt: "all medications and cals shall be stored in locked rooms."  4/13 at 9:24AM on the 500 hall entered Resident #49's room ations. Observation revealed ulin were stored in a plastic edication cart. The insulin ow of Nurse #2 while she was om.		for 4 weeks, 2 x week for 4 week weekly x 4 weeks, then monthly thereafter by the QI N Follow up will be taken immediupon the identification of any medication storage issue with the involved staff by the QI Nurse.  The results of the medication storage audits will be forwarded to the Executive QI Committee by the QI Nurse mo for review for follow up action as deemed appropriate, evalua of the effectiveness of the plan, and to determine the free formal and to determine the free continued in the standard page 10 medical pa	urse. ately nthly tion uency	
	Nurse #2 prepared	five medications at the Resident #117. The nurse		of and/or need for continued n	onitoring.	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			C 02/08/2013	
		345376		<del>-</del>			
	ROVIDER OR SUPPLIER  LAND NURSING AND R	REHABILITATION CENTER		2461	ADDRESS, CITY, STATE, ZIP CODE LEGION ROAD ETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	(OULD BE	(X5) COMPLETION DATE
F 431	medications. The ir unattended on top of the medication adm.  Observation on 1/24 Nurse #2 prepared #69. On 1/24/13 at prepared medication stated she had to go another hall. The ir unattended on top of #2 returned to the in 9:41AM and preparinjection. The nurse and administered the The insulin vials remedication cart una administration.  Observation on 1/24 Nurse #2 prepared	t's room and administered the neulin vials remained of the medication cart during ninistration.  4/13 at 9:30AM revealed ten medications for Resident 19:36AM, Nurse #2 locked the ns in the medication cart and to to the medication room on neulin vials remained of the medication cart. Nurse medication cart on 1/24/13 at the Lantus (insulin) 80 units for the entered the resident's room the medications and insulin.  The mained on top of the attended during the medication with the medication at 1/24/13 at 9:50AM revealed three medications for		431			
	room and administe insulin vials remain medication cart dur administration.	nurse entered the resident's ered the medications. The ed unattended on top of the ing the medication					
	vials of Lantus insu (regular) insulin, the two vials of Levemi	4/13 at 10:05AM revealed four lin, three vials of Novolin R ree vials of Novolog insulin, in insulin, and one vial of re in the plastic tray on top of					
	stated she kept the	1/24/13 at 10:12AM, Nurse #2 insulin on the medication cart pass and returned it to the					

### PRINTED: 02/13/2013 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 COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING С B. WING 345376 02/08/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2461 LEGION ROAD **CUMBERLAND NURSING AND REHABILITATION CENTER FAYETTEVILLE, NC 28306** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **DEFICIENCY**) F 431 Continued From page 24 F 431 medication room when the pass was completed. The facility policy was to keep all medications locked in the medication cart. Nurse #2 acknowledged she left the insulin vials on top of the cart unattended. She stated "I should have locked them in the cart." In an interview on 1/25/13 at 1:01PM, the Director of Nursing (DON) stated the staff was trained on facility protocol by the staff facilitator upon employment. The staff facilitator and pharmacist conducted medication pass observations of the staff. The DON stated the facility policy was to keep all medications locked in the cart unless they were in view of the nurse passing medications. She stated "that's fundamental nursing." Her expectation was for the staff to store medications properly by locking them up any time they left the medication cart unattended.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		345376	B. WING	Harris Allendaria	02/19/2013	
	ROVIDER OR SUPPLIER	D REHABILITATION CENTER		REET ADDRESS, CITY, STATE, ZIP CODE 2461 LEGION ROAD MAR () FAYETTEVILLE, NC 28306	6 2013	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	IFD.BE AND COMPLETION	
K 000 K 012 SS=E	conducted as per 1 at 42 CFR 483.70( Health Care section publications. This f construction utilizing locking arrangeme automatic sprinkler  CFR#: 42 CFR 48 NFPA 101 LIFE SA Building construction.	ode (LSC) survey was The Code of Federal Register a); using the 2000 Existing n of the LSC and its referenced acility is Type III protected g North Carolina Special nts, and is equipped with an system.	K 000	of Deficiencies and proposes this Ploof Correction to the extent that the summary of findings is factually correction and in order to maintain compliance with applicable rules and provisions quality of care of residents. The Plan of Correction is submitted as a writt allegation of compliance.  Cumberland Nursing and Rehabilitat response to this Statement of Deficiencies nor does in constitute an admission that any deficiency is accurate. Further, Cumberland Nursing and Rehabilitat reserves the right to refute any of the deficiencies on this Statement of	nt an System of the state of th	
,	Based on the obse on 2/19/2013 the form of the following	is not met as evidenced by: ervations and staff interviews bllowing Life Safety Item was empliant, specific findings  ealed penetrations in the rated anical room on the 300 are hallway. ealed penetrations in the rated anical room in the mail around piping in the back	к 012	Deficiencies through Informal Disp Resolution, formal appeal procedure and/or any other administrative or le proceeding.  The unsealed penetrations in the ceiling in the mechanical room or hallway/Special Care hallway were the unsealed penetrations in the ceiling in the mechanical room in main mechanical room around pithe back corner were sealed.	e gal rated n the 300 re sealed. e rated the ping in	
SS=D		3.70 (a) NFETY CODE STANDARD DERVSUPPLIER REPRESENTATIVE'S SIG		All mechanical rooms were insperunsealed penetrations. Any unserpenetrations were sealed at that	aled	

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.

Facility ID: 953074

If continuation sheet Page 1 of 4

CENTERS FOR MEDICARE & MEDICAID SERVICES		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING 01 - MAIN BUILDING 01  B. WING			02/19/2013	
	345376						
	PROVIDER OR SUPPLIER	D REHABILITATION CENTER		2	EET ADDRESS, CITY, STATE, ZIP CODE 461 LEGION ROAD AYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	SUMMARY ST/	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ROPRIATE	(X6) COMPLETION DATE	
K 018	Doors protecting or required enclosure hazardous areas a those constructed wood, or capable or minutes. Doors in required to resist the lare provided with a the door closed. It are permitted.	Continued From page 1 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3  Roller latches are prohibited by CMS regulations in all health care facilities.		.8	Mechanical rooms will be inspected for unsealed penetrations weekly X 4 weeks and after any work has been done in the mechanical rooms utilizing a QI audit tool.  The audits will be forwarded to the Executive QI Committee quarterly for review to determine the need for frequency or continued monitoring.  Rated door hardware was installed on the rated door in the central supply room.  All rated doors were inspected to ensure they have rated door hardware. Any discrepancies were corrected at that time.		
K 029 SS=E	Based on the obs on 2/19/2013 the fobserved as noncinclude: The centrated door hardway  CFR#: 42 CFR 48  NFPA 101 LIFE S  One hour fire rate fire-rated doors) of extinguishing systems and/or 19.3.5.4 pr	is not met as evidenced by: ervations and staff interviews following Life Safety item was ompliant, specific findings ral supply room did not have are installed on the rated door.  33.70 (a) AFETY CODE STANDARD  d construction (with ¾ hour or an approved automatic fire em in accordance with 8.4.1 otects hazardous areas. When omatic fire extinguishing system			Rated doors will be inspected r for rated door hardware week! weeks utilizing a QI audit tool.  The audits will be forwarded to Executive QI Committee quarter review to determine the need frequency or continued monitors.	y X 4 the rly for for	



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01  B. WING			(X3) DATE SURVEY COMPLETED	
	345376					02/19/2013	
	ROVIDER OR SUPPLIER	D REHABILITATION CENTER		2	REET ADDRESS, CITY, STATE, ZIP CODE 461 LEGION ROAD AYETTEVILLE, NC 28306		· <del></del>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC 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
K 029	option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  This STANDARD is not met as evidenced by: Based on the observations and staff interviews on 2/19/2013 the following Life Safety item was observed as noncompliant, specific findings include: The solled linen room on the 200 hallway had a hole in the rated wall just behind the door which left an unsealed penetration in that rated wall.  CFR#: 42 CFR 483.70 (a)		K	029	The hole in the rated wall behind the door in the soiled linen room on the 200 hallway was sealed.  All soiled linen rooms were inspected for unsealed penetrations. Any unsealed penetrations were sealed at that time.		
K 062 SS=E					Soiled linen rooms will be inspectured penetrations weekly X utilizing a QI audit tool.  The audits will be forwarded to Executive QI Committee quarter review to determine the need for frequency or continued monitor.		
	Based on the obse on 2/19/2013 the fo observed as nonco	s not met as evidenced by: rvations and staff interviews llowing Life Safety item was mpliant, specific findings tier head in the 200 shower by the light fixture.		:			
	CFR#: 42 CFR 483.70 (a)						





Facility ID: 953074

If continuation sheet Page 3 of 4



		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		345376	B. WiNG			02/19/2013		
	ROVIDER OR SUPPLIER	D REHABILITATION CENTER	•	STREET ADDRESS, CITY, 2461 LEGION ROAD FAYETTEVILLE, NO	·			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY)			(X5) COMPLETION DATE	
			K 062	The light fixture was moved away All shower rooms ensure the light the sprinkler head was ure the light fixt sprinkler head was QI audit tool.  The audits will be Executive QI Conreview to determ frequency or confidence or confidence with the sprinkler head was QI audit tool.	in the 200 shown from the sprint s were inspected fixture was not bad.  will be inspected ture is not blocking ekly X 4 weeks the forwarded to the inmittee quarterly in the need for the special state of the special stat	d to blocking  to make ing the utilizing  he ly for		
1			1	1		į.	[	

