FEB 1 7 2014

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/30/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DE	FICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.,		i co	TE SURVEY MPLETED
				4G		С
,		345505	B. WNG _			1/15/2014
	ER OR SUPPLIER HAB CENTER OF C	UMBERLAND	STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CUMBERLAND 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	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
SS=D CO A fato do con The plan objourned ass The to be high psy §48 be due §48 und This by: Ba interes left in con	develop, review an apprehensive plan of a facility must develop for each resident ectives and timeta dical, nursing, and eds that are identification and the facility of the facility of the resident of the resident's extensive under §4 to the resident's extensive facility of the resident f	CARE PLANS results of the assessment d revise the resident's	F2	279	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions se forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F279-How corrective action will be accomplished for each resident found to have been affected by the deficient practice— Resident #5 plan of care was	t 1.16.14
Re: 12/ frac mir indi	2/13. Diagnoses in cture and general nimum data set co icated Resident #:	nitted into the facility on included a left humerus weakness. The admission impleted on 12/9/13 was cognitively intact.			revised 1/16/14 to reflect ROM exercise to left upper extremity and refusals of care and therapy Completion date: 1/16/14	

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.

If continuation sheet Page, 1 of 16

Facility ID: 980423

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	Continued From page Extensive assistance assist was required wand personal hygiene two person physical a transfers and tollet us upper extremity was side (shoulder, elbow a cane/crutch/wheeld an active diagnosis. I listed. The care area for activities of daily I 12/3/13 in part read in left humerus fractuand thus requires ext completion." The plan 1/15/14 revealed no approaches/intervent humerus fracture or a occupational therapy A review of the physical 12/3/13 in part read in the aling at this time ar relatively good control.	of one person physical with bed mobility, dressing, b. Extensive assistance of assist was required with se. Range of motion to the indicated as impaired on one of, wrist, hand) with the use of shair. Fracture was listed as No rejection of care was assessment narrative note iving (ADL) signed on fall at home which resulted are, has muscle weakness tensive assistance for ADL and of care dated "12/2/13" to specific care tions that addressed a left refusals to participate in clan progress notes dated patient is status post fall and left humerus. She is wearing and tells me he pain is under oil."		279		ill be ential te ces d to of olan of curately ace or	2-7-14
	progress notes revea Resident #2, "refuse	pational therapy (OT) aled on 12/8/13 at 3:02 pm, d to participate in OT duled time and later in the			management weekly. Completion date: 2/7/14		
	day." On 12/9/13 at a "refused skilled OT, of scheduled therapy, in plan of care." On 12/ part read "refusing full/6/14 at 1:20 pm, no services."	12:27 pm, notes in part read consistent refusals of mpacting progress with OT 13/13 at 8:46 am, notes in urther therapy (OT)." On otes in part read "refused OT			How facility will monito corrective action(s) to endeficient practice will no occur- The RN Unit manager for unit will conduct weekly	nsure of re-	
1	During a tour observ	ation on 1/13/14 at 1:30 pm,			random audits of device t	ise.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE COMP	
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F 279 Continued From page 2 Resident #2's left arm was observed supported in a sling device. Her left arm was positioned lying against her body, supported by her right arm when she reached for the cordless phone on her		n was observed supported in ft arm was positioned lying ported by her right arm	F	279	device assessment, & care for 4 weeks. Completion 6 2/7/14	•	2.7-14
	when she reached for the cordless phone on her bed side table. During an observation on 1/13/14 at 2:00 pm, Resident #2 was observed resting in the bed. The arm sling was located on the bed and not intact to the left arm.		he		DON will complete month random audits of device us device assessment, & care for 2 months. Completion 2/9/14.	se, plan	2.9.14
	#2 when questioned wher sling on at all time that she was, however by the staff (no specishe had to wear it an not have to wear it (no mentioned). She add support sling came on She concluded her thad a shoulder fractus support her arm. Resulted interview to put his supporting her left and In an interview on 1/2 manager #2 when quarm sling was supported was supported in the sling. We the nursing assistant know if the sling is not on or therapy."	ed that sometimes the ff due to it was too loose. Toughts was that since she are she needed to wear it to sident #2 proceeded during er left arm into the sling, m with her right hand. 14/14 at 3:47 pm, unit restioned regarding when the sed to be applied to Resident to specific order when to be keep it on all the time and is usually will let the nurses of on and the nurse will put it in on 1/15/14 at 9:20 am, the			Results of audits will be presented in facility QA meeting. Completion date 2/9/14	:	2.9.14
		assistant instructed was suppose to wear the , unless in therapy and/or	-				

CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 279	In an interview on 1/1 (accompanied by the acknowledged that sh data set (MDS) for Re questioned regarding humerus fracture, she for developing a resic include medical inform She stated that she in on internal document acknowledged that sh plan for the left arm fin nursing added that he information that is inc assessed in-house. 483.20(k)(3)(i) SERV PROFESSIONAL ST. The services provide must meet profession This REQUIREMENT by: Based on observation resident, and family in to clarify a therapy re physician, which resit to a left humerus fract reviewed for fracture included: Resident #2 was adm	5/13 at 11:30 am, Nurse #5 director of nursing), ne completed the minimum esident #2. When further a care plan for the left e indicated that her process lent's plan of care did not mation from outside sources. Initiated plans of care based ation. Nurse #5 ne did not complete a care racture. The director of er understanding was that sluded on the MDS is ICES PROVIDED MEET ANDARDS d or arranged by the facility nal standards of quality. T is not met as evidenced an, record review, staff, interviews, the facility failed ferral ordered by the alted in a delay in treatment sture for 1 of 1 resident (Resident #2). The findings	F?	F281 - How will be accoresident for affected by practice — 1/9/14, the contacted to recomment visit on 12/2 motion exector resident Completion How corresponding to the completion of the completion of the completion of the completion of the corresponding to the completion of the completion of the corresponding to the corres	w corrective active mplished for equal to have been to consulting MD vio clarify dations from offing from 1/13/13. Range of the ercises were proviated active action will hed for those	was ce frided 1.15.4
		ncluded a left humerus weakness. The admission mpleted on 12/9/13			having the poter eted by the same	

		WAY DOOR OF DESIGNATION OF THE PROPERTY OF THE	NW 1000	ribi e	CONSTRUCTION	(X3) DATE S	SURVEY
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	COMPL	
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F 281	indicated Resident #2 Extensive assistance assist was required w and personal hygiene two person's physical transfers and toilet us upper extremity was i (shoulder, elbow, wris cane/crutch/wheelche an active diagnosis. T left humerus fracture 12/2/13. A review of the physic referral - ordered by	was cognitively intact. of one person physical with bed mobility, dressing, Extensive assistance of assist was required with se. Range of motion to the	£	281	deficient practice – Residents with outside appointments will be revie to ensure that outside office or outside referral source recommendations have be initiated as ordered. Compate: 2/9/14 Measures to be put in playsystemic changes made to ensure practice will not re-occur	ee visit en pletion ace or	2.9.14
	instructions that in paindependent home exand treat one - two vieight weeks, 3) should program focused on scapular strengthening active range of motion rotation 45, internal recompational therapy range of motion exertarm/shoulder. The reshould have begun at the linear interview on 1/2 stated this was the fit had been provided to arm/shoulder. In an interview on 1/2 manager stated that	art read "1) set up xercise program, 2) evaluate sits per week for total of ider: develop rotator cuff internal, external rotation, and and stabilization, 4) begin art flexion to 120, external otation 20." In on 1/15/14 at 9:20 am, the assistant (OTA) provided clses to Resident #2's left sident stated "this service long time ago." 15/14 at 9:37 am, the OTA art day that therapy exercises			Nurses and therapist staff educated to obtain recommendations upon residents' return from offi visits or outside referral so upon resident's return to t facility. If clarification is needed the nurse or therap will attempt to make initial contact within 24 hours. Completion date 2/7/14. New recommendations we copied upon residents' ret from office visits or outside referral sources and will be reviewed by the unit manage rehab director in morning	ce curces he coist al ill be urn de be ager or	2-7-14

CENTERS FOR MEDICARE & MEDICAID SERVICES

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CAROLIN	A REHAB CENTER OF C	UMBERLAND		1	4600 CUMBERLAND ROAD		,	
					FAYETTEVILLE, NC 28308			
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F 281	which instructed for the total left humerus fractory Resident #2's relar questioned related to orders brought back appointment, she indicates to have been of 12/13/13. She added needed to be done, shave clarified the order a delay in treatment, therapy services had shoulder due to she torders. In an interview on 1/1 #2 stated that she received from her nursing facility, her referral orders to the physical therapist cororders clearly." Resided in not recall the physorders back to her relative to her on 12/1 orders were not read the relative that clarifithought the relative in The PT concluded the therapy orders with the In an interview on 1/1 director of nursing with the relative or 1/1	nerapy services to begin due ture, until being made aware tive on 1/9/14. When further her expectation of received after a resident's icated that she expected the carried out as ordered on that if any clarification he expected the staff to ers immediately, to prevent She concluded that no been provided to the left hought there were no 5/14 at 10:30 am, Resident called on 12/13/13, when r appointment back into the elative handed the therapy physical therapist, and the mmented "I can not read the lent #2 concluded that she sical therapist gave the	F	281	up meeting. Completion de 2/9/14. A copy of orders or recommendations for there services will be placed in the plan of care book located is rehab director's office as a reference point. Completi date 2/9/14. How facility will monitor corrective action(s) to endeficient practice will no occur. Rehab Director/DON or designee will conduct aud new orders or recommend received from outside sour weekly X 4weeks. Result be reviewed in facility risk meeting for further recommendations. Complete date: 2/9/14.	apy the in the ton sure t re- it of ations rees s will	2.9.14	
		rders that accompanied a ointment, stated that she						

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F 281	Continued From page	e 6	F 28				
	expected if a residen with referral orders the staff, she expected the clarified with the refer	t came back into the facility hat were questionable by the he orders to have been rring physician, so that lid have been initiated as	AND THE REAL PROPERTY OF THE P				
	Resident #2's relative she physically gave to received from her ap therapist on 12/13/13 room sometime after also made the therapieft humerus was fract that the therapist resead the order in its call the ordering physicall the order that she call the properties and the order in the giving her back the order in the giving her back the order in the giving her back the order in the order in the giving her back the order in the order in the giving her back the order in the	ew on 1/15/14 at 8:40 pm, a revealed that on 12/13/13, he therapy referral orders pointment, to the physical b, in the physical therapy dinner. She added that she post aware that the resident's ctured. The relative added ponded that she could not entirety, and that she would sician to clarify the order. did not recall the therapist orders, nor did the therapist er regarding any clarification					
F 332 SS=D	Nurse #6 stated that for Resident #2 on 1 Resident #2 and a re on 12/13/13, around the resident's left arr added that she was referral orders accorshe was not aware or related to therapy or orders were given to physical therapist. 483.25(m)(1) FREE	iew on 1/15/14 at 8:55 pm, she was the primary nurse 2/13/13. She indicated that slative returned to the facility dinner, and she observed in was in a sling. Nurse #6 not aware that therapy inpanied the resident, and if any needed clarification ders. She concluded that no her by the relative or the MORE	F3	32			
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CAROLIN	A REHAB CENTER OF C	IIMBERI AND	4600 CUMBERLAND ROAD		600 CUMBERLAND ROAD		
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F 332	This REQUIREMENT by: Based on observatio interviews, the facility medication error rate residents observed dinot administering memouth and failed to fill (GT) with water after medication separately errors out of 25 medication separately errors out of 25 medication a 24 % memouth and failed to fill (GT) with water after medication separately errors out of 25 medication according to the following to the same according to the physical eventual of the physical eventual errors on the physical errors of the physical errors on the physical errors on the physical errors on the physical errors of the physical errors on the phys	re that it is free of s of five percent or greater. Is not met as evidenced ons, record review and staff failed to maintain a less than 5% for 1 of 7 uring a medication pass, by dications as ordered by ush the gastrostomy tube administering each y. There were 6 medication cation opportunities, which edication error rate (Resident uded: Initted into the facility on included psychosis, sions and dysphagia. Initial dictions were ordered y mouth 1) carvedilol 25 (ablet (9:00 am), 2) the tablet (8:00 am), 3) ablet (8:00 am), 4) namendar of am), 5) famotidine 40 mg 6) multivitamin liquid 10 m). Cation administration record tructed for the following	F	332	F332 - How corrective a will be accomplished for resident found to have be affected by the deficient practice — An order from the attending physician was received on 1/15/14 for resident #5 to medications administered enteral tube as indicated in physician's risk benefit statement. Completion de 1/15/14 How corrective action was accomplished for those residents having the potto be affected by the same deficient practice— Medication orders for all residents receiving enterant residents receiving enterant in the properties of the process o	ng have via n the ate: vill be tential ne I to ceive abe or ceiving ving ne care reflect	2-7-14
	medication to be adn carvedilol 25 mg, hyd mg, namenda 5 mg, multivitamin liquid 10	dralazine 50 mg, lisinopril 20 famotidine 40 mg and			A med pass observation v	will be	

CENTER	S FOR MEDICARE & I	MEDICAID SERVICES			C	MB NO.	0938-0391
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		345506	B, WNG_			01/1	6/2014
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D. D. D. C. 1111		HIDED! AND		4600	CUMBERLAND ROAD		
CAROLINA	A REHAB CENTER OF C	UMBERLAND		FAY	ETTEVILLE, NC 28306		
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	During a medication of at 9:05 am, Nurse #1 medications after take medication packets: of hydralazine 50 mg on tablet, namenda 5 mg mg one tablet and the into a cup, including rouse #1 once in Reswater into the cup whosen mixed, verified of GT, flushed the GT woured the mixed me the GT, followed by 1 in an interview on 1/1 stated that he had be development coordinate the GT. In an interview on 1/1 development coordinate GT. In an interview on 1/1 development coordinate GT.	crushed the following en from the original carveditol 25 mg one tablet, le tablet, lisinopril 20 mg one gone tablet, famotidine 40 en poured the medications multivitamin liquid 10 ml. sident #5's room, poured ere the medications had placement of the resident with 30 ml of water, and then dications from the cup into 20 ml of water. 14/14 at 1:00 pm, Nurse #1 en instructed by the staff ator "3 - 6 months ago" that dministered could be administered as he did via 14/14 at 1:12 pm, the staff ator, accompanied by the dicated that the staff was medications as ordered by died that if medications were via the GT, the expectation ation is administered		332	receiving enteral feedings. Completion date: 2/9/14 Measures to be put in pla systemic changes made to ensure practice will not re-occur At time of admission the medication orders for the resident will be reviewed to ensure accurate transcription the EMAR. Completion da 2/7/14 Each nurse will be in-servi on administering medication via gtube and a med pass observation will be complet for each nurse. Completion date: 2/9/14 How facility will monitor corrective action(s) to end deficient practice will not occur-	o oon to ate: iced ons eted on	2.7.14
F 406 SS=D	policy dated 9/16/13, medication at a time into feeding tube; foll as ordered by the ph medications one at a 483.45(a) PROVIDE.	cordance with the facility which in part read "pour one into the syringe and instill ow with 15 ml water flush, or ysician, repeat other time." /OBTAIN SPECIALIZED	F	406	SDC and/or UM for each will conduct med pass observation for 2 residents weekly for 4 weeks and Pharmacy RN will conduct monthly observation of me	s st	

CENTERS FOR MEDICARE & MEDICAID SERVICES

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-					pass for at least 1 resident		
F 332	Continued From page	8	F	332	· -		
			<u> </u>		enteral tube for 2 months.		
		pass observation on 1/14/14			Completion date: 2/9/14		2-9-14
		crushed the following			, , , , , , , , , , , , , , , , , , ,		
	medications after take	en from the original carvedilol 25 mg one tablet,			Results of weekly audits v	vill be	
		ne tablet, lisinopril 20 mg one			presented at facility risk/C		
	tablet, namenda 5 mg	one tablet, famotidine 40			meeting for further		
	1 0	en poured the medications			recommendations. Comple	etion	
		multivitamin liquid 10 ml.			· ·	Ction	2.9-14
		sident #5's room, poured ere the medications had			date: 2/9/14.		
		placement of the resident					
		ith 30 ml of water, and then					
		dications from the cup into					
	the GT, followed by 1	20 ml of water.					·
	in an intentew on 1/1	4/14 at 1:00 pm, Nurse #1					
		en instructed by the staff				•	
	development coordin	ator "3 - 6 months ago" that					
	the medications he a						
		administered as he did via					
	the GT.						
	In an interview on 1/1	14/14 at 1:12 pm, the staff					
	development coordin	ator, accompanied by the					
	director of nursing inc	dicated that the staff was					
		medications as ordered by					
		ided that if medications were					
	was that each medic	ria the GT, the expectation at the GT, the expectation	1				
		cordance with the facility					
	policy dated 9/16/13,	which in part read "pour one					
		into the syringe and instill					
		ow with 15 ml water flush, or					
	as ordered by the ph medications one at a	ysician, repeat other					
F 406		OBTAIN SPECIALIZED	F	406			
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NAME OF PI	ROVIDER OR SOFFLIER		4600 CUMBERLAND ROAD				
CAROLIN	A REHAB CENTER OF C	UMBERLAND	FAYETTEVILLE, NC 28306				
			1		PROVIDER'S PLAN OF CORRECTION		~
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 406	Continued From page	⇒ 9	F	406	1100 11011 0011001114		<u> </u>
					will be accomplished fo	r each	ļ
		tative services such as, but			resident found to have	een	
İ		al therapy, speech-language			affected by the deficien	t l	
		nal therapy, and mental ervices for mental illness			practice –		- 1
		on, are required in the			1/9/14, the consulting M	Dwas	
		nsive plan of care, the facility			contacted to clarify	D Mus	İ
		uired services; or obtain the				ffice	
		m an outside resource (in			recommendations from c	, ,	
		3.75(h) of this part) from a			visit on 12/13/13. Range		İ
	provider of specialize	ed rehabilitative services.			motion exercises were pr		
					to resident #2 on 1/15/14		
		T is not met as evidenced			Completion date: 1/15/1	1	1.15.4
	by: Based on observation	ons, record review, and staff			How corrective action	will be	
ļ	interviews, the facility	y failed to provide therapy				ATH DC	
	related services as m	nedically indicated for a			accomplished for those		
	resident with a left hu	umerus fracture for 1 of 2			residents having the po		
		or rehab services (Resident			to be affected by the sa	me	
	#2). The findings incl	luded:			deficient practice -		
	D - 11 - 110 - 110 - 110 - 110	witted into the facility on			Residents with outside		
		nitted into the facility on included a left humerus			appointments will be rev	iewed	
		weakness. The admission			to ensure that outside of		
	minimum data set co				or outside referral source		
1		2 was cognitively intact.					
	Extensive assistance	e of one person physical			recommendations have		a odl
		with bed mobility, dressing,			initiated as ordered. Con	npiction	レイイナ
	and personal hygien	e. Extensive assistance of			date: 2/9/14		
		al assist was required with			·		
		se. Range of motion to the indicated as impaired on one			Measures to be put in	lace or	
	eide (shoulder elhou	w, wrist, hand) with the use of			systemic changes made		
	a cane/crutch/wheel	chair. A fracture was listed as			ensure practice will no		
		Restorative nursing program			1 -	•	
		exercises; splint or brace			re-occur		
	device was not indic	ated. Occupational therapy			Nurses and therapist sta	i wiii be	
	was indicated with 2	54 minutes of therapy			educated to obtain		

CENTERS FOR MEDICARE & MEDICAID SERVICES

		INCEDIOALE GERCAIGE	240) 11/2	TD1 F 2	CONSTRUCTION	(X3) DATE	SHOWEY
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	COMP	
			72 00120			(:
		345505	8. WING			01/	15/2014
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				460	00 CUMBERLAND ROAD		
CAROLINA	A REHAB CENTER OF C	UMBERLAND		FA	YETTEVILLE, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 406	received. Physical the minutes of therapy reassessment narrative living (ADL) signed o home which resulted muscle weakness an assistance for ADL or dated "12/2/13" to 1/1 humerus fracture. A review of the physic referral - ordered by in part read "left two instructions that in paindependent home exand treat one - two vieight weeks, 3) should program focused on scapular strengthenin active range of motion rotation 45, internal rewas observed to be in exercises was perfor "this service should? After the therapy sessions and/or bein lin an interview on 1/2 interv	erapy was indicated with 310 ceived. The care area on note for activities of daily in 12/3/13 in part read "fall at in left humerus fracture, has different to the transition of the properties of the requires extensive ompletion." The plan of care 15/14 did not indicate a left cei/occupational therapy ohysician #1 dated 12/13/13 part humerus fracture" with int read "1) set up kercise program, 2) evaluate sits per week for total of der: develop rotator cuff internal, external rotation, ag and stabilization, 4) begin in: flexion to 120, external	F	406	recommendations upon residents' return from officiality or outside referral so upon resident's return to the facility. If clarification is needed the nurse or therap will attempt to make initial contact within 24 hours. Completion date 2/7/14. New recommendations will copied upon residents' return office visits or outside referral sources and will be reviewed by the unit manarehab director in morning up meeting. Completion december 2/9/14. A copy of orders or recommendations for them services will be placed in plan of care book located rehab director's office as a reference point. Completed date 2/9/14. How facility will monitor corrective action(s) to endeficient practice will no occur-	ources he he he he he he he he he he he he he	2-9-14
	had been provide to shoulder/arm.	Resident #2's left			Rehab Director/DON or designee will conduct aud	lit of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245505	B. WNG			1	3
		345505	D. VVING	_		15/2014	
NAME OF PROVIDER OR SUPPLIER CAROLINA REHAB CENTER OF CUMBERLAND				₄	STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 408	In an interview on 1/1 manager acknowledg Resident #2 was adm fractured left humerus supported in a sling, a had been provided to 1/15/14. The rehab m not aware that there we that were received from 12/13/13, which in to begin to the should Resident #2's relative. In an interview on 1/1 #2 stated that she was received therapy to h 1/15/14. She added thave began much so physician had sent the order with specific insher shoulder. In an interview on 1/1 physical therapist after referral order form datherapy services to b acknowledged that si relative presented sir 12/13/13. The PT addreadable, therefore, so clarification was need relative informed the concluded that she dorders with the order provide any related of the nonlinear signification was need relative informed the concluded that she dorders with the order provide any related of the nonlinear significance of the relative of	5/14 at 9:42 am, the rehabled that she was aware that nitted into the facility with a s, with her left arm and that, no therapy services the left shoulder/arm until manger added that she was were therapy referral orders, on the orthopaedic physician istructed for therapy services der, until made aware by a on 1/9/14. 15/14 at 10:30 am, Resident as upset that she had not er left shoulder/arm until hat she felt therapy should oner, being that the refacility a therapy referral structions regarding care to 15/14 at 10:50 am, the er shown the physician regarding care to 15/14 at 10:50 am, the er shown the physician regarding to the shoulder; he recalled the resident's milar orders to her on ded that the orders were not she informed the relative that ded, and she thought the primary nurse. The PT id not clarify the therapy ing physician, nor did she	F	406	new orders or recommends received from outside sour weekly X 4weeks. Results be reviewed in facility risk meeting for further recommendations. Compledate: 2/9/14.	ces s will c/QA	2-9-14

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION		(DEIAH IOWHOM HOWDER.	A. BUILD	A. BUILDING			c	
	345505 B. WING				01/	5/2014		
NAME OF PROVIDER OR SUPPLIER CAROLINA REHAB CENTER OF CUMBERLAND				46	REET ADDRESS, CITY, STATE, ZIP CODE 100 CUMBERLAND ROAD AYETTEVILLE, NC 28306			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	IO PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	e l	(X5) COMPLETION DATE	
F 406	delay in rehab services to the left fracture humerus, stated that she expected if a physician referral order for therapy was received, she expected the order to have been clarified and therapy services initiated as ordered. In a telephone interview on 1/15/14 at 8:40 pm, Resident #2's relative revealed that on 12/13/13, she physically gave the therapy referral orders to the physical therapist in the physical therapy room sometime after dinner. She added that she also made the therapist aware that the resident's left humerus was fractured. The relative added that the therapist responded that she could not read the order in its entirety, and that she would call the ordering physician to clarify the order. She added that she did not recall the therapist giving her back the orders, nor did the therapist follow back up with her regarding any clarification		F	406				
F 425 SS=D	Nurse #6 stated that for Resident #2 on 1: on 12/13/13 Resident to the facility around resident's left arm wathat she was not awa orders accompanied was not aware of any to therapy orders. Shwere given to her by therapist. 483.60(a),(b) PHARI ACCURATE PROCE		F	425				

<u> </u>	O I ON MEDIONINE &	MEDIONID OF LANGER				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			C 01/15/2014			
NAME OF PROVIDER OR SUPPLIER CAROLINA REHAB CENTER OF CUMBERLAND			ST 46	REET ADDRESS, CITY, STATE, ZIP CODE 00 CUMBERLAND ROAD AYETTEVILLE, NC 28306	1 01/10/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 425	them under an agree §483.75(h) of this par unilcensed personne law permits, but only supervision of a licen. A facility must provide (including procedures acquiring, receiving, administering of all dithe needs of each result in the facility must emparable as or all aspects of the services in the facility. This REQUIREMENT by: Based on observation pharmacist interview medication (ranitidine as ordered for 1 of 7	ment described in It. The facility may permit It o administer drugs if State under the general sed nurse. It is pharmaceutical services that assure the accurate dispensing, and rugs and biologicals) to meet sident. It is provided to the services of the who provides consultation provision of pharmacy	F 425	F425 - How corrective as will be accomplished for resident found to have be affected by the deficient practice — 1/14/14, nurse #3 received to administer ranitidine wharrives form pharmacy and pharmacy was contacted to nurse #3 to obtain medical ranitidine syrup through a delivery. The medication arrived at 1220 pm and wandministered to resident #1230pm. How corrective action was accomplished for those residents having the pote to be affected by the sam deficient practice —	l order hen d by tion stat as 6 at $1 \cdot 1 + 1 + 1 = 1$ ill be	
	Resident #6 was admitted into the facility on 11/29/09. Diagnoses included dementia and stomach protection. A review of the physician order for January 2014 revealed that ranitidine 10 milliliters (ml) was to be administered daily for stomach protection.			Each residents' medicatio were reviewed to ensure t medications were available administration. Completi date: 2/7/14	hat all le for	
		cation administration record tructed that ranitidine 10 ml		Measures to be put in pl		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245505	8. WNG			1	3
) 01/	15/2014	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A REHAB CENTER OF C	TIMPERI AND		46	00 CUMBERLAND ROAD		-
CAROLIN	A REHAB CENTER OF C	VINDERLAND		F#	AYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 425	Continued From page	e 14	F	425			
	was to be administer	ed daily at 8:00 am.			ensure practice will not		
					re-occur		
		pass observation on 1/14/14			i c-occui	:	
		indicated that she did not			NT	1	
		nedication available on the		ļ	Nurses will be in-serviced	i on the	
	medication cart. She then proceeded to the medication room and was unable to locate the medication. She stated that the medication was "not available" and that she had to reorder the				procedure for obtaining		
					medications from the pha	rmacy	
					and ensuring all medication	ons are	
	medication from pharmacy. Nurse #2 added that				available or ordered each		
	the medication was last administered on 1/13/14			1	Completion date: 2/7/14		2-7.14
	at 8:00 am per the medication electronic				Completion date, 2, 7, 1		
	administration record. At 9:45 am, Nurse #2 called the pharmacy and notified that there was no ranitidine liquid available to be administered as ordered.				TT 6		1
				ļ	How facility will monito		
					corrective action(s) to e		
	Olucieu.				deficient practice will no	ot re-	
	In an interview on 1/	14/14 at 11:03 am with Nurse		ļ	occur-		
		d ranitidine to Resident #6 on		l			
	1/13/14 acknowledge			SDC will conduct med pa	100		
	administered ranitidine 15 ml to the resident on 1/13/14, she called Nurse #4 at home and Nurse				-		
					observation for 1 nurse po	n uiiit	
	#4 informed her that				weekly for 4 weeks and		
		rther questioned, Nurse #3			Pharmacy RN will condu		
	indicated that she did not recall what day Nurse				monthly med pass observ	ation	_
		d the medication, and that			for 1 nurse. Completion	date:	2.7.14
		h pharmacy if the medication	.		2/7/14		
	had been reordered. Nurse #3 concluded that she discarded the empty bottle on 1/13/14 and acknowledged that she was aware that there was			- 1	20 77 2 1		
					D14 C1-1 1/4	!11 %	
	no additional ranitidir			- [Results of weekly audits		
	medication cart on 1/13/14.				presented at facility risk/0	ĮΑ	
					meeting for further		
	On 1/14/14 at 11:55 am, the unit manager #1 reported that the medication (ranitidine) had			1	recommendations. Comp	letion	2.9.14
					date: 2/9/14.		2717
	arrived from the phai	macy.					
		cation administration record 1/14 at 12:30 pm, Resident					

NAME OF PROVIDER OR SUPPLIER CAROLINA REHAB CENTER OF CUMBERLAND (A) 10 SUMMARY STYNEMENT OF DEFICIENCIES EXPECTED BY INL. REGULATORY OR LISC IDENTIFYING INFORMATION) FAST TEVELLE, NO. 2005 F 425 Continued From page 15 #8 received ranitidine 10 ml, which was originally scheduled to be administered as expected the resident's medication to be available and administered as reduced. In an interview on 1/15/14 at 41:13 pm, the pharmacist eveeled per review of Resident's Major Pharmacist added that a 45 - 47 day supply was dispensed on the facility should have head 100 millimets or disclosion still available to be administered as ordered. Nurse #4 who administered that last supply of ranitidine on 1/13/14 was not available to be inflerviewed.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER CAROLINA REHAB CENTER OF CUMBERLAND SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUSY BE PRECEDED BY FULL TAGY TAGY FREFIX TAGY F 425 Continued From page 15 #6 received ranitidine 10 ml, which was originally scheduled to be administered at 8:00 am. In an interview on 1/15/14 at 11:43 am, the director of nursing stated that she expected the resident's medication to be available and administered at 65 at 7 day supply was dispensed and that the facility was on 12/9/13. The pharmacist revealed per review of Resident #6 pharmacist revealed per review of Resident #6 pharmacist revealed that at 5 - 47 day supply was dispensed and that the facility should have had 100 millithers of medication was being administered as ordered, the facility should have only exhausted 35 days of supply. Nurse #4 who administered the last supply of ranitidine on 1/13/14 was not available to be		A BOILDING			С			
CAROLINA REHAB CENTER OF CUMBERLAND (X4) ID PRIEFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 425 Continued From page 15 #6 received raniltidine 10 ml, which was originally scheduled to be administered at 8:00 am. In an interview on 1/15/14 at 11:43 am, the director of nursing stated that she expected the resident's medication to be available and administered as ordered. In an interview on 1/15/14 at 4:13 pm, the pharmacist revealed per review of Resident #6 pharmacy profile the last time that raniltidine liquid was dispensed and that the facility was on 12/9/13. The pharmacist added that a 45 - 47 day supply was dispensed and that the facility should have had 100 millilitiers of medication was being administered as ordered, the facility should have only exhausted 35 days of supply. Nurse #4 who administered the last supply of raniltidine on 1/13/14 was not available to be			345505	B. WNG	8. WNG0			
F 425 Continued From page 15 #6 received ranilidine 10 ml, which was originally scheduled to be administered at 8:00 am. In an interview on 1/15/14 at 11:43 am, the director of nursing stated that she expected the resident's medication to be available and administered as ordered. In an interview on 1/15/14 at 4:13 pm, the pharmacist revealed per review of Resident #6 pharmacy profile the last time that ranitidine ilquid was dispensed to the facility was on 12/9/13. The pharmacist added that at 45 - 47 day supply was dispensed and that the facility should have had 100 mllilliters of medication was being administered as ordered, the facility should have only exhausted 35 days of supply. Nurse #4 who administered the last supply of ranitidine on 1/13/14 was not available to be					4600 CI	UMBERLAND ROAD		
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	F 425	#6 received ranitidine scheduled to be adm In an interview on 1/1 director of nursing sta resident's medication administered as orde In an interview on 1/1 pharmacist revealed pharmacy profile the was dispensed to the pharmacist added the dispensed and that the 100 milliliters of medical administered on 1/14 concluded if the medical administered as ordered only exhausted 35 decentions.	a 10 ml, which was originally inistered at 8:00 am. 5/14 at 11:43 am, the ated that she expected the to be available and red. 5/14 at 4:13 pm, the per review of Resident #6 last time that ranitidine liquid facility was on 12/9/13. The at a 45 - 47 day supply was ne facility should have had cation still available to be //14. The pharmacist ication was being red, the facility should have ays of supply.	F	425			