NUMPLAY OF CORRECTION DEAM OF CORRECTION DEAM OF CORRECTION DEAM OF PROVIDER OR SUPPLIER Control is wind STREET ADDRESS. CITY, STATE, ZIP CODE Control is wind Control is wind <thcontro is="" th="" wind<=""> Control is wind <t< th=""><th colspan="2" rowspan="2">CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th><th colspan="2">(X2) MULTIPLE CONSTRUCTION</th><th colspan="2">(X3) DATE SURVEY COMPLETED</th></t<></thcontro>	CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
NMME OF PROVIDER OR SUPPLIER Image: Construct of the construction of the consthe construction of the construction of the						С	
CAROLINA REHAB CENTER OF CUMBERLAND 4500 CUMBERLAND ROAD PATER PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) In (FACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) In (FACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) In (FACH DEFICIENCY) In (FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMENT (FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO TO SHOULD BE CROSS-REFERENCED TO SHOULD BE CROSS-REFERENCE ACTION SHOULD BE CROSS-REFER			345505	B. WING _			11/2015
CAROLINA REHAB CENTER OF CUMBERLAND FAYETTEVILLE, NC 28306 (M) ID PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDE BY FULL RECULATORY OR LSC DENTIFYING INFORMATION) ID PREFX TAG PROVIDERS AND F CORRECTION (EACH DEFICIENCY MUST BE PRECEDE BY FULL RECULATORY OR LSC DENTIFYING INFORMATION) D PREFX TAG PREFX (EACH DEFICIENCY OR LSC DENTIFYING INFORMATION) 0(6) F 309 483.25 PROVIDE CARE/SERVICES FOR SS=D F 309 F 309 3/8/15 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. F 309 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 Fs allegation of compliance. All alleged deficiencies cited have been or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center Fs allegation of compliance. All alleged deficiencies cited have been or will take the actions set forth in the following plan of compliance. All alleged deficiencies cited have been or will take the actions set forth in the following plan of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F309 Hypercholestrolemia (leuvated through the adominal wall into the stomach, to allow nuttition to be administered directly into the stomach.	NAME OF F	ROVIDER OR SUPPLIER				ODE	
PREFIX TAG (EACH DEFICIENCY MILLS LIDENTIFYING INFORMATION) PREFX TAG (EACH DEFICIENCY) COMPLET TAG COMP	CAROLIN	IA REHAB CENTER (OF CUMBERLAND				
SS=D HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide enteral nutrition (a way to provide food through a tube placed in the stomach) as ordered for 1 of 1 resident reviewed for tube feeding (Resident #1). Findings included: Resident #1 was admitted into the facility on 2/6/15. Diagnoses included Gastrostomy Tube (G-Tube). Depression, Diabetes, 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 set forth in the following plan of correction constitutes the centerF s allegation of compliance. All alleged deficiencies cited have been will be completed by the dates indicated. F309 Review of the admission alert sheet dated 2/6/15 read "Pe gGlucerna 1.2". A pag refers to a feeding tube placed through the abdominal wall into the stomach, to allow nutrition to be administered directly into the stomach. How corrective action will be	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide enteral nutrition (a way to provide food through a tube placed in the stomach) as ordered for 1 of 1 resident reviewed for tube feeding (Resident #1). Findings included: Resident #1 was admitted into the facility on 2/6/15. Diagnoses included Gastrostormy Tube (G-Tube), Depression, Diabetes. Hypercholesterolemia (elevated cholesterol in the blocod) and Hypertension. The Minimum Data Set was in progress. The FL2 (level of care screen tool) created on 2/6/14 indicated the resident mental status was intermittent to person, however not oriented to place or time, and was totally dependent with ambulation, transfers and eating. Special nutritional needs was indicated with a feeding tube placed through the abdominal wall into the stomach, to allow nutrition to be administered directly into the stomach.				F 30	09		3/8/15
by: Based on record review and staff interviews, the facility failed to provide enteral nutrition (a way to provide food through a tube placed in the stomach) as ordered for 1 of 1 resident reviewed for tube feeding (Resident #1). Findings included: Resident #1 was admitted into the facility on $2/6/15$. Diagnoses included Gastrostomy Tube (G-Tube), Depression, Diabetes, Hypercholesterolemia (elevated cholesterol in the blood) and Hypertension. The Minimum Data Set was in progress. The FL2 (level of care screen tool) created on $2/6/14$ indicated the resident mental status was intermittent to person, however not oriented to place or time, and was totally dependent with ambulation, transfers and eating. Special nutritional needs was indicated with a feeding tube and a therapeutic diet: Glucerna 1.2 liters = 0-4 ml (milliliters) with a goal rate 60 ml/hour.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 set forth in the following plan of correction. The following plan of correction constitutes the centerF s allegation of compliance. All alleged deficiencies cited have been or will be accomplished for those residents found to have been affected by the deficient practice?Review of the admission alert sheet dated 2/6/15 read "Peg Glucerna 1.2." A peg refers to a feeding tube placed through the abdominal wall into the stomach, to allow nutrition to be administered directly into the stomach.Resident #1 has been discharged. 02/13/2015How corrective action will be		provide the necessary or maintain the high mental, and psycho accordance with the	ary care and services to attain nest practicable physical, osocial well-being, in				
pm Nurse #1 documented "Resident admitted, potential to be affected by the same		by: Based on record refacility failed to prov provide food throug stomach) as ordered for tube feeding (Ref Resident #1 was ac 2/6/15. Diagnoses if (G-Tube), Depressi Hypercholesterolene blood) and Hyperte was in progress. The tool) created on 2/6 mental status was in not oriented to place dependent with am Special nutritional refeeding tube and a liters = 0-4 ml (milling ml/hour. Review of the administered direct administered direct A review of the nurse	eview and staff interviews, the vide enteral nutrition (a way to ph a tube placed in the ed for 1 of 1 resident reviewed esident #1). Findings included: dmitted into the facility on included Gastrostomy Tube ion, Diabetes, nia (elevated cholesterol in the nsion. The Minimum Data Set the FL2 (level of care screen 6/14 indicated the resident intermittent to person, however e or time, and was totally bulation, transfers and eating. needs was indicated with a therapeutic diet: Glucerna 1.2 liters) with a goal rate 60 ssion alert sheet dated 2/6/15 a 1.2." A peg refers to a d through the abdominal wall o allow nutrition to be ly into the stomach. ses notes dated 2/6/15 at 3:39		 admission and do not const agreement with the alleged herein. The plan of correct completed in the compliance federal regulations as outlin in compliance with all federal regulations the center has ta take the actions set forth in plan of correction. The follo correction constitutes the ce allegation of compliance. A deficiencies cited have beer completed by the dates indie F309 How corrective action will be accomplished for those resi have been affected by the d practice? Resident #1 has been disch 02/13/2015 How corrective action will be accomplished for those resi 	itute deficiencies ion is e of state and ed. To remain al and state aken or will the following wing plan of enterF s II alleged n or will be cated. e dents found to eficient arged.	

03/04/2015

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.

Electronically Signed

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-039 (X3) DATE SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
					С		
		345505	B. WING			02/11/2015	
NAME OF I	PROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				46	600 CUMBERLAND ROAD		
CAROLII	NA REHAB CENTER (OF COMBERLAND		F/	AYETTEVILLE, 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) COMPLE DATE	
F 309	Continued From no	ago 1		00			
1 309	Continued From pa	-	F 3	309			
		1 2/7/15 at 10:33 pm the nurse ve entered an order: Glucerna			deficient practice?		
		gastrostomy tube (tube in			All residents with enteral tube feeding		
		ir hours for diet." At 10:36 pm,			orders were reviewed by the Registered	ł	
		ted "Bolus feeding provided."			Dietician for accuracy. 02/09/2015		
	A review of the phy	sician order summary report					
		led an active phone order that			What measures will be put into place or		
		ucerna 1.2 Cal liquid (240 ml)			systemic changes made to ensure that		
	5	urs for diet." The start date			the deficient practice will not occur?		
	was indicated as 2/8/15.				Registered Dietician in-serviced on polic	су	
	A review of the nurses notes dated 2/8/15 at 3:02 pm, Nurse #1 documented "Bolus tube feedings				#711 Enteral and Parenteral Support 02/12/2015		
		On 2/9/15 at 4:42 pm, Nurse			Registered DieticianFs contact number		
	#1 documented "No				was placed at each nursing unit.		
		sician order summary further			02/12/2015		
		nued verbal order that directed			All staff nurses in-serviced on policy #7	11	
	on 2/9/15 "Enteral f	feed - Provide patient with			Enteral and Parental Support 03/08/201	5	
		ml/hour continuously."			All newly hired staff nurses will be		
		e plan initiated on 2/9/15 in			in-serviced during orientation. No staff		
		dent requires tube feeding			nurse will be allowed to work until		
		tion: Provide tube feeding per			in-service is complete.		
	physician order."	tition documented on part of			All staff nurses in-serviced on entering		
		etitian documented as part of 2/10/15 "Glucerna 1.2 240 ml			enteral tube feedings into the electronic medical record system. 03/08/2015		
		ie to pump not available.			All newly hired staff nurses will be		
		bolus feeding per nursing			in-serviced during orientation. No staff		
		is received, feedings will be			nurse will be allowed to work until		
		(ml)/hour continuously."			in-service is complete. 03/08/2015		
	A review of the me	dication administration record			All new admissions/re-admissions with		
	(MAR) revealed the				enteral tube feeding orders will be		
		2/7/15 at 10:31 pm.			audited, using the admission audit tool,		
		2/7/15 at 10:35 pm "Glucerna			ensure tube feeding orders are entered		
		tional supplement) 120 ml via			into the electronic medical records syste	em	
	G-Tube every four	2/7/15 at 10:35 pm for			accurately. 03/08/2015 Facility Dietitian Consultant will complet		
		quid (nutritional supplements)			enteral nutrition accuracy audits weekly		
		240 ml via G-Tube every four			times 4 weeks and at least monthly		
						1	
		MAR did not reflect Resident			thereafter to ensure compliance.		

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If continuation sheet Page 2 of 3

ND PLAN OF CORRECTION		. ,	TIPLE CONSTRUCTION	(X3) DATE COM	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED C 02/11/2015	
		B. WING				
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2		11/2010
CAROLII	NA REHAB CENTER	OF CUMBERLAND		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		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 309	(except at 10:36 pr Nurse #1 who docu Resident #1's orde available on 2/10/1 In an interview on 2 Director of Nursing have been clarified received enteral fea after admission. Th sticky note, which r primary nurse for F 7 pm - 7 am. The s #1 was the nurse of In an interview on 2 stated if she admin	to the facility) and 2/7/15 in per the nurse note). Jumented on 2/6/15 at 3:39 pm rs were verified was not 5 or 2/11/15 to be interviewed. 2/11/15 at 11:13 am, the interim stated she expected orders to so the resident could have eding as soon as possible, he DON further provided a reflected Nurse #2 was the Resident #1 on 2/6, 2/7/15 from sticky note also indicated Nurse in 2/7/15 from 7am - 11 pm. 2/11/15 at 11:53 am, Nurse #2 istered tube feedings to the er her care, such would be	F 3	How the facility plans to performance to make su are sustained: The admission audit too in the morning meeting times 4 weeks, 1 time p weeks, monthly times 3 times 3 quarters and as 03/08/2015 Audit results will be revie monthly times 3 months quarters and as needed Facility Dietitian audit re reviewed in QA monthly quarterly time 3 quarters 03/08/2015	ure that solutions I will be reviewed 5 times per week ber week times 4 months, quarterly needed. ewed in QA , quarterly times 3 . 03/08/2015 sults will be times 3 months,	

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Facility ID: 980423

If continuation sheet Page 3 of 3