DEPART	MENT OF HEALTH	AND HUMAN SERVICES			FOR	M APPROVED
CENTER	S FOR MEDICARE	& MEDICAID SERVICES	-		OMB N	<u> 0938-0391</u>
-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY
		345505	B. WING		0	C 7/01/2015
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	
				4	600 CUMBERLAND ROAD	
CAROLIN	IA REHAB CENTER C	JF CUMBERLAND		F	AYETTEVILLE, NC 28306	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	483.10(e), 483.75(l) PRIVACY/CONFIDI The resident has th confidentiality of his records. Personal privacy ind medical treatment, communications, per meetings of family a does not require the room for each residen Except as provided section, the residen release of personal individual outside the The resident's right and clinical records resident is transferr institution; or record The facility must ke contained in the residen release is required	(4) PERSONAL ENTIALITY OF RECORDS e right to personal privacy and or her personal and clinical cludes accommodations, written and telephone ersonal care, visits, and and resident groups, but this e facility to provide a private ent. in paragraph (e)(3) of this t may approve or refuse the and clinical records to any ie facility. to refuse release of personal does not apply when the ed to another health care I release is required by law. ep confidential all information ident's records, regardless of methods, except when by transfer to another n; law; third party payment	F 1		DEFICIENCY)	7/29/15
ABORATORY	This REQUIREMEN by: Based on record re interviews the facilit privacy by exposing Record (MARs) cor diagnosis and list of #4 and 5) of 5 samp	NT is not met as evidenced eview, observations, and staff y failed to provide personal the Medication Administration taining the resident 's name, f medications for 2 (Residents oled residents observed. ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		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 rema	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

07/22/2015

PRINTED: 08/19/2015

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

CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· ,	DATE SURVEY COMPLETED	
	IDENTIFICATION NUMBER.	A. BUILDING	3	COMPLETED	
	345505	B. WING		07/01/2015	
VIDER OR SUPPLIER		Ī	•		
REHAB CENTER C	OF CUMBERLAND				
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIOI DATE	
ontinued From pa	qe 1	F 164	4		
he findings include) During a tour of t /30/2015 at 5:30 p in the hall was obse ledication Adminis ablet screen open a he screen displayed hich exposed the ind list of medication e unattended by st hade from 5:30 pm 4 's personal infor isplayed and unsu- urse (Nurse #5) re hedication cart was art from the 600 ha uring an interview t 5:38 pm, she stat hedication cart to s siting a resident of hy she had not loo hy she had not loo sure Resident #4 onsisting of his name hedications was not l was in a hurry an ack. "Nurse #5 fin he facility policy was rivacy rights of res esident information ewed. She stated ablet screen to proof formation from pu) During a tour of t /30/2015 at 5:50 p	ed: he 700 hall of the facility on m the medication storage cart erved in the hall with the tration Record (MAR) on the and facing toward the hallway. ed the MAR for Resident #4 resident ' s name, diagnosis, ons. The cart was observed to taff. Continuous observation to 5:37 pm revealed Resident mation remained publicly pervised for 7 minutes. The sponsible for the 700 hall s observed returning to the all at 5:37 pm. with Nurse #5 on 6/30/2015 ted she had left the speak with a family member in the 600 hall. When asked eked the tablet screen to ' s private information me, diagnosis, and list of of publicly displayed she stated in thought that I would be right urther stated she understood is for staff to protect the idents by not leaving personal in where it could be publicly is he should have locked the tect Resident #4 ' s personal blic view. he 800 hall of the facility on m the medication storage cart		 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 center is allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F164 How corrective action will be accomplished for each resident found thave been affected by the deficient practice: Medication Administration Records (MARS) were secured 6/30/15 How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: Current nurses in-serviced on HIPPA Policy -#101 "Privacy rules-standards of Practice will ne re-occur: All new LN's will receive education on HIPPA Policy - #101 "Privacy rules-standards of Practice" during orientation. 	g o o o o o f c ot	
	REHAB CENTER O SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS ontinued From pa he findings include) During a tour of t (30/2015 at 5:30 pm h the hall was obsidedication Adminis ablet screen open a he screen displayed hich exposed the nd list of medication e unattended by side ade from 5:30 pm 4 ' s personal infor isplayed and unsu- urse (Nurse #5) re- redication cart was att from the 600 ha uring an interview t 5:38 pm, she star- tedication cart to s- siting a resident o hy she had not loo sure Resident #4 onsisting of his na- redications was no I was in a hurry ar- ack. " Nurse #5 fi- te facility policy war- rivacy rights of res- seident information ewed. She stated iblet screen to pro- formation from pu-) During a tour of t (30/2015 at 5:50 p- n the hall was obsi- n the tablet screer allway. The tablet	WIDER OR SUPPLIER REHAB CENTER OF CUMBERLAND SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ontinued From page 1 he findings included:) During a tour of the 700 hall of the facility on '30/2015 at 5:30 pm the medication storage cart in the hall was observed in the hall with the ledication Administration Record (MAR) on the iblet screen open and facing toward the hallway. he screen displayed the MAR for Resident #4 hich exposed the resident 's name, diagnosis, and list of medications. The cart was observed to e unattended by staff. Continuous observation hade from 5:30 pm to 5:37 pm revealed Resident 4 's personal information remained publicly isplayed and unsupervised for 7 minutes. The urse (Nurse #5) responsible for the 700 hall redication cart was observed returning to the art from the 600 hall at 5:37 pm. uring an interview with Nurse #5 on 6/30/2015 t 5:38 pm, she stated she had left the redication cart to speak with a family member siting a resident on the 600 hall. When asked hy she had not locked the tablet screen to sure Resident #4 's private information onsisting of his name, diagnosis, and list of redications was not publicly displayed she stated I was in a hurry and thought that I would be right ack. " Nurse #5 further stated she understood re facility policy was for staff to protect the rivacy rights of residents by not leaving personal isident information where it could be publicly ewed. She stated she should have locked the iblet screen to protect Resident #4 's personal formation from public view.) During a tour of the 800 hall of the facility on '30/2015 at 5:50 pm the medication storage cart in the hall was observed in the hall with the MAR for esident #5 which exposed the resident 's name	REHAB CENTER OF CUMBERLAND ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID ontinued From page 1 F 164 he findings included:) During a tour of the 700 hall of the facility on /30/2015 at 5:30 pm the medication storage cart in the hall was observed in the hall with the ledication Administration Record (MAR) on the ublet screen open and facing toward the hallway. he screen displayed the MAR for Resident #4 hich exposed the resident 's name, diagnosis, nd list of medications. The cart was observed to e unattended by staff. Continuous observation tade from 5:30 pm to 5:37 pm revealed Resident 4 's personal information remained publicly splayed and unsupervised for 7 minutes. 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During a tour of the 800 hall of the facility on '30/2015 at 5:50 pm the medication storage cart in the hall was observed in the hall with the MAR in the tablet screen open and	REHAB CENTER OF CUMBERLAND 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28300 Isummary Statement of DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) IPREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH ODERCTIVE ACTION SHOLLD BE CROSS-REFERENCE DI THE APPROPRIATE DEFICIENCY) ontinued From page 1 he findings included: 1) During a tour of the 700 hall of the facility on 30/2015 at 5:30 pm the medication storage cart the hall was observed in the hall with the ledication Administration Record (MAR) on the bible screen open and facing toward the hallway. he screen displayed the MAR for Resident #4 hich exposed the resident 's name, diagnosis, and list of medications. The cart was observed to e unattended by staff. Continuous observation fade from 5:30 pm to 5:37 pm revealed Resident 4's personal information remained publicly splayed and unsupervised for 7 minutes. The turse (Nurse #5) responsible for the 700 hall ediciation cart twas observed to the dedication cart twas observed to sure Resident #4's private information posisting of his name, diagnosis, and list of redication cart to speak with a family member siting a resident that 1 would be right ack. " Nurse #5 further stated she understood to facility policy was for staff to protect the rivacy rights of resident #4's private information posisting of his name, diagnosis, and list of redications was not publicly displayed she stated hy she had not locked the tablet screen to sure Resident #4's private information privacy rights of resident bay to leaving personal formation from public view.) During a tour of the 800 hall of the facility on growent. She stated she understood formation from public view.) During a tour of the 800 hall of the facility on growent. She stated she understood formation from public view.) During a tour of the 800 hall of the facility on growent to the ablet screen displayed	

Facility ID: 980423

	RS FOR MEDICARE				a	<u>3-039</u>	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURV COMPLETE		
		0.45505			С		
		345505	B. WING		07/01/20	15	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
CAROLI	NA REHAB CENTER (OF CUMBERLAND		4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE COMP E APPROPRIATE DA	X5) PLETIO ATE	
F 164	observation made f revealed Resident a remained publicly of 5 minutes. The num the 800 Hall medica returning to the car 807 at 5:55 pm. During an interview at 5:56 pm, she sta the MAR exposed of top of the cart to ac resident in another had not shut down Resident #5 ' s priv publicly displayed s had locked (shut do Nurse #6 further sta facility policy that " resident personal in where the public ca she should have loo tablet which display information before administer medicat During an interview on 7/01/2015 at 9:3 interviewed the two protect residents ' public display on 6/ #6). She further sta be allowed to return completed in-servic confidentiality of resi	nge 2 Attended by staff. Continuous from 5:50 pm to 5:55 pm #5 ' s personal information lisplayed and unsupervised for rse (Nurse #6) responsible for ation cart was observed t from resident room number with Nurse #6 on 6/30/2015 ted she had left the cart with on the screen of the tablet on aminister medications to a room. When asked why she the tablet screen to insure ate information was not she stated " I thought that I own) the tablet screen. " ated she understood it was nurses protect the privacy of nformation by not leaving it an see it. " Nurse #6 stated cked the MAR screen on the ved (Resident #5 ' s) personal leaving it unattended to ions in a room down the hall. with the facility Administrator 80 am, she stated she had o nurses who had failed to personal information from 30/2015 (Nurse #5 and Nurse ated the two nurses would not n to work until they had cing on the facility policy for sident healthcare and personal dministrator stated it was her rses secure documents	F 16		ugh Friday X 1 and monthly X 1 reviewed at Risk further problem rrective nt practice will eviewed at ce meeting X 1		

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION (X3)	NO. 0938-039 DATE SURVEY COMPLETED	
		345505	B. WING		C 07/01/2015	
	PROVIDER OR SUPPLIER	DF CUMBERLAND		STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / 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) COMPLETIO DATE	
F 164 F 282 SS=G	(DON) on 7/01/201 was her expectation secure residents ' unauthorized public During an interview 4:30 pm, she stated nurses follow the far Right to Confidentia expected to lock the secured to the top of leaving the carts un all facility nurses re policy for Residents when they were him 483.20(k)(3)(ii) SEF PERSONS/PER C/ The services provide	5 at 10:55 am, she stated it in that the facility nurses personal information to avoid view. with the SDC on 7/01/2015 at d it was her expectation that ucility policy for Residents ' ality. She stated nurses are e MAR screens on the tablets of medication carts when nattended. She further stated ceived training on the facility s ' Right to Confidentiality ed. RVICES BY QUALIFIED	F 164		7/29/15	
	by: Based on record re interview and staff i failed to follow the o assistance with beo fracture for 1 of 3 s #1) The findings include Resident #1 was ac 5/22/2009 with diag disorder, Cerebral I limited mobility. The Minimum Data	NT is not met as evidenced eview, observations, resident nterviews the facility staff care plan for two staff d mobility resulting in a hip ampled residents. (Resident ed: dmitted to the facility on proses which included bipolar Palsy, Diabetes, joint disease, Set (MDS) dated 5/19/2015 #1 was moderately cognitively		F 282 How corrective action will be accomplished for each resident found t have been affected by the deficient practice: -C.N.A involved in resident care at the time of fall was re-trained on 6/25/2015 How corrective action will be accomplished for those residents havin the potential to be affected by the same deficient practice:	g	

Facility ID: 980423

If continuation sheet Page 4 of 15

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	08/19/2015 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345505	B. WING 07/01		C 01/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLI	NA REHAB CENTER (OF CUMBERLAND		4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	impaired. The MDS required extensive person staff suppor and hygiene care. resident was totally activities of daily liv The resident 's AD (CAA) dated 5/19/1 triggered due to ina self-care in all ADL dated 5/11/2015 ind to provide ADL self- mobility, range of m Cerebral Palsy. " goal as " the reside of function through plan intervention ind Nurses Assistant (N hygiene. " Resident #1 's care indicated " the resi Psycho-active drug disorder, and contra indicated the goal a sustain serious inju care plan interventi for bed mobility " a bathing. " Review of the faciliti 6/22/2015 revealed concerning a fall inv date: " (NA #1) call room. This writer, (Resident fell on left care and was lying side. Resident said The resident was a Resident assisted t	S also indicated the resident assistance consisting of two t with transfers, bed mobility, The MDS also indicated the dependent on staff for all	F 28	 -Current residents plan of care tas (electronic kardex in PCC) were an for the level of assistance needed ADLs. -Current residents plan of care tas (electronic kardex in PCC) were up with appropriate level of assistance needed for ADLs. C.N.As and Lice nursing staff were in-serviced on ld of documentation (electronic karde PCC) of appropriate level of assistance needed for ADLs. Measures to be put in place or sys changes made to ensure practice re-occur: -All new LN's and C.N.As will rece education on where to locate inform for appropriate assistance with AD during orientation. -All residents care plan tasks will audited on admission and updated changes by Unit Manager and/or designee. -Current residents care plan tasks audited for accuracy with Quarterly plan review by Unit Manager and/or designee -10% of total census will be audite ensure staff are following appropriate assistance levels for ADLs by the S and or designee daily Monday throw Friday X1 month, weekly X 1 month. 	udited for sks odated ensed ocation ex in ance temic will not sive mation L's be with s will be y care or ed to ate SDC ugh	

Facility ID: 980423

PRINTED: 08/19/2015

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		יחוד			0938-039	
	OF DEFICIENCIES	IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
			A. DOILD				C	
		345505	B. WING					
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
	NA REHAB CENTER (4600 CUMBERLAND ROAD					
CARULII		OF COMBERLAND		F	AYETTEVILLE, NC 28306			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 282	Continued From pa	ae 5	F 2	282				
		erated. The facility physician	1 2	.02				
		om, new order to send to the			-Results of audits will be reviewed	at		
	hospital emergency room. 911 called,				Quality Assurance weekly Risk			
		gement System) EMS arrived			Management meeting for further pr	oblem		
	and resident sent to ED. "	o (Emergency Department)			resolution.			
		: dated 6/22/2015 at 7:10 pm			How facility will monitor corrective			
		sident #1 's fall read: "			action(s) to ensure deficient practic	e will		
	Situation - fall on 6/	22/2015. Resident was lying			not re-occur-:	_		
		on to side rail while receiving						
		NA #1) and when NA went to			-Results of audit will be reviewed a			
	reach for wash clothes resident 's legs began to slip off the bed. When (NA #1) tried to hold her				Quarterly Quality Assurance meeting	ng X 1.		
		her (NA #1) thed to hold her						
		ter and that 's when she (NA						
		ed to hold onto the resident 's						
		sident #1) fell and hit her head						
		Background - Resident unable						
		continent to B&B. Requires						
		ent care and ADL 's. arance - This writer assessed						
		e, resident assisted to her						
		aceration cleaned and ice						
		erated. Recommendations -						
		patient care and ADL 's.						
	Author: (LPN #1). "							
	LPN #1 was unavai	ated 6/22/2015 at 7:40 pm						
		ent was taken to an acute care						
		department by Emergency						
		at 7:45 pm. Resident #1 was						
		p fracture as a result of the						
		emained in the hospital at the						
	time of this investig							
		view with NA #1 on 7/01/2015 erified Resident #1 had fallen						
		incident report. NA #1 stated						
		Resident #1 when she lost						
		he resident slid off of the bed	1					

If continuation sheet Page 6 of 15

	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT		NSTRUCTION		<u>NO. 0938-039</u> DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI			COMPLETED		
		345505	B. WING				07/01/2015	
IAME OF F	PROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP C	ODE		
CAROLIN	NA REHAB CENTER	OF CUMBERLAND			CUMBERLAND ROAD TTEVILLE, 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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE	
F 282	Continued From pa	age 6	F 28	82				
		#1 further stated she had not		-				
	worked at the facility long and was not familiar with Resident #1 ' s care plan intervention of: two							
		toileting, bathing, and bed						
	mobility.	During an interview with the facility Administrator						
		2:50 am, she stated she had						
		cumstances of Resident #1 's						
		nd determined that NA #1 had						
		re planned interventions of: "						
		he resident with bed mobility						
		e Administrator stated she had						
		on 6/24/2015 and obtained he	r					
		ing Resident #1 ' s fall. She nad stated " I did not know the						
		vo people for changing. This						
		ot relayed to me until after the						
		her Kardex. " The						
		ed that she and the DON						
		ronic Kardex which is intended						
		tion concerning resident care						
		nd NA's, including how many ned to assist in ADL's. She						
		dex was found not to contain						
		w many staff are needed to						
		s in ADL's. The administrator						
	stated that she auc	lited several resident ' s						
		s and determined the						
		mber of staff needed to assist						
		L ' s was present in all of the She further stated NA #1 had						
		om work pending the results o						
		The Administrator stated her	•					
		or the Nurse 's Aides and						
		appropriate number of staff to						
			1					
		DL ' s as outlined in each						
F 323	resident 's care pla	an.	F 3:				7/29/15	

If continuation sheet Page 7 of 15

		AND HUMAN SERVICES	_			FORM	08/19/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED C
		345505	B. WING			07/01/2015	
_	PROVIDER OR SUPPLIER	OF CUMBERLAND		4	TREET ADDRESS, CITY, STATE, ZIP CODE 600 CUMBERLAND ROAD AYETTEVILLE, NC 28306	••••	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323 SS=G	HAZARDS/SUPER The facility must en environment remain as is possible; and	-	F	323			
	by: Based on record re interview and staff i prevent a fall result sampled residents. included: Resident #1 was ac 5/22/2009 with diag disorder, Cerebral f limited mobility. The Minimum Data indicated Resident impaired. The MDS required extensive person staff suppor and hygiene care. resident was totally activities of daily liv Resident #1 ' s care indicated " the resi Psycho-active drug disorder, and contra indicated the goal a sustain serious inju care plan interventi	NT is not met as evidenced eview, observations, resident nterviews the facility failed to ing in a hip fracture for 1 of 3 (Resident #1) The findings dmitted to the facility on proses which included bipolar Palsy, Diabetes, joint disease, Set (MDS) dated 5/19/2015 #1 was moderately cognitively 5 also indicated the resident assistance consisting of two t with transfers, bed mobility, The MDS also indicated the dependent on staff for all ing (ADL ' s). e plan dated 5/11/2015 dent is at risk for falls due to use, incontinence, seizure actures. " The care plan is " the resident will not ry through next review. " The on included - " Assist x 2 staff nd " Assist x 2 staff for			F 323 How corrective action will be accomplished for each resident four have been affected by the deficient practice: -C.N.A involved in resident care at time of fall was re-trained on 6/25/2 How corrective action will be accomplished for those residents h the potential to be affected by the sideficient practice: -Current residents plan of care tas (electronic kardex in PCC) were au for the level of assistance needed f ADLs. -Current residents plan of care tas (electronic kardex in PCC) were up with appropriate level of assistance needed for ADLs. C.N.As and Licer nursing staff were in-serviced on lo of documentation (electronic kardez PCC)of appropriate level of assistance needed for ADLs.	the 2015. aving ame ks dited or ks dated sed cation x in	

Facility ID: 980423

If continuation sheet Page 8 of 15

TATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	<u>. 0938-039</u> E SURVEY IPLETED	
	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING			C	
		345505	B. WING		07/01/2015		
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•		
CAROLIN	NA REHAB CENTER (OF CUMBERLAND		4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ILD BE	(X5) COMPLETIO DATE	
F 323	Continued From pa	ige 8	F3	323			
	Review of the facilit June, 2015 reveale witnessed fall on 6/ receiving hygiene c incident of incontine indicated Resident comprehensive acc Licensed Practical Review of the facilit 6/22/2015 revealed concerning a fall in date: " (NA #1) call room. This writer, (Resident fell on left care and was lying side. Resident said The resident was a Resident assisted t stable, laceration to pack applied as tole was called at 7:25 p hospital emergency (Emergency Medica resident sent to Em An Incident Report which related to Re Situation - fall on 6/ on left side holding patient care from (N reach for wash clot slip off the bed. WI (Resident #1) back landed in fecal mat #1) lost her and trie gown and she (Res	ty Incident/Accident report for d the resident sustained a (22/2015 at 7:10 pm while eare from NA #1 after an ence. The facility report # 1 was assessed and a cident report was filled out by a Nurse (LPN). ty Accident Report dated I the following information volving Resident #1 on that led for help from resident ' s (LPN #1) came to assist. side of her bed during patient face down and on her left d, " I fell and my hip hurts. " ssessed head to toe. to her back, vitals taken and to forehead cleaned, and ice erated. The facility physician tom, new order to send to the (room. 911 called, EMS al Services) arrived and hergency Department) ED. " dated 6/22/2015 at 7:10 pm esident #1 ' s fall read: " (22/2015. Resident was lying on to side rail while receiving NA #1) and when NA went to hes resident ' s legs began to hen (NA #1) tried to hold her her (NA #1 ' s) arm and hand ter and that ' s when she (NA ed to hold onto the resident ' s isident #1) fell and hit her head		 Measures to be put in place or s changes made to ensure practic re-occur: -All new LN's and C.N.As will re education on where to locate info for appropriate assistance with A during orientation. -All residents care plan tasks wi audited on admission and update changes by Unit Manager and/or designee. -Current residents care plan tas audited for accuracy with Quarter plan review by Unit Manager and designee. -10% of total census will be aud ensure staff are following approprassistance levels for ADLs by the and or designee for daily Monda Friday X 1 month, weekly X 1 monthly X 1 month. -Results of audits will be review Quality Assurance weekly Risk Management meeting for further resolution. How facility will monitor correctivaction(s) to ensure deficient practice of the procession of the order of the or	e will not ceive ormation DL's Il be ed with ks will be rly care l/or ited to vriate e SDC y through onth and ed at problem e		
	to voice needs. Incone assist with pati	Background - Resident unable continent to B&B. Requires ent care and ADL ' s. arance - This writer assessed		-Results of audit will be reviewe Quarterly Quality Assurance mee			

Facility ID: 980423

		(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		TE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	CO	MPLETED
		345505	B. WING		C 07/01/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
CAROLII	NA REHAB CENTER (OF CUMBERLAND		4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 323	back, vitals taken, I pack applied as tole use two assist with Author: (LPN #1). " LPN #1 was unava A Progress Note da indicated the reside hospital emergency Transport Services diagnosed with a hi fall. Resident #1 re time of this investig In a telephone inter at 12:30 pm, she ve as described in the she was changing I control of her and t onto the floor. NA a worked at the facilit	e, resident assisted to her laceration cleaned and ice erated. Recommendations - patient care and ADL ' s. ilable for an interview. ated 6/22/2015 at 7:40 pm ent was taken to an acute care y department by Emergency at 7:45 pm. Resident #1 was ip fracture as a result of the emained in the hospital at the pation. view with NA #1 on 7/01/2015 erified Resident #1 had fallen incident report. NA #1 stated Resident #1 when she lost he resident slid off of the bed #1 further stated she had not ty long and was not familiar	F 32	3		
	staff to assist with t mobility. During an interview on 7/01/2015 at 12 investigated the cirr fall on 6/22/2015 at not followed the ca two staff to assist th and bathing. " The interviewed NA #1 of statement concerni stated that NA #1 h resident needed tw					

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		AND HUMAN SERVICES				FORM	08/19/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		345505	B. WING	·			C 01/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLII	NA REHAB CENTER (OF CUMBERLAND			600 CUMBERLAND ROAD AYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323 F 431 SS=D	needs to nurses an Kardex was found r how many staff wer residents in ADL 's she audited several 's and determined staff needed to ass present in all of the further stated NA # work pending the re Administrator stated Nurse 's Aides and number of staff to p outlined in each res 483.60(b), (d), (e) D LABEL/STORE DR The facility must en a licensed pharmac of records of receip controlled drugs in accurate reconciliat records are in order controlled drugs is in reconciled. Drugs and biological labeled in accordan professional princip appropriate access instructions, and the applicable. In accordance with facility must store a locked compartmer	d NA's, She stated that the not to contain information on re needed to assist the . The administrator stated that I resident's electronic Kardex the omission of the number of ist resident 's with ADL's was audited Kardex's. She 1 had been suspended from esults of her investigation. The d her expectation was for the I nurses to use the appropriate berform resident ADL's as sident's care plan. DRUG RECORDS, UGS & BIOLOGICALS Inploy or obtain the services of cist who establishes a system at and disposition of all sufficient detail to enable an tion; and determines that drug r and that an account of all maintained and periodically als used in the facility must be noce with currently accepted oles, and include the ory and cautionary e expiration date when State and Federal laws, the III drugs and biologicals in nts under proper temperature t only authorized personnel to		323 431			7/29/15

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	-	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		345505	B. WING _			C 01/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CAROLI	NA REHAB CENTER (4600 CUMBERLAND ROAD		
OAROEI				FAYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 431	Continued From pa	ge 11	F 43	31		
	permanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except when package drug distrii quantity stored is m be readily detected.					
	by: Based on record re- interviews the facilit medication storage The findings include During a tour of the 6/30/2015 at 5:30 p on the hall was obs medication drawers cart was observed fu unattended by staff made from 5:30 pm medication cart rem unsupervised for 7 #5) responsible for was observed retur hall at 5:37 pm. During an interview at 5:38 pm, she sta medication cart to s visiting a resident o why she had not loo stated " I was in a loo	700 hall of the facility on m the medication storage cart erved in the hallway with the facing toward the hall. The to be unsecured and . Continuous observation to 5:37 pm revealed the nained unlocked and minutes. The nurse (Nurse the 700 hall medication cart ning to the cart from the 600 with Nurse #5 on 6/30/2015		 F431 How corrective action will be accomplished for each resident for have been affected by the deficient practice: -Medication Carts were locked to a medications 6/30/2015 How corrective action will be accomplished for those residents h the potential to be affected by the sideficient practice: -Current nurses in-serviced on loc medication carts when not in attent to secure medications. Measures to be put in place or sys changes made to ensure practice or re-occur: -All new LN¿s will receive educations 	und to t secure naving same king dance temic will not	

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PRINTED: 08/19/2015

CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL		MB NO. 0938-039 (X3) DATE SURVEY				
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED			
		B. WING			C 07/01/2015			
VAME OF PROVIDER OR SUPPLIER			l	STREET ADDRESS, CITY, STATE, ZIP COL		07/01/2013		
CAROLINA REHAB CENTER OF CUMBERLAND				4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLE			
F 431	Continued From page 12 understood the facility policy was for staff to lock a medication cart whenever they stepped away from it. She further stated she should not have left the cart unlocked. During a tour of the 800 hall of the facility on 6/30/2015 at 5:50 pm the medication storage cart on the hall was observed in the hallway next to resident room number 803 with the medication drawers facing toward the hall. The cart was observed to be unsecured and unattended by staff. Continuous observation made from 5:50 pm to 5:55 pm revealed the medication cart remained unlocked and unsupervised for 5 minutes. The nurse (Nurse #6) responsible for the 800 hall medication cart was observed returning to the cart from resident room number 807 at 5:55 pm. During an interview with Nurse #6 on 6/30/2015 at 5:56 pm, she stated she had left the cart to administer medications to the resident in room number 807. When asked why she had not locked the medication cart she stated " I thought that I had locked the cart. " Nurse #6 further stated she understood it was the facility policy that " nurses lock the medication cart before going into room #807 to administer medications. During a tour of the 100 hall and the 200 hall of the facility on 6/30/2015 at 6:10 pm the medication storage carts for the 100 hall and the 200 hall were observed parked at the nursing station with the medication drawers facing toward the halls. The carts were observed to be unsecured and unattended by staff. Continuous		F4	31 orientation.				
				 -4 Medication carts each unit audited for locked when not ir to secure medications by the designee for daily Monday thr X 1 month, weekly X 1 month X 1 month. -Results of audits will be revie Quality Assurance weekly Ris Management meeting for furth resolution. How facility will monitor correct action(s) to ensure deficient p not re-occur-: -Results of audit will be revier Quarterly Quality Assurance m for further problem resolution 	a attendance DON and or ough Friday and monthly ewed at k her problem ctive ractice will wed at neeting X 1			

		& MEDICAID SERVICES				<u>). 0938-039</u>	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
NAME OF	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CO	DE		
CAROLI	NA REHAB CENTER (OF CUMBERLAND		4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 431	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 43	31			

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		AND HUMAN SERVICES					FORM	08/19/2015 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345505	B. WING			C 07/01/2015		
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP COD	E	-	
CAROLINA REHAB CENTER OF CUMBERLAND			4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	IOULD	BE	(X5) COMPLETION DATE
F 431	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 4	431				

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