DEPART	MENT OF HEALTH	AND HUMAN SERVICES			·	FORM	APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	<u>MB NO.</u>	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	СОМ	E SURVEY IPLETED
		345505	B. WING				C 22/2015
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	011	22/2013
	A REHAB CENTER (46	00 CUMBERLAND ROAD		
CAROLI		JI COMBERLAND		FA	YETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST 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 000	INITIAL COMMENT	ſS	F 00	00			
	07/22/2015 a comp conducted.	ough 07/17/2015 and on laint investigation survey was ugh 07/17/2015 an extended ted.					
	483.20 (F309) at a	scope and severity (J) scope and severity (J) scope and severity (J)					
	when Nurse #1 disc undressed in her be dislodged complete efforts to resuscitat unsuccessful. The removed on 07/17/2 facility provided an of compliance. The compliance at a sco harm with the poter harm that is not imm	pardy began on 06/13/2015 covered Resident #1 ed with her tracheostomy by from her neck, and the e her at that time were Immediate Jeopardy was 2015 at 4:05 PM when the acceptable credible allegation e facility will remain out of ope and severity of no actual netial of no more than minimal mediate jeopardy (D). The rocess of full implementation at that time.					
	Jeopardy on 07/16/ Immediate Jeopard 4:05 PM when the f allegation of complia out of compliance a of D (no actual harr minimal harm that i ensure monitoring s effective.	vas informed of Immediate 2015 at 4:48 PM and y was abated 07/17/2015 at acility implemented a credible ance. The facility remained at the lower scope and severity n with potential for more than s not immediate jeopardy) to systems put in place are					
F 157 SS=J	483.10(b)(11) NOT (INJURY/DECLINE		F 15	57			8/10/15
		DER/SUPPLIER REPRESENTATIVE'S SIGI			TITLE		(X6) DATE
	ically Signed						08/06/2015

Electronically Signed

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.

PRINTED: 09/17/2015

		AND HUMAN SERVICES				FORM	09/17/2015 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY IPLETED C
		345505	B. WING				22/2015
NAME OF F	PROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	NA REHAB CENTER	OF CUMBERLAND			600 CUMBERLAND ROAD AYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	Continued From page 1			57			
	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).						
	and, if known, the r or interested family change in room or specified in §483.7 resident rights und	so promptly notify the resident resident's legal representative a member when there is a roommate assignment as 15(e)(2); or a change in er Federal or State law or cified in paragraph (b)(1) of					
	the address and ph	cord and periodically update none number of the resident's e or interested family member.					
	by: Based on record re physician interview the physician abou	NT is not met as evidenced eview, staff interviews and r, the facility staff did not notify t adverse behavioral ng pulling at her tracheostomy			The Statements included are not a admission and do not constitute agreement with the alleged deficien herein. The plan of correction is		

Facility ID: 980423

If continuation sheet Page 2 of 40

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				APPROVE 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	СОМ	E SURVEY PLETED
		345505	B. WING _			C 22/2015
NAME OF I	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZI	P CODE	
CAROLII	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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 157	Continued From pa	-	F 1			
	residents who had	zed the safety of one of four tracheostomies, Resident #1.		completed in the complia federal regulations as out in compliance with all fed	tlined. To remain eral and state	
	when Nurse #1 four with her tracheosto	ppardy began on 06/13/2015 nd Resident #1 undressed my tube dislodged completely the efforts to resuscitate her		regulations the center has take the actions set forth plan of correction.		
	at that time were ur Jeopardy was remo	nsuccessful. The Immediate byed on 07/17/2015 at 4:05 PM byided a credible allegation of		How the corrective action accomplished for those re have been affected by the	esidents found to	
	compliance. The fa	acility will remain out of ope and severity of no actual ntial of no more than minimal		practice: ¿ On 6/13/2015 Reside approximately 12:45 p.m.	ent # 1 at	
	harm that is not imr	mediate jeopardy (D). The rocess of full implementation		unresponsive and not bre CPR was attempted by fa 911 was called. Upon an continued CPR efforts an pronounced dead at the f	eathing by staff. acility staff and rival, EMS team ad later	
	Findings included:			¿ The Resident had mi that she could remove an	ttens in place d were therefore	
	specialty hospital to indicated that Resid	harge Summary from a the facility dated 06/10/2015 dent #1 had a discharge		not considered a restrain that resident frequently to and attempted to dislodge	ook off mittens e trach.	
	same Discharge Su the resident had en	placed on 04/29/2015. The ummary further indicated that icephalopathy, and that as a tatus waxed and waned.		ذ All LPNs and RNs we 7/16/2015 regarding phys interventions for trach pa airways, and tracheostom ذ	sician notification, tients to protect	
	accompanied Resid included a Medicaid which revealed Res	hission paperwork which dent #1 from the hospital d FL2 Form dated 06/10/2015 sident #1 had a tracheostomy herapy, and that the resident		How corrective action will accomplished for those re potential to be affected by deficient practice: ¿ All Licensed Practica Pagistered Nurses were	esident having y the same I Nurses and	
	tracheostomy tube. An Interdisciplinary			Registered Nurses were 7/17/2015 regarding the f 1. Documentation and which states the Charge	following policies: Notification,	

TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	IPLE CONSTRUCTION		0938-039 SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		PLETED
					(2
		345505	B. WING			22/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	FE, ZIP CODE	
CAROLI	NA REHAB CENTER	OF CUMBERLAND		4600 CUMBERLAND ROAD FAYETTEVILLE, NC 2830		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	I OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETIO DATE
F 157	Continued From pa	age 3	F 1	57		
	dislodging her tube this goal was that F tracheostomy. A review of the faci Assessment dated #1 was admitted to a diagnosis of resp of cognition was co because the reside the same assessm totally dependent u locomotion, dressin hygiene, and bathin "Extremities," the a and left arm reflexed In an interview with nurse on 07/15/207 from the time of ad Resident #1 was kn behaviors and that	ility's Nursing Admission 06/10/2015 revealed Resident to the facility on 06/10/2015 with biratory failure and that her level build not be determined ent was nonverbal. In addition, thent revealed Resident #1 was upon staff assistance for ng, eating, toilet use, personal ng. Under the category of assessment indicated that right es were within normal limits. In the Minimum Data Set (MDS) 15 at 3:35 PM, she stated that limission on 06/10/2015, nown to have restless she pulled at her	 patient. Included in the in-service was emphasis that anxiety and agitation is reportable to the physician. 2. All Licensed Practical Nurses and Registered Nurses not scheduled on 07/17/2015 will be in-serviced prior to returning to work. 3. The care plans for the three remaining tracheostomy patients were reviewed by the Corporate Quality Improvement Monitor for accuracy and completeness. 4. On 7/16/2015, all Certified Nurses Assistants were in-serviced on notifying the charge nurse of change in resident condition, using the clinical alerts in the 			
	restless behaviors interdisciplinary me The MDS nurse sta exact date and time meeting, but that u on Thursday morni 06/11/2015. She fu "common knowledg her mittens frequer discussion about c getting a medicatio MDS nurse stated	addition, she stated that her was discussed in detail in an eeting and also on daily rounds. ated she could not recall the e of the interdisciplinary sually the meetings were held ngs, and that Thursday fell on urther explained that it was ge" that Resident #1 pulled off ntly, and that there was ontacting the physician about on for agitation control. The the resident was admitted to the mittens she had from the		Measures put into pla deficient practice will 1. DON and/or desi Monday-Friday X (4) the Change in Condi Assessment notificat and the Communicat for completion for all patients. 2. DON and/or desi Monday-Friday X (4) Behavior and Progres	gnee will daily four weeks will audit ition and Transfer ion documentation ion Progress Notes Tracheostomy gnee will daily four weeks audit	

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE	E CONSTRUCTION	MB NO. (X3) DATE	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	` '				PLETED
			D. MINIO				C
		345505				07/2	22/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 600 CUMBERLAND ROAD		
CAROLII	NA REHAB CENTER	OF CUMBERLAND		F/			
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 157	Continued From no	200 4		-			
1 107	Continued From pa because the facility	•	F 15	1	interventions to prevent de-cannula	ation	
	07/16/2015 at 2:00 History and Physica 06/11/2015, he did	not record any combative or problems related to her			How the facility plans to monitor ar ensure correction is achieved and sustained	nd	
	tracheostomy tubin #1 did not exhibit s when he examined reports of such beh that he knew that th admission to the fa pulling at the trache order for the mitten physician stated he from a staff membe pulling at her trache	g or device, because Resident uch behaviors at the time her, and he had not received navior. The physician stated he resident wore mittens upon cility due to her history of her eostomy, and that he wrote an is on 06/11/2015. The e did not recall getting a call er regarding the resident eostomy, but that he did Resident #1 had expired on			 ¿ The Director of Nursing will represults of the audits weekly x (3) m in the Weekly Quality Assurance Rimeeting for problem resolution. ¿ The Administrator will report the results of the audits to the quarterly Quality Assurance meeting X (1) quality Assurance meeting X (1) quality for tracking and trending of complia and further problem resolution. 	onths isk e / uarter	
	dated 06/12/2015 a mittens continued t	gress notes revealed a note at 11:56 PM indicated that o be used for tracheostomy #1. This progress note was 2.					
	#1's nurses, Nurse Nurse #2 stated that out of bed when sh the first day of her the resident up in h across from the nu be monitored. Nur- resident was aroun to get up or exhibit	onducted with one of Resident #2, on 07/15/2015 at 2:37 PM. at Resident #1 had tried to get e was assigned to her during stay in the facility, so she kept ier chair in the day room rse 's station so that she could se #2 explained that when the d other people, she did not try restless behaviors. She I seen Resident #1 pull at her					

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	COF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	TIPLE CONSTRUCTION). 0938-039 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		MPLETED
		345505	B. WING		07	C 7/ 22/2015
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	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 157	actually pull on her addition, Nurse #2 that the mittens we Resident #1 becaus capable of removin Per the Minimum D assessment dated no range of motion Another progress n AM documented th several times durin mittens and grabbin note was signed by In a telephone inter 07/22/2015 at 2:22 not recall many det documented in the but stated if she do was observed pullin then it happened. I worked the 3:00 PM 06/12/2015 and that written late, after he stated that when th pulling off her mitter tracheostomy tube, daughter left from a Resident #1 becam left. She added that she removed her m tracheostomy, so s replaced her mitter she had to wear the she felt no need to	re, but never had seen her tracheostomy tube. In stated that she wasn ' t sure re a helpful intervention for se she was very alert and g them herself. Data Set (MDS) 5-Day 06/13/2015, Resident #1 had impairment. Hote dated 06/13/2015 at 12:37 at Resident #1 was observed g the shift removing her ng at her tracheostomy. This	F 1	57		

If continuation sheet Page 6 of 40

	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED
	ST CONNECTION		A. BUILDIN	NG	C	
		345505	B. WING _			/22/2015
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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 157	mittens. She state whether the resider her mittens or pull a before then. In add not her idea to keep for observation and in the day room wh 3:00 PM on 06/12/2 A progress noted d documented, "tra (resident) wearing fu upper extremities of to remove trach. (tr continue to monitor Nurse # 3. In an interview with assistant on 07/15/ that when she went 06/13/2015 betwee found that Residen mittens. She expla	lained the need for the d that she was uncertain nt had been known to remove at her tracheostomy tube dition, she stated that it was p the resident in the day room I that the resident was already en she came onto her shift at	F 15	57		
	stated that Nurse # to wear mittens all pulling at her trache to the resident's root the nurse's directio A progress note wh 06/13/2015 at 8:32 "Situation: res still, not moving or continuously pulls h at O2 (oxygen) hoo (tracheostomy.)CN and I had to put mit	ich documented dated PM revealed the following: (resident) found in bed lying breathing. Background: She her mitts (mittens) off and pulls				

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	<u>RS FOR MEDICARE</u> OF DEFICIENCIES	& MEDICAID SERVICES		TIPLE CONSTRUCTION		0. 0938-039 TE SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:		NG	· · /	MPLETED
		345505	B. WING		C 07/22/2015	
NAME OF	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP C		/22/2010
CAROLI	NA REHAB CENTER (OF CUMBERLAND		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 COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 157	(tracheostomy). Sh need it." Assessme breathing, no respon rub. Charge nurse with crash cart, che (cardiopulmonary rowas called and con- until EMS (emerger Chest compression until EMS arrived. responsible party list reached. [Family roward of the other two kids show This note was signed In an interview with 11:27 AM, Nurse # to Resident #1 for j the day shift from 3 she received a repor- nurse who informed the mittens to keep tracheostomy site. were no other inter- from pulling at her for checking on her free On 07/16/2015 at 1 conducted with Nur acting as the charg (Nurse #3 worked to 06/13/2015.) Nurse with a tracheostom behaviors, such as she would keep the close monitoring fo if this intervention w	he stated, "I don ' t ent: Found laying in bed not onse to verbal cue or sternal was brought into room along est compressions and CPR esuscitation) were began. 911 tinued to stay on phone ncy medical service) arrived. Is and CPR was performed All 3 family members on the st were called and not nember] Ms. [xxxx] called back er about the situation. The wed up shortly thereafter."		57		

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPI	LE CONSTRUCTION	X3) DATE	E SURVEY
AND PLAN O	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING	3		
		345505	B. WING				C 22/2015
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	 	
CAROLIN	NA REHAB CENTER O	OF CUMBERLAND			4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT	ı	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETION DATE
F 157	Continued From pa	ige 8	F 1	57	,		
	In a second intervie	ew with Nurse #1 on					
		3 PM, she stated that the					
	the night shift repor	sly cared for Resident #1 on rted to her that the resident					
		ner tracheostomy but did not as to how to keep them on					
	her. Nurse #1 state	ed that the facility was					
		hat with that in mind, there could do to keep the resident					
	from pulling off her	mittens or pulling at her					
		that she would not have ician about her restless					
	adverse behaviors.						
		:45 AM, an interview was					
		unit manager from the unit resided. The unit manager					
	stated that she was	s not working on the date when					
		out her tracheostomy tube, ould be her expectation that if a					
	resident displayed r	restless or adverse behaviors					
		ally harm him/her, the buld contact the physician to					
		In addition, she stated that if a ar with a resident, she should					
		m the previous shift nurse,					
		iew progress notes, the history , the discharge summary					
	information from the	e hospital in order to					
	understand the resi behaviors.	ident ' s needs and possible					
		the acting Director of Nursing, nsultant nurse were notified of					
		ardy in a meeting on					
	The facility provided	d the following credible					

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PRINTED: 09/17/2015

		AND HUMAN SERVICES				FORM	09/17/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		345505	B. WING				C 22/2015
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLII	NA REHAB CENTER (OF CUMBERLAND			1600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 157	allegation on 07/17/ How the corrective for those residents by the deficient prace On 6/13/15 Nurses made two attempts On 6/13/2015 at ap on interview with the the time, Resident at unresponsive and r attempted by facility Upon arrival, EMS f and later Resident at the facility. Nurses notification. All LPN on 7/16/2015 regard How corrective active those resident having the same deficient All Licensed Practice Nurses were in-serve the following policies 1. Documentation at the Charge Nurse is the Phy Party whenever the care of the in-service was emp agitation is reportat 2. All Licensed Practice Nurses not schedul serviced prior to ret 3. The care plat tracheostomy patie	 /2015 at 1:09 PM. action will be accomplished found to have been affected ctice: documented resident #1 to remove tracheostomy. proximately 2:00 p.m., based e nurse and CNA on duty on at #1 was found to be not breathing. CPR was y staff and 911 was called. team continued CPR efforts #1 was pronounced dead at notes do not reflect MD Ns and RNs were in-serviced ding physician notification. on will be accomplished for ng potential to be affected by practice: cal Nurses and Registered viced on 7/17/2015 regarding es: and Notification, which states a responsible for notifying vician and or the Responsible re is a change related to the patient. Included in the hasis that anxiety and on the physician. 	F	157			

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	<u>RS FOR MEDICARE</u> OF DEFICIENCIES		(Y2) MU			. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
		345505	B. WING			C
	PROVIDER OR SUPPLIER	545505	D. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	07/	22/2015
	NA REHAB CENTER (OF CUMBERLAND		4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 157 F 309 SS=J	Certified Nur- in-serviced on notific change in resident clinical alerts in the system and verbally Assistants not sche in-serviced prior to On 07/17/2015 at 3 credible allegation with unit managers licensed staff who se education regarding adverse behaviors tracheostomy which safety. Interviews w revealed that they h education about the residents frequently exhibited behaviora mittens, and reportin nurse immediately. stated they received the importance of k themselves. 483.25 PROVIDE C HIGHEST WELL BI Each resident must provide the necessa or maintain the high mental, and psycho	 Jeteness.On 7/16/2015, all ses Assistants were ying the charge nurse of condition, using the electronic medical record y. Any Certified Nurses eduled on 07/16/2015 will be returning to work. :20 PM, verification of the was evidenced via interviews, supervising nurses, and other stated they received in-service g the notification of the behavioral changes or other such as pulling at the nould impact the resident's with nursing assistants had been provided in-service e importance of monitoring y, especially those who al issues such as removing ng such behaviors to the The nursing assistants also d in-service education about eeping resident from harming CARE/SERVICES FOR 	F 1			8/10/15

Facility ID: 980423

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		AND HUMAN SERVICES & MEDICAID SERVICES	_			FORM	09/17/2015 APPROVED 0938-0391
	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SU COMPLE C	
		345505	B. WING)			_ 22/2015
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	NA REHAB CENTER (OF CUMBERLAND			1600 CUMBERLAND ROAD FAYETTEVILLE, 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 SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 11	F	309			
	by: Based on physicial visitor interview, an	NT is not met as evidenced n interview, staff interviews, d record review, the facility			The Statements included are not admission and do not constitute	-	
	failed to develop an interim care plan to address the tracheostomy needs and adverse behavioral symptoms related to tracheostomy safety for one of one resident who was found unresponsive after pulling out her tracheostomy, Resident #1.				agreement with the alleged deficie herein. The plan of correction is completed in the compliance of st federal regulations as outlined. To in compliance with all federal and regulations the center has taken of	ate and o remain state	
	when Nurse #1 disc undressed in her be dislodged complete efforts to resuscitat	pardy began on 06/13/2015 covered Resident #1 ed with her tracheostomy ly from her neck, and the e her at that time were			take the actions set forth in the fol plan of correction. How the corrective action will be accomplished for those residents have been affected by the deficier	lowing found to	
	removed on 07/17/2 facility provided an of compliance. The compliance at a sco	Immediate Jeopardy was 2015 at 4:05 PM when the acceptable credible allegation e facility will remain out of ope and severity of no actual			practice. The initial care plan being develop not fully address the specialized c needs for the Tracheostomy.	are	
	harm that is not imr	ntial of no more than minimal mediate jeopardy (D). The rocess of full implementation at that time.			On 07/16/15, The MDS nurse con an audit of the current (3) three tracheostomy residents to ensure Care Plan objectives, care needs, special needs for tracheostomy ar	the and	
	Findings included:				mittens was accurate and comple At the time of the audit, there w	vere no	
	specialty hospital to indicated that Resid diagnosis of respira tracheostomy place Discharge Summar resident had encep result, her mental s	ed on 04/29/2015. The same y further indicated that the halopathy, and that as a tatus waxed and waned.			new admissions with tracheostom How the correct action will be accomplished for those residents potential to be affected by the san deficient practice. On 07/16/15, the MDS Nurse conducted an audit to validate the presence of an accurate current O Plan for the current (3) three	having a ne Care	
		hission paperwork which dent #1 from the hospital			tracheostomy residents which add medical and nursing objectives an		

Facility ID: 980423

If continuation sheet Page 12 of 40

	-	AND HUMAN SERVICES			0		APPROVE 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	Сомі	E SURVEY PLETED	
		345505	B. WING				C 7/22/2015	
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
CAROLI	NA REHAB CENTER	OF CUMBERLAND		46 F/				
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE	
F 309	Continued From pa	age 12	F 3	09				
	included a Medicai which revealed Res with 28% oxygen the wore mittens due to tracheostomy tubes. An Interdisciplinary Barrier Update from remove Resident # dislodging her tubes this goal was that F tracheostomy. A review of the faci Assessment dated #1 was admitted to a diagnosis of resp of cognition was un because the resides the same assessment totally dependent un locomotion, dressin hygiene, and bathin "Skin" the comment (tracheostomy) mic Motor Control " se resident was docur gait and poor balar A review of the faci 06/10/2015 reveales marked as present Review of the prog a note made upon 2:32 PM which stat	d FL2 Form dated 06/10/2015 sident #1 had a tracheostomy herapy, and that the resident o her pulling at the a Plan of Care Discharge and in the hospital listed a goal to a the spital listed a spital			interventions for tracheostomy and needs. On 07/16/15, the MDS Nurse, of Nursing, Unit Manager, and Hou Supervisors received education by Staff Development Coordinator on following Procedure points: the Ca will be activated upon admission, t Comprehensive Care plan will be completed within 7 days of the com of the Comprehensive Assessmen Care Plan will be updated by each discipline on an ongoing basis as of in the patient occur and reviewed quarterly, On 07/16/15, all Licensed Nurs staff were educated by the Staff Development Coordinator on the O Plan process, objectives, and interventions for patients with tracheostomy and mittens. All Licensed Nursing staff not scheduled on 07/16/15 will be in-set by the Staff Development Coordinator prior to returning to work. Measures put into place to ensure deficient practice will not occur: The Director of Nursing and or designee will audit the 24 hour Cha review using the eMAR documenta and Order Listing Reports daily X 4 Monday-Friday to ensure accurate updated Care Plan objectives and interventions for all tracheostomy p Don and/or designee will daily N ¿ Friday X 4 weeks will audit the C in Condition and Transfer assessmed	Director use the the re Plan he npletion t, the changes sing Care erviced ator that the art ation 4 weeks and batients. Monday hange		

-					FORM	09/17/201 APPROVEI 0938-039
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COMF	E SURVEY PLETED
	345505	B. WING _				22/2015
ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
IA REHAB CENTER (OF CUMBERLAND	4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306				
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG			ЗE	(X5) COMPLETION DATE
assistance of one s assist x 1 (with the member.) Admitted " This progress An interview was co 07/15/2015 at 2:37 was the nurse who the day she was ad 06/10/2015, and tha her mittens which h hospital. Nurse #2 admission, while sh tried to get out of be kept Resident #1 in because when she did not try to get ou that she was monito when she was in he Nurse #2 stated tha with her mittens off seen the resident p Nurse #2 also state that the mittens we resident from pullin because the reside of removing the mit were a soft cotton-1 hand and that there the wrist to help kee A review of the med was no interim care #1's tracheostomy of tendencies of pullin or tubing. In an interview with	taff member.) Ambulates with assistance of one staff d with mittens on both hands note was signed by Nurse #2. Onducted with Nurse #2 on PM. Nurse #2 stated that she worked with Resident #1 on mitted to the facility on at the resident was wearing ad been given to her by the stated that right after he was on duty, Resident #1 ed. She explained that she the day room during the day was around other people, she t of bed. Nurse #2 also stated ored by more staff members er geri-chair in the day room. At she had seen the resident before, but she had not ever ull at the tracheostomy strap. At the tracheostomy strap. At the tracheostomy int was very alert and capable tens. She stated the mittens ike material on the palm of the e was a Velcro fastener around ep them in place. the Minimum Data Set (MDS)	F 30	09	Unit Manager, and House Supervisor receive education during orientation the Staff Development Coordinator of following Procedure points: the Care will be activated upon admission, the Comprehensive Care plan will be completed within 7 days of the comp of the Comprehensive Assessment, Care Plan will be updated by each discipline on an ongoing basis as ch in the patient occur and reviewed quarterly for all tracheostomy patient How the facility plans to monitor and ensure correction is achieved and sustained: The Director of Nurses will repor results of the audits to the weekly Qu Assurance Risk Meeting for further problem resolution for one (3) month The Administrator will report the results of the audits to the QA comm	ors will by on the Plan e oletion the nanges ts. d ort the uality h. e nittee	
	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER NA REHAB CENTER O SUMMARY STA (EACH DEFICIENCY REGULATORY OR LA Continued From parassistance of one s assistance of pullin because the resident p Nurse #2 also state that the mittens wer resident from pullin because the reside of removing the mit were a soft cotton-I hand and that there the wrist to help kee A review of the med was no interim care #1's tracheostomy of tendencies of pullin or tubing. In an interview with	IDENTIFICATION NUMBER: 345505 PROVIDER OR SUPPLIER VA REHAB CENTER OF CUMBERLAND SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 assistance of one staff member.) Ambulates with assist x 1 (with the assistance of one staff member.) Admitted with mittens on both hands " This progress note was signed by Nurse #2. An interview was conducted with Nurse #2 on 07/15/2015 at 2:37 PM. Nurse #2 stated that she was the nurse who worked with Resident #1 on the day she was admitted to the facility on 06/10/2015, and that the resident was wearing her mittens which had been given to her by the hospital. Nurse #2 stated that right after admission, while she was on duty, Resident #1 tried to get out of bed. She explained that she kept Resident #1 in the day room during the day because when she was around other people, she did not try to get out of bed. Nurse #2 also stated that she was in her geri-chair in the day room. Nurse #2 stated that she had seen the resident with her mittens off before, but she had not ever seen the resident pull at the tracheostomy strap. Nurse #2 also stated that she was not even sure that the mittens were helpful in preventing the resident from pulling at her tracheostomy because the resident was very alert and capable of removing the mittens. She stated the mittens were a soft cotton-like material on the palm of the hand and that there was a Velcro fastener around the wrist to help keep them in place. A review of the medical record revealed there was no interim care plan to address Resident #1's tracheostomy care or her behavioral tendencies of pulling at the tracheostomy device	RS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: 345505 B. WING PROVIDER OR SUPPLIER 345505 B. WING VA REHAB CENTER OF CUMBERLAND SUMMARY STATEMENT OF DEFICIENCIES ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 13 assistance of one staff member.) Ambulates with assist x 1 (with the assistance of one staff member.) Admitted with mittens on both hands F 30 " This progress note was signed by Nurse #2. An interview was conducted with Nurse #2 on 07/15/2015 at 2:37 PM. 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I	RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES FCORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING_ 345505 PROVIDER OR SUPPLIER A REHAB CENTER OF CUMBERLAND B. WING	MENT OF HEALTH AND HUMAN SERVICES ON SF COR MEDICARE & MEDICAID SERVICES ON OF DEFICIENCIES (X1) PROVIDERUSUPPLERUCLAN (X2) MULTIPLE CONSTRUCTION A REHAB CENTER OF CUMBERLAND STREET ADDRESS, CITY, STATE, ZIP CODE MAREHAB CENTER OF CUMBERLAND STREET ADDRESS, CITY, STATE, ZIP CODE MAREHAB CENTER OF CUMBERLAND STREET ADDRESS, CITY, STATE, ZIP CODE MAREHAB CENTER OF CUMBERLAND STREET ADDRESS, CITY, STATE, ZIP CODE Continued From page 13 STREET ADDRESS, CITY, STATE, ZIP CODE assistance of one staff member.) Ambulates with assist 1 (with the assistance of one staff member.) Antruster was signed by Nurse #2 and Updated Care Plan objectives and interventions for all Tracheostomy patients. Continued From page 13 F 309 assistance of one staff member.) And Nurse #2 and Off 102 COTS, and that the resident was wearing the resident was wearing the resident was wearing the resident was wearing the optical. Nurse #2 stated that she kas not even sure sheen she was around other people, she there noise Assessment, Care Plan will be updated by each discipline on a nongoing basis as chard that she was monitored by more staff members when she was around other people, she that the mittens we helpicht in preventing the resident was not even sure correction for all tracheostomy patient. Core Plan will be updated by ach discipline on a nongoing basis as chard that there was a Velco fastener around the writs to help keep them in place. Areview of the medical r	MENT OF HEALTH AND HUMAN SERVICES FORM. SF OR MEDICARE & MEDICAD SERVICES OMB NO. or DEFICIENCIES (X1) PROVIDERSUPPLERCIA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILING (X3) DATE AREHAB CENTER OF CUMBERLAND B WING (X3) DATE VA REHAB CENTER OF CUMBERLAND STREET ADDRESS, CITY, STATE, 2IP CODE 4600 CUMBERLAND ROAD FAVETTEVILLE, NC 28306 VA REHAB CENTER OF CUMBERLAND PROVIDERS NUM OF CORRECTION REQUATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 13 assistance of one staff member.) Admitted with mittens on both hands * This progress note was signed by Nurse #2 and interview was admitted to the facility on 07/15/2015 at 2:37 PM. Nurse #2 stated that she was the nurse who worked with Resident #1 on 06(702015, and that the resident was wearing her mittens which had been given to her by the bocause when she was in the griver. Other by the obcause when she was in the griver. Nurse #2 stated that she had not ever swhen she was in her geri-Chair in the day room what she was in outbug. Nores staff did not try to get out of bed. Nurse #2 also stated that she was in ontered by more staff members, When she was anot even sure that the mittens were helpful in preventing the resident from pulling at her tracheostomy because the resident was very alert and capable of removing the mittens. She stated the mittens were a soft cotton-like material on the pain of the and and that here was a Velcro fastener around the wrist to help keep them in place. How the facility plans to monitor and ensure correction is achieved and sustained: New worked with Merse seident #1's t

If continuation sheet Page 14 of 40

		& MEDICAID SERVICES	(X2) MULT	TIPLE CONSTRUCTION). 0938-039 TE SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:		NG		MPLETED	
						С	
		345505	B. WING			7/22/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	, CODE		
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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	
F 309	Continued From pa	ige 14	F 30	09			
	on 07/15/2015 at 3	35 PM, she stated that from					
		on on 06/10/2015, Resident #1					
		restless behaviors and that					
		acheostomy. The MDS nurse nterim care plan to address her					
		s and her restless behaviors					
		nitiated immediately upon					
		nursing facility admission					
		MDS Nurse stated that the					
		ould be completed by any of					
		re taking care of Resident #1					
		esponsible for completing an assed upon her diagnoses and					
		needs. The MDS nurse added					
		e MDS nurses who wrote care					
		sident #1 was not in the facility					
		e a formal nursing care plan					
		ys of her admission. She					
		im care plan was supposed to					
		ess her care needs regarding ncluding her behavior of					
		eostomy, until the formal care					
		ted. In addition, she stated					
		ncern among the nursing staff					
		#1 's restless behavior and					
		her tracheostomy, and that					
		in detail in an interdisciplinary n daily rounds. The MDS					
		buld not recall the exact date					
		rdisciplinary meeting, but that					
		is were held on Thursday					
	mornings, and that	Thursday fell on 06/11/2015.					
		ed that it was "common					
		esident #1 pulled off her					
		and that there was discussion					
		e physician about getting a ation control. The MDS nurse					
		was admitted to the facility					
	wearing the mittens		1			1	

If continuation sheet Page 15 of 40

		& MEDICAID SERVICES	0.00). 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · /	TE SURVEY MPLETED	
		345505	B. WING		07	C 7/22/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		/22/2015	
CAROLI	NA REHAB CENTER (OF CUMBERLAND	4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION 3 CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 309	restraints, including because the facility A review of the phys order dated 06/11/2 for stability of trach no other orders reg for Resident #1. In an interview with 07/16/2015 at 2:00 History and Physica record any combati related to her trache her tracheostomy tu did not exhibit such had not received re physician stated that wore mittens upon her history of her put that he wrote an or 06/11/2015. The pl recall getting a call the resident pulling he did receive a cal expired on 06/13/20 Per the Minimum D assessment dated partial list of diagno respiratory failure, r symbolic dysfunctio In addition, the sam resident was receiv was not receiving re	not have any access to mittens, in the facility	F 30	9			

Facility ID: 980423

If continuation sheet Page 16 of 40

			()(0)			D. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY MPLETED
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		345505	B. WING _			//22/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
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	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 309	Continued From pa	age 16	F 30	9		
		npairment for Resident #1, restraints checked for the				
	A progress note dated 06/13/2015 at 12:37 AM documented, "Resident able to verbalize needs to staff, resident was observed several times during shift removing mittens and grabbing at trach (tracheostomy). Resident alert x 2 (oriented to person and place), confusion noted." This note was signed by Nurse #7.					
	07/22/2015 at 2:22 actually worked on on 06/12/2015, but was over in order to notes. She stated details about what progress note on 0 documented that th pulling on her trach happened. Nurse is observed Resident pulling at her trache after her family me #7 stated that Resi upset when her fam Nurse #7 stated sh mittens and explain them. She stated to the resident had be mittens or pull at he then. In addition, so of any other interver	rview with Nurse #7 on PM, she stated that she the 3:00 PM to 11:00 PM shift that she stayed after her shift o document in the progress that she could not recall many she documented in the 6/13/2015, but stated if she he resident was observed heostomy tube, then it #7 stated that when she #1 pulling off her mittens and eostomy tube, it occurred right mber left from a visit. Nurse dent #1 became fidgety and nily member left that day. He went to her and replaced her hed to her why she had to wear that she was uncertain whether een known to remove her er tracheostomy tube before she stated she was not aware entions in place to address or pulling at the tracheostomy				

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	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
					С
	345505	B. WING		07	/22/2015
PROVIDER OR SUPPLIER				DE	
NA REHAB CENTER (OF CUMBERLAND				
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETIO DATE
	-	F 309			
(resident) wearing upper extremities d to remove trach. (tr	mittens on bilat (bilateral) I/t (due to) resident attempting acheostomy)will continue to				
11:27 AM, Nurse # to Resident #1 for j and that she receiv shift's nurse who in needed the mittens her tracheostomy s had no knowledge being used to keep her tracheostomy of frequently, at least no one reported to kept in the day roor	1 stated that she was assigned ust one day on 06/13/2015 red a report from the previous formed her that the resident to keep her from pulling at site. Nurse #1 explained she of any other interventions Resident #1 from pulling at other than checking on her every 2 hours. She added that her that the resident should be m near the nurse 's station.				
11:03 AM with the w Resident #1 undress the interview, she s the resident on 06/ The visitor stated th the resident ' s room wearing no gown o that she had not sta resident ' s room lo whether she was be the resident was as she did not want to	visitor who discovered ssed on 06/13/2015. During stated that she came to visit 13/2015 shortly after 2:00 PM. hat when she started to enter m, she noted the resident was r other clothing. She stated ayed in the entrance of the ong enough to determine reathing and she just assumed sleep. The visitor stated that embarrass the resident, so				
	OF DEFICIENCIES F CORRECTION PROVIDER OR SUPPLIER VA REHAB CENTER SUMMARY STA (EACH DEFICIENC' REGULATORY OR L Continued From pa documented "tra (resident) wearing upper extremities of to remove trach. (tr monitor." This not In an interview with 11:27 AM, Nurse # to Resident #1 for j and that she receiv shift's nurse who in needed the mittens her tracheostomy of frequently, at least no one reported to kept in the day root An interview was co 11:03 AM with the of Resident #1 undrest the interview, she st the resident on 06/ The visitor stated th the resident 's root wearing no gown of that she had not star resident 's room low whether she was b the resident was as she did not want to	OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345505 PROVIDER OR SUPPLIER VA REHAB CENTER OF CUMBERLAND SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 documented "trach care provided. Resd (resident) wearing mittens on bilat (bilateral) upper extremities d/t (due to) resident attempting to remove trach. (tracheostomy)will continue to monitor." This note was signed by Nurse # 3. In an interview with Nurse #1 on 07/16/2015 at 11:27 AM, Nurse #1 stated that she was assigned to Resident #1 for just one day on 06/13/2015 and that she received a report from the previous shift's nurse who informed her that the resident needed the mittens to keep her from pulling at her tracheostomy site. Nurse #1 explained she had no knowledge of any other interventions being used to keep Resident #1 from pulling at her tracheostomy other than checking on her frequently, at least every 2 hours. She added that no one reported to her that the resident should be kept in the day room near the nurse 's station. An interview was conducted on 07/15/2015 at 11:03 AM with the visitor who discovered Resident #1 undressed on 06/13/2015. During the interview, she stated that she came to visit the resident on 06/13/2015 shortly after 2:00 PM. The visitor stated that when she started to enter the resident 's room, she noted the resident was wearing no gown or other clothing. She stated that she had not stayed in the entrance of the resident 's room long enough to determine whether she was breathing and she just assumed the resident was asleep. The visitor stated that she did not want to embarrass the resident, so <td>PF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 345505 B. WING</td> <td>OF DEFICIENCIES (X1) PROVIDERSUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: 345505 B. WING 345505 B. WING </td> <td>OF DEFICIENCIES [X1] PROVIDERSUPPLIER-LLA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILING (X3) DA COL SPOVIDER OR SUPPLIER 345505 B. WING 07 PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 07 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE FRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PRCVX PRCVDERS PLANO OF CORRECTION (EACH ORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY MUST BE FRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PRCVX PRCVXDERS PLANO OF CORRECTION (EACH ORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY MUST BE AT STATE TAG F 309 Continued From page 17 documented "Trach care provided. Resd (resident) wearing mittens on bilat (bilateral) upper extremities d/f (due to) resident attempting to remove trach. (tracheostomy)will continue to monitor." This note was signed by Nurse # 3. F 309 In an interview with Nurse #1 on 07/15/2015 at 11:27 AM, Nurse #1 stated that she was assigned to Resident #1 for just one day on 06/13/2015 and that she received a report from the previous shift's nurse who informed her that the resident needed the mittens to keep Resident #1 from pulling at her tracheostomy site. Nurse #1 explained she had no knowledge of any other interventions being used to keep Resident #1 from pulling at her tracheostomy other than checking on her frequently, at least every 2 hours. She added that no on reported to her that the resident should be kept in the day room near the nurse ' s station. No</td>	PF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 345505 B. WING	OF DEFICIENCIES (X1) PROVIDERSUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: 345505 B. WING 345505 B. WING	OF DEFICIENCIES [X1] PROVIDERSUPPLIER-LLA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILING (X3) DA COL SPOVIDER OR SUPPLIER 345505 B. WING 07 PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 07 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE FRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PRCVX PRCVDERS PLANO OF CORRECTION (EACH ORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY MUST BE FRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PRCVX PRCVXDERS PLANO OF CORRECTION (EACH ORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY MUST BE AT STATE TAG F 309 Continued From page 17 documented "Trach care provided. Resd (resident) wearing mittens on bilat (bilateral) upper extremities d/f (due to) resident attempting to remove trach. (tracheostomy)will continue to monitor." This note was signed by Nurse # 3. 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If continuation sheet Page 18 of 40

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MI II T	IPLE CONSTRUCTION). 0938-039 TE SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:		NG		MPLETED
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		345505	B. WING			/22/2015
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 / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 309		ge 18 and reported it to her. She staff member then went into	F 30	09		
	another resident ' s came back out of th another nursing ass	room for a brief moment, then hat resident's room and got sistant to assist her with #1. She stated that after the				
	nursing assistants of for a few minutes, t	hen one of the nursing t of the room and ran to get				
	2:40 PM with the nu was assigned to Re interview, she state the resident with he between 12:35 and resident cough. Sh the resident ' s roor okay, and Resident difficulty. NA #1 sta Resident #1's room that she needed to she and another nu entered Resident # the tracheostomy tu resident throat area covered the trached side." She further so one mitten complet	onducted on 07/15/2015 at ursing assistant (NA #1) who esident #1. During the d that the last time she saw er tracheostomy intact was 12:40 PM when she heard the ne explained that she went into m to make certain she was #1 was breathing without ated she went back into n after a visitor had reported be dressed. She stated that ursing assistant (NA #2) 1's room and discovered that ube was not present on the a, and that the mask that ostomy site was "off to the stated that the resident had ely off, and that the other was				
	the resident had blo that the right hand I NA #1 stated she th not breathing, and t to arouse the reside checking for a pulse She stated that she	her left hand. NA #1 stated bod on both of her hands, but had the most blood present. hen realized Resident #1 was that she and NA #2 attempted ent by tapping on her feet, e, and providing a sternal rub. then left the room to get a stated that the nurse did not				

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	CO	MPLETED	
		345505	B. WING		07	C 7/ 22/2015	
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP C		//_	
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	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE	
F 309	#1 during the shift, rounds every 2 hou In an interview with on 06/13/2015, Nur PM, she stated that touch when she en started CPR. Nurs resident with a trac agitated behaviors, in the day room for A progress note da which was signed b following: (Note: documented as a " "Situation lying still, not movin She continuously pulls h at O2 (oxygen) hoo (tracheostomy.) Cl and I had to put mit mid-shift today and (tracheostomy). Sh need it." Assessme breathing, no respon rub. Charge nurse with crash cart, che (cardiopulmonary ru was called and con until EMS (emergen	he should check on Resident but that she usually made her rrs. the nurse who was in charge rse #3, on 07/16/2015 at 1:40 t the resident was cool to tered the resident ' s room and e #3 stated that if she had a heostomy who had restless or she would keep the resident close monitoring. ted 06/13/2015 at 8:32 PM by Nurse #1 documented the This progress note was not Late Entry.") : res (resident) found in bed ng or breathing. Background: her mitts (mittens) off and pulls okup and trach NA (certified nursing assistant) ts (mittens) back on redirect her not to pull at trach he stated, "I don ' t ent: Found laying in bed not onse to verbal cue or sternal was brought into room along est compressions and CPR esuscitation) were began. 911 tinued to stay on phone ncy medical service) arrived. hs and CPR was performed	F3	09			
	A review of the loca	. " al police department Event Log evealed that Resident #1's					

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		AND HUMAN SERVICES				FORM	09/17/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345505	B. WING				C 22/2015
NAME OF	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 Y 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) COMPLETION DATE
F 309	death occurred at 2 s body was release on 06/13/2015. In an interview with on 07/16/2015 at 8: was not acting as th Resident #1 pulled on 06/13/2015, but residents have a ca nursing care with re The Administrator, the facility's consult immediate jeopardy at 2:40 PM. The facility provided allegation on 07/17. Credible Allegation This allegation of co compliance with ap To demonstrate cor applicable law, the the actions set forth compliance. The for constitutes the cent All alleged deficient resolved by the dat How the corrective for those residents by the deficient pra The initial care plan	2:41 PM and that the resident ' ad to the mortuary at 3:15 PM the acting Director of Nursing :50 AM, she stated that she he Director of Nursing when out her tracheostomy and died it was an expectation that are plan to provide direction for esidents with special needs. acting Director of Nursing, and tant nurse were notified of the y in a meeting on 07/16/2015 d the following credible /2015 at 1:09 PM: of Compliance for F 309: ompliance is submitted in plicable law and regulation. ntinuing compliance with center has taken or will take n in the following allegation of plowing credible allegations ter's allegation of compliance. cies have been or will be es indicated. action will be accomplished found to have been affected	F3	309			

If continuation sheet Page 21 of 40

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	CO	MPLETED C
		345505	B. WING		07	//22/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
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	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 309	Continued From pa	-	F 30	9		
	of the current (3) th ensure the Care PI special needs for tr accurate and comp At the time of the a admissions with tra How corrective acti	udit, there were no new icheostomy needs. on will be accomplished for ng potential to be affected by				
	to validate the pres Care Plan for the c residents which ad objectives and inte special needs. On 07/16/15, the M Unit Manager, and education by the Si on the following Pre will be activated up Comprehensive Ca within 7 days of the Comprehensive As be updated by eacl	are plan will be completed e completion of the sessment, the Care Plan will n discipline on an ongoing n the patient occur and				
	educated by the St on the Care Plan p interventions for pa mittens. All Licensed Nursin 07/16/15 will be in-	censed Nursing staff were aff Development Coordinator rocess, objectives, and tients with tracheostomy and og staff not scheduled on serviced by the Staff dinator prior to returning to				

If continuation sheet Page 22 of 40

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION	(X3) DAT	0938-039
ט PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		PLETED
		345505	B. WING			C 22/2045
AME OF F	PROVIDER OR SUPPLIER	0+0000		STREET ADDRESS, CITY, STATE, ZIP CO		22/2015
	NA REHAB CENTER (OF CUMBERLAND		4600 CUMBERLAND ROAD		
				FAYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 309	Continued From pa	ge 22	F 30	9		
	credible allegation	was evidenced via interviews				
		, supervising nurses and other				
		stated they received in-service g the importance of interim				
		initiation of interventions to				
		esidents, as well as the				
		ssing residents for changes in				
F 323	condition. 483.25(h) FREE OI		F 32	23		9/15/15
SS=J	HAZARDS/SUPER		1 52	.0		5/15/15
		sure that the resident ns as free of accident hazards				
		each resident receives on and assistance devices to				
	This REQUIREMEN	NT is not met as evidenced				
	Based on physicial staff interviews, and failed to implement	n interview, visitor interview, d record review, the facility effective interventions nt one of four residents who		The Statements included are admission and do not constitu agreement with the alleged d herein. The plan of correctio	ute eficiencies	
	had a tracheostomy and removing the tr	y, Resident #1, from dislodging acheostomy tube.		completed in the compliance federal regulations as outline in compliance with all federal	of state and d. To remain and state	
	when Nurse #1 fou with her tracheosto	pardy began on 06/13/2015 nd Resident #1 undressed my dislodged completely from fforts to resuscitate her at that		regulations the center has tal take the actions set forth in the plan of correction. How the corrective action will	ne following	
	Jeopardy was remo when the facility pro	ssful. The Immediate oved on 07/17/2015 at 4:05 PM ovided an acceptable credible ance. The facility will remain		accomplished for those resid have been affected by the de practice: ¿ Based on documentation	ficient	

Facility ID: 980423

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	1			<u>MB NO.</u>	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	СОМ	E SURVEY PLETED
		345505	B WING				
		545505	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	07/2	22/2015
	PROVIDER OR SUPPLIER				600 CUMBERLAND ROAD		
CAROLI	NA REHAB CENTER (OF CUMBERLAND			AYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 323	Continued From an		FO	00			
F 323	Continued From pa	-	F 32	23	the design of the second s		
		e potential of no more than			tracheostomy, no changes in inter- were made.	ventions	
	The facility was in t	is not immediate jeopardy (D).				2.15	
		corrective action at that time.			j. On 6/13/2015 at approximately p.m., based on interview with the r		
					and CNA on duty on at the time, R		
	Findings included:				#1 was found to be unresponsive a		
					breathing. CPR was attempted by		
	Resident #1's Disch	harge Summary from a			staff and 911 was called. Upon an	rival,	
		o the facility dated 06/10/2015			EMS team continued CPR efforts	and	
		dent #1 had a discharge			later pronounced at the facility.		
	diagnosis of respira	atory failure, with a			¿ All LPNs and RNs were in-ser		
		ed on 04/29/2015. The same			7/17/2015 regarding Change in Co		
		ry further indicated that the halopathy, and that as a			and Physician Notification utilizing eINTERACT Model. This model	line	
		status waxed and waned.			encompasses recognizing a change	ne	
					reviewing background to clarify ch		
	A review of the adm	nission paperwork which			occurred, denoting assessment ar		
		dent #1 from the hospital			observation and notifying physiciar		
		d FL2 Form dated 06/10/2015			changes to notify of interventions p		
		sident #1 had a tracheostomy			place and further orders the physic	cian	
	with 28% oxygen the wore mittens due to	herapy, and that the resident o her pulling at the			may order.		
	tracheostomy tube.				How the corrective action will be		
					accomplished for those residents I		
		Plan of Care Discharge and			potential to be affected by the sam	ie	
		n the hospital listed a goal to 1's mittens without her			deficient practice	and	
		s or lines, and that a barrier to			¿ All Licensed Practical Nurses Registered Nurses were in-service		
	this goal was that F				7/17/2015 regarding the following		
	tracheostomy.				eINTERACT bullets:		
					1) Recognizing a change in patier	nt status	
	A review of the faci	lity's Nursing Admission			and/or behaviors.		
		06/10/2015 revealed Resident			2) Reviewing patient background	to verify	
		the facility on 06/10/2015 with			change.	5	
		iratory failure and that her level			3) Documenting observation and		
		able to be determined			assessing the patient to identify po	ossible	
		nt was nonverbal. In addition,			causes of changes.		
		ent revealed Resident #1 was			4) Notification of Physician to info		
	liolally dependent u	pon staff assistance for	1		interventions put in place and rece	eive new	

Facility ID: 980423

If continuation sheet Page 24 of 40

			()(0)	TID.			
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION (SURVEY
			A. BUILD	ING		C	
		345505	B. WING				, 2/2015
AME OF F	ROVIDER OR SUPPLIER			_	TREET ADDRESS, CITY, STATE, ZIP CODE	0//2	2/2015
					600 CUMBERLAND ROAD		
	A REHAB CENTER (OF CUMBERLAND			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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 323	Continued From na	ae 24					
1 323	Continued From pa	-	FC	323			
		ig, eating, toilet use, personal ig. Under the category of			orders if Physician deems appropriate.		
		t box documented, "trach			i On 7/16/2015, all residents in ho	ouse	
		line, clean." Under the			on this date with a tracheostomy (3	5450	
		tion of the assessment, the			residents with tracheostomies) were	<u>,</u>	
		nented as having an unsteady			reviewed for trach care orders, care		
	gait and poor balan				and interventions by the Staff	• *	
					Development Coordinator and Unit		
	A review of the facil	lity's Device Assessment dated			Managers. All were validated and in	า	
		d that "Mittens" were not			place.		
	marked as present	on the assessment.			¿ MDS Coordinators and Unit Mar		
					were in-serviced by the Staff Develo		
		ress notes revealed there was			Coordinator 7/17/2015 on initiating t		
		admission on 06/10/2015 at			care plan at admission. As a routine		
		ed, "O2 (oxygen) at 4 LPM ia trach (tracheostomy) collar.			practice, the Director of Nursing, Sta Development Coordinator and/or Ur		
		abored. Skin warm and dry.			Managers will review all new admiss		
		and with assist $x = 1$ (with the			with tracheostomies and/or mittens		
		taff member.) Ambulates with			next business day to ensure that the		
		assistance of one staff			and/or mittens have been care plan		
		d with mittens on both hands			and that all special needs have beer		
	" This progress n	note was signed by Nurse #2.			addressed. Care plans of the remain	ining	
					three tracheostomy patients were		
		onducted with Nurse #2 on			reviewed and updated to reflect, the	•	
		PM. Nurse #2 stated that she			medical and nursing objectives for		
		worked with Resident #1 on			tracheostomies. ¿ All Licensed Practical Nurses ar	ad	
		mitted to the facility on at the resident was wearing			¿ All Licensed Practical Nurses ar Registered Nurses were in-serviced		
		ad been given to her by the			7/16/2015 regarding the Documenta		
		stated that right after			and Notification policy, which states		
		e was on duty, Resident #1			Charge Nurse is responsible for noti		
		ed. She explained that she			the Physician and or the Responsibl		
		the day room during the day			Party whenever there is a change re		
		ecause when she was around			to the care of the patient with a		
		id not try to get up unassisted.			tracheostomy exhibiting intolerance	for	
		d that she was monitored by			the tracheostomy tube.		
		s when she was in her / room. Nurse #2 stated that			All Licensed Practical Nurses and Registered Nurses not scheduled or		

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(Y2) MILLIT	гірі	E CONSTRUCTION	MB NO.	E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
							C
		345505	B. WING				22/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				4	600 CUMBERLAND ROAD		
CARULI	NA REHAB CENTER (OF COMBERLAND		F	AYETTEVILLE, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 323	Continued From pa	nge 25	F 32	23			
. 020		ad not ever seen the resident	1.5/	20	returning to work.		
		tomy strap. Nurse #2 also			i. On 7/16/2015, all Certified Nur	ses	
		s not even sure that the mittens			Assistants were in-serviced on not		
		venting the resident from			the charge nurse of change in resi		
		eostomy because the resident			condition, using the clinical alerts in		
	-	capable of removing the			electronic medical record system a		
	mittens.				verbally. Any Certified Nurses Ass not scheduled on 07/16/2015 will b		
	In an interview with	the Minimum Data Set (MDS)			in-serviced prior to returning to wo	-	
		nsible for writing care plans)			in-serviced prior to returning to wo	κ.	
	· ·	:35 PM, she stated that from			Measures put into place to ensure	that the	
		on on 06/10/2015, Resident #1			deficient practice will not occur:		
		restless behaviors and that					
		acheostomy. In addition, she			Daily Monday-Friday X (4) weeks a		
		as a concern among the			weekly X 4 weeks the Director of N		
	behavior and attem	ling Resident #1's restless			and or designee will conduct an au Behavior and Progress note		
		that this was discussed in			documentation on tracheostomy pa	atients	
		ciplinary meeting and also on			for reporting, notification, and upda		
		MDS nurse stated she could			interventions to prevent de-cannula		
		date and time of the			Director of Nursing and or designe		
		eting, but that usually the			conduct daily Monday through Frid		
		d on Thursday mornings, and			audits X (4) four weeks of the Poin		
		n 06/11/2015. She further is "common knowledge" that			Care documentation Change in Co alerts for tracheostomy patients for		
		off her mittens frequently, and			reporting, notification, and updated		
		ussion about contacting the			interventions to prevent de-cannula		
		tting a medication for agitation			Director of Nursing and or designe		
	control.				conduct daily Monday through Frid		
					four CNA interviews X (4) four wee		
		sician's orders revealed an			ensure understanding and docume		
		2015 for "mittens to both hands			of eInteract Change in Condition a	iens	
		" (tracheostomy.) There were orders regarding the			entry. New hire Licensed nurses will be		
		r restlessness or agitation.			in-serviced during orientation rega	rdina	
					the Documentation and Notification		
	In an interview with	Resident #1's physician on			which states the Charge Nurse is	· - , ,	
		PM, he stated that in his			responsible for notifying the Physic		
	History and Physica	al dated 06/11/2015, he did not			or the Responsible Party wheneve	r there	

		& MEDICAID SERVICES			OMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	СОМ	E SURVEY PLETED
		345505	B. WING			C 22/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT		22/2015
				4600 CUMBERLAND ROAD		
ARULII	NA REHAB CENTER (JF CUMBERLAND		FAYETTEVILLE, NC 2830	06	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	I OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETIC DATE
F 323	Continued From pa	ae 26	F 32	3		
. 020		ve behavioral problems	1 52		the care of the	
		eostomy, such as pulling at		is a change related to patient with a trached		
		ubing or device, because she		intolerance for the tra		
		behaviors at that time and he		New hire Certified Nu		
	had not received re	ports of such behavior. The		be in-serviced during		
		at he knew that the resident		notifying the charge r		
		admission to the facility due to		resident condition, us		
		ulling at the tracheostomy, and		in the electronic med	ical record system	
		der for the mittens on		and verbally.	Janth Canalina Inc	
		hysician stated he did not		Medical Facilities of N with the assistance o		
i		from a staff member regarding ors such as pulling at her		Consultants shall cor		
		ring to get out of bed. The		analysis regarding the		
		ed that he did receive a call		history beginning July		
		er after Resident #1 had		cause analysis shall		
	expired on 06/13/20	015 around mid-afternoon.		changes needed to for		
				compliance rather that		
		ata Set (MDS) 5-Day		with the Requirement		
		06/13/2015, Resident #1		copy of the root caus		
		vioral symptoms, no rejection Indering behaviors. There was		provided to CMS and		
		functional impairment for		September 21st, 201 the systemic changes		
		here were no restraints		facility to foster a cult		
	checked for the res			safety with a particula		
				centered care shall b		
		ted 06/13/2015 at 12:37 AM		and the State monthl	y for six months. The	
		dent able to verbalize needs to			ill be responsible and	
		observed several times during		accountable for the p		
		ens and grabbing at trach		care, treatment and s	services.	
		esident alert x 2 (oriented to		How the facility plane	to monitor and	
	was signed by Nurs	confusion noted." This note		How the facility plans ensure correction is a		
				sustained		
	In a telephone inter	view with Nurse #7 on		The Director of Nursi	ng will report the	
		PM, she stated that she		results of the audits v		
	actually worked on	the 3:00 PM to 11:00 PM shift		in the Weekly Quality	assurance Risk	
		that she stayed after her shift		Meeting for problem		
		o document in the progress		The Administrator wil		
	notes. She stated f	that she could not recall many	ĺ.	the audits to the quar	terly ()uality	1

		& MEDICAID SERVICES	1			<u>OMB NO.</u>	APPROVE 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				· · /	E SURVEY PLETED
		345505	B. WING				0
	PROVIDER OR SUPPLIER	343505	B. WING_		EET ADDRESS, CITY, STATE, ZIP CODE	07/2	22/2015
					0 CUMBERLAND ROAD		
CAROLI	NA REHAB CENTER (OF CUMBERLAND			ETTEVILLE, 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 323	•••••••••••••••••••••••••••••••	-	F 32			_	
	progress note on 00 documented that the pulling on her trach happened. Nurse # sitting in the day roo her 3:00 PM to 11:0 received a report fr the resident 's nee kept Resident #1 se with her family mem her. Nurse #7 state Resident #1 pulling her tracheostomy to family member left that Resident #1 be her family member she went to her and explained to her wh Nurse #7 explained calm down after sh mittens to her. She whether the resider her mittens or pull a before then. In add aware of any other address restless be tracheostomy tube. A progress noted d documented "tra (resident) wearing r upper extremities d to remove trach. (tr monitor." This prog Nurse # 3.	ated 06/13/2015 at 1:51 AM ch care provided. Resd mittens on bilat (bilateral) //t (due to) resident attempting racheostomy)will continue to gress note was signed by		t Mv s r t a c c v c r r t s c c r r r r r f r	Assurance meeting X (2) quarter tracking and trending of compliar Medical Facilities of North Carolin with the assistance of RS Conne shall conduct a root cause analys regarding the facilities survey his beginning July 1, 2011. The root analysis shall specify the system changes needed to foster sustain compliance rather than cyclic cor with the Requirements of Particip copy of the root cause analysis s proved to CMS and the State. A report of the systemic changes in the facility to foster a culture of q safety with a particular focus on r centered care. Reports will be pi CMS and the State monthly for s months. The Director of Nursing responsible and accountable for provision of quality care, treatme services.	ace. ha, Inc., ction, Inc sis tory cause c hed npliance hation. A hall be written itiated in uality and esident rovided to x will be the	
		Nurse #1 on 07/16/2015 at 1 stated that she was assigned					

If continuation sheet Page 28 of 40

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION). 0938-039 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		MPLETED
		345505	B. WING		07	C // 22/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
CAROLI	NA REHAB CENTER (OF CUMBERLAND				
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 323	to Resident #1 for j and that she receiv shift 's nurse who i needed the mittens her tracheostomy s had no knowledge being used to keep her tracheostomy of frequently, at least In an interview with on 07/16/2015 at 33 Resident #1 had de capable of removin mittens were not co She added that the restraint-free facility chemical restraints circumstances for a An interview was co 11:03 AM with the Resident #1 undres the interview, she s the resident on 06/7 The visitor stated th the resident's room wearing no gown of that she had not star resident was as she did not want to she backed out of t a staff member that dressed. The visitor Resident #1 neede	ust one day on 06/13/2015 ed a report from the previous nformed her that the resident to keep her from pulling at ite. Nurse #1 explained she of any other interventions Resident #1 from pulling at other than checking on her	F 32			

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	OF DEFICIENCIES	& MEDICAID SERVICES	(Y2) MILLIT	IPLE CONSTRUCTION		TE SURVEY	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		NG		MPLETED	
						С	
		345505	B. WING		07	/22/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC			
CAROLI	NA REHAB CENTER (OF CUMBERLAND		4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 323	member in the hall explained that the s another resident's r came back out of th another nursing assistants dressing Resident # nursing assistants c for a few minutes, t assistants came out another nurse. In an interview with assistant (NA #1) o stated that when sh #1 on 06/13/2015 b she found that Resi mittens. She expla nurse, Nurse #1, if the mittens all the ti stated that Nurse # to wear the mittens pulling at her trache to the resident's root the nurse's direction stated that the last her tracheostomy in 12:40 PM when she She explained that room to make certa Resident #1 was br #1 stated she went room after a visitor unclothed and need that she and anothe entered Resident # the tracheostomy tu	and reported it to her. She staff member then went into room for a brief moment, then nat resident 's room and got sistant to assist her with #1. She stated that after the entered the room, they stayed hen one of the nursing it of the room and ran to get Resident #1's nursing n 07/15/2015 at 2:40 PM, she he went to check on Resident between 8:00 Am and 9:00 AM, ident #1 was not wearing her ined she then went to ask the the resident needed to wear ime. The nursing assistant 1 told her the resident needed all the time to keep her from eostomy tube, so she returned om and applied the mittens per n. During the interview, she time she saw the resident with ntact was between 12:35 and e heard the resident cough. she went into the resident 's ain she was okay, and reathing without difficulty. NA back into Resident #1 's had reported that she was ded to be dressed. She stated er nursing assistant (NA #2) 1's room and discovered that ube was not present on the a, and that the mask that		23			

Facility ID: 980423

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STATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED	
		345505	B. WING		07	C / 22/2015	
	PROVIDER OR SUPPLIER	OF CUMBERLAND		STREET ADDRESS, CITY, STATE, ZIP COE 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
F 323	partially in place on the resident had blo that the right hand h NA #1 stated she th not breathing, and t to arouse the reside checking for a pulse She stated that she nurse. NA #1 also tell her how often sl #1 during the shift, rounds every 2 hou In an interview with on 06/13/2015, Nur PM, she stated that touch when she end started CPR. Nurse resident with a track agitated behaviors, in the day room for stated that if the res the tracheostomy tu effectively, she wou consider a possible preventing self-harr In an interview with 1:40 PM, she stated restless behaviors of tube, she would kee perhaps in the day station. Nurse #3 a behaviors or pulling could not be contro contact the physicia	ely off, and that the other was her left hand. NA #1 stated ood on both of her hands, but had the most blood present. hen realized Resident #1 was that she and NA #2 attempted ent by tapping on her feet, e, and providing a sternal rub. then left the room to get a stated that the nurse did not he should check on Resident but that she usually made her rs. the nurse who was in charge se #3, on 07/16/2015 at 1:40 the resident was cool to tered the resident's room and e #3 stated that if she had a heostomy who had restless or she would keep the resident close monitoring. She also stless behaviors or pulling at ubing could not be controlled ild contact the physician to medication to assist with	F 3.	23			

Facility ID: 980423

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		AND HUMAN SERVICES				FORM	09/17/2015 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 22/2015
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CAROLI	NA REHAB CENTER (OF CUMBERLAND			000 CUMBERLAND ROAD AYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323		ge 31 ted 06/13/2015 at 8:32 PM	F 32	23			
	which was signed b	by Nurse #1 documented the his progress note was not was					
		: res (resident) found in bed ng or breathing. Background:					
	continuously pulls h at O2 (oxygen) hoo (tracheostomy.)CN	A (certified nursing assistant)					
	mid-shift today and (tracheostomy). Sh need it." Assessme	ent: Found laying in bed not					
	rub. Charge nurse with crash cart, che (cardiopulmonary re	onse to verbal cue or sternal was brought into room along est compressions and CPR esuscitation) were began. 911					
	until EMS (emerger	tinued to stay on phone ncy medical service) arrived. is and CPR was performed . "					
	Log dated 06/13/20 death occurred at 2	al police department's Event 15 revealed that Resident #1's 2:41 PM and that the resident's to the mortuary at 3:15 PM on					
	the facility's consult	acting Director of Nursing, and ant nurse were notified of the y in a meeting on 07/16/2015					
	The facility provided allegation on 07/17	d the following credible /2015 at 1:40 PM:					

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						<u>). 0938-039</u> TE SUDVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED
						С
		345505	B. WING _		07	//22/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
CAROLI	NA REHAB CENTER (OF CUMBERLAND				
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLET	
F 323	This allegation of or compliance with ap To demonstrate cor applicable law, the the actions set forth compliance. The for constitutes the cent All alleged deficient resolved by the dat How the corrective for those residents by the deficient pra Based on docu resident #1 to remo- in interventions wer On 6/13/2015 a based on interview duty on at the time, unresponsive and r attempted by facility Upon arrival, EMS and later pronounce All LPNs ar 7/17/2015 regarding Physician Notifica Model. This model change, reviewi change occurred, d observation and changes to notify of further orders the How corrective actif those resident having the same deficient	ompliance is submitted in plicable law and regulation. ntinuing compliance with center has taken or will take n in the following allegation of ollowing credible allegations ter's allegation of compliance. cies have been or will be es indicated. action will be accomplished found to have been affected ctice: mentation, after attempts by ove tracheostomy, no changes re made. at approximately 2:15 p.m., with the nurse and CNA on Resident #1 was found to be not breathing. CPR was y staff and 911 was called. team continued CPR efforts ed at the facility. nd RNs were in-serviced on g Change in Condition and ation utilizing the eINTERACT encompasses recognizing a ng background to clarify lenoting assessment and/or notifying physician of f interventions put in place and physician may order.	F 32	23		

Facility ID: 980423

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 09/17/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		345505	B. WING				C 22/2015
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLII	NA REHAB CENTER (OF CUMBERLAND			600 CUMBERLAND ROAD AYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	were reviewed for the and interventions by Coordinator and Un- validated and in pla MDS Coordinate in-serviced by the S 7/17/2015 on initiate As a routine practic Staff Development Managers will revier trachs and/or mitter ensure that the trace care planned and the been addressed. All Licensed Pra- the Documentation states the Charge N notifying the Physic Party whenever the care of the patient. All Licensed Practic Nurses not schedul in-serviced prior to On 7/16/2015, a were in-serviced on change in resident of alerts in the electron verbally. Any Certiff scheduled on 07/16 to returning to work On 07/17/2015 at 3 credible allegation of with unit managers, licensed staff who se	rach care orders, care plans, y the Staff Development it Managers. All were ce. ors and Unit Managers were staff Development Coordinator ing the care plan at admission. e, the Director of Nursing, Coordinator and/or Unit w all new admissions with ns on the next business day to h and/or mittens have been nat all special needs have actical Nurses and Registered viced on 7/16/2015 regarding and Notification policy, which Nurse is responsible for ian and or the Responsible re is a change related to the cal Nurses and Registered ed on 07/16/2015 will be returning to work. all Certified Nurses Assistants notifying the charge nurse of condition, using the clinical nic medical record system and ied Nurses Assistants not 6/2015 will be in-serviced prior	F 3	23			

Facility ID: 980423

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION		E SURVEY	
ID PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		IPLETED	
		345505	B. WING			C /22/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		22/2015	
	NA REHAB CENTER (OF CUMBERLAND		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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 323	prevent accidents for tracheostomies, su	-	F 3	23			
F 328 SS=D	483.25(k) TREATM NEEDS	ENT/CARE FOR SPECIAL	F 3	28		8/10/15	
	special services: Injections; Parenteral and enter Colostomy, uretero Tracheostomy care Tracheal suctioning Respiratory care; Foot care; and Prostheses.	stomy, or ileostomy care; ;					
	by: Based on staff inter facility failed to con continuous positive machine which resu- rates for 1 of 6 sam receiving respirator A 07/08/15 hospital documented Reside discharge were "ac failure, multifactoria failure and history of pneumonia." The s "He is on 2 liters (or	NT is not met as evidenced rview and record review the nect continuous oxygen into a airway pressure (CPAP) ulted in low oxygen saturation upled residents (Resident #6) y care. Findings included: discharge summary ent #6's principle diagnoses on ute on chronic respiratory al, secondary to chronic heart of lung cancer, and right- sided summary also documented, xygen) via nasal cannulaHe avenous antibiotics for possible		The Statements included admission and do not col agreement with the alleg herein. The plan of correc completed in the complia federal regulations as ou in compliance with all feo regulations the center ha take the actions set forth plan of corrective action accomplished for those r have been affected by th practice:	nstitute ed deficiencies ection is ince of state and tlined. To remain leral and state s taken or will in the following n will be esidents found to		

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	OMB NO. (X3) DATE	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		PLETED
						2
		345505	B. WING			22/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
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	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 328	Continued From pa	ge 35	F 32	28		
	airway pressure (Bi	iPAP) at night. During the day BiPAPI talked to the		Rehab Center of Cumberland	1.	
	respiratory therapist and the patient can use continuous positive airway pressure (CPAP) at night." 07/08/15 hospital discharge instructions			How corrective action will be accomplished for those resid potential to be affected by the deficient practice: Licensed nurses were in-serv	e same	
	documented, "CPAP at night." Resident #6 was admitted to the facility on 07/09/15. His documented diagnoses included lung cancer, chronic obstructive pulmonary disease (COPD), and pneumonia.		Nursing Policies and Procedu Respiratory Care, Respirator Equipment, which states, ¿ Li nurses will administer and ma respiratory equipment, oxyge	y/Oxygen censed aintain n		
	documented Reside	Admission Assessment ent #6 was alert and oriented ne, and situation, and his		administration, and oxygen e physician¿s order and in acc standards of practice¿.		
	documented the re- of breath upon exe	t. The assessment also sident experienced shortness rtion, and fine crackles were al lower lobes of his lungs.		Measures put into place to en deficient practice will not occ Daily Monday-Friday X (2) tw weekly X 2 weeks the Directo and or designee will conduct	ur: o weeks and or of Nursing	
	07/09/15 included u liters of continuous	tting orders to the facility on use of CPAP at night and 2 oxygen via nasal cannula.		with CPAP Oxygen connection proper oxygenation per physic and in accordance with stand New hire Licensed Nurses with	cian¿s order Is of practice. Il receive	
	Resident #6 was al person/place/time,	I progress note documented ert and oriented to and was verbal with clear ations were documented as		education during orientation of Policies and Procedures #27 Respiratory Care, Respirator Equipment, which states,¿ Li	01, y/Oxygen	
	even with shortness exercise. The resid pursed breathing, a	s of breath upon exertion or dent was educated on lip and his oxygen saturation was f oxygen per minute.		nurses will administer and ma respiratory equipment, oxyge administration, and oxygen e physician¿s order and in acc standards of practice.	aintain n quipment per	
	(NA) informed her t Resident #6 on the	ess note Nurse #4 00 PM a nursing assistant that she (the NA) placed CPAP per family request e) was involved in completing		How the facility plans to mon ensure correction is achieved sustained:		

	-	AND HUMAN SERVICES				FORM	09/17/201 APPROVE 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345505		· · ·	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		B. WING			C 07/22/2015			
NAME OF PROVIDER OR SUPPLIER CAROLINA REHAB CENTER OF CUMBERLAND				40	TREET ADDRESS, CITY, STATE, ZIP CODE 600 CUMBERLAND ROAD AYETTEVILLE, NC 28306	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 328	a wound treatment. documented a fami #6 was short of bre saturation was 78% reported she remov oxygen via the nase oxygen saturation of According to Nurse questioned why the the CPAP. The NA the resident's CPAF oxygenation. Nurse familiar with the spe being utilized for Re instruction manual, "T-connector" was continuous oxygen oxygen was connee "T-connector" the n resident's oxygen s %. A 07/10/15 2:40 AM Resident #6's oxyg oxygen and the CP On 07/10/15 Reside "The resident has a status/difficulty brea as a problem. Goa "The resident will h symptoms) of poor review date. The re breathing pattern a respirations, norma respiratory rate/patt The resident will ha SOB (shortness of	At 10:15 PM Nurse #4 ily member reported Resident ath, and the resident's oxygen owith the CPAP running. She yed the CPAP, and began al cannula, with the resident's climbing to 93 - 95%. #4, the family member e oxygen was not hooked into a stated connecting oxygen into P was not necessary for proper e #4 documented she was not ecific type of CPAP machine esident #6 so she located the and discovered that a to be used to feed the into the CPAP. Once the cted to the CPAP via the surse documented the aturation rates were 93 - 96 A progress note documented en saturation was 93% with AP in place.	F 3	28	The Director of Nursing will report to results of the audits weekly x (1) m the Weekly Risk Meeting for proble resolution. The Administrator will report the rest the audits to the quarterly Quality Assurance Meeting X (1) quarter for tracking and trending of compliance	onth in m sults of or		

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345505		(X2) MULTIPLE CONSTRUCTION A. BUILDING			X3) DATE SURVEY COMPLETED	
			A. BUILDIN		С	
	NAME OF PROVIDER OR SUPPLIER		B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	07/22/201	
	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	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE
F 328	"Correct CPAP usa changes in orientat anxiety, and air hur A late-entry progres documented Nurse oxygen saturation r complained of the r of breath. The CPA pillow next to the re- treatment was prov the CPAP was appl gradually reaching the family complain applied correctly, a the family's departu- saturation was up t A 07/11/15 12:39 P Nurse #3, a unit ma members of Reside comfortable keepin since the resident's very low the past tw documented the re- the nursing home a At 2:10 PM on 07/1 interviewed the sec Resident #6 on 07/ resident was discha 07/11/15 with comp how to feed oxyger She reported Nurse worked with continu- with CPAP usage I instruction manual reported she had w	ge" and "Monitor/document ion, increased restless, nger." as note for 7/10/15 at 8:40 PM #5 found Resident #6's rate to be 64% after family resident being extremely short AP mask was found on the esident's face. A nebulizer rided to help oxygen flow and lied, with the oxygen saturation 87%. According to the note, ned that the CPAP was not nd Nurse #6 intervened. Upon ure the resident's oxygen	F 32			

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				T1-			0938-039	
AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345505		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
			A. DOILD				С	
		B. WING			07/22/2015			
NAME OF I	PROVIDER OR SUPPLIER	•		ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
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 PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE	
F 328	feed into the CPAP informed Nurse #5 referred her to the of Nurse #3 stated no feed oxygen into Ro nights of 07/09/15 a resident's low oxyg to Nurse #3, she wa facility-wide educat oxygen in conjuncti At 4:50 PM on 07/1 Nurse #5 was no lo and multiple attemp unsuccessful. At 5:25 PM on 07/1 was supposed to a night of 07/09/15 th CPAP because she out the nurse (Nurs multi-tasking. Accor realized when revie and CPAP connect thought controlled t concentrator actual level. This nurse sta working on 07/09/1 way Resident #6's of there was no in-ser which informed the achieve maximum was receiving conti services. At 9:38 AM on 07/1	 According to Nurse #3, she that she was incorrect, and CPAP instruction manual. t using the "T-connector" to esident #6's CPAP on the and 07/10/15 contributed to the en saturation rates. According as not aware of any ion about utilizing continuous on with CPAP therapy. 6/15 the administrator stated onger employed by the facility, ots to reach her by phone were 6/15 Nurse #4 stated a nurse pply the CPAP, but on the he NA applied Resident #6's e (the NA) was trying to help se #4) who was already ording to Nurse #4, she also ewing Resident #6's oxygen ion that the dial which the staff the liters of oxygen on the liters of oxygen on the liters of oxygen on the section about the oxygen fed into his CPAP, but vicing following this incident rest of the staff about how to oxygenation when a resident nuous oxygen and CPAP 7/15 the interim director of 		328	3			
	nursing (DON) and (SDC) stated there	staff development coordinator was no facility-wide CPAP/oxygen usage as of yet,						

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CENTERS FOR MEDICARE & MEDICAID SERVICES ITATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345505		(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED C	
		B. WING		07	07/22/2015	
	PROVIDER OR SUPPLIER	DF CUMBERLAND		STREET ADDRESS, CITY, STATE, ZIP 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE
F 328	building utilizing a C At 9:52 AM on 07/1 interview, Nurse #6 intervened to help N from the family of F family was upset, s evening in a row the saturation was very did not know how to oxygenated while o explained that Nurs think the resident's and the family repo night before which a oxygen was fed into "T-connector". Acc alleged Resident #6 when they found his commented when s intervening on 07/1 and his lips were pi oxygen was connect the nurse reported saturation was up a stated there had be about how to keep	esidents currently in the CPAP machine. 7/15, during a telephone stated on 07/10/15 she Nurse #5 resolve grievances Resident #6. She reported the aying this was the second at the resident's oxygen o low. They alleged the staff o keep the resident n his CPAP. Nurse #6 se #5 was saying she did not oxygen fed into the CPAP, rted instructions were read the specified that continuous	F 3			

Facility ID: 980423

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