PRINTED: 11/13/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345376	B. WING		C <b>09/27/2017</b>
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  2461 LEGION ROAD  FAYETTEVILLE, NC 28306	1 09/2//2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
F 000	INITIAL COMMENTS	3	F 00	0	
F 157 SS=D	new complaint investi two day complaint ca 9/20/17 and conclude activity was combined 483.10(g)(14) NOTIF (INJURY/DECLINE/R	Y OF CHANGES ROOM, ETC)	F 15	7	11/5/17
	consult with the resid	nediately inform the resident; ent's physician; and notify, her authority, the resident			
		ving the resident which as the potential for requiring n;			
	mental, or psychosoc deterioration in health	n, mental, or psychosocial reatening conditions or			
	a need to discontinue	erse consequences, or to			
	(D) A decision to tran resident from the faci §483.15(c)(1)(ii).				
	(14)(i) of this section,	fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2)			
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	L	TITLE	(X6) DATE

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

10/20/2017

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

**Electronically Signed** 

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		ATE SURVEY OMPLETED
		345376	B. WING _			C 09/27/2017
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2461 LEGION ROAD FAYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C  (EACH CORRECTIVE ACTIC  CROSS-REFERENCED TO TH  DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 157	physician.  (iii) The facility must resident and the res when there is-  (A) A change in roor as specified in §483  (B) A change in resid State law or regulation (e)(10) of this section (iv) The facility must update the address phone number of the This REQUIREMENT by:	also promptly notify the dent representative, if any, or roommate assignment 10(e)(6); or dent rights under Federal or ons as specified in paragraph	F	157		
	physician 's intervie the physician and th and bruises for 1 of (Resident #45).  The findings include  Resident #45 was at 6/30/16 and had a d infarction (MI or hea pacemaker and dem The Care Area Asse Status dated 5/23/17 but at times confuse for Falls noted the re she was not always transfers/ambulation	ws, facility staff failed to notify e Responsible Party of a fall foresidents reviewed for falls  d: dmitted to the facility on fagnosis of myocardial rt attack)) atrial fibrillation, fientia.  ssment (CAA) for Cognitive r noted the resident was alert d and disoriented. The CAA esident was at risk for falls as		The Resident Representative Barber and physician for Rewas notified of the Resident fall and bruises on 09/22/20 of Nursing, with documentat notification in the clinical recis no longer employed at the On 9/26/2017 Nurse's Progrand Risk Management Repoy1/2017 to 9/25/2017 were All Residents to include Resensure the physician and ReRepresentative had been not documented changes in continclude falls and bruises. All areas of concern were addrefacility Nurse Consultant on notification to the physician arepresentative and documented changes in continclude falls and bruises.	sident #45 sustaining a 17 by Director ion of the ord. Nurse #4 e facility. ress Notes orts from reviewed for ident #45 to esident otified of all idition, to identified essed by the 9/26/17with and Resident	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY IPLETED	
		345376	B. WING			C
NAME OF D	20VIDED OD CUIDDUED	343376	B: WING_	CTDEET ADDRESS CITY STATE 71D CC	•	9/27/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
CUMBERI	AND NURSING AND	REHABILITATION CENTER		2461 LEGION ROAD		
				FAYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 157	Continued From p	age 2	F 1	57		
F 157	post hospitalization acute inferior MI. The was started on an Antiplatelet medic decrease the clumand inhibit the form. The most recent Massessment (Quaresident #45 had was independent required limited as a. On 9/22/17 at 9 (roommate of Reshad fallen the Thu (8/31/17) and the (9/7/17). The Roof #45 fell she rang had who came in and grown across who came in and grown 8/24/17 through the commentation of On 9/22/17 at 10:4 #7 stated in an intifall but the resider #45 had fallen. The alert, oriented and On 9/22/17 at 10:5 Resident #45 had fallen.	n and was found to have an The CAA revealed the resident tiplatelet therapy at that time. ations are a class of drugs that uping of platelets in the blood mation of blood clots.  Minimum Data Set (MDS) rterly) dated 7/17/17 revealed severe cognitive impairment, with transfers and toileting and esistance with ambulation.  30 AM, Resident #21 ident #45) stated Resident #45 rsday before Labor Day Thursday after Labor Day mmate stated when Resident her call bell to notify the staff got her up.  se 's notes for Resident #45 ugh 9/22/17 revealed no falls or bruises.  49 AM, NA (nursing assistant) erview she was not aware of a at 's roommate said Resident e NA stated Resident #21 was	F 1	notification in the clinical recall license nurses and Nursii (NAs) to include NA #7 and interviewed by the Staff Fact 10/25/2017 with questions to Are you aware of any reside within the past 3 months? If when, and who did you repeassessment will be complete notification to the physician Representative with docume clinical record by the Director by 11/05/2017, for any ident unreported resident falls. A toe assessment was complete 9/21/2017 by the Treatment Treatment Aide to identify an ensure that the physician ar Representative had been not bruise. Notification to the physician to the physician resident Representative will documentation in the clinical completed by the Director of 11/05/2017, for any identifie bruises.  100% in-servicing was initial 10/4/2017 and will be completed by the Staff Facilitat Nursing assistants to include NA #5, regarding immediate acute changes in condition the and bruises to the nurse. All nursing assistants will received service during orientation by Facilitator.	ng assistants NA #5, will be illitator by o include: 1. ents' falling yes, who, ort it to? An ed and and Resident entation in the or of Nursing iffied 100% head to eted on nurse and ny bruises and nd Resident otified of the hysician and th all record will be f Nursing by d unreported ted on leted by or with all e NA #7 and ely reporting to include falls I newly hired we the in	
	the fall. The NA fu bruises which she	d the resident to get up after rther stated the resident had had reported to a nurse but e name of the nurse she told.		100% In-servicing was initia 9/252017 and will be comple 11/05/2017 by Staff Facilitat license nurses to include the	eted by or with all	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					
		345376	B. WING				27/2047
NAME OF D	ROVIDER OR SUPPLIER	0.0070			TREET ADDRESS, CITY, STATE, ZIP CODE	09/	27/2017
NAME OF FI	NOVIDER OR SUFFLIER						
CUMBERL	AND NURSING AND RE	HABILITATION CENTER			461 LEGION ROAD		
				F	AYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157	Continued From page	e 3	F ′	157			
F 197	On 9/22/17 at 11:15 A made of the resident resident was observe that mostly covered to quarter sized bruise juround bluish colored inches in diameter on a purple bruise at the that was approximate inches wide with slight.  On 9/22/17 at 12:14 If there had been no refor Resident #45. The they discussed falls in and there had been no resident.  On 9/22/17 at 3:40 Pl conducted with the new worked Monday through the Supervisor state member that Resident The Supervisor state member should have Supervisor further state done an assessment, Improvement) documprogress notes and in family.  On 9/22/17 at 4:01 Pl conducted with the acconsultant #2. The A	AM an observation was a straight shows a sust below the left knee, a bruise approximately 1.5 at the right lower buttock and base of the right little toe by 2.5 inches long and 1.5 at swelling.  PM the Administrator stated ports of a fall or of bruises and Administrator further stated and their morning meetings to reports of falls for this.  M an interview was cursing supervisor that agh Friday on the 7 AM to 3 isor stated none of the staff at #45 had a fall or bruises. It is the roommate told a staff at #45 had fallen the staff reported it immediately. The sted the nurse should have a initiated the QI (Quality ent related to falls in the otified the physician and the M an interview was dministrator and Nurse dministrator stated the NAs		157	supervisor regarding notification of the physician and Resident Representative acute changes in condition to include fand bruises with documentation of the notification in the clinical records. All newly hired License Nurses will receive the in service during orientation by the Staff Facilitator.  Nurse's Progress Notes and Risk Management Reports will be reviewed All Residents to include Resident #45, weekly x 8 weeks then monthly x 1 mo to ensure that the physician and reside representative was notified immediately all identified acute changes in condition include falls and bruises utilizing an Ac Change Notification QI Audit Tool by St Facilitator. Notification to the physician and Resident Representative with documentation in the clinical record an re training with the license nurse, will be completed by the Staff Facilitator/Quali Improvement Nurse during the audit, for any identified areas of concern. The Director of Nursing will review and initiate the Acute Change Notification QI Audit Tool weekly for 8 weeks then monthly for 1 month for completion and to ensure a areas of concern are addressed. The Director of Nursing will forward the results of the Acute Change notification Audit Tools to the Executive QI Commitmentally x 3 months. The Executive QI Commitmentally x 3 months and review the Acute Change Notification QI Audit Tools to determine trends and issues that may need further interventic	for nth nt y of n to ute saff de entry or all son / or	
	were supposed to rep	port any bruises to the nurse. ther stated if someone told a fallen but did not know			issues that may need further intervention put into place and to determine the need for further and / or frequency of	ons	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		(X3) DATE SURVEY COMPLETED		
		345376	B. WING _				C <b>27/2017</b>
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 03/	2112011
CUMBERL	AND NURSING AND RE	HABILITATION CENTER			61 LEGION 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	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 157	Continued From page	: 4	F 1	57			
	when, the nurse shou so it could be investig	ld report it to administration ated.			monitoring.		
	the physician were ob- assessment for Resid stated he did not find get an X-ray of the rig On 9/22/17 at 5:55 Pt interview that Resider 2-2 ½ weeks ago. The told her she did not hi the resident 's vital si an assessment and the to the right arm that s dressing on it. The nu- document the fall as s and had planned to de- must have forgotten. not report the fall to the thought she told the no- On 9/22/17 at 6:23 Pt stated in an interview not say anything to hi a fall. After examining the Physician stated to	ent #45. The Physician any major injury but would the foot.  M, Nurse #4 stated in an ant #45 did have a fall about the Nurse stated the resident there head and she checked gns which were OK and did the only injury was a skin tear the cleaned and put a clear tree stated she did not she was in a hurry to leave to be comment it the next day but the Nurse stated she did the on-coming nurse but the practitioner.  M, the resident 's Physician the nurse practitioner did m about the resident having the resident did have bruises attiplatelet medication),					
		he Nurse Practitioner stated one of the staff had reported 45 had fallen.					
	-	port of the right foot for /22/17 was negative for .					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345376	B. WING _			C 9/27/2017	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 2461 LEGION ROAD FAYETTEVILLE, NC 28306		3/2//2017	
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F 157	stated in an intervier about the fall she was in the build action would depend whether the fall was whether or not the reach they were checks and monitor found but she might hospital depending to b. On 9/22/17 at 12: conducted with a fair resident 's clinical resident 's clinical resident 's in the facility last Sa roommate told her therefore there head. The family resident had a lot of stated no one from to or bruises.  On 9/22/17 at 1:02 is conducted with the interview of the facility laroommate told them and hit her head. The facility called to notificated with the interview of the facility called to notificated with the interview of the facility called to notificated with the interview of the facility called to notificated with the interview of the facility called to notificated with the interview of the facility called to notificated with the interview of the facility called to notificate worked Monday through the facility called the facility called to notificate worked Monday through the facility called the facil	PM an interview was mily member stated she saw the resident had fallen and hit ly member stated she saw the facility notified her on what the nurse told her, witnessed or not and esident hit her head. The curther stated if the fall was fould do neuro (neurological) closely in house if no injuries send the resident to the for what the nurse told her.  45 PM an interview was mily member listed on the ecord as contact #2. The fed in an interview that she resident had fallen and hit for member stated she saw the foruses. The Family Member the facility notified her of a fall or bruises.  PM an interview was resident had fallen twice the RP stated no one from the fight in fall or bruises.  PM an interview was resident had fallen twice the RP stated no one from the fight in of a fall or bruises. The staff dent had a fall or bruises. The	F 1	57			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345376	B. WING _		C <b>09/27/2017</b>
	ROVIDER OR SUPPLIER  _AND NURSING AND R	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  2461 LEGION ROAD  FAYETTEVILLE, NC 28306	, 33/2/12311
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION
	member that Reside member should have Supervisor further st assessment, initiate document related to and notify the physic.  On 9/22/17 at 5:55 Finterview that Reside weeks ago. The Nurher she did not hit he assessment and too okay and the only in right arm that she clederessing on it. The Note document the fall be leave that day and he next day but mustated she heard Rea family member and member she had fall Nurse stated she did the RP.  483.10(j)(2)-(4) RIGITO RESOLVE GRIECOLVE GRIECOLYE GRIECOLYECOLYECOLYECOLYECOLYECOLYECOLYECOLY	the roommate told a staff int #45 had a fall, the QI (Quality Improvement) falls in the progress notes in an and the family.  PM, Nurse #4 stated in an int #45 did have a fall 2-2 ½ is estated the resident told interpretate in the state of the eaned and she did an interpretate in the state of the eaned and put a clear in the eane	F1		11/5/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X		IDENTIFICATION NUMBED:		TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345376	B. WING _			C 9/27/2017	
	ROVIDER OR SUPPLIER  _AND NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP ( 2461 LEGION ROAD FAYETTEVILLE, NC 28306			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 166	paragraph. Upon rea copy of the grievarde policy m  (i) Notifying resider postings in promine facility of the right to (meaning spoken) grievances anonyn of the grievance of can be filed, that is address (mailing an number; a reasonal completing the revito obtain a written of grievance; and the independent entities be filed, that is, the Quality Improveme Agency and State of program or protectivity in the facility; main information associate example, the identification of the independent entities be filed, that is, the Quality Improveme Agency and State of program or protectivity in the facility; main information associate example, the identification associate example, the identification of the	ents' rights contained in this equest, the provider must give ance policy to the resident. The	F	166			

	DF DEFICIENCIES CORRECTION			) DATE SURVEY COMPLETED		
		345376	B. WING			C <b>09/27/2017</b>
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, 2 2461 LEGION ROAD FAYETTEVILLE, NC 28306	ZIP CODE	09/2//2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE (IENCY)	(X5) COMPLETION DATE
F 166	investigated;  (iv) Consistent with § reporting all alleged vabuse, including injurand/or misappropriation anyone furnishing seprovider, to the admiras required by State (v) Ensuring that all vinclude the date the gammary statement of the steps taken to invammary of the pertinas to whether the gricconfirmed, any correctaken by the facility and the date the writt (vi) Taking appropriation accordance with State of the residents' right or if an outside entity the State Survey Age Organization, or local confirms a violation for rights within its area of (vii) Maintaining evideresult of all grievance 3 years from the issuidecision.  This REQUIREMENT by:	483.12(c)(1), immediately riolations involving neglect, ies of unknown source, on of resident property, by rvices on behalf of the nistrator of the provider; and law;  written grievance decisions grievance was received, a of the resident's grievance, estigate the grievance, a nent findings or conclusions it's concerns(s), a statement evance was confirmed or not cive action taken or to be a result of the grievance, en decision was issued;  e corrective action in e law if the alleged violation is is confirmed by the facility having jurisdiction, such as ncy, Quality Improvement I law enforcement agency or any of these residents'	F1	F166		
	staff interviews the fa	cility failed to follow facility grievances related to		A resident concern forn for resident # 175 griev		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′			TE SURVEY MPLETED
		345376	B. WING			C 9/27/2017
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•	19/2//2017
	10110211 011 001 1 21211			2461 LEGION ROAD	_	
CUMBERL	AND NURSING AND R	EHABILITATION CENTER		FAYETTEVILLE, NC 28306		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 166	Continued From pag	e 9	F 1	66		
		for one (Residents # 175 ) eviewed for grievances. The		medication concern on 9/18/2 Social Worker. The Director of initiated an investigation on 9 related to the medication con-	of Nursing /20/2017	
		vealed Resident # 175 was ty on 7/12/17. The resident		include resident and staff inte include Medication Aide #2 (M	rview to	
		rebrovascular accident,		Nurse #6). The grievance rela	•	
	chronic pain, diabete	es, and hypertensive disorder.		medication concern for reside	ent #175 was	
				addressed with a resolution of		
		nt's admission minimum data		by Director of Nursing with co	•	
		ent, dated 7/19/17, revealed		documentation on the resider		
	the resident was cog	nitively intact.		form. The Director of Nursing the resolution for the medicat		
	On 9/20/17 a review	of grievances revealed two		with resident #175 on 9/21/20	17. A copy	
		pleted for Resident # 175.		of the completed resident cor		
		as received on 9/18/17. The		with documented resolution w		
	summary of the cond	cern noted the resident had		to resident #175 on 9/21/2017	7 by Social	
	received his medicat	ions late on 9/17/17. There		worker.		
	was no further inform	nation in regards to the late		100% interview of all alert and	d oriented	
	medications. The se	cond form was dated as		residents to include resident #	# 175 will be	
	received on 9/19/17.	The summary of the		completed on 9/26/2017 by F	acility	
	concern was listed a	s "didn't receive his 8 PM		Consultant to assure all griev	ances have	
	Insulin on 9-19."			been resolved. These intervie	ew questions	
				include: Have you voiced any	concerns	
	On each form there	were different steps noted		recently to staff? Do you feel	your	
	which could be taker	n during the investigative		concerns were resolved? If no	o, give brief	
	process. As of 9/20/	17 resident interview and		explanation, and Do you have	e any new	
	staff interview had no	ot been checked on either		concerns? Social Worker will	address all	
		noted to be checked as of		areas of new and unresolved		
	9/20/17 were "staffin	g review" and "other-MAR		voiced during the interviews to		
	review."			a resident concern form and t	•	
				the appropriate personnel for	proper	
		erviewed on 9/20/17 at 1:50		resolution by 9/29/2017.	_	
		ad concerns about not		100% audit of all resident cor		
		s on Sunday, 9/17/17. The		9/1/2017 to 9/25/2017, to incl		
		utinely received OxyContin		resident #175, was reviewed	-	
		t stated on Sunday evening		Facility Consultant on 9/26/20		
		ch of a nurse and could not		all resident concerns were co		
	ting one on the hall.	The resident stated he		resolved timely with follow up	aiscussion	1

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING			(3) DATE SURVEY COMPLETED			
		345376	B. WING _				27/2017
NAME OF PR	ROVIDER OR SUPPLIER		1	S1	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	2172017
					161 LEGION ROAD		
CUMBERL	AND NURSING AND F	REHABILITATION CENTER			AYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 166	Continued From pa	ge 10	F 1	166			
F 166	should not have had medications. The remissed medications insulin and another pain medication. The aformal complaint whim know that he had medications on Surformal complaint of him know that he had medications on Surformal complaint of him know that he had medications on Surformal complaint of him know that he had medications on Surformal complaint of him know that he had state aware that any reside that they had not reside that they had not reside the surformal complaint of him know that had been grievance. According to the adhad given the grieval hired DON who had previous week. The not been informed to issues in the grieval complaint of him to be add to late medications. Found another grieval to late medications. The DO the resident's MAR	d to struggle to get his esident stated one of his awas his seven units of nightly medication was his narcotic he resident stated he had filed with the social worker letting and missed some of his hady.  I the administrator was ted she had not been made dents had voiced concerns ceived medications.  Ind the director of nursing ewed on 9/20/17 at 4:15 PM. Itated she had talked to staff riview and she had found there has related to medications.  Indicate the facility's newly a started employment the head administrator stated she had here had been medication nuces.  In ON on 9/20/17 at 4:15 PM she with a started employment the head here had been medication nuces.  In ON on 9/20/17 at 4:15 PM she with a started employment the head here had been medication nuces.  In ON on 9/20/17 at 4:15 PM she with a started employment the head here had been medication nuces.  In ON on 9/20/17 at 4:15 PM she with a started employment the had here had been medication nuces.  In ON on 9/20/17 at 4:15 PM she with a started employment the had here had been medication nuces.  In ON on 9/20/17 at 4:15 PM she with a started employment the had here had been medication nuces.  In ON on 9/20/17 at 4:15 PM she with a started employment the had here had been medication nuces.  In ON on 9/20/17 at 4:15 PM she with a started employment the had here had been medication nuces.	F1	1166	of the concern with the resident. Any concerns identified will be corrected wi follow up resolution by the Social Work and oversite by the Facility Consultant. 100% audit of the last 30 days of reside concern forms will be completed on 9/26/2017 by the Facility Consultant to assure appropriate investigation, follow up, resolution and notification of appropriate persons. Any area of concerns noted during the audit will be given to the Administrator for further investigation, follow up and resolution in 9/29/2017.  The Facility Consultant initiated in-serv on 10/11/2017 for the Administrator, Director of Nursing, Social Worker, Dietary manager, Maintenance director and Activities Director on proper grieval resolution to include investigating grievances in a prompt manner, initiating corrective measures and timely follow with resident and/or family member to 10 completed by 11/05/2017.  The Social worker will review and provide a copy of the resident\family grievance policy to all alert and oriented residents include resident number # 175 by 10/17/2017. The Social worker will mai copy of the resident\family grievance policy to the responsible party by 11/05/2017 for all none alert and orient residents.  The Social worker will interview 10% or alert and oriented residents to include resident# 175 for new concerns and to	er ent  by ice nce ng up oe ide s to I a ed	
	supervisor beginnin	who had been the nursing g at 11 PM on 9/17/17. The s of 9/20/17 at 4:15 PM an			ensure concerns have been resolved utilizing a Resident Concern Interview tool. The Resident Concern Interview C		

		A. BUILDING		COMP	PLETED
	345376	B. WING			C / <b>27/2017</b>
NAME OF PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	03/	2112011
	THA BUILTATION OF NEED		2461 LEGION ROAD		
CUMBERLAND NURSING AND RE	HABILITATION CENTER		FAYETTEVILLE, NC 28306		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC 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 166 Continued From page	e 11	F 16	6		
administrative staff m staff members (MA # been responsible for medications on 9/17/  During an interview w on 9/21/17 at 11:18 A resident's 9/19/17 gri Insulin on 9/19/17 ha accurately. The SW administrative persor grievance. The SW s the Insulin dose was would need to be claim the staff of the staff o	with the social worker (SW) Wi		tool will be completed weekly for 8 and monthly for 1 month. Any new unresolved concerns made during interviews will be placed on a Resiconcern form by the Social Worker forwarded to appropriate personne proper investigation, follow up and resolution. The Administrator will reand initial the Resident Concern In QI tool and resident concern forms for 8 weeks and monthly for 1 mon completion and to ensure all areas concerns have been addressed wit proper resolution.  The Administrator will forward the rof the Resident Concern Interview the Executive QI Committee month months. The Executive QI Commit meet monthly x 3 months and revie Resident Concern Interview Tool to determine trends and / or issues the need further interventions put into a land to determine the need for further / or frequency of monitoring.	or the the dent and for view verview weekly th for of h esults Tool to ly x 3 ee will w the at may blace	
brought to her attention the meeting was dished the meeting was dished the meeting was dished the meeting was dished to her attention the meeting was dished to her attention to	on on that morning before nissed.	F 22	4		11/5/17

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  NG	, ,	ATE SURVEY OMPLETED
		345376	B. WING _			C <b>09/27/2017</b>
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 2461 LEGION ROAD FAYETTEVILLE, NC 28306		03/27/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 224	abuse, neglect, misa property, and exploit subpart. This include freedom from corpor seclusion and any planot required to treat 483.12(b) The facility implement written possible (b)(1) Prohibit and prexploitation of resider resident property,  (b)(2) Establish polici investigate any such (b)(3) Include training \$483.95,  This REQUIREMEN by:  Based on record reviamily interview, and (Resident # 135) out with wounds the faci dressing changes to Stage III pressure uldersident had diagnost disease with hemodi disease, history of courgery, hypertension fibrillation, and sever disease.  Review of the reside	ppropriation of resident ation as defined in this as but is not limited to all punishment, involuntary hysical or chemical restraint the resident's symptoms.  If must develop and alicies and procedures that:  The revent abuse, neglect, and ants and misappropriation of the sand procedures to	F 2	F 224  On 9/21/17, a Head to Toe S Assessment was completed # 135 to include her coccyx onew skin issues identified or coccygeal wound. On 9/22/2 wound was cleansed, Santyl dressing applied by the Treat per the physician's orders. On The Director of Nursing (DOI aware that Resident #135 fait dressing changes as ordered 8/6/17, 8/12/17, 8/13/17, 8/18/26/17, 8/27/17, 9/2/17, 9/3/18/26/17, Resident #135 was 9/28/17, Resident #135 was	on Resident ulcer with no changes to 17, the coccyx ointment and tment Nurse on 9/25/17, N) was made illed to receive d for 8/5/17, 9/17, 8/20/17, 17, 9/9/17, ses. On	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	` ′	E SURVEY IPLETED
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		345376	B. WING _			09	/27/2017
NAME OF P	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
				24	61 LEGION ROAD		
CUMBERL	AND NURSING AND	REHABILITATION CENTER		F	AYETTEVILLE, NC 28306		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 224	Continued From p	page 13	F2	224			
	revealed the resid	lent was cognitively intact. The			Wound Physician and returned to the		
	resident was also	coded as having 7 vascular			facility with new orders for treatment of	f	
	ulcers and a Stag	e III pressure ulcer.			Coccyx wound: Cleanse with soap and	i	
					water, apply crushed Flagyl 500		
	According to Augu	ust 2017 wound ulcer flow			milligrams, cover with Aquacel Silver a	nd	
		#135's vascular ulcers were			a foam dressing to be changed every		
		t lower leg, right lower leg, left			other day and as needed. Resident #1	35	
		e, left outer great toe, right great			had follow up appointment with the		
	_	I. The pressure ulcer was			Wound Physician on 10/5/17 with no		
	located on the res	sident's Coccyx.			change in orders for treatment to the		
	D : :	:			coccyx and another appointment		
		ident's care plan, last updated			scheduled for October 19, 2017.		
		led the staff had identified the ulceration caused by diabetes			On 10/12/17, A 24 hour report was ser	at to	
		scular disease and a pressure			the Health Care Registry regarding the		
		r the resident was that she			allegation of neglect and an investigati		
	_	ve healing of her ulcers and not			was initiated by the Administrator.	OII	
		nes. Staff were directed on the			On 10/17/2017, a 100% audit of all		
	•	de treatment as ordered.			Treatment Administration Records (TA	Rs)	
	' '				from 8/1/2017-9/30/2017 was initiated	-	
	Review of physici	an orders revealed a current			the Facility Nurse Consultant/Director	-	
		on 5/31/17, for daily dressing			nursing to ensure all dressing changes		
	changes to the co	ccyx pressure ulcer. The order			were performed as ordered by the		
	directed staff to cl	eanse the ulcer and apply			physician to include Resident #135. Th	ıe	
	Santyl ointment a	nd a dry dressing daily.			100% audit of all TARs will be complete	ed	
					by 11/05/2017. Any areas of concern		
		icility was asked to provide the			identified during the audit to include		
		from the resident's thinned			missing documentation will be		
		nich would have been in effect			immediately addressed by the Facility		
	_	eptember, 2017 for the resident's			Nurse Consultant/Director of Nursing to		
	vascular ulcers.				include additional retraining, physician		
	On 0/25/47 of 5:4	2 DM the DON (director of			notification, and/ or initiating the protoc	:01	
		3 PM, the DON (director of			for neglect if indicated.		
		a physician's order, dated cers located on the resident's			This protocol includes reporting to the administrator, filing of a 24 hour report		
		r legs. This order specified the			and contacting the police if a reasonab		
		ave daily dressing changes to			suspicion of a crime has occurred, drug		
		staff were to cleanse these			testing and suspending the employee	9	
		and apply Santyl and a dry			suspected of neglect pending outcome	of	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		SURVEY PLETED
							С
		345376	B. WING _			09	/27/2017
NAME OF P	ROVIDER OR SUPPLIER	•	<u> </u>	STI	REET ADDRESS, CITY, STATE, ZIP CODE	•	
				246	61 LEGION ROAD		
CUMBERI	LAND NURSING AND	REHABILITATION CENTER		FA	YETTEVILLE, NC 28306		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 224	Continued From p	page 14	F 2	224			
	dressing.				investigation, and interviews of staff a	nd	
	aroosing.				residents. Any concerns will be		
	On 9/26/17 at 4:4	6 PM, the facility administrator			immediately addressed by the Directo	of	
		ty's wound protocol as the			Nursing by completing a skin referral,		
	1 *	y being used for Resident			initiating a treatment, documenting		
	#135's left great t	oe, left outer great toe, left heel,			observations in the clinical record, and		
	right great toe, an	d right heel during the months			notifying the administrator, physician,	and	
	_	nd September, 2017. The			RP for any allegations/observations of		
	'	irected that betadine should be			neglect.		
		ers every day or every other day			On 10/12/2017, a 100% inservice was		
	and the affected a	areas checked daily.			initiated by the Staff Facilitator for all s		
	Davison of the A	t 0047 TAD and 0 anto only an			to include Certified Nursing Assistants		
	Review of the Aug			(CNAs), licensed nurses, social worke			
		ed no documentation on the dates Resident # 135's			dietary, maintenance, activities, therap managerial staff, and agency staff	y,	
	_	necked or changed to any of her			regarding neglect. No staff will be allow	wed	
	_	her Stage III pressure ulcer:			to work until completion of the inservice		
		12/17, 8/13/17, 8/19/17, 8/20/17,			The neglect in service advised that all	•	
		9/2/17, 9/3/17, 9/9/17, and			alleged violations involving mistreatme	ent.	
	9/10/17.				misappropriation of resident property,	,	
					neglect, or abuse are reported as soon	n as	
	On 9/22/17 at 3:1	4 PM Facility Nurse Consultant			possible to the Administrator. Any		
	# 1 provided a list	of nurses who had been			employee who witnesses abuse/negle	ct or	
	1 '	esident # 135's dressing			suspects abuse/neglect, must first pro		
		ne September, 2017 weekends.			the resident and immediately report th	е	
		55 AM the director of nursing			alleged abuse/neglect to his/her		
		list of nurses who had been			supervisor, who will then report the		
		eekend dressing changes in			incident to the Administrator and/or DO		
	, ·	Resident # 135. According to			The inservice further advises that failu	re	
		ant and DON one of the hall			to report any concern related to abuse/neglect will result in disciplinary		
		shift and evening shifts on the done the dressing changes. The			action and possible termination of		
		as responsible and the dates			employment.		
		ch they were identified to be			All new hired licensed nurses, CNAs,		
	responsible are a				Dietary staff, therapy staff, manageria		
	1 -	o 3:00 PM -Nurse # 4			staff or agency staff will be inserviced		
		o 11:00 PM- Nurse # 4			during orientation by the Staff Facilitat	or	
		o 3:00 PM- Nurse # 4			regarding the neglect in service includ		
		o 11:00 PM- Nurse # 4			that all alleged violations involving	J	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345376	B. WING			1	27/ <b>2017</b>
NAME OF PE	ROVIDER OR SUPPLIER	0.00.0	<del></del>	S.	TREET ADDRESS, CITY, STATE, ZIP CODE	1 09/	2112011
NAME OF T	COVIDER OR SOLT LIER				, , ,		
CUMBERL	AND NURSING AND I	REHABILITATION CENTER			461 LEGION ROAD		
				Ь.	AYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 224	Continued From pa	ge 15	F 2	224			
	8/12/17- 7:00 AM to	o 3:00 PM-Nurse # 1			mistreatment, misappropriation of resid	lent	
		o 11:00 PM-Nurse # 1			property, neglect, or abuse are reporte		
		3:00 PM -Nurse # 7			as soon as possible to the Administrator		
	8/13/17-3:00 PM to	11:00 PM- Nurse # 1			On 10/3/2017, a 100% inservice was		
		3:00 PM-Nurse # 8			initiated by the Director of Nursing for a	all	
	8/19/17-3:00 PM to	11:00 PM-Nurse # 8			licensed nurses that when the treatmen		
	8/20/17-7:00 AM to	3:00 PM-Nurse # 1			nurse is off on the weekends nurses ar	e	
	8/20/17-3:00 PM to	11:00 PM -Nurse # 1			to complete their own treatments. 7-3		
	8/26/17-7:00 AM to	3:00 PM-Nurse # 4			complete odd number rooms and 3-11		
	8/26/17- 3:00 PM to	o 11:00 PM-Nurse # 1			complete even number rooms this is no	ot	
	8/27/17-7:00 AM to	3:00 PM-Nurse # 4			optional. Document by initialing on MA		
	8/27/17-3:00 PM to	11:00 PM-Nurse # 1			immediately after completing treatmen	t. If	
	9/2/17-7:00 AM to 3				treatments cannot be completed hall		
		11:00 PM-Nurse # 2			nurse must notify nursing supervisor		
		3:00 PM-Nurse # 3/or Nurse #			and/or Director of Nursing. All Refusal	of	
	1				treatments must be documented on		
		11:00 PM-Nurse # 2/ or Nurse			Treatment Administration Record and i	n a	
	#1				nursing progress note to include		
	9/9/17-7:00 AM to 3				notifications of Medical Director and		
		11:00 PM-Nurse # 1			Resident Representative of treatment		
		3:00 PM-Nurse # 4			refusal. No licensed nurse will be		
	9/10/17-3:00 PIVI to	11:00 PM-Nurse # 1			allowed to work until completing this		
	Nurse # 2 who has	I been identified as			inservice. All newly hired and agency licensed nurses will be inserviced on		
	Nurse # 3, who had	day and had shared			orientation by the Staff Facilitator		
		other day, was interviewed on			regarding missed dressing changes an	d	
	•	. The nurse stated she had not			the expectation that all treatments order		
		changes. The nurse was not			by the physician will be completed as	,icu	
	aware it was her re				ordered and documented on the TAR is	n	
	aware it was ner re	Sportsibility.			the absence of a treatment nurse or ot		
	Nurse # 4, who had	been identified as			designated nurse to include on the		
		of the week-end days as either			weekends.		
	•	esponsible, was interviewed on			The Assistant Director of Nursing/Nurs	ing	
		urse # 4 stated she had not			supervisor will conduct audits of 10% of	-	
		changes for Resident # 135			TARs utilizing the TAR audit tool for		
	•	and September week-end days			documentation weekly for twelve weel	(S	
		urse stated she was charge			to include Resident # 135 to ensure		
		sponsibilities, and she was not			dressing changes are completed as		
	aware it had been h	ner responsibility to change the			ordered by the physician. Any areas of		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` ′	PLE CONSTRUCTION  G	' '	TE SURVEY
		245270	B. WING			С
		345376	B. WING_			)9/27/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
CHMBEDI	AND NUIDSING AND DE	HABILITATION CENTER		2461 LEGION ROAD		
COWIDERL	AND NORSING AND RE	HABILITATION CENTER		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)	N SHOULD BE	(X5) COMPLETION DATE
F 224	Continued From page dressings.	<del>2</del> 16	F 2	concern noted during the aud		
	was interviewed on 9 nurse stated she had changes. The nurse snear the end of Augusteen made aware drefer responsibilities.  Nurse # 8, who had bresponsible for one de 9/26/17 at 1:29 PM. To	y responsible on two days, /25/17 at 9:25 AM. The not done the dressing stated she had just started st, 2017 and she had not essing changes were one of		immediately addressed by the include additional training, ph notification, and/ or initiating t for neglect if indicated.  The DON will forward the res audit tool for documentation t Executive QI Committee mon months. The Executive QI Comeet monthly x 3 months to r audit results of the TAR audit documentation. Any issues, c and/or trends identified will be by implementing changes as to include continued frequence.	ysician he protocol  ults of TAR heto the thly x 3 mmittee will eview the tool for concerns, e addressed necessary,	
	dressing changes.			monitoring.	•	
	was interviewed on 9 nurse stated she had changes. The nurse stime to do it. The nurse shave a treatment nurse when the treatment number the facility maschedule for the hall changes. The nurse shedule for the odd number tooms, and the evening responsible for the ornot do. The nurse state went over the new redirections. They just I desk. The nurse state given the other responsible for the ornot do.	ay for the dressing changes, 1/26/17 at 4:42 PM. The not done the dressing stated there was not enough se stated the facility used to se on the week-ends, and urse quit during the summer anagement staff left a paper nurses to do dressing stated the paper schedule nurses were responsible for r rooms or even numbering shift nurses were less the dayshift nurses did ted management never				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		INSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345376	B. WING			1	C <b>27/2017</b>	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2461 LEGION ROAD FAYETTEVILLE, NC 28306			2112011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE	
F 224	24 Continued From page 17		F	224				
	halls, deal with family issues/events that ca with week-end house the phone.	cation assistants on other y concerns, deal with ame up with residents, deal ekeeping issues, and answer						
	on 9/27/17 at 9:20 A only done the dressii August and Septemb that was when the re	on 8 days, was interviewed M. The nurse stated she had ng changes one time during per for Resident # 135, and esident's family member had requested it. The nurse						
	approached her and requested it. The nurse stated she had not charted the one day she had done it. The nurse stated on the other days, she had not done the resident's dressing changes.  The nurse stated there was not enough time to do							
	work double shifts ar medication cart resp	s given her other nurse stated she often had to nd she often had her own onsibilities as well as cover icians who could not give						
	intravenous fluids, In nurse stated she had who had worked in A dressing changes no	sulin, or tube feedings. The distalked to the previous DON, august 2017, about the ot being done on the						
	stated the new DON	ne DON had left. The nurse had not been at the facility to talk to her about the						
	revealed she had just previous week and s	DN on 9/25/17 at 9:19 AM st been employed the he had not been made dressing changes for						
		ministrator on 9/26/17 at he missed dressing changes						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED
		345376	B. WING _		C 09/27/2017
	ROVIDER OR SUPPLIER  LAND NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  2461 LEGION ROAD  FAYETTEVILLE, NC 28306	03/2//2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE	
F 224 F 241 SS=D	had not been brough staff had probably tol was no longer emplo  The resident's vascul on 9/25/17 at 11:15 A vascular physician Rulcer dressings should changed daily as a standard daily a	to her attention and that the d the previous DON, who yed.  ar physician was interviewed M. According to the esident # 135's vascular d have been checked or andard of good practice. Sician, when he initially saw D17, her vascular disease int that the family knew the bly need bilateral point.  Y AND RESPECT OF  Treat and care for each and in an environment that be or enhancement of his or egnizing each resident's lity must protect and the resident.  This is not met as evidenced on, record review and staff failed to promote a resident' llowed the resident to wait the same table were alled the resident 's without telling the resident eviewed for dignity (Resident).	F 2		owed to dents at l. ity when d was
		mitted to the facility on liagnosis of adult failure to		Nursing.  Meals observed to include breakfalunch and dinner initiated on 10/3/	·

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		E SURVEY MPLETED
				_			С
		345376	B. WING _			09	9/27/2017
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				2	461 LEGION ROAD		
CUMBERI	LAND NURSING AND	REHABILITATION CENTER		F	AYETTEVILLE, NC 28306		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI. TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 241	Continued From p	page 19	F	241			
	thrive, anxiety and	-			Facility Nurse Consultant to ensure that	at	
					residents were being provide meals at		
	The resident 's C	are Plan dated 5/13/16 noted			same time to include resident # 29 and		
	the resident was a	at risk for aspiration related to			that no resident was pulled backwards	; <u>.</u>	
		mentia, was dependent on staff			Any identified areas of concerns were		
	for feeding and to	feed resident slowly. The Care			addressed with re-education during the	е	
	Plan directed staf	f to sit resident upright when			audit by Director of Nursing to be		
	feeding and giving	g fluids.			completed by 11/05/2017.		
					All alert and oriented resident were		
		num Data Set (MDS)			interviewed on 10/3/2017 by the Socia		
		d 8/15/17 revealed the resident			Worker utilizing a Dignity Interview Too		
		g term memory loss and severe			resident concern form was completed	by	
		ent and was totally dependent			10/3/2017 and forwarded to the	_	
	on staff for all acti	vities of daily living.			Administrator for any identified areas concerns.	of	
		sessment for Cognitive Loss			100% in-servicing was initiated on		
		ed the resident was alert and			10/4/2017 by Facility Nurse Consultan	t	
	nonverbal and un	able to state her basic needs.			with all nursing assistants to include nursing assistant # 5 in regards to help	oina	
	a. On 9/21/17 at 1	12:15 PM Resident #29 was			to take residents to eat and to participa		
	observed to be re	clined in a Geri-chair in the			in various activities. Serve the residen		
		at a table with 2 other			meals and in some cases, to help ther	n	
	_	was observed to feed one of the			eat if they cannot do it for themselves.		
	residents at the ta	able who was also sitting in a			Residents must be feed in a manner th	nat	
	Geri-chair and the	e central supply manager was			is not too fast for meal intake. Ensure	all	
	feeding another re	esident who was sitting in a			residents in room and dining room hav	e'e	
		same table. Resident #29 was			their trays passed out and residents		
	observed sitting in	n the Geri-chair beside the table			needing assistance are being fed at th		
		e dining room and waiting to be			same time. No resident should be sittii	•	
		finished feeding the resident			at table while other residents have the		
		leal cart and removed the meal			trays and are eating. All residents at o		
	tray for Resident	#29 to feed the resident.			table should eat at the same time. Alw	-	<b> </b>
	0 0/04/45 : : :	50 DM II O 1 1 C 1			make resident aware before you provid		<b> </b>
		50 PM the Central Supply			any care to be completed by 11/05/20	17.	<b> </b>
	_	n an interview the social worker			Meals to be observed to include		<b> </b>
		esident #29 and NA #5 told the			breakfast, lunch and dinner by	A	
	social worker she	would feed the resident.			Administrative Staff member from Teal		<b> </b>
	0= 0/04/47 + 4.5	O DNA NIA #E -+-+-!			or B to ensure that residents were being	•	
	⊥ ∪n 9/21/1/ at 1:0	2 PM NA #5 stated in an			provide meals at the same time to incl	uae	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
		345376	B. WING _		0:	C <b>9/27/2017</b>	
NAME OF P	ROVIDER OR SUPPLIER		'	STREET ADDRESS, CITY, STATE, ZIP CO			
				2461 LEGION ROAD			
CUMBERI	LAND NURSING AND RE	HABILITATION CENTER		FAYETTEVILLE, NC 28306			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 241	Continued From page	e 20	F 2	41			
	one and pay attention feeding. The NA state to feed Resident #29 meal trays on the 400 On 9/22/17 at 8:05 A an interview that all the should have been feed NA should have let the Resident #29 and other out trays on the 400 stated she routinely or room and she had not be on 9/21/17 at 12:3	M the Administrator stated in haree residents at the table of at the same time and the he social worker feed her staff could have passed Hall. The Administrator observed meals in the dining of observed this to happen.		resident # 29 and that no repulled backwards utilizing a Care Audit- Meal Observation week for 4 weeks, weekly for then monthly for 1 month. A concerns will be addressed Nursing/Assistant Director of during the audit. The Director will review and initial the Reaudit- Meal Observations for weekly X 8 weeks and monthmonth.  10 % of alert and oriented repulsion interviewed by the Social Was a Dignity Interview Tool weekly X 1 month. A reconcern form will completed	Resident ons 3 X a or 4 weeks and ny areas of by Director of f Nursing or of Nursing sident Care r completion chly X 1 esident will be orker utilizing kly X 8 weeks esident by the Social		
	<ul> <li>b. On 9/21/17 at 12:31 PM Resident #29 was observed to be reclined in a Geri-chair beside a table in the main dining room. NA #5 finished feeding one of the 3 residents at the table and went to the meal cart and removed a meal tray. The NA was observed to walk behind Resident #29 's Geri-chair and in a rushed manner pulled the Geri-chair backwards to the next table. When the NA moved the chair, Resident #29 was observed to throw up her hands and make a sound as if she was startled. The NA was then observed to sit down beside the resident to feed her.</li> <li>On 9/21/17 at 1:02 PM NA #5 stated in an interview she told the resident it was time to eat but did not tell the resident she was going to move her chair.</li> <li>On 9/22/17 at 8:05 AM the Administrator stated in an interview NA #5 should have told the resident she was going to move her chair.</li> </ul>			Worker and forwarded to the Administrator for any identific concerns. The Administrator and initial the Dignity Intervice completion weekly X 8 week X 1 month.  The Director of Nursing will results of the Resident Care Observation and the Dignity to the Executive QI Committ 3 months. The Executive QI will meet monthly x 3 month the Resident Care Audit- Me Observation and Dignity Intervention and Tolerand Tolerand to determine the need for for frequency of monitoring	ed areas of will review ew tool for as and monthly forward the Audit-Meal Interview Tool tee monthly x Committee s and review eal erview Tool to sues that may ut into place		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345376	B. WING		C <b>09/27/2017</b>
	ROVIDER OR SUPPLIER	EHABILITATION CENTER	:	STREET ADDRESS, CITY, STATE, ZIP CODE 2461 LEGION ROAD FAYETTEVILLE, NC 28306	00/21/2011
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 242 F 242 SS=D	Continued From page 483.10(f)(1)-(3) SEL RIGHT TO MAKE COMMAKE	ge 21  LF-DETERMINATION - HOICES  as a right to choose activities, g sleeping and waking times), viders of health care services or her interests, assessments, d other applicable provisions  as a right to make choices or her life in the facility that	F 242	DEFICIENCY)	a all
	on 7/27/2014, he wa 8/29/2017 after a ho included Non-Alzhe Disease and Depres The Annual Minimus 5/30/2017 indicated cognitively impaired coded totally dependent	as last readmitted on ospitalization. His diagnoses imer's Dementia, Parkinson's ession.  The Data Set (MDS) dated Resident #44 was severely with behaviors. He was dent for hygiene and bathing.		Worker utilizing a Dignity Interview To resident concern form was completed 10/3/2017 and forwarded to the Administrator for any identified areas concerns.  A 100% audit will be completed by Fawound Consultant on 10/5/2017 to incresident # 44 to ensure residents receasions a shower according to choice and shows schedule. Any negative findings will be	ool. A I by  of acility clude eive ower
	His Care Area Asse	ssment dated 5/30/2017		addressed immediately by the Director	or of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345376	B. WING			C	
NAME OF D	DOMBER OF SURPLIER	343376	B. WING _	OTDEET ADDRESS SITY STATE 7		/27/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	P CODE		
CUMBERI	AND NURSING AND	REHABILITATION CENTER		2461 LEGION ROAD			
				FAYETTEVILLE, NC 28306			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 242	Continued From p	age 22	F 2	242			
F 242	revealed Resident assistance for bed personal hygiene, locomotion on the His most recent caindicated he requitoileting and dress deficit and impaired. The Quarterly MD Resident #44 was toileting, and persphysical assist.  Review of Hallway Resident #44 was Tuesday on second Review of the Active records for bathing revealed Resident on any shift. It included baths. There of showers from 8 records.  Review of the number of showers from 8 records.  Review of the number of showers from 8 records.  Review of the number of showers from 8 records.  An interview on 9/Member stated Revisited by the family week. The Family	t #44 required extensive I mobility, transfers, toileting, bathing, dressing, eating and unit.  are plan revised 8/31/2017 red total assistance with sing related to his cognitive ad mobility.  S dated 9/05/2017 indicated totally dependent for bathing, onal hygiene with one person  / 300's Shower Book indicated to receive showers every ad shift.  vities of Daily Living (ADL) g from 8/01/2017 to 9/12/2017 t #44 did not receive a shower licated he received full or partial were no documented refusals //01/2017 to present in the ADL  sing notes from 8/01/2017 to no mention of Resident #44	F 2	Nursing during the time completed by 11/05/201 100% in-servicing initiate Consultant on 9/25/2017 assistants to include age to Cleaning and bathing Both of these task are a unless resident prefers of Showers to be given by unless resident prefers of cannot be performed for performed timely, the nunctified. The nurse must care needed is provided a timely and accurate m assistants must notify the refusals of care so that in document in progress nonotification of Resident If the care being refused to 11/05/2017. All newly him assistants, to include ago in-serviced on Cleaning residents. Both of these requirement unless residents. Showers to be schedule unless resident otherwise. If care cannously reason or performed must be notified. The number of the care needed is president in a timely and and Nursing assistants must about all refusals of care can document in progress notification of Resident If	ed by Facility for all nursing ency staff, related your residents. daily requirement otherwise. shower schedule otherwise. If care any reason or urse must be e ensure that the for the resident in anner. Nursing e nurse about all nurse can ote to include Representative of to be completed by res nursing ency staff will be and bathing your task are a daily dent prefers te given by shower t prefers t be performed for d timely, the nurse rese must ensure provided for the accurate manner. notify the nurse es to to include		
	shower at least or of the week could	nce a week and the remainder be bed baths.		the care being refused of by Staff Facilitator. Nursing Supervisor will r	luring orientation		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			71. 501251			، ا	2
		345376	B. WING				27/2017
NAME OF P	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 007	2172017
				24	461 LEGION ROAD		
CUMBERL	AND NURSING AND RE	EHABILITATION CENTER		F	AYETTEVILLE, NC 28306		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 242	Continued From page	e 23	F:	242			
	An interview on 9/10/	/2017 at 6:40 PM, Nursing			residents to include resident # 44 to		
		ated Resident #44 was kept			ensure showers are being provide per	the	
		needed. She explained she			shower schedule or resident preference		
	tried to toilet every tw	•			utilizing a Shower audit tool weekly for		
		if she is the only aide on			weeks and monthly for 1 month. The	ĺ	
	Hallway 300 then sho	owers cannot be given			assigned nursing assistant will be		
	because there would	be no one to watch the			immediately retrained during the audit	oy	
	other residents. She	added sometimes the			Nursing Supervisor for any identified		
	nursing assistants ar	e pulled to other units and			areas of concern. The DON will review	,	
	that leaves Hallway 3	300 short of staff on the			and initial the Shower audit tools week	y	
	Dementia Unit.				for 8 weeks and monthly for 1 month for	r	
					completion and to ensure all areas of		
	An interview on 9/11/			concerns were addressed.			
		ated Resident #44 was			10 % of alert and oriented resident will		
	_	very Tuesday on second			interviewed by the Social Worker utilizi	-	
		he was to get a shower			a Dignity/ Choices Interview Tool week	y X	
		if he was combative. She			8 weeks and monthly X 1 month. A		
		ort to the nurse in charge if			resident concern form will completed b	-	
		d his shower or if he became			the Social Worker and forwarded to the		
		tinued to say it is hard to get			Administrator for any identified areas o concerns. The Administrator will review		
		there is only one NA by 300 or if the second			and initial the Dignity/Choices Interview		
		go to another hall to share			tool for completion weekly X 8 weeks a		
	staffing assignments	_			monthly X 1 month.	iiu	
	Julian Gustan Gu	•			The Director of Nursing will forward the	,	
	An interview on 9/12/	/2017 at 12:45 PM, the			results of the Resident Care Audit-Mea		
		ursing (DON) revealed her			Observation and the Dignity/ Choices	•	
		sidents are given their			Interview Tool to the Executive QI		
		ed and as their care plan			Committee monthly x 3 months. The		
		tated the nursing staff should			Executive QI Committee will meet mon	thly	
		d if residents refused then			x 3 months and review the Resident Ca	-	
	the refusals should b	e documented in the			Audit- Meal Observation and Dignity/	ĺ	
	resident's record.				Choices Interview Tool to determine	ſ	
					trends and / or issues that may need		
	An interview on 9/12/	/2017 at 3:40 PM, the			further interventions put into place and	to	
	Administrator revealed	ed it was an expectation that			determine the need for further and / or	ĺ	
	residents received th	eir showers as care planned			frequency of monitoring	ĺ	
	on their shower days	or at their request. She				ĺ	
	continued by stating	if the residents refused the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	, ,	E SURVEY PLETED
		345376	B. WING		1	C / <b>27/2017</b>
NAME OF PI	ROVIDER OR SUPPLIER	J		STREET ADDRESS, CITY, STATE, ZIP CODE		
CUMBERI	AND NURSING AND RE	EHABILITATION CENTER		2461 LEGION ROAD		
				FAYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 242	Continued From page	e 24	F 24	12		
	· ·	ed to be documented in the he Responsible Party (RP)				
F 248	483.24(c)(1) ACTIVIT	TIES MEET	F 24	18		11/5/17
SS=D	INTERESTS/NEEDS	OF EACH RES				
	(c) Activities.					
	(1) The facility must p	provide, based on the				
		ssment and care plan and				
	the preferences of each resident, an ongoing program to support residents in their choice of					
	-	/-sponsored group and				
		nd independent activities,				
	_	interests of and support the				
	1 * *	d psychosocial well-being of				
	and interaction in the	raging both independence				
		T is not met as evidenced				
	by:	i is not met as evidenced				
		ons, record review, and		F 248		
		views, the facility failed to		1 2 13		
	-	activity program designed to		Resident # 44 was provided 1:1 ir	ı room	
		participate in one on one		activities on 10/5/2017 by Activity		
		supervised activity outdoors		documentation in the electronic m		
	for one of one sample	ed resident (Resident #44).		record. Resident # 44 was provide	ed a	
	Findings included:			supervised activity outdoors by ac aide on 10/18/2017 with documen	-	
	Posidont #44 was ad	Imitted to the facility initially		the electronic medical record.  100% audit will be completed on		
	on 7/27/2014. His di			11/05/2017 by the Social Worker	with a 7	
		agnoses included Izheimer's Dementia,		day look back to ensure all reside		
		hrenia, Chronic Kidney		being provided ongoing Activities		
	1 -	and Vascular Dementia.		of interest to the residents in an e		
	Diocaco, Dyophagia	and raddalar Domentia.		meet each resident's needs. Activ		
	An activity assessme	ent dated 5/24/2017		engage the resident as evidenced		
		t interests as outside, family		facility Activity calendar, in room	_,	
		nish music and one on one		documentation or group participat	ion	
	İ		1	The state of the s		1

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345376	B. WING	B. WING		C <b>09/27/2017</b>			
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 09	12112011		
TWANTE OF T	TO VIDEIT OIT OOI 1 EIEIT				61 LEGION ROAD				
CUMBERI	AND NURSING AND	REHABILITATION CENTER							
				FA	YETTEVILLE, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 248	Continued From p	age 25	F 2	248					
	-	sident #44 refused group			documentation. The Activity Director w	/ill			
	activities.	sident #44 relused group			assure activities are immediately provi				
	donvinco.				as appropriate to the resident for any	ucu			
	The Care Area As	sessment Worksheet dated			identified areas of concerns during the				
		ed Resident #44 made poor			audit.				
		uired monitoring and			All Activity Staff were in-serviced by th	е			
	redirecting. The w	orksheet also indicated			Facility Consultant on 10/5/2017 related				
	Resident #44 had	a language barrier. The			the requirement to provide Activities th	at			
		ed Resident #44's primary			are of interest to the residents in an ef				
	language is Spani	sh.			to meet each residents needs and that				
					engage the resident in a group or in ro				
		are plan created on 08/01/2016			activity with daily documentation in the	!			
		2017 indicated he had an			electronic medical record.	4.4			
		vised/organized recreation			10% of residents to include resident #4	14			
		ttle or no involvement, lack of d to progressive disease. The			activity documentation and visual observation of in room and/or group				
		lent #44 to participate in 2 - 3			activity participation will be reviewed/				
	T -	through his next review. His			observed weekly for 8 weeks and mon	ithly			
		s included "engage resident in			for 1 month utilizing a Activity Attendar				
	group activities."	3.3.			QI Audit tool to ensure ongoing activiti				
					are being offered that engage the resid				
	The Documentation	on Survey Report of Activities			by Activity Director. The Activity staff				
	dated July 2017 to	September 2017 revealed no			member will be retrained during the au	ıdit			
		ties from 7/01/17 to 7/09/17,			for any identified areas of concern by t				
		28/17, from 8/09/17 to 8/15/17,			Activity Director. The Administrator wil				
	and from 8/29/17 t	to 9/08/17.			review and initial the Activity Attendand	e			
					QI Audit Tool weekly for 8 weeks and				
		ress Notes for the months of			monthly for 1 month for completion and	d to			
		ember 2017 were found in			ensure all areas of concerns are				
		edical Records. The Activity			addressed.  The Administrator will forward the resu	ulto			
		rovide any documentation of the resident received outside or			of the Activity Attendance QI Audit Too				
	in-room activities i				the Executive QI Committee monthly x				
	iii 100iii activities t	apon roquost.			months. The Executive QI Committee				
	The Quarterly Min	imum Data Set (MDS) dated			meet monthly x 3 months and review t				
		ed Resident #44 was severely			Resident Care Audit- Meal Observatio				
		ed with long and short term		and Dignity/ Choices Interview Tool to					
	memory problems	<u> </u>			determine trends and / or issues that r	nay			
				need further interventions put into place					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345376	B. WING _				27/2017		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	21/2011		
				2	461 LEGION ROAD				
CUMBERI	AND NURSING AND RE	HABILITATION CENTER		F	AYETTEVILLE, NC 28306				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 248	Continued From page	e 26	F 2	248					
	documented resident listening to music, sit	int Form dated 9/05/2017 interests as watching TV, ting outside and one on one ent #44 did not attend group			and to determine the need for further a / or frequency of monitoring.	nd			
	An observation on 9/ revealed Resident #4 wheelchair watching	4 in his room in his							
	Resident #44's family was not receiving any from staff at the facility								
	#1 revealed she had #44 refusing care or I she redirected him w medications and he u shift. She also explai	0/2017 at 6:15 PM, Nurse no concerns with Resident his activities. She explained hen he refused care or isually complied later in the ined she had no knowledge for any sunlight or any							
	Nursing Assistant #2 could, but there were was only one Nursing Hallway and many tin Assistant (if schedule another unit to assist lunch/dinner. This th Assistant on the 300 returned or until the r stating she had not se	n 9/10/2017 at 6:23 PM, stated she did the best she a "lot of times when there g Assistant on the 300 nes the second Nursing d) was called to go to with care or to relieve for en left on one Nursing Hallway until someone lext shift." She continued by een the activities staff take the unit to go outside when							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345376	B. WING				C 27/2047	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2461 LEGION ROAD FAYETTEVILLE, NC 28306			27/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 248	she worked the 300 On 9/11/2017 at 8:50 observed sitting up in that same day at 1:1 bed resting quietly. In an interview on 9/2 Activities Director rev Activity Aide for the 3 longer at the facility. trying to replace the acknowledged Resid music and movies. Sliked to go outside. Sprovided the services documented.  An interview was cor 12:05 PM with Nursin had not seen Reside months.  During an interview of Nursing Assistant #4 seen him go outside explained her usual at Hallway. She contin	Hallway.  O AM, Resident #44 was an bed eating breakfast. Later O PM he was observed in 13/2017 at 11:35 AM, the vealed there had been an 800 Hallway but she was no She explained she was vacant staff positions. She lent #44 preferred Spanish She also acknowledged he She stated the prior staff had		248	DEFICIENCY)			
	Administrator indicat the residents to rece indicated in their care facility would focus o activities for Residen	on 9/13/2017 at 2:10 PM, the ed her expectation was for live the care and activities as e plans. She expressed the n providing one on one t #44, take him outside and						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345376	B. WING		C 09/27/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	09/2//2017	┨	
				2461 LEGION ROAD		١	
CUMBERL	AND NURSING AND R	EHABILITATION CENTER		FAYETTEVILLE, NC 28306			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION		
F 250	Continued From pag	e 28	F 25	0		ĺ	
					11/5/17	1	
F 250 SS=D	483.40(d) PROVISION RELATED SOCIAL S		F 25	0	11/5/17		
	social services to atta practicable physical, well-being of each re This REQUIREMENT by: Based on record rev interview, and physic failed to coordinate of vascular physician to procedure was done of one resident with	T is not met as evidenced riew, family interview, staff cian interview the facility are with a consulting		F 250  Resident # 135 had a follow-up appointment scheduled on 9/26/2 Ward Clerk with the vascular surg Resident # 135 attended schedule	geon. ed		
	initially admitted to the resident had diagnost disease with hemodic disease, history of consurgery, hypertension fibrillation, severe per	ealed Resident # 135 was ne facility on 5/6/17. The ness of end stage renal alysis, coronary artery pronary artery bypass n, diabetes, anemia, atrial ripheral vascular disease.		appointment on 9/26/2017. Reside Representative made aware of the appointment results on 9/27/2017 Director of Nursing.  100% of all residents to include residents to include results to elephone orders and dischar summaries were audited for any rappointments on 10/6/2017 by Fa Consultant. Any identified areas of concern noted during the audit were	e by esident # rge request ricility of		
	Review of the resident's last quarterly minimum data set (MDS) assessment, dated 8/13/17, revealed the resident was cognitively intact. The resident was also coded as having 7 vascular ulcers.  Review of a vascular physician's consult follow up note, dated 7/27/17, revealed the physician had identified through testing that the resident had bilateral chronic total occlusion of the superficial femoral arteries. The vascular physician's plan was to place a femoral artery balloon and a patch and stent to help with blood supply for her vascular ulcers. The physician noted he planned			immediately addressed by Director Nursing/Facility Consultant. All rewith requested appointments from telephone orders or discharge sur have been made.  100% audit of all residents to include resident # 135 for NPO orders con by Facility Nurse Consultant on 10 Any identified areas of concern not during the audit were addressed be Director of Nursing on 10/6/2017.  100% in-servicing with all licensed to include agency nurses was initing 10/3/2017 by Director of Nursing	sidents n mmary ude mpleted 0/6/2017. oted by d nurses		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		345376	B. WING _		0:	9/27/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
OUMBEDI	AND MUDOING AND	DELIABILITATION OFNITED		2461 LEGION ROAD			
COMBER	AND NURSING AND	REHABILITATION CENTER		FAYETTEVILLE, NC 28306			
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F 250	Continued From p	age 29	F 2	50			
	to do the left leg fithe right leg.  There was no nota progress notes what to take place. On 9/11/17 the first the nursing notes to schedule an apphysician. Nurse # 11:44 AM that a cavascular physiciar appointment, and extremity continued circulation. The nurefused to go to president's response.  Interview with the 9/20/17 at 12 noor scheduled to under 8/8/17, but never lesident was given NPO (nothing by resident was resolt the resident was regoing to the hospilleft leg continued facility was not covascular physiciar done. The RP staff	ation in the resident's facility then the vascular procedure was at documentation appeared in in regards to the facility's efforts pointment with the vascular at 6 documented on 9/11/17 at all had been placed to the 1's office to make an that the resident's left lower at to worsen because of no area noted the resident had revious appointments per the aible party.  The resident's responsible party on a revealed the resident was arego the vascular procedure on the procedure because the materials and the procedure the state of the resident's to get worse and she felt the mmunicating well with the min order to get the procedure teed one day she was present.		regarding appointments: Nurse check daily prior to the start of pass to see if any of their ass residents have MD appointment include time. Nurse must to e resident is up, dressed and reappointment. Nurse should the encourage resident to go to the appointment for any refusals. continues to refuses, nurse mattending MD and Resident Representative with document nursing progress note. Once returns from appointment: Chepaperwork for new orders, neappointment, dressing change sure that Resident Represent aware of any new orders and appointments. Make sure documedication changes, adding a NPO orders, treatment changen notification of Resident Representation Represent	f medication igned ents to naure that eady for the y and neir If resident ust notify station in a a resident eck ext es etc. Make ative is follow upsument a medication, es and esentative in completed d nurses to iced during ator daily prior to o see if any ve MD Nurse must dressed and		
	done, and she sav ulcer had worsene was exposed. The the facility call and vascular physiciar	's dressing changes were being withat the resident's left leg ed to the point that the tendon e RP stated she demanded that diget the resident back to the h.		ready for the appointment. Nutry and encourage resident to appointment for any refusals. continues to refuses, nurse mattending MD and Resident Representative with documer nursing progress note. Once returns from appointment: Ch	go to their If resident ust notify Itation in a a resident		

OL: VILI	C . C	MEDIO/ ND OLIVIOLO	_			<del></del>	. 0000 0001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345376	B. WING			09/	27/2017
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CUMBERI	AND NURSING AND RE	HABILITATION CENTER		2461 LEGION ROAD FAYETTEVILLE, NC 28306			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION			(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 250	Continued From page	e 30	F	250			
		/17 at 2:40 PM revealed the			paperwork for new orders, next		
		ad been working with the			appointment, dressing changes etc. Ma	ake	
	_	office to get Resident # 135's			sure that Resident Representative is		
		with the vascular physician.			aware of any new orders and follow up		
					appointments. Make sure document		
		nterviewed on 9/22/17 at 10			medication changes, adding a medicat	ion,	
		eferenced her appointment			NPO orders, treatment changes and		
		resident was first scheduled			notification of Resident Representative	in	
	-	edure on 8/8/17, but had not			a nursing progress note		
	had the procedure co				100% in-servicing with all nursing		
	resident had not beer	п керт NPO.			assistants was initiated on 10/3/2017 b	У	
	The ward clerk contin	nued and said the procedure			Facility Nurse Consultant regarding Please check appointment list located	on	
		for 8/21/17. The ward clerk			glass case in break room for any assig		
		not go to that appointment			residents that may be NPO for that day		
		understanding the resident			All care provided and refusals must be		
		The ward clerk stated she			documented on the shift that task is		
	had been off work on	8/21/17, and it was			performed to be completed by		
	"probably" 8/25/17 or	the following week before			11/05/2017. All newly hired nursing		
		she was supposed to be			assistants will be in-serviced during		
		ling the procedure. The ward			orientation by the Staff Facilitator		
		ay she was made aware, she			regarding Please check appointment li		
	-	hysician's office and was told			located on glass case in break room fo		
	-	to a specific person. The left a message for the			any assigned residents that may be NF for that day. All care provided and refus		
		rk stated the person called			must be documented on the shift that t		
		ey would talk to the vascular			is performed.	uon.	
		he resident since she had			Ward clerk in-serviced on 10/17/2017	bv	
	missed two appointm				Administrator on the importance of	,	
					scheduling appointments per telephone	е	
		d she never heard back and			order request, discharge summary and	l in	
		e called on 9/11/17 to talk to			a timely manner. This includes		
	the office.				documenting after scheduling		
		AM a staff member at the			appointment and notifying the responsi		
		office was interviewed. The	·		get		
		ed the resident's vascular			appointment schedule for any reason		
	-	one on 8/8/17 because the			ward clerk is to notify Director of Nursir	ıg	
		t NPO. The staff member nt did not show up for the			immediately.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345376	B. WING		0.0	C		
NAME OF D	ROVIDER OR SUPPLIER	0-2070		STREET ADDRESS, CITY, STATE, ZIP CODE	08	/27/2017		
NAME OF FI	NOVIDER OR SUFFLIER							
CUMBERL	AND NURSING AND RE	HABILITATION CENTER		2461 LEGION ROAD				
				FAYETTEVILLE, NC 28306				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 250	F 250 Continued From page 31		F 25	0				
	8/21/17. Interview with the res	sident's RP on 9/20/17 at 12 she accompanied the		Treatment Nurse was in-service 10/17/2017 by Corporate Woun Consultant regarding: Treatmen must monitor wounded resident	d it nurse			
		7 appointment, the vascular		Physician appointments to assu				
		y decided to admit the		residents attend the scheduled	iic tiiat			
		al the next day for a planned		appointments. Treatment nurse	need to			
	amputation of the res			assure all recommendations are				
	ampatation of the rec	nderite leit leg.		through new dressing orders, fo				
	Record review revealed the resident was hospitalized on 9/13/17 and underwent a left			appointments etc. Treatment nu	•			
				write any telephone orders need				
		utation. During the same		make resident representative av				
	-	sident had a right superficial		any new orders and follow up				
		alization and endovascular		appointments with documentation	on in the			
	intervention to her rig	ht leg. (a procedure to help		electronic medical record. If a w	ound			
	circulation to her righ	t lower leg).		worsens the treatment nurse muthe Physician for any new order				
	The resident's vascu	lar physician was interviewed		notified resident representative	of			
		AM and stated when he		worsening of wound to include,	•			
		ent her vascular disease was		changes to dressings with docu				
		at the family knew the		in the electronic medical record.				
	resident would proba			100% in-servicing initiated on 10				
		scular physician stated they		by the Facility Nurse Consultant				
		avascular procedures.		Director of Nursing, RN Supervi				
	_	cular physician, he had not		Facilitator, Quality Improvement				
		e resident's leg was declining		regarding the admissions check				
		exposed until the staff made		completed after each new admit				
		9/12/17. The vascular		identify any requested appointm				
		as his understanding that one sed procedure appointments		discharge summary. Upon compadmission checklist the DON, R				
		ent not being kept NPO, and		Supervisor, Staff Facilitator or C				
		due to the resident being		to notify the Ward Clerk of the re				
		eling well. The physician		appointment to be completed by				
		alerted that the tendon had		100% in-servicing initiated on 10				
		en would have tried to admit		by the Facility Nurse Consultant				
	-	espital to better manage		Director of Nursing, RN Supervi				
		h had kept her from having		Facilitator, Quality Improvement Nurse				
	the procedures on 8/			regarding monitoring the pink te				
				orders 5 X a week for orders for				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		345376	B. WING _			09/2	27/2017	
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	=	•		
				2461 LEGION ROAD				
CUMBERI	AND NURSING AND RE	EHABILITATION CENTER		FAYETTEVILLE, NC 28306				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE	
F 250	Continued From page	e 32	F 2	requested appointments. Upon pink telephone orders the Dire Nursing, RN Supervisor, Staff or Quality Improvement Nurse the Ward clerk aware that apphas been requested. Upon each new admission to the RN Supervisor, Staff Facil Quality Improvement Nurse will discharge summary using the checklist 5 X a week X 8 week monthly X 1 month. Once Admichecklist completed, the Ward be made aware of the request appointment. The DON will reinitial the Admission Checklist completion weekly X 8 weeks X 1 month. Any identified area concerns will be corrected dur by Assistant Director of Nursin The pink telephone orders will reviewed by the RN Supervisor Facilitator and Quality Improve 5 X a week for 8 weeks and month to assure that Ward cle aware of any requested appointment of any requested appointment of any requested appointment of the DON will provide oversight reviewing the pink telephone of week X 8 weeks and monthly Any identified areas of concernorected at the time of review The Director of Nursing will for results of the Admission check Executive QI Committee montmonths. The Executive QI Commet monthly x 3 months and Admission Checklist to determand / or issues that may need interventions put into place and in	ector of Facilitator of Facilitator or ill review Admission of Clerk is ted view and for and monthly X ork is made northly X or ma	or ke  y the on to thly udit urse 1 de K a ch.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345376	B. WING		C <b>09/27/2017</b>		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u>-</u>	00/21/2011	
CUMBERL	AND NURSING AND RE	HABILITATION CENTER		2461 LEGION ROAD FAYETTEVILLE, NC 28306			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
F 250 F 281	programme programme and programme pr		F 25	determine the need for further and frequency of monitoring.	d / or	11/5/17	
SS=E	PROFESSIONAL STA	ANDARDS	1 20			11/3/17	
	The services provided as outlined by the cormust-  (i) Meet professional	d or arranged by the facility, mprehensive care plan,					
	staff interviews the fa document the administ three (Residents # 13 sampled residents refindings included:  1. Record review revereadmitted to the faci had a diagnosis of diagnosis of diagnosis of the resident was at risk for Two of the care plant perform finger stick be the facility protocol ar medication as ordere.	nt's care plan, last updated the staff had identified the or complications of diabetes. interventions directed staff to lood sugars as ordered per nd administer the resident's d.		Resident #97 no longer at facility. Resident # 175 was assessed for 10/17/2017 by Director of Nursing Resident # 175 pain medication wadministered per the MAR on 10/by Medication Aide. Resident # 13 assessed for pain on 10/17/2017 Facilitator. Resident # 135 was administered pain medications per MAR on 10/17/2017 by medication Nurse #1, Nurse #2, Nurse #6 and Medication aide #2 were in-service 10/4/2017 by Facility Consultant in Document medications on the MAR it has been given to include narcotic blood sugars. Document narcotics narcotic count sheet as soon as yout of the drawer. All refusals should in the factor of the drawer. All refusals should be still the death with the factor of the fac	r pain on g. vas 17/2017 35 was by Staff er the on aide. d ced on regarding AR after otics and s on the you pull it buld be		
	data set (MDS) assessment, dated 9/5/17, revealed the resident was cognitively intact.			initialed and circled on the front of MAR and the reason should be we the back. Never give any medicate from manager to include inculing.	ritten on tions		
	Review of the resider	it's physician orders		from memory to include insulin. A	iways		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		345376	B. WING _			09	/27/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRES	SS, CITY, STATE, ZIP CODE				
CUMPED	I AND NUBBING AND	REHABILITATION CENTER		2461 LEGION R	ROAD				
CUMBER	LAND NURSING AND	REHABILITATION CENTER		FAYETTEVILL	_E, NC 28306				
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EA	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD SS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 281	Continued From p	age 34	F 2	81					
F 281	revealed an order to have sliding scameals and at bedt 150 to 200 the resunits of Humalog Interview with the revealed he though when he was supproverage recently.  Review of the resimedication administer following documented the was 154 and she zero units of Insul documented the radicumented she radicumented sh	dated 8/21/17, for the resident ale insulin coverage before ime. For blood sugar levels of sident was ordered to receive 2 Insulin.  resident on 9/20/17 at 1:20 PM that there had been a morning bosed to get sliding scale Insulin and he had not received any.  dent's September 2017 istration record (MAR) revealed mentation: On 9/1/17 Nurse # resident's 6:00 AM blood sugar documented she administered in. On 9/2/17 Nurse # 1 esident's blood sugar at 6:00 she documented she units of Insulin. On 9/8/17 ented the resident's blood sugar 74 and she documented she units of insulin.  I Medication Aide # 2 esident's blood sugar was 182. entation the resident received in.  # 1 documented the resident's of fine MAR revealed that for its of Insulin had been given on a zero had been placed on the	F2	follow ord physician special ininsulin to Also read scale dos 100% aud by Facility resident's from 9/1/1 sliding scale and consultar 100 % Me 9/26/2017 with all lical aides' to expense to include to include MAR after narcotics soon as y refusals s	and medication Aide # 2 weed on Medication Administrate Document medications on a rit has been given to includ and blood sugars. Document on the narcotic count sheet you pull it out of the drawer. Should be initialed and circle	ng is. liding 2017 llin hat lered. cility ed on nt n liding e  , rere tion the e nt as All			
	On 9/9/17 at 6 AM Medication Aide # 2 documented the resident's blood sugar was 182. There was documentation the resident received zero units of Insulin.  On 9/14/17 Nurse # 1 documented the resident's blood sugar at 6:00 AM was 164 and she documented she administered zero units of Insulin. Review of the MAR revealed that for each time zero units of Insulin had been given on the above dates, a zero had been placed on the MAR with a line drawn through it.  Nurse # 1 was interviewed on 9/22/17 and confirmed she had not given Resident # 97 his			medicatio Nurse #2, Nurse #6 in-service to include MAR afte narcotics narcotics soon as y refusals s the front o should be	on aides to include Nurse #1  and medication Aide # 2 well on Medication Administrate Document medications on er it has been given to include and blood sugars. Document on the narcotic count sheet you pull it out of the drawer.	ere tion the e nt as All d on			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345376	B. WING_			0:	C 9/27/2017	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE  2461 LEGION ROAD  FAYETTEVILLE, NC 28306				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 281	9/2/17, 9/8/17, and stated Resident # 9 sliding scale orders 8/21/17. Nurse # 1 sorder the resident ut coverage for blood only. The nurse state by what she remems coverage to be for the residency, and she instructions on 9/1/1 to note the order has to note the ord	e Insulin coverage on 9/1/17, 9/14/17 at 6:00 AM. Nurse # 1 7 used to have different prior to his readmission on stated according to the old sed to get sliding scale sugar readings above 200 red she therefore was going bered the sliding scale he resident per his previous had not referenced the MAR's 7, 9/2/17, 9/8/17, and 9/14/17 d changed.  Consultant # 1 identified Nurse o would have been medication aide and Insulin on 9/9/17 for Resident # 97.  be reached during the  vealed Resident # 175 was ity on 7/12/17. The resident rebrovascular accident, es, and hypertensive disorder.  ent's minimum data set (MDS) 7/19/17, revealed the resident ct.  ent's care plan, dated 7/19/17, in thad chronic pain,	F 2	insured following including the regard including includi	ulin. Always follow orders on the Mark low physician's order on the Mark ude special instructions when ministering insulin to include before the meals. Also read Mark correctly rect sliding scale dose of insulin or 4/2017 by Facility Nurse insultant/Director of Nursing. All not addications on the market license nurses will be in-service staff facilitator during orientation arding Medication Administration to ude Document medications on the market license and blood sugars. Documer cotics and blood sugars. Documer cotics on the narcotic count sheet on as you pull it out of the drawer. A usals should be initialed and circled front of the Mark and the reason and be written on the back. Never of medications from memory to includin. Always follow orders on the Market line and the physician's order on the Market line special instructions when ministering insulin to include before the market line scale dose of insulin.  Sistant Director of Nursing/Staff cilitator will monitor 10% of all licent sees and medications aides to include sea and medications aides to include sea and medications aides to include and the market license for slidile insulin and Narcotics are given Market and timely. The Assistant ector of Nursing/Staff Facilitator will ment and Narcotics are given Market and timely. The Assistant ector of Nursing/Staff Facilitator will and the license nurse and/or	to e or for n ewly d by o e e nt as All d on give ude UAR. to e or for		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  2461 LEGION ROAD  FAYETTEVILLE, NC 28306			72172017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 281	mouth - signed "S" Zestril 2.5 mg by mo Aspirin 81 mg by mo Claritin 10 mg by mo Buspirone 5 mg by r  Further review of the revealed the Oxycor 9/17/17 had been signed were circled indicatin There was no explain MAR.  A review of the Cont Receipt/Count Sheer revealed there was no OxyContin had been OxyContin supply at  Nurse # 2 was interv Nurse # 2 stated she shift supervisor begion over until 9:30 AM on that MA # 2 was sch give medications on had been late for wo stayed until the DON not recall exactly ho morning of 09/17/17  Nurse # 6 was interv Nurse # 6 stated she nurse during the we medications on Resi 3:00 PM to 11:00 PM stated she should hab back of the MAR for	ams (mg) every 12 hours by buth daily- signed "S" buth daily- signed "S" buth daily- signed "S" buth daily- signed "S" mouth daily - signed "S" mouth daily - signed "S" e September 2017 MAR atin 10 mg due at 8 PM on gned "SS" and the initials ang it had not been given. mation on the back of the  rolled Substance t for the resident's OxyContin no documentation the a removed from the resident's any time on 9/17/17.  riewed on 9/20/17 at 5:30 PM. e had worked as the night nning on 9/16/17 and stayed an 9/17/17. Nurse # 2 recalled eduled for 9/17/17 dayshift to Resident # 175's hall, but but and she (Nurse # 2) had but had arrived. Nurse # 2 could but medications were given the	F 2	281	medication aide for all identified areas concern during the audit. The DON will review and initial the Medication Pass Audit Tool weekly x 8 weeks then mont x 1 month to ensure all areas of concerare addressed.  The Director of Nursing will forward the results of the Medication Pass Audit To to the Executive QI Committee monthly 3 months. The Executive QI Committee will meet monthly x 3 months and reviet the Medication Pass Audit Tool to determine trends and / or issues that m need further interventions put into place and to determine the need for further at / or frequency of monitoring.	chly crn e ol / x e e w	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	REHABILITATION CENTER	2	TREET ADDRESS, CITY, STATE, ZIP CODE 461 LEGION ROAD EAYETTEVILLE, NC 28306	•		
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F 281	Continued From pa	age 37	F 281				
	OxyContin and she	ne resident did not want the had not given it, and she nented this on the back of the					
	and again on 9/22/ she had not been I MA # 2 stated she	ewed on 9/21/17 at 6:50 AM 17 at 3:40 PM. MA # 2 stated ate on the morning of 9/17/17. had worked the previous night 09/16/17 until 7 AM on					
	there was no staff in she could not go he had not given Resi	stated at 7:00 AM on 9/17/17 member to replace her, and ome. MA # 2 confirmed she dent # 175 his 8:00 AM /Contin, Zestril, Aspirin,					
	Claritin, or Buspiro she signed her initi single "S" was not MAR. MA # 2 did n	ne on 9/17/17. MA # 2 stated als with two letters, and the the initial she used on the ot know how the "S" had been sident # 175's MAR by the					
	and the administrar explanation for the Resident # 7's Oxy Claritin. The DON facility on 9/17/17 a	7 at 3:45 PM with the DON tor revealed they had no "S" which appeared by Contin, Zestril, Aspirin, and stated she had been in the and it was her understanding ving medications and would sible for them.					
	initially admitted to resident had diagn disease with hemo disease, history of surgery, hypertens fibrillation, severe p	evealed Resident # 135 was the facility on 5/6/17. The oses of end stage renal dialysis, coronary artery coronary artery bypass ion, diabetes, anemia, atrial peripheral vascular disease, section with colostomy					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTF		(X3) DATE SURVEY COMPLETED		
		345376	B. WING _				C <b>27/2017</b>	
	ROVIDER OR SUPPLIER  _AND NURSING AND R	EHABILITATION CENTER		2461 LEG	DDRESS, CITY, STATE, ZIP CODE ION ROAD EVILLE, NC 28306	1 00,	2112011	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 281	Review of the resided data set (MDS) asservealed the resider Record review reveal hospitalized from 9/1 underwent a left about The resident was respirately and also the resident was respirately, and also the recocyx.  Review of the resided dated 9/16/17, reveal receive Tramadol 50 hours.  Review of the resided (medication administresident's Tramadol to be given at 8:00 AReview of the resident would have administration at the AM on 9/17/17. The out for the 8:00 AM in the resident would have administration at the AM on 9/17/17. The out for the 8:00 AM in the resident would have administration at the AM on 9/17/17. The out for the 8:00 AM in the resident would have administration at the AM on 9/17/17.	ent's last quarterly minimum essment, dated 8/13/17, at was cognitively intact.  aled the resident was 13/17 until 9/16/17 and ove the knee amputation.  admitted to the facility on was to receive wound care for ular ulcers to her right lower to a Stage III pressure ulcer to ent's readmission orders, aled the resident was to milligrams (mg) every eight ent's September 2017 MAR tration record) revealed the was transcribed to the MAR AM; 12:00 PM; and 8:00 PM.  ent's Tramadol Controlled Count Sheet revealed the had 16 doses available for administration time of 8:00 ere was no Tramadol signed	F2	281	DELIGITY			
	2 had signed she ha 9/17/17. Nurse # 2 was interv Nurse # 2 stated she	viewed on 9/21/17 at 4 PM. e was giving medications on R had been blank by the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345376	B. WING _			C 9/27/2017	
	ROVIDER OR SUPPLIER	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  2461 LEGION ROAD  FAYETTEVILLE, NC 28306			9/2//2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION DATE	
F 281	inadvertently initialed The nurse confirmed resident the 8:00 AM signed as giving on 9  Medication Aide (MA) 9/21/17 at 6:50 AM. worked the previous 9/16/17 to 7:00 AM oo 7:00 AM on 9/17/17 treplace her, and she stated she stayed and on a hall other than the 135 resided. MA # 2 sas many of the medic Resident # 135's hall hall, but was not able to sresponsibilities were hall or verify all of the administered.  Review of the resider Substance Receipt/C was no Tramadol sign dose on 9/18/17. Review at 8 AM on 09/1 Nurse # 2 was interview with the residence of the medical states of the provided at 8 AM whadministered the medical states of the provided at 8 AM whadministered the medical states of the provided at 8 AM whadministered the medical states of the provided at 8 AM whadministered the medical states of the provided at 8 AM whadministered the medical states of the provided at 8 AM whadministered the medical states of the provided at 8 AM whadministered the medical states of the provided at 8 AM whadministered the medical states of the provided at 8 AM whadministered the medical states of the provided at 8 AM whadministered the medical states of the provided at 8 AM whadministered with the residence of the provided at 8 AM whadministered with the residence of the provided at 8 AM whadministered with the residence of the provided at 8 AM whadministered with the residence of the provided at 8 AM whadministered with the provided at 8 AM what a provi	there instead of on 9/18/17. she had not given the dose of Tramadol she /17/17.  If a was interviewed on MA # 2 stated she had night shift (11:00 PM on n 9/17/17). MA # 2 stated at here was no staff member to could not go home. MA # 2 d starting giving medications he one where Resident # stated she tried to administer eations as she could on after she finished her first to administer all of them. Say how medication handled on the resident's medications she had not with the September MAR and signed she had given a 8/17.  Sewed on 9/21/17 at 4 PM. She had signed she gave ten she had not dication on 9/18/17.  Ident on 9/22/17 at 9:48 AM recall a time when she ever	F2	281			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345376	B. WING		C 09/27/2017	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  2461 LEGION ROAD  FAYETTEVILLE, NC 28306	03/21/2011	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 309 F 309 SS=E	FOR HIGHEST WE  483.24 Quality of life Quality of life is a fu applies to all care a residents. Each res facility must provide services to attain or practicable physica well-being, consiste comprehensive ass  483.25 Quality of ca Quality of care is a applies to all treatm facility residents. Ba assessment of a re that residents recei accordance with pra practice, the compre	PROVIDE CARE/SERVICES ELL BEING  The standamental principle that and services provided to facility sident must receive and the at the necessary care and a maintain the highest and services, and psychosocial and with the resident's essment and plan of care.  The standamental principle that the services are fundamental principle t	F 309		11/5/17	
	provided to residen consistent with prof the comprehensive and the residents' g  (I) Dialysis. The fact residents who requiservices, consistent of practice, the compared care plan, and the repreferences.	ent. sure that pain management is ts who require such services, ressional standards of practice, person-centered care plan, roals and preferences.  cility must ensure that rice dialysis receive such that with professional standards reprehensive person-centered residents' goals and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345376	B. WING _			09/	27/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CUMPER	AND MUDOING AND	DELIABILITATION CENTED		2	461 LEGION ROAD		
CUMBERI	AND NURSING AND	REHABILITATION CENTER		F	AYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From pa	age 41	F 3	309			
	Based on record re	eview, family interview, and facility failed to provide			F 309		
		and coordination of care with a			On 9/21/17, a head to toe skin		
		physician to assure a			assessment was completed on Reside	nt	
	_	was done for one (Resident #			#135 to include the coccyx ulcer with n		
	135) out of one res	ident with vascular ulcers. The			new skin issues identified or changes t	.0	
	findings included:				the coccygeal wound. On 9/22/17, the		
					coccyx wound was cleansed, Santyl		
		evealed Resident # 135 was			ointment and dressing applied by the		
		the facility on 5/6/17. The			treatment nurse per the physician's		
		oses of end stage renal dialysis, coronary artery			orders. On 9/25/17, The Director of Nursing (DON) was made aware that		
		coronary artery bypass			Resident #135 failed to receive dressir	າຕ	
		ion, diabetes, anemia, atrial			changes as ordered for 8/5/17, 8/6/17,	•	
		peripheral vascular disease.			8/12/17, 8/13/17, 8/19/17, 8/20/17,		
	•	·			8/26/17, 8/27/17, 9/2/17, 9/3/17, 9/9/17	<b>,</b>	
	Review of the resid	lent's last quarterly minimum			and 9/10/17. On 9/28/17, Resident #1	35	
	, , ,	sessment, dated 8/13/17,			was seen by the wound physician and		
		ent was cognitively intact. The			returned to the facility with new orders		
		coded as having 7 vascular			treatment of the coccyx wound: Cleans		
	ulcers.				with soap and water, apply crushed Flat 500 milligrams, cover with Aquacel Silv		
		lent's care plan, last updated			and a foam dressing to be changed ev		
	'	ed the staff had identified the			other day and as needed. Resident #1	35	
		Iceration caused by diabetes			had a follow up appointment with the		
		cular disease. The goal for the			wound physician on 10/5/17 with no change in orders for treatment to the		
		he would show positive healing of develop further ones. Staff			coccyx and another appointment		
		ne care plan to provide			scheduled for October 19, 2017.		
	treatment as ordere				Schoduled for Colober 10, 2017.		
					On 8/8/17, Resident #135 attended the	•	
	According to Augus	st, 2017 wound ulcer flow			appointment with Carolina Vascular for		
	records the resider	nt had vascular ulcers on her			vascular procedure, but was unable to		
		lower leg, left great toe, left			undergo the procedure due to eating		
	_	heel, right heel, and right			breakfast prior to arrival. The procedur		
	great toe.				was cancelled on 8/8/17, and Resident	]	
					#135 returned to the facility.		
		acility was asked to provide the om the resident's thinned			On 8/8/17, Resident #135 was		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345376	B. WING _			1	C <b>27/2017</b>
	ROVIDER OR SUPPLIER  LAND NURSING AND RE	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  2461 LEGION ROAD  FAYETTEVILLE, NC 28306			1 03/	2172017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	for August and Septe vascular ulcers.  On 9/25/17 at 5:13 P nursing) provided a p 7/25/17, for the ulcer right and left lower le resident was to have these areas. The staulcers with saline and dressing.  On 9/26/17 at 4:46 P provided the facility's treatment modality be #135's left great toe, right great toe, and ri of August, 2017 and Review of Resident 1 administration record was to have the follow changed daily. Santidry dressing per the August and a dry dressing ap be checked and char 2107 TAR.  The left outer great to right great toe were to the dressing was to the dressing was to the dressing was to the dressing was to the single provided the follow changed daily. Santidry dressing per the August and a dry dressing appeared to the ward and a dry dressing appeared to the ward and a dry dressing appeared to the ward and the follow changed the following per the August 107 TAR.	M, the DON (director of obysician's order, dated is located on the resident's gs. This order specified the daily dressing changes to ff were to cleanse these diapply Santyl and a dry  M, the facility administrator wound protocol as the eing used for Resident left outer great toe, left heel, ght heel during the months September, 2017.  I 35's August, 2107 treatment I (TAR) revealed the resident wing dressing changes.	F3	809	re-scheduled for an appointment with Carolina Vascular on 8/21/17 by the was clerk.  On 8/21/17, Resident #135 was scheduled to attend the appointment we Carolina Vascular. Resident #135 did go to the appointment due to complaint of nausea.  On 9/12/17, Resident #135 arrived for appointment at Carolina Vascular for evaluation of bilateral lower extremities. Resident #135 was transported to Cappear Valley Medical Center  On 9/17/17, Resident #135 returned to facility from Cape Fear Valley Medical Center.  On 9/26/17, Resident #135 went to Carolina Vascular for evaluation of bilateral lower extremities.  On 10/17/2017, a 100% audit of all Treatment Administration Records (TAI for the 8/1/2017-9/30/2017 was initiated by the Facility Nurse Consultant and Director of Nursing to ensure all dressic changes were performed as ordered by the physician to include Resident #135. The 100% audit of all TARs will be completed by 11/05/2017. Any areas of concern identified during the audit to include missing documentation will be immediately addressed by the Director Nursing to include additional retraining physician notification, and/ or any new orders.	rith not ts	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTI G		(X3) DATE COMP	SURVEY
		345376	B. WING			1	27/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	03/	2112011
	10115211 011 001 1 2.2.1				GION ROAD		
CUMBERI	AND NURSING AND RE	HABILITATION CENTER			EVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		3E	(X5) COMPLETION DATE
F 309	Continued From page	e 43	F3	09			
	documentation on the Resident # 135's dres changed to any of he 8/6/17, 8/12/17, 8/13/ 8/26/17, 8/27/17.	nber, 2017 TAR revealed the		begii by th all ap rema to a	10/6/2017, a 100% audit of all char inning August 1, 2017 was comple ne facility nurse consultant to ensu ppointments requiring residents to ain with nothing by mouth (NPO) p scheduled appointment was corre	ted ire prior	
	resident was to have changes: The right and left low changed daily. Santy dry dressing per the S		compose the factorial Direction	wed and that the procedure was pleted. Any areas of concern erved was immediately addressed facility nurse consultant and/ or ctor of Nursing (DON).  10/4/2017 a 100% inservice was	by		
	The left great toe, left outer great toe, left heel, right heel, and right great toe were to be painted with betadine. The dressing was to be checked daily and changed every three days per the September, 2017 TAR.			Cons Facil rega chan	ated by the Facility Nurse sultant/Director of Nursing/Staff litator for all licensed nurses arding the expectation that dressing will be completed by the hall ses in absence of the treatment nu	_	
	documentation on the Resident # 135's dres	nber 2017 TAR revealed no e following weekend dates ssings were checked or r vascular ulcers: 9/2/17, /10/17.		com com not a	clude on weekends. The 7-3 shift pletes odd numbered rooms and 3 pletes even numbered rooms. This an option. Document by initialing the atment Administration Record ediately after completing treatment.	s is ne	
	135 was admitted to underwent amputatio the necrotic areas on	ed on 9/13/17 Resident # the hospital where she n of her left leg secondary to her left leg not being ment and revascularization.		nurs Direc treat Trea	tments cannot be completed the hase must notify nursing supervisor/ of ctor of Nursing. All refusals of tments must be documented on the atment Administration Record and nursing progress note to include	of e	
	(RP) on 9/20/17 at 12 concerned the reside appear to be changed visited. The resident appeared old, and the	ident's responsible party noon revealed she was nt's dressings did not on some days when she s RP stated the dressings ere was no date on the ated she had talked to staff		Resi refus No li until hired	ications of the physician and the ident Representative of treatment sal. icensed nurse will be allowed to w completing this inservice. All new d and agency licensed nurses will rviced on orientation by the Staff	ly	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7 t. BOILDI	_		، ا	
		345376	B. WING _				27/2017
NAME OF PI	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	2112011
					461 LEGION ROAD		
CUMBERL	AND NURSING AND RE	HABILITATION CENTER			AYETTEVILLE, NC 28306		
0411.1=	CLIMMADY CT	TATEMENT OF DEFICIENCIES					0/5
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	e 44	F;	309			
	members regarding h				Facilitator regarding missed dressing		
	momboro rogaranig r	ior correctine.			changes and the expectation that all		
	On 9/22/17 at 3:14 P	M Facility Nurse Consultant			treatments ordered by the physician wi	II	
		nurses who had been			be completed as ordered and		
	responsible for Resid				documented on the TAR in the absence	e of	
	changes during the S	September, 2017 weekends.			a treatment nurse or other designated		
	On 9/26/17 at 10:55	AM the director of nursing			nurse to include on the weekends.		
	(DON) provided a list	of nurses who had been			On 10/4/2017, a 100% inservice for all		
		end dressing changes in			licensed nurses was initiated by the		
	_	sident # 135. According to			Director of Nursing regarding following		
		and DON one of the hall			orders for scheduled appointments to		
	_	ft and evening shifts on the			include ensuring the resident remains	on	
		e the dressing changes. The			NPO status prior to arriving for a		
		esponsible and the dates			procedure. This inservice provides		
		ney were identified to be			education to the licensed nurses to alw	-	
	responsible are as fo 8/5/17-7:00 AM to 3:				document any new orders for NPO state prior to an appointment in the resident?		
	8/5/17- 3:00 PM to 11				medical record (PCC) and on the	5	
	8/6/17- 7:00 AM to 3:				Medication Administration Record (MA	B)	
	8/6/17- 3:00 PM to 11				on the scheduled date of appointment.	11)	
	8/12/17- 7:00 AM to 3				No licensed nurse will be allowed to wo	ork	
	8/12/17- 3:00 PM to				until completing this inservice. All newly		
	8/13/17-7:00 AM to 3				hired and agency licensed nurses will b		
	8/13/17-3:00 PM to 1				inserviced on orientation by the Staff		
	8/19/17-7:00 AM to 3	:00 PM-Nurse # 8			Facilitator regarding following orders fo	r	
	8/19/17-3:00 PM to 1	1:00 PM-Nurse # 8			scheduled appointments to include		
	8/20/17-7:00 AM to 3	:00 PM-Nurse # 1			ensuring the resident remains on NPO		
	8/20/17-3:00 PM to 1	1:00 PM -Nurse # 1			status prior to arriving for a procedure.		
	8/26/17-7:00 AM to 3	:00 PM-Nurse # 4			This inservice provides education to the		
	8/26/17- 3:00 PM to	11:00 PM-Nurse # 1			licensed nurses to always document ar	ny	
	8/27/17-7:00 AM to 3				new orders for NPO status prior to an		
	8/27/17-3:00 PM to 1				appointment in the resident's medical		
	9/2/17-7:00 AM to 3:0				record (PCC) and on the Medication		
	9/2/17-3:00 PM to 11				Administration Record (MAR) on the		
		00 PM-Nurse # 3/or Nurse #			scheduled date of appointment.		
	1   0/2/47 2:00 DM to 44	.00 DM Numa a # 0/ = = Numa =			The Assistant Director of Nursing/Nurs		
		:00 PM-Nurse # 2/ or Nurse			Supervisor will conduct audits of 10% o	)I	
	# 1 9/9/17-7:00 AM to 3:0	00 PM Nurse # 4			TARs utilizing the TAR documentation audit tool weekly for twelve weeks to		
	1.6 ()) IVIA UU. 1-1   1616	JU I IVI-INUISE##	1		i audictoolweekivioltweiveweeksto		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345376	B. WING				C / <b>27/2017</b>	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	12112011	
					461 LEGION ROAD			
CUMBERI	AND NURSING AND I	REHABILITATION CENTER			AYETTEVILLE, NC 28306			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIEI	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 309	Continued From pa	nge 45	F;	309				
	· ·	11:00 PM-Nurse # 1			include Resident #135 to ensure dress	ina		
		3:00 PM-Nurse # 4			changes are completed as ordered by	-		
		11:00 PM-Nurse # 1			physician. Any areas of concern noted			
					during the audits will be immediately			
	Nurse # 3, who had	d been identified as			addressed by the DON to include			
		day and had shared			additional training, physician notification			
		other day, was interviewed on			and/ or initiating the protocol for negle	ct if		
		. The nurse stated she had not			indicated.			
		changes. The nurse was not			The Nursing Supervisor will conduct	4		
	aware it was her re	sponsibility.			audits of 10% of scheduled appointme	nts		
	Nurse # 4 who had	I been identified as			utilizing the weekly for twelve weeks including Resident #135 to ensure all			
	Nurse # 4, who had been identified as responsible on six of the week-end days as either				appointments requiring residents to			
		esponsible, was interviewed on			remain with nothing by mouth (NPO) p	rior		
		urse # 4 stated she had not			to a scheduled appointment was corre			
		changes for Resident # 135			followed. The Q.I tool for monitoring	,		
		and September week-end days			appointments will also ensure that			
	she worked. The nu	urse stated she was charge			documentation in the electronic medic			
		sponsibilities, and she was not			record has occurred regarding the time	€,		
		ner responsibility to change the			date, location, and reason for the			
	dressings.				scheduled appointment. and that the			
	N # 0b - b				procedure was completed. Any areas			
	Nurse # 2, who had	ally responsible on two days,			concern will be immediately addressed the DON to include additional retrainin	-		
		9/25/17 at 9:25 AM. The			The DON will forward the results of the	-		
		ad not done the dressing			Tool for monitoring appointments to the			
		e stated she had just started			Executive QI Committee monthly for the			
	_	gust, 2017 and she had not			months. The Executive QI Committee			
		dressing changes were one of			meet monthly for three months to revie	ew		
	her responsibilities.				the audit results of the Q.I. tool for			
					monitoring appointments. Any issues,			
	Nurse # 8, who had				concerns, and/or trends identified will			
		day, was interviewed on			addressed by implementing changes a			
		. The nurse stated she did not			necessary, to include continued freque	ncy		
		had or had not done the			of monitoring.			
	dressing changes.							
	Nurse # 7, who had	d been identified as						
	· ·	day for the dressing changes						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345376	B. WING _			C <b>9/27/2017</b>	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2461 LEGION ROAD FAYETTEVILLE, NC 28306		312112011	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF ( X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 309	nurse stated she changes. The nur time to do it. The have a treatment when the treatme months the facility schedule for the hanges. The nur directed that days either the odd nur rooms, and the eversponsible for the not do. The nurse went over the new directions. They judesk. The nurse signer the other responsible for me hall nurses had to administer responsible for me halls, deal with fair issues/events that with week-end how the phone.  Nurse # 1, who hapartially responsition 9/27/17 at 9:20 only done the dre August and Septe that was when the approached her a stated she had not done it. The nurse had not done the The nurse stated the dressing change.	large 46 In 9/26/17 at 4:42 PM. The had not done the dressing se stated there was not enough nurse stated the facility used to nurse on the week-ends, and int nurse quit during the summer or management staff left a paper hall nurses to do dressing se stated the paper schedule shift nurses were responsible for inher rooms or even number or evening shift nurses were enough the dayshift nurses did stated management never or responsibility or gave ust left the paper schedule at the stated it was an impossible task asponsibilities which were placed of the nurse stated she often medications for two halls, be redication assistants on other milly concerns, deal with the days are used as solely or one on 8 days, was interviewed of AM. The nurse stated she had assing changes one time during the more for Resident # 135, and the resident's family member had and requested it. The nurse stated on the other days, she resident's dressing changes. The nurse stated she had the stated on the other days, she resident's dressing changes. The nurse stated she often had to ges given her other he nurse stated she often had to	F	309			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2461 LEGION ROAD FAYETTEVILLE, NC 28306	, 0.	512112011
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F 309	medication cart resp for medication techn intravenous fluids, Ir nurse stated she had who had worked in A dressing changes not week-end but then the stated the new DON long enough for her problem.  Interview with the Dorevealed she had just previous week and saware of the lack of Resident # 135.  Interview with the act 12:15 PM revealed thad not been brough staff had probably to was no longer employ.  The resident's vascular physician Fulcer dressings show changed daily as a saccording to the phy the resident would probat amputations at some 1 b. Record review resident would probat amputations at some 1 b. Record review resident noted the	and she often had her own onsibilities as well as cover icians who could not give isulin, or tube feedings. The did talked to the previous DON, august 2017, about the obeing done on the ine DON had left. The nurse had not been at the facility to talk to her about the one of the ine makes of the had not been made dressing changes for a liministrator on 9/26/17 at the missed dressing changes in the her attention and that the old the previous DON, who be one of the ine had not been checked or is standard of good practice. It is standard of good practice, is sician, when he initially saw 2017, her vascular disease oint that the family knew the ably need bilateral is point.	F3	09		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP  2461 LEGION ROAD  FAYETTEVILLE, NC 28306	CODE	00/21/2011
(X4) ID PREFIX TAG			ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 309	Continued From pag	e 48	F3	309		
	noted he was schedule evaluate the arterial	The vascular physician uling noninvasive studies to anatomy and determine the culation) to the lower				
	dated 7/27/17, reveal identified through test bilateral chronic total femoral arteries. The was to place a femoral attent to help with vascular ulcers. The to do the left leg first the right leg. The vas procedure was explain.	ian's consult follow up note, led the physician had sting that the resident had occlusion of the superficial evascular physician's plan al artery balloon and a patch oblood supply for her physician noted he planned and then at a later time do scular physician noted the ined to the resident and she nderstood and agreed to the				
	notes from 7/27/17 to notations regarding of further vascular considerations. Review of the reside revealed on 8/7/17 to was documented as stringy tissue and 40 measurements were centimeters (cm). Or the resident missed at there was document exposed in the residemeasurements were 8/28/17 the tendon wexposed, and the measurements.	nt's wound care notes ne resident's left leg ulcer 20 % necrotic; 40 % grey % slough. The 2.5 cm X 2.0 X 0 n 8/21/17, the day on which a procedure appointment,				
		measurements were 9.0 X				

AND DIAN OF CORRECTION IDENTIFICATION NUMBER		1 ' '	PLE CONSTRUCTION  IG	(X3)	(X3) DATE SURVEY COMPLETED		
		345376	B. WING			C	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI  2461 LEGION ROAD  FAYETTEVILLE, NC 28306	DE	09/27/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 309	3.0 X 0.8 cm. On 9/	ge 49 11/17 the tendon was osed, and the measurements	F3	09			
	were 10.4 X 4.5 X 1 There was no notati						
	the nursing notes in to schedule an apport physician. Nurse # 6 11:44 AM that a call vascular physician's appointment, and th extremity continued circulation. The nurs	at the resident's left lower to worsen because of no se noted the resident had vious appointments per the					
	9/20/17 at 12 noon of scheduled to undergate 8/8/17, but never has resident was given a NPO (nothing by more resident's RP stated the hospital on 8/8/1 when they found should be sausage they sent had ong the procedure rescheduled for a second was nauseated and hospital. The RP stated one day set to the stated one day set to the scheduled for a second hospital. The RP stated one day set to the scheduled for a second hospital of the stated one day set to the scheduled for a second hospital of the scheduled for a second ho	sident's responsible party on revealed the resident was go the vascular procedure on a the procedure because the a breakfast tray and not kept buth) by facility staff. The the resident actually went to 17 to have the procedure, and the had eaten a piece of the back to the facility without at the RP stated it was becond time, and the resident did not feel up to going to the sted the resident's left leg are and she felt the facility ting well with the vascular of get the procedure done. The she was present when the changes were being done,					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG	(X	(3) DATE SURVEY COMPLETED
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F 309	Continued From pag and she saw that the worsened to the poir exposed. The RP sta facility call and get the vascular physician.  Interview with the worse administrator on 9/2/1 facility's ward clerk he vascular physician's procedure scheduled. The ward clerk was in AM. The ward clerk was in AM. The ward clerk is book and verified the for the vascular procedure scheduled for the resident to be them to a facility nurse recall to which nurse. The ward clerk continues and the resident did was her understanding.	e 50 resident's left leg ulcer had it that the tendon was ited she demanded that the ite resident back to the				
	resident had not gon and that she needed reschedule the proce on the day she was revascular physician's needed to speak to a clerk stated she left a The ward clerk states said that they would regarding the resider appointments. The w	and was not aware the e to the procedure until later to be following up to edure. The ward clerk stated made aware, she called the office and was told she a specific person. The ward a message for the person. d the person called back and talk to the vascular physician nt since she had missed two yard clerk stated she never wound care nurse called on				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	12:25 PM revealed the NPO was for the sor provide a note for stated he then made prepared and sent to to be NPO. The dieta not received any note anyone that the reside morning of 8/8/17.  Nurse #4, who was a #135 on 8/8/17, was PM. The nurse stated after the resident had breakfast tray on the nurse stated there was resident had eaten on the hospital but the procedure.  Interview with Nurse 9/25/17 at 11:45 AM assigned NA for Resistated she was in the aware the resident had tray by another staff is stated when she got resident had her breat told her she was not was not aware of what tray when it was serve had eaten or not.	tary manager on 9/22/17 at the procedure for a resident to staff to either tell him verbally him. The dietary manger sure a tray was not the hall for a resident who is ry manager stated he had en or communication from the ent was to be NPO on the signed to care for Resident interviewed on 9/22/17 at 6 at she arrived at the facility already been served the morning of 8/8/17. The as confusion to whether the enot, and she was sent to hysician did not do the served above the dent # 135 on 8/8/17. NA # 5 dining room and was not ad been served a breakfast member on 8/8/17. The NA to the resident's room, the akfast before her and she supposed to eat. The NA at the resident had on the ed to verify if the resident	F	309			
		office was interviewed. The ed the resident's vascular					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  NG	_	(X3) DATE SURVEY COMPLETED
		345376	B. WING _			C <b>09/27/2017</b>
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, S 2461 LEGION ROAD FAYETTEVILLE, NC 28	,	03/2//2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH CORRE	SPLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 309	resident was not ken confirmed the reside second procedure w 8/21/17.  Interview with the re noon revealed when resident to the 9/12/ physician immediate resident to the hospi amputation of the re Record review revea hospitalized on 9/13 above the knee amphospitalization the refemoral artery recan intervention to her right The resident's vascu on 9/25/17 at 11:15 initially saw the resident would probate severe to the point the resident would probate amputations. The variant wanted to first try into According to the vast been made aware thand the tendon was the appointment for physician stated it wor the resident's mission was due to the resident the second one was nauseous and not fer	lone on 8/8/17 because the of NPO. The staff member and did not show up for the which had been scheduled for sident's RP on 9/20/17 at 12 as he accompanied the 17 appointment, the vascular by decided to admit the tall the next day for a planned sident's left leg.  Alled the resident was alled the resident was perfect that a right superficial alization and endovascular ght leg.  Allar physician was interviewed AM and stated when he dent her vascular disease was that the family knew the	F	309		
	been exposed, he th	nen would have tried to admit ospital to better manage				

	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION    BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  LAND NURSING AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 461 LEGION ROAD AYETTEVILLE, NC 28306			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 312 SS=D	buring an interview w 9/21/17 at 2:40 PM the acknowledged the fact resident NPO on the administrator stated at tray, her staff felt that not supposed to eat. staff felt the resident procedure and therefor the procedure. The at 8/21/17 her staff felt to go.  483.24(a)(2) ADL CADEPENDENT RESID (a)(2) A resident who activities of daily living services to maintain opersonal and oral hygometric that the procedure and therefore the procedure and the procedure and the procedure to go.  483.24(a)(2) ADL CADEPENDENT RESID (a)(2) A resident who activities of daily living the procedure and the provide assistiving for two (Resident activities of daily living 175). The findings incomplete the facility failed to the facility had diagnoses of certain the procedure and the procedure that the procedure is the procedure that the procedure	in had kept her from having 8/17 and 8/21/17.  With the administrator on the administrator collity failed to keep the morning of 8/8/17. The although they served the atthe resident knew she was The administrator stated her was hesitant to have the ore ate intentionally to avoid diministrator stated on the resident just did not want RE PROVIDED FOR SENTS  Is unable to carry out greceives the necessary good nutrition, grooming, and giene.  The is not met as evidenced they, resident interview, the staff interviews the facility stance with activities of daily attentions of the serviewed for care needs. The reviewed for care needs arovide feeding and toileting the 99) and assistance with great at bedtime (Resident #		312	F 312 On 10/18/17, Resident # 99 was provid with feeding assistance and received toileting assistance by the assigned hanursing assistant. Resident # 175 was provided assistant with bedtime activities of daily living (ADLs) on 10/15/2017 by assigned hall nursing assistant. NA #6 and Medication Aide # 3 were in-serviced on 10/3/2017 Facility Nurse Consultant in regards to helping residents use the toilet and get dressed. Toileting may include to provide total assistance.	II ce I on 7 by	11/5/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 037	2112011
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CUNDERL	AND NURSING AND R	EHABILITATION CENTER		F	AYETTEVILLE, NC 28306		
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F 312	assessment, dated a was cognitively intace needing extensive a hygiene, dressing, be needs.  Review of the resider revealed the resident migraines, and diaber plan also identified the non-ambulatory, use and needed assistant dressing, and transfed directed staff to transmechanical lift and a daily living needs.  The resident was int PM and stated he had (9/17/17) evening an could not find anyon the resident he went help but there was nhim. The resident stawho needed to help somewhere," but he According to the ressomeone to assist he called his family mer member arrived around prepare and go to be available staff member.  According to staffing was the 3:00 PM to	ent's minimum data set (MDS) 7/19/17, revealed the resident ct. The resident was coded as sisistance from staff with his athing, and bed mobility  ent's care plan, dated 7/19/17, at had chronic pain, etic neuropathy. The care the resident was at a wheelchair for mobility, noe with his hygiene, er needs. The care plan efer the resident with a tessist him with his activities of  erviewed on 9/20/17 at 1:50 and a migraine on Sunday and wanted to go to bed but the to help him. According to the on the hall and asked for the ot anyone available to assist the ated he was told the person him was "around could never find them. tident after he tried to find tim for about two hours, he mber. He said his family und 9 PM and helped him the debecause there was no the one to assist him.  I sheets for 9/17/17 Nurse # 6 11:00 PM nurse on Resident	F	312	Residents should be checked for toiletineeds no less than every two hours. To transfer, and reposition your residents include the chair and bed. This task mube performed in a timely manner and based upon the resident's preference. Help to take residents to eat and to participate in various activities. Serve the residents meals and in some cases, assist the residents to eat if necessary. Residents must be fed in a manner than to too fast for meal intake. Ensure all residents in rooms and in the dining roof have trays passed out and residents needing assistance are being fed at the same time and reporting to hall nurse if care cannot be provided timely. Reside # 175 and # 99 continue to receive time assistance with activities of daily living, feeding assistance and toileting assistance.  100% audit of all residents was initiated on 10/3/2017 by the Facility Consultant include resident # 175 and # 99 to assitimely personal care to include assistance with ADL's, feeding assistance and toileting assistance to be completed on 11/05/2017. Personal care will immediately be provided for the resider and re-training to the nursing assistant any areas of concern to be addressed Facility Consultant/Staff Facilitator durit audit.  100% of nursing assistants were re-educated on helping residents use the toilet and to get dressed. Toileting may include to provide total assistance or	urn, to ust  ne t is om e t tis om t to ure for by ng	
	# 175's hall. Nurse	Aide (nurse aide) # 6 was the  # shift NA. There were no			partial assistance. Residents should be checked for toileting needs no less that		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  IG	, ,	(X3) DATE SURVEY COMPLETED	
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NAME OF D	DOMED OF SURPLIED	343376	D. WING _			9/27/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	Ē		
CUMBERI	LAND NURSING AND	REHABILITATION CENTER		2461 LEGION ROAD			
				FAYETTEVILLE, NC 28306			
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F 312	Continued From p	age 55	F 3	12			
		rs on the staffing sheets for hall for the 3:00 PM to 11:00 PM		every two hours. Turn, transfere reposition residents to include and bed. This task must be per a timely manner and based up	the chair erformed in		
	date of 9/17/17 rev	information provided for the vealed there were twenty dent # 175's hall on 9/17/17.		resident's preference. Help to residents to eat and to particip various activities. Serve the remeals and in some cases, ass	take pate in esidents		
	According to Nurs resident had a hea and had given him Nurse # 6 she did and was being attemedication cart ar #175 needed assis Sunday evening (\$ she had not assist According to Nurs for bedtime medic	erviewed on 9/20/17 at 5:35 PM.  e # 6 she was aware the adache on 9/17/17 at 4:30 PM a medication. According to not normally give medications, entive to her duties on the ad was not aware Resident stance getting ready for bed on 0/17/17). The nurse confirmed ed the resident to bed.  e # 6 when she got to his room ations he was already in bed.  ewed on 9/21/17 at 4:10 PM.		eating if necessary. Residents fed in a manner that is not too meal intake. Ensure all reside and dining room have trays part and residents needing assistate being fed at the same time, are to hall nurse if care cannot be timely on 10/3/2017 to be com 11/05/2017. All newly hired reassistants will be in-serviced by Facilitator during orientation or residents use the toilet and to dressed. Toileting may include total assistance or partial assistance.	s must be fast for nts in room assed out nce are nd reporting provided npleted by nursing by the Staff n Help your get e to provide		
	NA # 6 stated she residents to care f 9/17/17. NA # 6 st 175's room a little he was already in him.  Interview with the 9/21/17 at 10:45 A call around 8 PM of The family member him he had been to find anyone to hell	thought she had "about fifteen" or on the evening shift of ated she got to Resident # after 9:00 PM to assist him and bed, but she had not assisted resident's family member on M revealed he had received a on 9/17/17 from Resident # 175. For stated Resident # 175 told o all of the halls and he couldn't poly him to go to bed. The family (the family member) then		Residents should be checked needs no less than every two transfer and reposition resider include the chair and bed. This be performed in a timely many based upon resident's prefere take residents to eat and to pay various activities. Serve the remeals and in some cases, asseating if necessary. Residents fed in a manner that is not too meal intake. Ensure all reside and dining room have their traout and residents needing ass	for toileting hours. Turn, hts to s task must her and hnce. Help to articipate in esidents sist with s must be of fast for hts in room hys passed		
	drove to the facility family member sta	y to help the resident. The steed when he arrived he only cople on the hall that evening.		being fed at the same time, ar to hall nurse if care cannot be timely.	nd reporting		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345376	B. WING _		<del></del>	09	/27/2017	
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE			
CUMPER	AND MUDOING AND	DELIABILITATION CENTER		2461	LEGION ROAD			
CUMBERI	LAND NURSING AND	REHABILITATION CENTER		FAY	ETTEVILLE, NC 28306			
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F 312	The family member help the resident pron 9/17/17. The far not enough staff.  2. Record review admitted to the fact had diagnoses of lailure, dementia, and the resident was sometimed to the resident was assistance from structure to the resident was assistance from structure to the resident was assistance from structure to the resident was assessed impairments and in his lower extremitical assessed as always bladder.  Review of the resident resident resident and need dressing, eating, to care plan directed mechanical lift and daily living needs.	age 56 er confirmed he was the one to prepare for bed and go to bed mily member stated there was a vivil revealed Resident #99 was still to on 11/19/14. The resident heart disease, acute kidney and Alzheimer's Disease.  Ident's annual minimum data ment, dated 4/20/17, revealed everely cognitively impaired. Coded as needing extensive aff with his hygiene, dressing, eating and bed mobility needs. With no upper extremity mpairments on both sides of es. Resident #99 was also by incontinent for bowel and dent's care plan, dated the resident was cognitive led assistance with bathing, ransferring, and mobility. The staff to transfer with a disassist him with his activities of taffing sheets for 9/17/17,	F3	F CONTROL OF THE PROPERTY OF T	Resident care audit tools will be completed by Assistant Director of Nursing/Nursing supervisor on 10% of residents to include resident # 175 and 99 to ensure residents received persocare to include assistance with ADL's reeding assistance and toileting assistance 3 X a week for 4 weeks and weekly X 4 weeks and monthly X 1 month. All nursing assistants will be mmediately retrained for any identified areas of concern by Assistant Directon Nursing/Nursing Supervisor during the observation. The Director of Nursing will and review the results of the resident care audit tool weekly X 12 weeks for completion and to ensure a sareas of concerns have been address. The Director of Nursing will forward the sults of the Resident Care Audit Tool he Executive QI Committee meet monthly x 3 months and review Resident Care Audit Tool to determine the need for further and / or requency of monitoring.	d # nal  d d f of e vill ll eed. x 3 will the		
	Medication Aide #: Nurse Assistant or were no other staf sheets for Resider to 3:00 PM Nurse  Review of the cens date of 9/17/17 rev	3 was the 3:00 PM to 11:00 PM in Resident #99 's hall. There if members on the staffing int #99 's hall after the 7:00 AM Assistant #8 ended her shift.  Sus information provided for the wealed there were twenty-one tent #99 's hall on 9/17/17.			isquerioj of monitoring.			

		(X3) DATE SURVEY COMPLETED	
B. WING		C 09/27/2017	
	STREET ADDRESS, CITY, STATE, ZIP CODE  2461 LEGION ROAD  FAYETTEVILLE, NC 28306	33/21/2311	
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F 31	2		
F 31	4	11/5/17	
	ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE  2461 LEGION ROAD  FAYETTEVILLE, NC 28306  ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRIA	

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		345376	B. WING_			C <b>09/27/2017</b>
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  2461 LEGION ROAD  FAYETTEVILLE, NC 28306	I	09/2//2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF  (EACH CORRECTIVE ACTION S  CROSS-REFERENCED TO THE AF  DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 314 SS=E	PREVENT/HEAL PR  (b) Skin Integrity -  (1) Pressure ulcers. comprehensive asse facility must ensure to the comprehensive assert ensure ulcers and on the compressure ulcers and demonstrates that the comprehensional standard healing, prevent inferform developing. This REQUIREMENT by:  Based on observation interview, and staff in assure one (Resident residents with pressure one (Resident residents with pressure one integrated to the comprehension of the c	Based on the sement of a resident, the hat- s care, consistent with does not develop pressure develop pressure does not develop pressure develop pressure develop pressure develop pressure develop pressure develop dev	F3	F 314 Treatment and Services Prevent/Heal Pressure Sores On 9/21/17, a Head to Toe Skin Assessment was completed on # 135 to include her coccyx ulco new skin issues identified or ch coccygeal wound by Treatment On 9/22/17, the coccyx wound cleansed, Santyl ointment and applied by the Treatment Nurse physician's orders. On 9/28/17, #135 was seen by the Wound F and returned to the facility with	Resident er with no anges to Nurse. was dressing e per the Resident Physician new orders	
	and history of bowel formation.	ripheral vascular disease, resection with colostomy nt's quarterly minimum data		for treatment of Coccyx wound: with soap and water, apply crus 500 milligrams, cover with Aqua and a foam dressing to be char other day and as needed. Residual control of the control of	shed Flagyl acel Silver aged every	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345376	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	343370		STREET ADDRESS, CITY, STATE, ZIP CODE	•	/27/2017	
NAME OF FI	NOVIDER OR SUFFLIER				-		
CUMBERL	AND NURSING AND RE	EHABILITATION CENTER		2461 LEGION ROAD			
				FAYETTEVILLE, NC 28306			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 314	Continued From pag	e 59	F 31	14			
	the resident had one	ent, dated 8/3/17, revealed Stage III pressure ulcer.		Representative made aware o wound orders by Director of N 9/28/2017. Resident #135 had	ursing on follow up		
		nt's care plan revealed it was		appointment with the Wound F	-		
		and last updated on 8/17/17		10/5/17 with no change in orde			
		ent's pressure ulcer. A		treatment to the coccyx, Resid			
	-	e resident's care plan was		Representative made aware o			
		a wound to her coccyx. The resident was that the coccyx		orders by Treatment Nurse on Resident # 135 another appoin			
	wound would show h			scheduled for October 19, 201			
	Would Would Show I	icaning.		Representative made aware o			
	Review of physician	orders revealed an order		appointment by Facility Nurse			
		ly dressing changes to the		on 10/10/2017.	Concanant		
		er. The order directed staff to		0.1.10,10,20111			
		d apply Santyl ointment and a		100 % audit of all residents he	ad to toe		
	dry dressing daily.	,		skin assessments for any chai	nges in skin		
				abnormalities was completed			
	August 2017 and Se	ptember 2017 pressure ulcer		Treatment Nurse and Treatme	nt		
	measurements were	reviewed revealing the		Medication Nurse Aide on 9/2	1/17 with		
	following: On 8/7/17	the coccyx pressure ulcer		Physician and Resident Repre	esentative		
		X 0.2 centimeters (cm) and		Notification of any identified ch	•		
		granulating with yellow		These assessments were doc	umented		
		ne Coccyx pressure ulcer		utilizing a census sheet.			
	measured 6.0 X 4.5			All current wounded residents			
		ng red/pink granulating tissue		assessed by the facility Treatn			
	with areas of red/pini	k non-granulating tissue.		initiated on 9/25/17 and compl			
	<b>T</b> I			9/27/17 with verification by the			
		ure ulcer was observed on		Nurse Consultant for an asses			
		as Nurse # 6 provided care.  /as observed to have both		dressing change per the physi physician notified of worsening			
	granulating tissue an			No identified areas of concern			
	granulating tissue all	a slougii.		Facility Treatment Nurse was			
	Review of the reside	nt's August 2017 and		by the Facility Nurse Consulta			
		atment administration records		backstage pressure ulcers, ex			
	-	notes revealed on the		Stage 3 on one week then to a			
	following weekend da			the next week. Unstageable w	•		
		esident's coccyx pressure		be staged accurately when the			
		een changed. The dates		is visible. The nurse must write			
	_	8/12/17, 8/13/17, 8/19/17,		physician's order for a Wound			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	201/1252 02 01/221/52	343370	B: Wiito		TDEET ADDDESS OF A STATE TO SODE	09/	27/2017
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CUMBERI	AND NURSING AND RE	HABILITATION CENTER		2	461 LEGION ROAD		
				F	AYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG			PREFIX (EACH CORRECTIVE ACTION SHOULI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 314	Continued From page	e 60	F3	314			
	8/20/17, 8/26/17, 8/27	7/17, 9/2/17, 9/3/17, 9/9/17,			include: location, pressure, frequency of	of	
		R was blank where nurses			change, intermittent or continuous		
		ne treatment was done.			pressure. If placed on hold, the nurse		
					must write a physician order to		
	On 9/22/17 at 3:14 Pf	M Facility Nurse Consultant			discontinue and physician order for		
		list of nurses who had been			current treatment. If the wound vac is o	off	
	responsible for Resid				greater than 2 hours, apply a wet to dry	/	
	changes during the S	eptember, 2017 weekends.			dressing and documented on the		
	On 9/26/17 at 10:55 A	AM the director of nursing			Treatment Administration Record		
		of nurses who had been			completed on 10-4-2017.		
		end dressing changes in			100% In- Service was initiated by Dire		
	_	ident # 135. According to			of Nursing to all Licensed Nurses, to be	9	
		one of the hall nurses for			completed by 11/05/2017: When the		
	_	ing shifts on the lists should			treatment nurse is off or on the weeker	ıd,	
		ng changes. The nurses			the nurses are to complete their own		
		ble and the dates and shifts			treatments.7-3 shift completes odd		
	· ·	lentified to be responsible			numbered rooms and 3-11 completes		
	are as follows:	00 DM M			even numbered rooms. This is not an		
	8/5/17- 7:00 AM to 3:				option. Document by initialing the		
	8/5/17- 3:00 PM to 11				Treatment Administration Record	ıe	
	8/6/17- 7:00 AM to 3:				immediately after completing treatment		
	8/6/17- 3:00 PM to 11				treatments cannot be completed the ha		
	8/12/17- 7:00 AM to 3 8/12/17- 3:00 PM to 1				nurse must notify nursing supervisor/ o Director of Nursing. All refusals of	I	
	8/12/17-3:00 PM to 3				treatments must be documented on the	<u>.</u>	
	8/13/17-3:00 AW to 3				Treatment Administration Record and in		
	8/19/17-3:00 PM to 1				the nursing progress note to include	11	
	8/19/17-3:00 AM to 3				notifications of the physician and the		
	8/20/17-7:00 AM to 3				Resident Representative of treatment		
	8/20/17-3:00 PM to 1				refusal.		
	8/26/17-7:00 AM to 3				The Director of Nursing will monitor the		
	8/26/17-3:00 PM to 1				Treatment Administration Records for		
	8/27/17-7:00 AM to 3				complete documentation 3 x week for 4	ı	
	8/27/17-3:00 PM to 1				weeks, weekly x 4 weeks, and then		
	9/2/17-7:00 AM to 3:0				monthly x 1 month utilizing the Treatme	ent	
	9/2/17-3:00 PM to 11:				Administration Record (TAR) Audit Too		
		00 PM-Nurse # 3/or Nurse #			for Documentation to ensure all	•	
	1				treatments are being completed per the	9	
	· ·	:00 PM-Nurse # 2/ or Nurse			physician's orders and documented on		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345376	B. WING _				C <b>27/2017</b>	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	2112011	
					461 LEGION ROAD			
CUMBERI	_AND NURSING AND RE	HABILITATION CENTER			AYETTEVILLE, NC 28306			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 314	partially responsible on 9/27/17 at 9:20 AN only done the dressir August and Septemb resident's family men and requested it. The charted the one day stated on the other day stated on the other day stated on the other day stated she often and she often had he responsibilities as we technicians who could insulin, or tube feeding had talked to the previn August 2017, about being done on the we had left. The nurse stated at the facility lon her about the problem.  Nurse # 4, who had the solely or partially responsible or partially responsed to R the August and September worked. The nurse stated dressing change to R the August and September worked. The nurse stated of the responsibilities as well as the solely or partially responsed to R the August and September worked. The nurse stated of the responsibilities as well as the solely or partially responsed to R the August and September worked. The nurse stated of the responsibilities are supported to the solely or partially responsed to R the August and September worked. The nurse stated to the responsibilities are supported to the solely or partially responsed to R the August and September worked. The nurse stated to the responsibilities are supported to the responsibilities are supported to the solely or partially responsed to the solely or	200 PM-Nurse # 4 200 PM-Nurse # 1 200 PM-Nurse # 4 1:00 PM-Nurse # 4 1:00 PM-Nurse # 1 200 PM-Nurse # 4 21:00 PM-Nurse # 1 200 PM-Nurse # 4 21:00 PM-Nurse # 4 21:00 PM-Nurse # 1 200 PM-Nurse #	F3	314	the treatment record. The Director of Nursing will review and initial the Pressulcers utilizing the Quality Improvement (QI) Tool for Monitoring Pressure Ulcer weekly x 8 weeks then monthly x 1 moto ensure dressing changes are per the physician order, wound was assessed, physician notified of any worsening. The Administrator will review all audits and sign.  The Director of Nursing will forward the results of the TAR Audit Tool and the Quality of Tool for Monitoring Pressure Ulcers to Executive Quality Improvement  Committee monthly. The Executive QI Committee will meet monthly x 3 month and review the TAR Audit Toll and the Quality Improvement and review the TAR audit Toll and the Quality Improvement and the Improvement of Im	etts nth ee ne ee etthe hs QI nay ee		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345376	B. WING		09/27/2017	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  2461 LEGION ROAD  FAYETTEVILLE, NC 28306	1 00/2//2011	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLET	TION
F 314	responsible on one was interviewed or nurse stated she h change. The nurse time to do it. The n have a treatment n when the treatmen months the facility schedule for the had changes. The nurse directed that daysh either the odd num rooms, and the everesponsible for the not do. The nurse swent over the new directions. They just desk. The nurse st given the other responsible for me halls, deal with famissues/events that with weekend houst the phone.  Nurse # 3, who had responsible on one	d been identified as e day for the dressing change, 19/26/17 at 4:42 PM. The ad not done the dressing e stated there was not enough urse stated the facility used to urse on the weekends, and t nurse quit during the summer management staff left a paper all nurses to do dressing e stated the paper schedule nift nurses were responsible for ber rooms or even number ening shift nurses were ones the dayshift nurses did stated management never responsibility or gave at left the paper schedule at the ated it was an impossible task ponsibilities which were placed Nurse # 7 stated she often medications for two halls, be dication assistants on other hilly concerns, deal with came up with residents, deal sekeeping issues, and answer debeen identified as a day and had shared nother day, was interviewed on	F 31	14		
	9/22/17 at 5:15 PM done the dressing aware it was her re Nurse # 2, who had	I. The nurse stated she had not change. The nurse was not				

			MPLETED			
		345376	B. WING		09/27/	2017
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  2461 LEGION ROAD  FAYETTEVILLE, NC 28306	1 09/27/	2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	) BE C	(X5) COMPLETION DATE
F 314	was interviewed on so nurse stated she had change. The nurse so near the end of Augubeen made aware do her responsibilities.  Nurse # 8, who had responsible for one of 9/26/17 at 1:29 PM. recall whether she had dressing change.  Interview with the received to be changed on so The RP stated the dot there was no date or she had talked to state concerns.  Interview with the Do revealed she had just previous week and saware of the lack of Resident # 135.  Interview with the ad 12:15 PM revealed to the state of the lack of Resident # 135.	9/25/17 at 9:25 AM. The d not done the dressing tated she had just started ust, 2017 and she had not ressing changes were one of	F 3 <sup>2</sup>			
F 333 SS=D	staff had probably to was no longer emplo 483.45(f)(2) RESIDE	ld the previous DON, who byed. :NTS FREE OF ERRORS	F 33	33	11.	/5/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULI IDENTIFICATION NUMBER:  A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345376	B. WING		C 09/27/2017		
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/21/2011		
CHMBEDI	AND NUIDSING AND D	EHABILITATION CENTER	:	2461 LEGION ROAD			
COMPEK	AND NURSING AND K	ENABILITATION CENTER		FAYETTEVILLE, NC 28306			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION			
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F 333	Continued From pag	ne 64	F 333	3			
	The facility must ens	sure that its-					
	medication errors.	free of any significant  T is not met as evidenced					
	_	view, resident interview, and		F 333			
		cility failed to assure morning					
		s given per sliding scale order		Resident #97 no longer at facility.			
		pled residents, Resident #97,		100% audit was completed on 10/5/17	-		
	on five days. The fin	dings included:		Facility Nurse Consultant on all reside			
	December view ways	aled Resident # 97 was last		receiving sliding scale insulin from 9/1			
		cility on 8/22/17. The resident		to 9/30 ensure that sliding scale insuling was given as ordered. Medical Director			
	had a diagnosis of d			made aware of any discrepancies duri			
	aa a alagiioolo ol a			the audit by Facility Consultant on	9		
	Review of the reside	nt's care plan, last updated		10/6/2017.			
		I the staff had identified the		100 % Medication Pass audits initiated	no b		
	resident was at risk t	for complications of diabetes.		9/26/2017 by Facility Consultant with a	all		
	-	interventions directed staff to		licensed nurse and medication aides'	.O		
		plood sugars as ordered per		ensure physician orders are being			
		and administer the resident's		followed to include orders for sliding s	cale		
	medication as ordere	ed.		insulin and narcotics and medications	n		
	Review of Resident:	# 97's readmission minimum		administered timely to be completed of 11/05/2017.			
		essment, dated 9/5/17,		100% of all licensed nurses and			
	,	t was cognitively intact.		medication aides to include Nurse #1	and		
				medication Aide # 2 were in-serviced			
	Review of the reside	nt's physician orders		Medication Administration to include			
		ated 8/21/17, for the resident		Document medications on the MAR af	ter		
	to have sliding scale	insulin coverage before		it has been given to include narcotics	and		
		e. For blood sugar levels of		blood sugars. Never give any medicat			
		ent was ordered to receive 2		from memory to include insulin. Alway	s		
	units of Humalog Ins	sulin.		follow orders on the MAR. Follow	_		
				physician's order on the MAR to include			
		sident on 9/20/17 at 1:20 PM		special instructions when administerin			
	_	there had been a morning		insulin to include before or after meals			
		sed to get sliding scale Insulin		Also read MAR correctly for correct sli	uing		
	coverage recently at	nd he had not received any.	1	scale dose of insulin on 10/4/2017 by	1		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345376	B. WING _			1	C <b>27/2017</b>	
NAME OF P	ROVIDER OR SUPPLIER		<del>-</del>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 09/	2112011	
TVAINE OF T	TOVIDER OR OUT FEILING				461 LEGION ROAD			
CUMBERL	AND NURSING AND F	REHABILITATION CENTER						
				Г.	AYETTEVILLE, NC 28306			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE	
F 333	Continued From page	ge 65	F;	333				
	medication administ the following documented the results of Insulin at 6:00 AM was 174 administered zero under the results of Insulin On 9/14/17 Nurse # blood sugar at 6:00	ted the resident's blood sugar and she documented she units of insulin.  Medication Aide # 2 sident's blood sugar was 182. Intation the resident received			Facility Consultant/Director of Nursing/Staff Facilitator. All newly hire license nurses will be in-serviced by th staff facilitator during orientation regare Medication Administration to include Document medications on the MAR aff it has been given to include narcotics a blood sugars. Never give any medicati from memory to include insulin. Always follow orders on the MAR. Follow physician's order on the MAR to include special instructions when administering insulin to include before or after meals Also read MAR correctly for correct slig scale dose of insulin. Assistant Director of Nursing/Staff Facilitator will monitor 10% of all licens nurses and medications aides to includ and medication aide # 2 utilizing a Medication Pass audit tool weekly X 8 weeks and monthly X 1 month to ensu	ter and ons s le g ding		
	Insulin. Review of the ach time zero units the above dates, a semantial MAR with a line drawn with a l	Iministered zero units of he MAR revealed that for s of Insulin had been given on zero had been placed on the wn through it.  Viewed on 9/22/17 and not given Resident # 97 his e Insulin coverage on 9/1/17, 9/14/17 at 6:00 AM. Nurse # 1 7 used to have different prior to his readmission on stated according to the old sed to get sliding scale sugar readings above 200 ted she therefore was going bered the sliding scale he resident per his previous			that medications to include orders for sliding scale insulin are given per the MAR and timely. The Assistant Director Nursing will retrain the license nurse a or medication aide for all identified are of concern during the audit. The DON review and initial the Medication Pass Audit Tool weekly x 8 weeks then mon x 1 month to ensure all areas of conce are addressed. The Director of Nursing will forward the results of the Medication Pass Audit To to the Executive QI Committee monthly 3 months. The Executive QI Committee will meet monthly x 3 months and reviet the Medication Pass Audit Tool to determine trends and / or issues that n need further interventions put into place	nd/ as will thly rn e pool y x e ew nay		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345376	B. WING			l	27/2017
	ROVIDER OR SUPPLIER  AND NURSING AND RE	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  2461 LEGION ROAD  FAYETTEVILLE, NC 28306			, , , , , , , , , , , , , , , , , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG				(X5) COMPLETION DATE
F 353 SS=E	instructions on 9/1/7, to note the order had On 9/22/17 Nurse Co # 5 as the nurse who responsible for the m coverage for 6 AM or Nurse # 5 could not be survey.  483.35(a)(1)-(4) SUF STAFF PER CARE PH 483.35 Nursing Servion The facility must have the appropriate comparation of provide nursing and resident safety and a practicable physical, well-being of each resident assessments and considering the resident assessments and considering the rediagnoses of the facility accordance with the facility accordance with the facility (Phase 2)]  (a) Sufficient Staff. (a)(1) The facility must sufficient numbers of of personnel on a 24-	ad not referenced the MAR's 9/2/17, 9/8/17, and 9/14/17 changed.  Insultant # 1 identified Nurse would have been edication aide and Insulin a 9/9/17 for Resident # 97.  The reached during the PLANS  The sufficient nursing staff with petencies and skills sets to related services to assure train or maintain the highest mental, and psychosocial sident, as determined by and individual plans of care		3333	and to determine the need for further a / or frequency of monitoring.	nd	11/5/17

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		345376	B. WING _			C 09/27/2017		
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 2461 LEGION ROAD FAYETTEVILLE, NC 28306	E	00/21/2011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
F 353	Continued From page (i) Except when waith this section, licensed (ii) Other nursing per limited to nurse aide (a)(2) Except when we this section, the facilinurse to serve as a duty.  (a)(3) The facility munurses have the spesets necessary to calidentified through redescribed in the plan (a)(4) Providing care assessing, evaluating resident care plans an eeds.  This REQUIREMEN by:  Based on record refamily interviews, an failed to provide sufficience.	red under paragraph (e) of d nurses; and resonnel, including but not s.  vaived under paragraph (e) of ity must designate a licensed charge nurse on each tour of residents and skill are for residents' needs, as sident assessments, and of care.  Includes but is not limited to g, planning and implementing and responding to resident's  T is not met as evidenced riew, resident interviews, d staff interview, the facility icient staff for three (Resident		F 353 Sufficient Staff Resident #135 did not receive changes per TAR which reveal	e dressing aled no			
	residents. The facilit staff for pressure and (Resident # 135) and daily living (Resident included:  1. Record review revinitially admitted to the resident had diagnost disease with hemodic disease, history of control of the resident had disease.	out of twenty-one sampled y failed to provide sufficient d vascular dressing changes d assistance with activities of its # 175 and 99). The findings realed Resident # 135 was ne facility on 5/6/17. The ses of end stage renal alysis, coronary artery bronary artery bypass n, diabetes, anemia, atrial		documentation on 8/5/17, 8/6 8/13/17, 8/19/2017, 8/20/17, 8 8/27/17, 9/2/17, 9/3/17, 9/9/1 9/10/17 by Nurse #1, Nurse # Nurse #3, and Nurse #2. Dire Nursing aware that resident # receive dressing changes. O Resident #135 returned to the new orders for treatment of C wound: Cleanse with soap an apply crushed Flagyl 500 mill cover with Aquacel Silver and dressing to be changed every	8/26/217, 7, and 44, Nurse #8, ector of £135 failed to n 9/28/2017 e facility with foccyx and water, igrams, I a foam			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		345376	B. WING_				/27/2017
NAME OF P	ROVIDER OR SUPPLIER	l		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00.	,
				24	61 LEGION ROAD		
CUMBERI	LAND NURSING AND	REHABILITATION CENTER		FA	AYETTEVILLE, NC 28306		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID		(X5)		
PRÉFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 353	Continued From p	page 68	F3	353			
	fibrillation, severe	peripheral vascular disease.			and as needed. Resident #135 had fol	low	
					up appointment with the Wound Physic		
		ident's last quarterly minimum			on 10/5/17 with no change in orders for	r	
		ssessment, dated 8/13/17,			treatment to the coccyx and another		
	revealed the resident was cognitively intact. The				appointment scheduled for October 19		
		coded as having 7 vascular			2017. Resident #175 and 99 facility fa		
	uicers and a Stag	e III pressure ulcer.			to provide assistance with activities of		
	Daviou of the res	ident's care plan, last updated			daily living. NA #6 and Medication Aid were in-serviced on 9/25/17 by Nurse	e #3	
		led the staff had identified the			Consultant in regards to helping your		
		ulceration caused by diabetes			residents use the toilet and to get		
		scular disease and a pressure			dressed. Residents # 175 and # 99		
		r the resident was that she			continue to receive assistance with		
		ve healing of her ulcers and not			activities of daily living.		
		nes. Staff were directed on the			Administrator/Director of		
	care plan to provi	de treatment as ordered.			Nursing/Scheduler reviewed the staffing	ıg	
					schedule to ensure sufficient numbers	of	
	_	2017 wound ulcer flow sheets			staff to provide nursing care to all		
		lent's vascular ulcers were			residents in accordance with resident	care	
		t lower leg, right lower leg, left			plans.		
		er great toe, left heel, right heel, e. The resident's pressure ulcer			On 0/19/2017 the Director of Nursing (	and	
	was located on he				On 9/18/2017 the Director of Nursing a Administrator reviewed the clinical state.		
	was located off fit	er Coccyx.			schedule to assure the sufficient staff	iiig	
	Review of physici	an orders revealed a current			were on duty to meets the care needs	of	
		on 5/31/17, for daily dressing			the residents. The Director of Nursing		
		occyx pressure ulcer. The order			review the daily clinical staffing needs		
		eanse the ulcer and apply			hours prior to the scheduled worktimes		
	Santyl ointment a	nd a dry dressing daily.			assure the clinical staff are on duty to		
					meets the needs of the residents. The		
		acility was asked to provide the			Case Mix Index will be reviewed week	•	
		from the resident's thinned			assure the acuity of the resident is tak	en	
		nich would have been in effect			in to account with the clinical staffing		
	vascular ulcers.	eptember, 2017 for the resident's			patterns to meet the needs of the residents.		
	On 9/25/17 at 5:1	3 PM, the DON (director of			On 10/18/2017 the Corporate Consulta	ant	
		a physician's order, dated			in-serviced the Administrator and Direct		
		cers located on the resident's			of Nursing regarding Sufficient Staff. T		

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBED:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345376	B. WING _				27/2017	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
				2	461 LEGION ROAD			
CUMBERL	AND NURSING AND RE	HABILITATION CENTER			FAYETTEVILLE, NC 28306			
(VA) ID	CLIMMADV CT	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)		(X5) COMPLETION DATE	
F 353	Continued From page	e 69	F3	353				
	right and left lower le	gs. This order specified the			Sufficient Staff in-service included the			
		daily dressing changes to			following: A. The facility must provide			
	these areas. The stat	ff were to cleanse these			services by sufficient numbers of each	of		
	ulcers with saline and	d apply Santyl and a dry			the following types of personnel on a			
	dressing.				24-hour basis to provide nursing care to	o		
					all residents in accordance with resider	nt		
		M, the facility administrator			care plans. B. The determination of			
		wound protocol as the			sufficient staff will be made based on the	ne		
		eing used for Resident			staff's ability to provide needed care to			
		left outer great toe, left heel,			residents that enable them to reach the			
	right great toe, and right heel during the months				highest practicable physical, mental an	d		
	of August, 2017 and	September, 2017.			psychosocial well-being.			
	D	10047 TAB			The facility has hired a new RN-Assiste			
		t 2017 TAR and September			Director of Nursing, 4 licensed practica			
		no documentation on the			nurses and 8 Certified Nursing Assistants fill the vecent position in the surrent	แร		
	following weekend da				to fill the vacant position in the current schedule. The facility will ensure we ha	,,,o		
	_	ked or changed to any of her r Stage III pressure ulcer:			a nurse to provide 8 hrs of RN coverage			
		17, 8/13/17, 8/19/17, 8/20/17,			daily. The Facility will utilize agency			
		/17, 9/3/17, 9/9/17, and			staffing to ensure daily staffing is suffic	ient		
	9/10/17.	777, 070777, 070777, 0110			according to the acuity level of the			
	0, 10, 11.				residents.			
	On 9/22/17 at 3:14 P	M facility nurse consultant #			On 9/18/2017, the Administrator and th	e		
	1 provided a list of nu				DON initiated a QI monitoring tool titled			
	responsible for Resid				Sufficient Staff tool to meet the needs of			
		September, 2017 weekends.			the residents based upon the acuity lev	/el		
		AM the director of nursing			as identified by the Case Mix Index sco			
	(DON) provided a list	of nurses who had been			The QI monitoring tool will assist with the	ne		
	responsible for week	end dressing changes in			facility assuring the residents reach the	ir		
	August, 2017 for Res	sident # 135. According to			highest practicable physical, mental an	d		
	the nurse consultant	and DON one of the hall			psychosocial well-being. The			
	nurses for the dayshi	ft and evening shifts on the			Administrator and the Director of Nursi	٠ ا		
		e the dressing changes. The			will utilize the Sufficient Staff tool daily,	at		
		esponsible and the dates			the beginning of each shift to include			
		ney were identified to be			nights and weekends for four weeks,			
	responsible are as fo				twice weekly for four weeks, weekly for			
	8/5/17- 7:00 AM to 3:				four weeks, and monthly times three			
	8/5/17- 3:00 PM to 1				months. Any identified issues will be			
	8/6/17- 7:00 AM to 3:	00 PM- Nurse # 4			addressed immediately with assuring the	ne		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345376	B. WING_			09/	27/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CUMBERI	AND NURSING AND RE	EHABILITATION CENTER			461 LEGION ROAD		
COMIDEIX	AND NORSING AND RE	INABILITATION CENTER		F	AYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 353	Continued From pag 8/6/17- 3:00 PM to 1 8/12/17- 7:00 AM to 3 8/12/17- 3:00 PM to 3 8/13/17-3:00 PM to 3 8/13/17-3:00 PM to 3 8/19/17-3:00 PM to 3 8/20/17-3:00 PM to 3 8/20/17-3:00 PM to 3 8/26/17- 3:00 PM to 3 8/27/17-3:00 PM to 3 8/27/17-3:00 PM to 3 9/2/17-3:00 PM to 1 9/2/17-3:00 PM to 1 9/3/17-7:00 AM to 3:1	1:00 PM- Nurse # 4 3:00 PM-Nurse # 1 11:00 PM-Nurse # 1 3:00 PM -Nurse # 7 11:00 PM- Nurse # 8 3:00 PM-Nurse # 8 3:00 PM-Nurse # 1 11:00 PM -Nurse # 1 11:00 PM -Nurse # 4 11:00 PM-Nurse # 4 11:00 PM-Nurse # 4 11:00 PM-Nurse # 4 11:00 PM-Nurse # 4	F	3353	proper staff are on duty or the utilization administrative nurses are pulled to the hall.  The Administrator will monitor the Sufficient Staff tool daily to assure the staffing patterns are appropriate to meet the needs of the residents care identified by their acuity level from the Case Mix Index report. The administrator will present findings at the monthly Executing QI Committee meeting for further recommendations for follow up as need or continued compliance in this area are to determine the need for and/or frequency of the continued QI monitoring	et ed ve ded ad	
	9/3/17-3:00 PM to 11 # 1 9/9/17-7:00 AM to 3: 9/9/17-3:00 PM to 11 9/10/17-3:00 PM to 1 9/10/17-3:00 PM to 1 9/10/17-3:00 PM to 1 Nurse # 1, who had be partially responsible on 9/27/17 at 9:20 All only done the dressin August and Septembethat was when the reapproached her and stated she had not close it. The nurse stated the the dressing changer responsibilities. The work double shifts ar	:00 PM-Nurse # 1 3:00 PM-Nurse # 4 11:00 PM-Nurse # 1 Deen identified as solely or on 8 days, was interviewed M. The nurse stated she had ng changes one time during per for Resident # 135, and sident's family member had requested it. The nurse harted the one day she had ated on the other days, she ident's dressing changes. re was not enough time to do			The scheduling coordinator will be notified in higher and weekend call-ins and no shows promptly. The scheduling coordinator will make necessary arrangements to ensure adequate staff are on duty. If the scheduling coordinatis unable to obtain adequate staff or if it outside of the scheduling coordinator's normal working hours, the director of nursing or assistant director of nursing be notified promptly. The facility administrator and director of nursing with provide ongoing monitoring daily to ensure that there is adequate clinical ston duty to provide needed care to residents that enable them to reach the highest practical physical, mental, and psychosocial well-being.  Current and newly hired staff will be in-serviced that the scheduling coordinator is the first point of contact from any and all scheduling issues that arises.	tor t is will II aff ir	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345376	B. WING				C <b>27/2017</b>
	ROVIDER OR SUPPLIER  AND NURSING AND RE	HABILITATION CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE  2461 LEGION ROAD  FAYETTEVILLE, NC 28306			
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F 353	intravenous fluids, Insurse stated she had who had worked in Adressing changes not week-end but then the stated the new DON long enough for her to problem.  Nurse # 7, who had be responsible on one de was interviewed on 9 nurse stated she had changes. The nurse stime to do it. The nurse have a treatment nurse when the treatment number to do it. The nurse stime to do it. The nurse state given the odd number rooms, and the eveni responsible for the or not do. The nurse state given the other responsible for medic halls, deal with family issues/events that ca with week-end house the phone. The nurse	cians who could not give sulin, or tube feedings. The talked to the previous DON, ugust 2017, about the to being done on the e DON had left. The nurse had not been at the facility to talk to her about the otalk the paper schedule of the paper schedule of the paper schedule of the paper schedule of the paper schedule at the end it was an impossible task on sibilities which were placed one nurse stated she often dications for two halls, be cation assistants on other or concerns, deal with me up with residents, deal keeping issues, and answer a stated she had tried to talk	F	353	while on shift. The scheduling coordinator's contact information will be posted in designated employee areas a will include subsequent points of conta which will be available 24/7, to avoid a single point of failure.	and	
	the phone. The nurse	e stated she had tried to talk f about the problem and was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345376	B. WING _			C 09/27/2017
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2461 LEGION ROAD FAYETTEVILLE, NC 28306		
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F 353	were times she couresponsibilities becomedication assistant could not do her result interview with the Expression of the lack of Resident # 135.  Interview with the at 12:15 PM revealed had not been brough staff had probably the was no longer empth.  2. Record review readmitted to the facility had diagnoses of controlic pain, diabeth.  Review of the residuance of the staff had probably the staff had diagnoses of controlic pain, diabeth.  Review of the residuance of the staff had probably the staff had diagnoses of controlic pain, diabeth.  Review of the residuance of the staff had probably the staff had diagnoses of controlic pain, diabeth.  Review of the residuance of the staff had probably the staff h	cording to the nurse, there ld not delegate her ause there were often ats on the weekends who sponsibilities.  ON on 8/25/17 at 9:19 AM ast been employed the she had not been made for dressing changes for dministrator on 9/26/17 at the missed dressing changes that to her attention and that the old the previous DON, who loyed.  Evealed Resident # 175 was lity on 7/12/17. The resident erebrovascular accident, the see, and hypertensive disorder.  Lent's minimum data set (MDS) 7/19/17, revealed the resident ct. The resident was coded as assistance from staff with his boathing, and bed mobility	F 3	53		
	and needed assista dressing, and trans directed staff to tran	the resident was ed a wheelchair for mobility, ince with his hygiene, fer needs. The care plan insfer the resident with a assist him with his activities of				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION  NG	(X3	(X3) DATE SURVEY COMPLETED		
		345376	B. WING			C <b>09/27/2017</b>	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 2461 LEGION ROAD FAYETTEVILLE, NC 28306	CODE	09/2//2017	
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F 353	daily living needs.  The resident was in PM and stated he h (9/17/17) evening a could not find anyor the resident he wen help but there was r him. The resident st who needed to help somewhere," but he According to the ressomeone to assist he called his family me member arrived aro prepare and go to bavailable staff memions that is a single of the staff members are someone to assist he are someone to assist he called his family member arrived aro prepare and go to bavailable staff members are someone to assist he are someone to assist he called his family member arrived aro prepare and go to bavailable staff members are someone to assist he are someone to assist he called his family members arrived aro prepare and go to bavailable staff members are sident # 175's has shift.  Review of census in date of 9/17/17 reversidents on Resident Nurse # 6 was internaced according to Nurse	terviewed on 9/20/17 at 1:50 ad a migraine on Sunday and wanted to go to bed but all to help him. According to at on the hall and asked for anot anyone available to assist ated he was told the person him was "around a could never find them. addent after he tried to find him for about two hours, he amber. He said his family and 9 PM and helped him and ed because there was no	F3				
	and had given him r hall nurse she did n and was being atter medication cart and had difficulties on S	medication. According to the ot normally give medications, nitive to her duties on the was not aware the resident unday evening. The nurse not assisted the resident to					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		345376	B. WING		0.0	C N27/2047
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  2461 LEGION ROAD  FAYETTEVILLE, NC 28306		0/27/2017
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F 353	bed. According to N room for bedtime me bed.  NA # 6 was interview NA # 6 stated she the residents to care for 9/17/17. NA # 6 stated 175's room a little aff he was already in be him.  Interview with the res 9/21/17 at 10:45 AM call around 8 PM on The family member shim he had been to a find anyone to help hember stated he (the drove to the facility to family member stated saw one or two peop The family member of help the resident pre on 9/17/17. The family as "really scarce."  An interview had beet tour of the facility on randomly interviewed corroborated Reside member's interview. family member of Rewas observed to resident # 175 on 9/1 the interview, the family member stated family f	urse # 6 when she got to his edications he was already in wed on 9/21/17 at 4:10 PM. Tought she had "about fifteen" on the evening shift of ed she got to Resident # ter 9:00 PM to assist him and d, but she had not assisted sident's family member on revealed he had received a 9/17/17 from Resident # 175. Stated Resident # 175 told all of the halls and he couldn't him to go to bed. The family me family member) then to help the resident. The d when he arrived he only ble on the hall that evening. Confirmed he was the one to pare for bed and go to bed ally member stated staffing the conducted during initial 9/21/17 at 9:35 AM with a diresident's family which and the sident # 25. Resident # 25 de on the same hall as (21/17 at 9:35 AM. During help the had been present on estarting asking" staff to	F 35	3		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345376	B. WING				C <b>27/2017</b>
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2461 LEGION ROAD FAYETTEVILLE, NC 28306		1 09/	2//2017
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F 353	assist the resident to PM that evening. The was after 9:00 PM be assistance. The fame "just didn't have anywassist the resident of A review of the staffing facility for the date of 11:00 PM shift reveal four halls there were facility's halls there with was scheduled Resident # 175's hall schedule.  The facility schedule at 9 AM. The schedule at 9 AM. The schedule to schedule two NAssiduring the 3:00 PM to have a second N 9/17/17 at 3:00 PM to have a second N 9/17/17 at 3:00 PM to evening shift of 9/17.  3. Record review readmitted to the facility had diagnoses of he failure, dementia, and Review of the reside	bed around 6:00 PM or 6:30 the family member stated it efore Resident # 25 received filly member stated the facility one to help" on the hall to an Sunday night.  In Sheets for the whole of 9/17/17 for the 3:00 PM to alled on two of the facility's two NAs. On one of the vas one NA and another NA at 6 PM to arrive. On I there was one NA on the  I was interviewed on 9/21/17 aller stated she routinely tried of for Resident # 175's hall of 11:00 PM shift, but she did and confirmed that there had of Resident # 175's hall for the	F	353	DEFICIENCY)		
	The resident was co- assistance from staff bathing, dressing, ea He was assessed wi impairments and imp	rerely cognitively impaired.  ded as needing extensive  f with his hygiene, dressing,  ating and bed mobility needs.  th no upper extremity  pairments on both sides of  Resident #99 was also					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, 2461 LEGION ROAD FAYETTEVILLE, NC 28306	ZIP CODE	09/27/2017
(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	N OF CORRECTION E ACTION SHOULD BE O TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 353	assessed as always i bladder.  Review of the resider 7/26/17, identified the impaired and needed dressing, eating, trancare plan directed stamechanical lift and as daily living needs.  According to the staff Medication Aide #3 w Nurse Assistant on R were no other staff m sheets for Resident # to 3:00 PM Nurse Assistant on Review of the census date of 9/17/17 revearesidents on Resident Interview with the res 9/21/17 at 10:00 AM in the facility on 9/17/17 came in Resident 's a Assistant #8 left to go went to retrieve the d to feed Resident #99. The tray from the staff to provide care for hir stated she left about Nurse Assistant #8 w 3:14 PM. She stated 5:00 PM on 9/17/17 a took over her assignment in the staff to provide care for hir stated she left about Nurse Assistant #8 w 3:14 PM. She stated 5:00 PM on 9/17/17 a took over her assignment in the staff to provide over her assignment in the staff to provide care for hir stated she left about Nurse Assistant #8 w 3:14 PM. She stated 5:00 PM on 9/17/17 a took over her assignment in the staff to provide care for hir stated she left about Nurse Assistant #8 w 3:14 PM. She stated 5:00 PM on 9/17/17 a took over her assignment in the staff to provide care for hir stated she left about Nurse Assistant #8 w 3:14 PM. She stated 5:00 PM on 9/17/17 a took over her assignment in the staff to provide care for hir stated she left about Nurse Assistant #8 w 3:14 PM. She stated 5:00 PM on 9/17/17 a took over her assignment in the staff to provide care for hir stated she left about the staff to provide care for hir stated she left about the staff to provide care for hir stated she left about the staff to provide care for hir stated she left about the staff to provide care for hir stated she left about the staff to provide care for hir stated she left about the staff to provide care for hir stated she left about the staff to provide care for hir stated she left about the staff to provide care for hir stated she left about the staff to provide care for hir stated she left about the	at 's care plan, dated resident was cognitive assistance with bathing, sferring, and mobility. The lift to transfer with a sist him with his activities of him with a sist him with his activities of him him his activities of him his activi	F3	353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  _AND NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  2461 LEGION ROAD  FAYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
F 354 SS=D	Interview with the Sc PM revealed she was She explained Medic to Resident #99 for the care. It was her undecomplete the Medicad 3:00 PM shift and the Nurse Assistant for 3 Medication Aide #3 with 4:00 PM. According was not aware she with the hall. She express responsible for Reside PM to 11:00 PM shift provide care to Reside than his medications tray to his family and fed him dinner. 483.35(b)(1)-(3) WAIDAYS/WK, FULL-TIME (1) Except when wait (f) of this section, the services of a register consecutive hours as (2) Except when wait (f) of this section, the registered nurse to so nursing on a full time (3) The director of nurse only when the occupancy of 60 or fed This REQUIREMENT by:	neduler on 9/21/17 at 3:30 s short staffed on 9/17/17. ation Aide #3 was assigned ne 3:00 PM to 11:00 PM erstanding she would tion Pass for 7:00 AM to en become the assigned :00 PM to 11:00 PM.  Tas interviewed on 9/22/17 at to Medication Aide #3, she as assigned the front part of sed someone else was ent #99 's care on the 3:00. She confirmed she did not lent #99 on her shift other. She did pass his dinner to her knowledge his family  VER-RN 8 HRS 7  TE DON  Ted under paragraph (e) or facility must use the end nurse for at least 8 day, 7 days a week.  Ted under paragraph (e) or facility must designate a serve as the director of basis.  Trising may serve as a charge facility has an average daily	F 35		11/5/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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CUMBERL	AND NURSING AND F	REHABILITATION CENTER			61 LEGION ROAD			
				FA	YETTEVILLE, NC 28306			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 354	Continued From pa	ge 78	F 3	354				
	interviews the facilit	ty failed to provide the services			Beginning on 10/5/2017 a registered			
		se (RN) for eight consecutive			nurse will provide onsite coverage daily	/		
		vo days of five days reviewed.			per the Medicare Guideline. In the eve			
	(09/09/2017 and 09				of a call out appropriate action will be			
	•	•			taken to ensure an RN covers the facili	ty		
	Findings included:				needs either by the Administrative			
					Nurses-RN's or scheduled floor staff			
	Review of time cloc	ck punch time for all licensed			registered nurses. All administrative			
	nursing staffing revealed no RN hours for staffing		nurses will be educated on 10/19/2017					
	on 9/9/2017 & 9/10	/2017.			that upon their role as the RN providing	1		
					coverage on the floor then they must			
		1/2017 at 10:30 AM with the			serve in an administrative			
		Nursing (DON) revealed she			capacity/supervisor providing oversight	to		
		N on 9/05/2017. She			the patients and clinical staff on duty.			
		role was the Nursing			On 9/18/2017 the Administrator and the			
		so explained there was no			Director of Nursing reviewed the staffin schedule to ensure sufficient numbers			
		ed Nurse to replace a nurse 08/2017. She explained a new			staff and registered nursing coverage to			
		ed and would be starting on			provide nursing care to all residents in	J		
		role would go back to being			accordance with resident care plans.			
	the Nursing Superv	-			On 9/8/2017 the Director of Nursing an	d		
	the realing capere	1001.			Administrator reviewed the clinical staff			
	During an interview	on 9/11/2017 at 12:50 PM,			schedule to assure the sufficient staff	9		
	_	evealed her expectation was			were on duty to meets the care needs	of		
		eight consecutive hours a			the residents. The Assistant Director of			
	day, seven days a	week. She explained the new			Nursing was hired 10/17/2017. On			
	Director of Nursing	would be starting on			10/18/2017 the scheduler and Director	of		
	9/12/2017 and then	the Interim Director of			Nursing were in-serviced by the			
	Nursing would become	ome the Nursing Supervisor.			administrator related to RN coverage in	1		
					the facility. Director of Nursing will			
	_	on 9/11/2017 at 3:35 PM with			continue to use staff audit tool to ensur			
	· ·	ler, she verified that no RN			Registered Nurse is scheduled daily. T	he		
		17 and 9/10/2017. She			new Director of Nursing will review the			
	•	duled RN resigned on			daily clinical staffing needs 24 hours pr			
		M. She explained she reported			to the scheduled worktimes to assure to	ne		
		dministrative Staff. She			clinical staff are on duty to meets the			
	•	was trying to hire more			needs of the residents along with assur	•		
	nurses.				the facility residents are provided with 8			
					consecutive hours of Registered Nursir	ıg		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345376	B. WING			C		
		343376				09/2	7/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE			
CUMBERI	AND NURSING AND RE	HABILITATION CENTER		2461 LEGION ROAD				
00				FAYETTEVILLE, NC 28306				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		<b>I</b>	(X5) COMPLETION DATE	
F 354	Continued From page	e 79	F3	Coverage. On 10/17/2017 the Corportin-serviced the Administrate of Nursing regarding Sufficithe requirement of the 8 hours consecutive Registered Nursing The Sufficient State of the following: A. It provide services by sufficient each of the following types on a 24-hour basis to provide all residents in accordant resident care plans. B. The of sufficient staff will be mattered that the staff's ability to provide residents that enable them highest practicable physical psychosocial well-being. On 9/18/2017 the Director Administrator reviewed the schedule to assure the sufficient staff are were on duty to meets the the residents. The Director review the daily clinical state hours prior to the schedule assure the clinical staff are meets the needs of the resinclude the 8 consecutive is registered nursing coverage Mix Index will be reviewed assure the acuity of the resin to account with the clinic patters to meet the needs. The facility has hired a new Director of Nursing on 10/1 registered nurses, 5 LPNs Certified Nursing Assistant vacant position in the current the open position that rem	tor and Direction and Direction Staff and Direction Staff and Direction Staff in-service. The facility ment numbers of personner ide nursing of the reach the alternation of Nursing and eclinical staff care needs of the facility of the care needs of the staff ng needs of the staffing of the resider weekly to staff the staffing of the resider weekly to staff the resider weekly to staff the staffing of the staffing of the staff the sta	tetor d  ce coust of cel care con concept		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345376	B. WING _			na/	27/2017
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	1 03/2	2112011
					1 LEGION ROAD		
CUMBERL	AND NURSING AND RE	HABILITATION CENTER		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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 354	Continued From page	80			time licensed nurse and 4 certified nurse assistant positions. These positions will be filled by 11/5/17. On 9/18/2017, the Administrator and the DON initiated a QI monitoring tool titled Sufficient Staff tool to meet the needs of the residents based upon the acuity leveral as identified by the Case Mix Index scott The QI monitoring tool will assist with the facility assuring the residents reach the highest practicable physical, mental an psychosocial well-being. The Administrator and the Director of Nursing will utilize the Sufficient Staff tool daily, the beginning of each shift to include nights and weekends for four weeks, twice weekly for four weeks, weekly for four weeks, and monthly times three months. Any identified issues will be addressed immediately with assuring the proper staff and RN coverage are on door the utilization of administrative nurse are pulled to the hall for appropriate coverage. The Administrator will monitor the Sufficient Staff tool daily to assure the staffing patters are appropriate to meet the needs of the residents care identified by their acuity level from the Case Mix Index report and registered nursing coverage. The administrator will present indings at the monthly Executive QI Committee meeting for further recommendations for follow up as need or continued compliance in this area and to determine the need for and/or frequency of the continued QI monitoring frequency of th	l e di of vel ore. he eir d mg at ent ded and mg.	44/5/47
F 490	483.70 EFFECTIVE			190			11/5/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E SURVEY IPLETED
		345376	B. WING		0.0	C 9/27/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	7/2//2017
				2461 LEGION ROAD		
CUMBERL	AND NURSING AND RE	EHABILITATION CENTER		FAYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 490	Continued From page	e 81	F 49	90		
SS=E		RESIDENT WELL-BEING				
	483.70 Administration A facility must be adrenables it to use its refficiently to attain or practicable physical, well-being of each rethis REQUIREMENT by:  Based on record revisable to provide lead systems and policies residents needs were 45, # 175 #99, and # sampled residents. The sampled residents are sampled residents are sampled residents are sampled residents. The sampled residents are sampled residents are sampled residents are sampled residents. The sampled residents are sampled residents are sampled residents. The sampled residents are sampled residents are sampled residents. The sampled residents are sampled residents are sampled residents are sampled residents. The sampled residents are sampled residents are sampled residents are sampled residents. The sampled residents are sampled residents are sampled residents. The sampled residents are sampled residents are sampled residents. The sampled residents are sampled residents are sampled residents. The sampled residents are sampled residents are sampled residents. The sampled residents are sampled residents are sampled residents. The sampled residents are sampled residents are sampled residents are sampled residents. The sampled residents are sampled residents are sampled residents are sampled residents. The sampled residents are sampled residents are sampled residents. The sampled residents are sampled residents are sampled residents are sampled residents. The sampled residents are sampled residents are sampled residents are sampled residents. The sampled residents are sampled residents. The sampled residents ar	ministered in a manner that esources effectively and maintain the highest mental, and psychosocial sident.  T is not met as evidenced riews, resident interviews, d staff interviews the facility ership to implement effective and procedures to assure emet for four (Residents # 135) out of twenty one the findings included:  66  ews, resident interview, and acility failed to follow facility e grievances related to for one (Residents # 175) eviewed for grievances.		483.70 EFFECTIVE ADMINIST RESIDENT WELL-BEING  F 490  On 10/11/17, the Corporate Fact Consultant Registered Nurse (Found and the conducted a meeting with the administrator and Director of Note (DON) to discuss the areas that failed to provide leadership to in effective systems and policies a procedures to ensure residents were met to include Residents #99, #135. These areas include facility procedures to resolve granted to medication concerns, to perform dressing changes, p sufficient staff for pressure and dressing changes, and assistant activities of daily living (ADLs).	cility RN) ursing t the facility mplement and ' needs #45, #175, ed following ievances neglecting roviding vascular nce with	
	Stage III pressure uld	cers.		10/18/17, the corporate facility RN, the administrator, and the I	consultant DON	
	initially admitted to the resident had diagnost disease with hemodial disease, history of co	ealed Resident # 135 was the facility on 5/6/17. The these of end stage renal fallysis, coronary artery foronary artery bypass		initiated a Quality Improvement plan to identify and address the causes of the ineffective system  This plan will ensure that the fa	root ns. cility	
	surgery, hypertension	n, diabetes, anemia, atrial		utilized its resources effectively	and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI	_		، ا	С	
		345376	B. WING				27/2017	
NAME OF PI	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 031	2772017	
					461 LEGION ROAD			
CUMBERI	AND NURSING AND RE	EHABILITATION CENTER			AYETTEVILLE, NC 28306			
()(1) ID	QUIMMADV QT	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 490	Continued From page	e 82	F.	490				
	fibrillation, severe pe	ripheral vascular disease.			efficiently to obtain and maintain the			
					highest practical level of wellbeing of ea	ach		
	Review of the resider	nt's last quarterly minimum			resident. On 10/18/17, the Corporate			
		ssment, dated 8/13/17,			facility consultant RN, administrator, ar	ıd		
	revealed the resident	t had 7 vascular ulcers.			DON implemented the plan of action to	,		
					include investigating the root cause of			
		physician's consult follow up			deficient practice in the areas of			
		revealed the physician had			grievances, neglecting to perform			
		ting that the resident had			dressing changes, and failing to provide	е		
		occlusion of the superficial			sufficient staff to perform dressing			
		vascular physician's plan			changes and ADL care.			
	and stent to help with	al artery balloon and a patch			On 10/19/17 the corporate facility			
	vascular ulcers.	i blood supply for fiel			On 10/18/17, the corporate facility consultant RN conducted an in-service			
		AM a staff member at the			with the administrator and the DON on			
		office was interviewed.			performing root cause analysis to			
		f member the resident went			determine systemic failure in order that	:		
		e the planned procedure on			corrections could be implemented to th			
		ble to have it because she			systems currently identified as ineffecti	ve.		
	had not been kept NF	PO (nothing by mouth). The						
		ascular physician's office			On 10/18/17, the administrator and DO			
		communicating with the			initiated an investigation to determine t	he		
		lity prior to the procedure,			root cause of ineffective systems to	_		
	-	een given verbal and written			include deficient practice in the areas of	ıf		
	communication abou	t the resident's NPO orders.			grievances, neglecting to perform	_		
	The word clork was i	nterviewed on 9/22/17 at 10			dressing changes, and failing to provide	3		
		confirmed she had received			sufficient staff to perform dressing changes and ADL care. The investigati	on		
		Resident # 135 NPO prior to			will be completed by 11/05/17. The roo			
	•	ad given the instructions to a			cause identified for each area will be			
		k was not able to state to			addressed immediately by the corporat	e		
		given the instructions.			facility consultant RN, administrator, ar			
		-			DON to include corrective action.			
	Interview with the die	tary manager on 9/22/17 at						
		ne procedure for a resident to			On 10/11/17, a plan of correction was			
	be NPO was for the s	staff to either tell him verbally			initiated by the corporate facility consul	tant		
	· ·	him. The dietary manger			RN and the administrator for failure to			
	stated he then made				follow facility procedures to resolve			
	prepared and sent to	the hall for a resident who is			grievances related to medication conce	erns		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345376	B. WING _				C <b>/27/2017</b>
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	2172011
				24	461 LEGION ROAD		
CUMBERL	AND NURSING AND I	REHABILITATION CENTER		F	AYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 490	Continued From pa	nge 83	F4	190			
	to be NPO. The die	etary manager stated he had			to include Resident #175. Refer to F 16	36.	
		ote or communication from					
	anyone that the resmorning of 8/8/17.	sident was to be NPO on the			On 10/12/2017, a plan of correction wa initiated by the corporate facility consul RN and the administrator for neglecting	Itant g to	
		assigned to care for Resident			perform dressing changes to vascular	and	
		is interviewed on 9/22/17 at 6			stage III pressure ulcers to include		
		ed she arrived at the facility			Resident #135. Refer to F 224.		
		ad already been served the			0-40/40/0047	_	
	•	ne morning of 8/8/17. The			On 10/12/2017, a plan of correction wa		
		was confusion to whether the or not, and she was sent to			initiated by the corporate facility consul RN and the administrator for failure to	lanı	
		physician did not do the			provide sufficient staff for pressure and	ı	
	procedure.	priyacian did not do the			vascular dressing changes to include		
	procedure.				Resident #135 and assistance with		
	Interview with Nurs	e Aide (Nurse Aide) # 5 on			activities of daily living (ADLs) to include	le	
		Vi revealed she was the			Residents #175 and #99. Refer to F 35		
		esident # 135 on 8/8/17. NA # 5			The administrator will review all audit to		
	-	he dining room when Resident			for plans of correction to include		
		ay was served to her in the			grievances, neglecting to perform		
	room by another sta	aff member who did not know			dressing changes, and providing suffic	ient	
	the resident was to	be NPO.			staff for dressing changes and ADL car	e	
					weekly for 12 weeks. Any areas of		
		administrator on 9/21/17 at 2:40			concern will be immediately addressed	by	
		the facility's procedure not to			the administrator.		
		no was designated NPO a tray					
	-	failed to follow their			A Plan of Correction was initiated for A	il	
	procedure.				Residents to include Resident #45 to		
		0.50			ensure the physician and Resident		
	4. Cross Refer to F	353.			Representative had been notified of all		
	Donad on record	wiew regident interviews			documented changes in condition, to		
		view, resident interviews, and staff interview, the facility			include falls and bruises. Nurse's Progress Notes and Risk Management		
		fficient staff for three (Resident			Reports will be reviewed for All Reside		
	•	99) out of twenty-one sampled			to include Resident #45, weekly x 8 we		
		ity failed to provide sufficient			then monthly x 1 month to ensure that		
		nd vascular dressing changes			physician and resident representative		
	•	nd assistance with activities of			notified immediately of all identified act		
	daily living (Reside				changes in condition to include falls an		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345376	B. WING _			09	/27/2017	
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
OUMBEDI	AND MUDOING AND DE	THA BU ITATION OF NITED	2461 LEGION ROAD		61 LEGION ROAD			
COMBER	AND NURSING AND RE	HABILITATION CENTER		FA	AYETTEVILLE, NC 28306			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE	
					DEFICIENCY)			
F 490	Continued From page	e 84	F 4	190				
				bruises utilizing an Acute Change				
					Notification QI Audit Tool by Staff			
		admitted to the facility on			Facilitator. Notification to the physician			
		agnosis of myocardial			and Resident Representative with			
	,	t attack)) atrial fibrillation,			documentation in the clinical record an			
	pacemaker and deme	entia.			re training with the license nurse, will be			
					completed by the Staff Facilitator/Qual	-		
		mum Data Set (MDS)			Improvement Nurse during the audit, for	or		
	Assessment (Quarterly) dated 7/17/17 revealed Resident #45 had severe cognitive impairment,				any identified areas of concern. The			
					Director of Nursing will review and initia			
	T	n transfers and toileting and			the Acute Change Notification QI Audit			
	required limited assis	stance with ambulation.			Tool weekly for 8 weeks then monthly			
					1 month for completion and to ensure a	all		
		M, Resident #21 (roommate			areas of concern are addressed.			
	· · · · · · · · · · · · · · · · · · ·	ed Resident #45 had fallen						
		Labor Day (8/31/17) and the						
	Thursday after Labor	Day (9/7/17.			The administrator will present the finding	ngs		
					of the audit tools for the plans of			
		s notes for Resident #45			correction and the results of the			
	from 8/24/17 through				investigation for root cause analysis fo	r		
	documentation of falls	s or bruises.			the ineffective systems to the QI			
					committee for review. The QI committee			
		AM an observation was			will meet monthly for 3 months to revie			
		with NA #5 revealing that			the audits and ensure that the root cau			
		iple bruises. The resident			of ineffective systems has been identifi			
		e a pale blue bruise that			and corrected. Any areas of concern to			
		ght knee cap and a quarter			include identified trends will be review			
	-	w the left knee, a round			recommendations for follow up will occ			
		approximately 1.5 inches in			as needed to include increased freque	ncy		
		lower buttock and a purple			of monitoring. The Regional Vice			
		the right little toe that was			president will provide ongoing weekly			
		ches long and 1.5 inches			sight of the building weekly to ensure t	he		
	wide with slight swell	ing.			facility is compliance with the plans of			
					corrections and quality assurance			
		M it was confirmed with			processes.			
		ident had fallen 2-2 ½ weeks						
	_	d she did not document the						
	fall as she was in a h	-						
	planned to document	it the next day but must						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ·	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345376	B. WING			C
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  2461 LEGION ROAD  FAYETTEVILLE, NC 28306		9/27/2017
(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 CORRE ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 490	have forgotten. The N report the fall to the of she told the nurse practice. On 9/22/17 at 6:30 Pl Nurse Practitioner that the resident had falled During an interview of resident 's physician made aware of the resident at 3:40 Pl nursing supervisor the Friday on the 7 AM to been informed the resident. The Administrator was	Jurse stated she did not n-coming nurse but thought actitioner.  M it was confirmed with the at she had not been notified	F	190		
F 514 SS=D	confirmed she had no resident's falls and be administrator it was the discuss falls in morning 45's fall had not been the administrator, she aware of the resident been investigated.  483.70(i)(1)(5) RES RECORDS-COMPLE LE  (i) Medical records. (1) In accordance with standards and practice.	ot been made aware of the pruises. According to the pruises. According to the me facility 's procedure to mag meetings and Resident # on discussed. According to e should have been made 's fall so that it could have	F	514		11/5/17

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345376	B. WING		C 09/27/2017		
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	:	STREET ADDRESS, CITY, STATE, ZIP CODE 2461 LEGION ROAD FAYETTEVILLE, NC 28306	09/2//2017		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION		
F 514	(ii) A record of the re (iii) The comprehens provided;  (iv) The results of an and resident review determinations cond (v) Physician's, nurs professional's program (vi) Laboratory, radiservices reports as This REQUIREMEN by:	mented;  ble; and  organized  ord must contain- ation to identify the resident;  esident's assessments;  sive plan of care and services  my preadmission screening evaluations and ducted by the State;  se's, and other licensed	F 514	, · · · · · · · · · · · · · · · · · · ·			
	warranted a physicial failed to assure the The facility failed to record in relation to bruises and a fall ar vascular procedures The findings include	residents whose condition an notification, the facility medical record was complete. have an accurate medical Resident # 45 sustaining and Resident # 135 missing a prior to a leg amputation.		Resident # 45 attending physician ma aware of a fall and bruising on 9/22/1 Facility Consultant with documentation the electronic medical record. Reside 45, Resident Representative made and of a fall and bruising on 9/22/17 by Fa Consultant with documentation in the electronic medical record. Resident # had a follow-up appointment schedule on 9/26/17 by Facility Secretary with	7 by n in nt # ware acility  # 135		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345376	B. WING _			09/	27/2017	
NAME OF PI	ROVIDER OR SUPPLIER	•	<u>'</u>	STR	EET ADDRESS, CITY, STATE, ZIP CODE	·		
				246	1 LEGION ROAD			
CUMBERI	LAND NURSING AND	REHABILITATION CENTER		FAY	ETTEVILLE, NC 28306			
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	3E	(X5) COMPLETION DATE	
				DEFICIENCY)				
F 514	Continued From p	<del>-</del>	F 5	514				
		o the facility on 5/6/17. The			vascular surgeon. Resident # 135			
		noses of end stage renal			attended scheduled appointment on			
		odialysis, coronary artery			9/26/2017 with documentation in the			
	_	f coronary artery bypass			electronic medical record by Treatmen			
		sion, diabetes, anemia, atrial			Nurse. Resident Representative made	,		
	fibrillation, severe	peripheral vascular disease.			aware of the appointment results with			
					documentation in the electronic medic			
		ular physician's consult note,			record on 9/272017 by Treatment Nurs			
		vealed the physician had			100% of all residents to include reside	nt #		
	_	testing that the resident had			135 telephone orders and discharge			
	bilateral chronic to	otal occlusion of the superficial			summaries were audited from 8/1/201	7 to		
	femoral arteries.	The vascular physician's plan			10/11/2017 for any request appointme	nts		
	was to place a fer	moral artery balloon and a patch			completed on 10/13/2017 by Facility			
	and stent to help	with blood supply for her			Nurse Consultant. Any identified areas			
	vascular ulcers be	ecause he had identified she			concern noted during the audit were			
	was at risk for los	ing her limb. The physician			immediately addressed by Director of			
		to do the left leg first and then			Nursing. All residents with requested			
	at a later time do	the right leg. The vascular			appointments from telephone orders o	r		
		ne procedure was explained to			discharge summary have been made.			
		she acknowledged she			100% audit was completed on 9/1/201	7		
		greed to the procedure.			by Facility Consultant on all residents			
					include resident # 45 to ensure that all			
	There was no not	ation in the resident's medical			incidents to include falls and bruising v	vere		
	record when the	procedure was to take place,			appropriately entered into the electron			
		mpleted, or facility's efforts to			medical record and that RR and physic			
		n the vascular physician until			had been notified of the incident. For a			
		se # 6 documented she had			incidents without documentation in the	•		
		an's office secondary to the			electronic medical records the Facility			
		ing ulcers and obtained an			Consultant documented the details of	the		
		ne vascular physician to see the			incident on an incident progress note t			
	resident on 9/12/				ensure documentation of the incident			
	. 35.45.11 511 51 121	• • •			notification of RR and physician is pre-			
	There was no doo	cumentation in the medical			in the electronic medical record.	23		
		the resident's procedure was			100 % of all care plans were reviewed	by		
	not completed.	The residence procedure was			Facility Consultant on 9/1/2017to ensu	,		
	not completed.				that the care plans accurately reflect the			
	There was no day	cumentation in the resident's						
					resident to include history of falls. The	ſ		
		bout the facility's efforts to			care plan was immediately corrected			
	reschedule the va	iscular procedure.			during the audit by Minimum Data Set			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345376	B. WING		00	C // <b>27/2017</b>		
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	09	1/2//2017		
	10110211 011 001 1 21211			2461 LEGION ROAD				
CUMBERL	AND NURSING AND R	EHABILITATION CENTER		FAYETTEVILLE, NC 28306				
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F 514	10:45 AM revealed to done and the facility documented in the re	ministrator on 9/22/17 at ne procedure had not been	F 51	Nurse for any identified areas of concerns.  100% in-servicing was initiated or 9/15/2017 by Director of Nursing licensed nurses in regards to documentation in the electronic materials.	of all			
	appointments, the fa the vascular procedu communicate with th physician. 2. Resident #45 was 6/30/16 and had a di infarction (MI or hear pacemaker and dem	cility's efforts to reschedule ire, and the facility's efforts to e resident's vascular admitted to the facility on agnosis of myocardial t attack)) atrial fibrillation, entia.		record. To include Document after single Incident to include but not a fall or unsupervised exit under the incident progress note. Assess the resident from head to toe to inclusing incident from head to toe to inclusing notify the attending physicic complete an incident report and infamily and/or resident representation aware and document in the medical control of the incident representation.	er every limited to the le de vital fan, make the tive			
	of Resident #45) star Resident #45 fell on Day (August 31, 201 Labor Day (Septemb stated when the resident and staff came in Review of the clinical	M Resident #21 (roommate ed in an interview that the Thursday before Labor 7) and the Thursday after er 7, 2017). Resident #21 dent fell, she put on her call n and got her up.  I record dated 8/24/17 aled no documentation of a		records. The physician or mid-lev provider on call may order x-rays scans or pain medications, so be include any new orders in your nunote and results of any radiology with MD and RR notification. Neu checks must be documented per physician order/facility protocol uneuro check progress note for all suspected head injury. A nurse's must be written regarding bruises were not previously present. An in	, CT sure to urse's reports iro inder the note s that			
	#7 stated in an intervalent, oriented and realert, oriented and 10:59 interview about 2 we Resident #45 had a rego to the bathroom a nurse who assisted to the fall. The NA furth bruises which she had	AM, NA (nursing assistant) riew that Resident #21 was liable.  AM, NA #5 stated in an eks ago a nurse told her fall when trying to get up to nd identified Nurse #4 as the he resident to get up after er stated the resident had ad reported to a nurse but ame of the nurse she told.		report must be completed and the RR must be notified with docume the medical records. Complete a referral form. Notify the Don and Administrator immediately of all b this could be considered an "injur unknown origin" and requires furt investigation. Generate a nurse's when you schedule an appointme Example: "Appointment with Dr. S orthopedics made for Monday, M at 2:45pm due to leg pain; facility	e MD and Intation in Intain in Intation in Intain in			

		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	REHABILITATION CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 2461 LEGION ROAD FAYETTEVILLE, NC 28306				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 514	On 9/22/17 at 11:15 resident 's bruises blue bruise was not below the left knee. the right buttock and the right foot at the was approximately wide with slight sween Review of the clinic through 9/22/17 revibruises.  On 9/22/17 at 3:40 that worked Monday to 3 PM shift stated (Quality Improvemenurse 's notes that in the event of a fall stated no one had resident #45 to her On 9/22/17 at 4:01 an interview they dimeeting and there is bruises for Resident further stated if a reshould report it. The saw bruises on a renotify the nurse and do an assessment a report.  On 9/22/17 at 5:55 interview Resident weeks ago and she her up but was unal	S AM an observation of the was made with NA #5. A pale ed on the right knee and just There was a bluish bruise on d a purple bruise on the top of base of the right little toe that 2.5 inches long and 1.5 inches elling of the foot.  all record dated 8/24/17 realed no documentation of PM the Nursing Supervisor by through Friday on the 7 AM in an interview they had a QI ent) document as part of the was supposed to be filled out a fall or bruises for	F	514	driver will transport to and from doctors office. Resident Representative made aware". If a resident refuses to go to ar appointment or the appointment is cancelled for any reason, this must be documented. The MD and RR must be notified of the reasoning for not attendi an appointment with documentation in medical records. When an appointmen rescheduled, this also must be documented in the medical records. In addition, chart when the resident returns to the nursing home. Example: "Resident returned from ortho appointment in no observed acute distress; new orders received for weigh bearing as tolerated to both lower extremities and tramadol 50 mg orally of PRN pain. Resident Representative Ja Simmons (niece) aware" to be complete by 11/05/2017. All newly hired nurses be in-serviced by the Staff Facilitator during orientation in regards to Docume after every single Incident to include but not limited to a fall or unsupervised exitunder the incident progress note. Asset the resident from head to toe to include vital signs, notify the attending physicial complete an incident report and make family and/or resident representative aware and document in the medical records. The physician or mid-level provider on call may order x-rays, CT scans or pain medications, so be sure include any new orders in your nurse's note and results of any radiology report with MD and RR notification. Neuro checks must be documented per physician order/facility protocol under the physician order/facility protocol under th	ng the t q6h ne ed will ent tt ss e in, the		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		` ′	ATE SURVEY OMPLETED	
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F 514	fall because she was	any documentation of the in a hurry to leave and had the fall the next day but	F	514	neuro check progress note for all suspected head injury. A nurse's note must be written regarding bruises that were not previously present. An incider report must be completed and the MD and RR must be notified with documentation the medical records. Complete a skin referral form. Notify the Don and Administrator immediately of all bruises this could be considered an "injury of unknown origin" and requires further investigation. Generate a nurse's note when you schedule an appointment. Example: "Appointment with Dr. Skylar orthopedics made for Monday, March at 2:45pm due to leg pain; facility van driver will transport to and from doctors office. Resident Representative made aware". If a resident refuses to go to an appointment or the appointment is cancelled for any reason, this must be documented. The MD and RR must be notified of the reasoning for not attending an appointment with documentation in medical records. When an appointment rescheduled, this also must be documented in the medical records. In addition, chart when the resident return to the nursing home. Example: "Resider returned from ortho appointment in no observed acute distress; new orders received for weight bearing as tolerated both lower extremities and tramadol 50 mg orally q6h PRN pain. Resident Representative Jane Simmons (niece) aware."  The Quality improvement will audit nursing progress notes and incidents to include falls and bruising utilizing an Auditional progress notes and incidents to include falls and bruising utilizing an Auditional progress notes and incidents to include falls and bruising utilizing an Auditional progress notes and incidents to include falls and bruising utilizing an Auditional progress notes and incidents to include falls and bruising utilizing an Auditional progress notes and incidents to include falls and bruising utilizing an Auditional progress notes and incidents to include falls and bruising utilizing an Auditional progress notes and incidents to include falls and bruising utilizing an Auditional progress	and n in sas as of Brd sand the tis as as as a sent the total control of		

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NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
CUMBERI	AND NURSING AND RE	HABILITATION CENTER		2461 LEGION ROAD FAYETTEVILLE, NC 28306				
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F 514	COMMITTEE-MEMBI QUARTERLY/PLANS  (g) Quality assessme  (1) A facility must mai and assurance comminimum of:  (i) The director of nurse.	(i)(ii)(h)(i) QAA ERS/MEET Int and assurance. Intain a quality assessment iittee consisting at a		514	QI Changes in Condition tool 5 X a week for 8 weeks and monthly X 1 month to ensure that appointments, refusal of appointments, falls and bruising is identified in the electronic medical recowith notification of RR and physician. A identified areas of concern will be immediately corrected and the licensed nurse will be re-trained by Quality Improvement during the audit. The Director of Nursing will review and initiathe Audit QI Changes in Condition tool a week for 8 weeks and monthly X 1 month for completion.  The Director of Nursing will forward the results of the Audit QI Changes in Condition tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet month x 3 months and review the Audit QI Changes in Condition tool to determine trends and / or issues that may need further interventions put into place and determine the need for further and / or frequency of monitoring.	rd ny al 5 X	11/5/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
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F 520	Continued From pag	ge 92	F 5	520			
	staff, at least one of	r, a board member or other					
	(g)(2) The quality assessment and assurance committee must :						
	coordinate and eval identifying issues w	rterly and as needed to uate activities such as th respect to which quality surance activities are					
		lement appropriate plans of ntified quality deficiencies;					
	Secretary may not r records of such com such disclosure is re	ormation. A State or the equire disclosure of the amittee except in so far as elated to the compliance of a the requirements of this					
	committee to identify deficiencies will not sanctions.	faith attempts by the y and correct quality be used as a basis for					
	Based on observation interviews the facilit Assurance (QAA) Complemented procedinterventions the cofollowing the 7/21/1 was the recited definition.	on, record review and staff y's Quality Assessment and ommittee failed to maintain dures and monitor the mmittee put into place 7 recertification survey. This ciencies in the areas of Choices (F242). These		F520 The Administrator, DON and were educated by the Corpor Consultant on the QI process implementation of Action Pla Monitoring Tools, the Evaluation process, and modification and if needed to prevent the records.	rate s, to include ns, tion of the QI ad correction		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
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CUMBERL	AND NURSING AND I	REHABILITATION CENTER						
				Г	AYETTEVILLE, NC 28306			
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F 520	Continued From pa	ge 93	F t	520				
F 520	deficiencies were resurvey of 9/27/17. facility shows a pat sustain an effective Assurance program. The tag is cross refereive and staff into promote a resident the resident to wait same table were be resident 's Geri-chathe resident for 1 or dignity (Resident #2 During the 7/21/17 facility had a F241 residents in a dignity staff allowed a resident care dubrief while eating.  F242 Choices: Basinterviews, and recoffer showers as so residents (Resident During the 7/21/17 facility had a F242	The continued failure of the tern of the facility's inability to Quality Assessment and a.  Gerenced to:  Gerenced	F	520	deficient practice to include promoting dignity and offering showers on 10/4/2017. The Administrator, DON ar QI Nurse were educated by corporate consultant on the QA process to includidentifying issues that warrant development and establish a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effectiv QA program on 10/4/2017. The Facility Consultant completed 1000 audit of previous citations and action plans within the past year to include promoting dignity and offering showers ensure that the QI committee has maintained and monitored interventions that were put into place. Action plans with that were put into place. Action plans with the work of the Administrator on 11/05/17 for any concerns identified. All data collected for identified areas of concerns to include promoting dignity a offering showers will be taken to the Quality Assurance committee for review monthly x 6 months by the Quality Improvement Nurse. The Quality Assurance committee will review the day and determine if plan of corrections are being followed, if changes in plans of action are required to improve outcomes.	e  s e  to  s vere the  and v  ata es,		
	policy that allows a safe smoker to smoke any time he/she wanted and to smoke unsupervised.				if further staff education is needed, and increased monitoring is required. Minut of the Quality Assurance Committee wi	l if es II		
	stated she attribute Assessment and As	onducted with the 26/17 at 12:15 PM. She d the fact that their Quality ssurance had not worked been changes in the			be documented monthly at each meeting by Administrator.  The Corporate Consultant will ensure to facility is maintaining an effect QA program by reviewing and initialing the	he		

AND DIAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 520	Continued From page administrative staff re had hired new staff ar	e 94 ecently. She expressed she nd was working on resolving not have been addressed by		m pi ac pi al fo Fi th al Ti A pi Q id ac		re The rain	DAIL	