STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER: CUMBERLAND NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 2461 LEGION ROAD FAYETTEVILLE, NC 28306

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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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| F 658 | SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) | F 658 | | | | $483.21(b)(3) Comprehensive Care Plans  
The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-  
(i) Meet professional standards of quality.  
This REQUIREMENT is not met as evidenced by:  
Based on observations, record review and resident and staff interviews, the facility failed to administer topical medications as ordered by the physician for 1 of 1 resident reviewed for receiving care according to professional standards (Resident #4).  
Findings Included:  
Resident #4 was admitted to the facility on 04/24/14 with diagnoses which included diabetes mellitus and multiple furuncles (bumps under the skin caused by infected and inflamed hair follicles).  
A review of Resident #4's Minimum Data Set (MDS), dated 03/03/18, revealed Resident #4 to be cognitively intact and required total assistance with her Activities of Daily Living. The MDS indicated Resident #4 had open lesions other than ulcers, rashes and cuts.  
A review of Resident #4's Care Plan, last updated 10/10/17, revealed Resident #4 had been care planned for potential or actual skin integrity related to the diagnosis of multiple furuncles with a goal of Resident #4's furuncles to be healed by the completion of antibiotic therapy. Interventions included medications and treatment as ordered.  
F 658 | The process that led to the deficiency is assigned hall nurses failed to administer resident # 4 topical medications as ordered by the physician.  
Resident # 4 was administered topical medications as ordered by the physician on 4/24/2018 by the assigned nurse with oversight by the Facility nurse consultant. 100 % Medication Pass audit was initiated on 4-17-2018 by the Facility Consultant and Staff Facilitator (SF) utilizing a Medication Pass Audit Tool with all licensed nurses to include agency staff and medication aides to ensure that orders were being followed as transcribed on the Medication Administration Record (MAR) to include resident # 3 topical medications to be completed by 5/3/2018. Licensed nurse to include agency staff or medication aide will be re-educated during Medication Pass audit for any identified areas of concern by the Facility Consultant and Staff Facilitator.  
100 % in-servicing was initiated on 4/17/2018 by the Staff Facilitator with all licensed nurses to include agency staff and medication aides in regards to medications are to be administered as

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed  
TITLE:  
DATE: 05/03/2018

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.
A review of Resident #4's April 2018 Medication Administration Record (MAR) indicated Resident #4 had physician orders for Hibiclens Liquid (a topical antiseptic cleanser) to be used as a daily body wash to her groin, buttocks and underarms. The MAR indicated Resident #4 had physician orders for Clindamycin Solution 1% (a topical antibiotic solution) to be applied to her groin, buttocks and bilateral axillae (underarms) twice daily. The Hibiclens Liquid had been signed off on the MAR by Nurse #2 as having been administered at 8:00 a.m. on 04/16/17 and 04/17/18 as ordered. The Clindamycin Solution had been signed off on the MAR by Nurse #2 as having been administered at 8:00 a.m. on 04/16/17 at 8:00 a.m. and 4:00 p.m. as ordered and on 04/17/18 at 8:00 a.m. as ordered.

During an interview with Resident #4 on 04/17/18 at 10:50 a.m., Resident #4 stated her skin had not been treated with the Hibiclens Liquid or Clindamycin Solution on 04/16/18 or 04/17/18 and stated the staff had barely ever treated her skin with either topical medication from the time they had been ordered.

During an interview with Nurse #2 on 04/17/18 at 11:00 a.m., Nurse #2 stated her initials on the MAR indicated she had administered a medication as ordered. When asked about her initials on 04/16/18 and 04/17/18 for the Hibiclens Liquid and Clindamycin Solution, Nurse #2 stated she had not administered these medications. When asked why she had signed them off as having been administered, Nurse #2 stated the Nursing Assistants were supposed to administer those medications.

During an interview with the Administrator of
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<td>04/17/18 at 12:20 p.m., the Administrator stated it was her expectation nursing staff administer medications as ordered.</td>
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<td>determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.</td>
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<td>ADL Care Provided for Dependent Residents</td>
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<td>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews, the facility failed to provide showers as scheduled for 1 of 1 resident reviewed (Resident #3). Findings Included: Resident #3 was admitted to the facility on 02/20/18 with diagnoses which included quadriplegia. A review of Resident #3's Minimum Data Set (MDS), dated 02/27/18, revealed Resident #3 was cognitively intact and required total dependence on staff for his Activities of Daily Living. The MDS indicated Resident #3 felt it was very important for him to be able to choose between a tub bath, shower, bed bath or sponge bath. A review of Resident #3's Care Plan, last updated on 02/13/18, indicated Resident #3 required total dependence on staff for bathing and personal hygiene related to impaired mobility, impaired balance, physical limitations and the diagnosis of</td>
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<td>performed for any reason or performed timely, the nurse must be notified. The nurse must ensure that the care needed is provided for the resident in a timely and accurate manner. Nursing assistants must notify the nurse about all refusals of care so that nurse can document in progress note to include notification of Resident Representative of the care being refused to be completed by 5/3/2018. All newly hires nursing assistants, to include agency staff will be in-serviced on Cleaning and bathing your residents. Both of these task are a daily requirement unless resident prefers otherwise. Showers to be given by shower schedule unless resident prefers otherwise. If care cannot be performed for any reason or performed timely, the nurse must be notified. The nurse must ensure that the care needed is provided for the resident in a timely and accurate manner. Nursing assistants must notify the nurse about all refusals of care so that nurse can document in progress note to include notification of Resident Representative of the care being refused during orientation by 5/3/2018. Staff Facilitator/Quality improvement nurse will monitor 10% of all residents to include resident # 3 to ensure showers are being provide per the shower schedule utilizing a Shower audit tool weekly for 8 weeks and monthly for 1 month. The assigned nursing assistant will be immediately retrained during the audit by Staff Facilitator/Quality Improvement nurse for any identified areas of concern. The DON will review and initial the Shower audit tools weekly</td>
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### F 677

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7a shift at the facility and had never given Resident #3 a shower on his scheduled shower nights. NA #3 stated she had offered him a shower one time and Resident #3 had refused. NA #3 stated she had spoken with a day shift NA who had told her not to worry about it because Resident #3 got a good bed bath on day shift.

During an interview with the Administrator on 04/17/18 at 12:20 p.m., the Administrator stated it was her expectation nursing staff provide showers to residents as scheduled.

### F 867

**SS=D**

**QAPI/QAA Improvement Activities**

**CFR(s): 483.75(g)(2)(ii)**

- §483.75(g) Quality assessment and assurance.
- §483.75(g)(2) The quality assessment and assurance committee must:
  - (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
  - This REQUIREMENT is not met as evidenced by:
  - Based on staff interview and record review, the facility's quality assurance (QA) process failed to implement, monitor and revise as needed the action plan developed for the revisit survey dated 9/27/17 in order to achieve and sustain compliance. This was for one recited deficiency on complaint survey on 4/17/18. The deficiency was in the area of professional standards at CFR 483.21. The continued failure during two federal surveys of record showed a pattern of the facility's inability to sustain an effective quality assurance program.
  - The findings included:

  - F 867
    - The Administrator, DON and QI Nurse were educated by the Corporate Consultant on the QI process, to include implementation of Action Plans, Monitoring Tools, the Evaluation of the QI process, and modification and correction if needed to prevent the reoccurrence of deficient practice to include professional standards on administering medications.
    - The Administrator, DON and QI Nurse were educated by corporate consultant on the QA process to include identifying issues that warrant development and
This tag is cross referenced to:

CFR 483.21 (F658) - Based on observations, record review and resident and staff interviews the facility failed to administer topical medications as ordered by the physician for 1 of 1 residents reviewed for receiving care according to professional standards (Resident #4).

During the revisit survey on 9/27/17 the facility was cited for failure to administer and document the administration of medications for three residents (Residents #135, #97, and #175) of three sampled residents reviewed for medications.

During an interview with the Administrator on 4/17/18 at 2:15 PM she reported the facility’s Quality Assessment and Assurance program may have failed due to the continued change in staff including the Director of Nursing position. She stated they had a system in place and had completed the monitoring on the medication pass deficiency previously cited. She added she had already started a plan of correction for this complaint survey.

establish a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA program on administering medications. The Administrator/Facility Nurse consultant completed 100% audit of previous citations and action plans within the past year to include professional standards on administering medications and offering showers to ensure that the QI committee has maintained and monitored interventions that were put into place. Action plans were revised and updated and presented to the QI Committee by Administrator on 4/26/2018 for any concerns identified.

All data collected for identified areas of concerns to include professional standards on administering medications and 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 data and determine if plan of corrections are being followed, if changes in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by Quality Improvement Nurse/Administrator. The Corporate Consultant will ensure the facility is maintaining an effect QA program by reviewing and initialing the Executive committee Quarterly meeting minutes and ensuring implemented
### F 867

Continued From page 6

- Procedures and monitoring practices to address interventions, to include promoting dignity and offering showers and all current citations and QI plans are followed and maintained Quarterly x2. The Facility Consultant will immediately retrain the Administrator, DON and QI nurse for any identified areas of concern.

- The results of the Monthly Quality Assurance meeting minutes will be presented by the Administrator and/or DON to the Executive Committee Quarterly x 2 for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.

### F 880

Infection Prevention & Control

**CFR(s): 483.80(a)(1)(2)(4)(e)(f)**

**§483.80 Infection Control**

The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

**§483.80(a) Infection prevention and control program.**

The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

- A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals.
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<td>F880</td>
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providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility’s IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:

Based on observation, record review and staff interviews the facility failed to dispose of personal protective equipment (PPE) prior to exiting an isolation room (Room 242) for 1 of 1 rooms posted for contact isolation precautions (Vancomycin Resistant Enterococcus in a wound). Findings included:

Review of the facility policy dated August 2005 revealed under "Points to Remember- Personal protective equipment should be used once and properly disposed of in the trash before leaving the room."

Review of the posted Contact Precautions sign on the door of room 242 revealed gowns were to be worn if clothing could become contaminated.

In an observation on 04/17/18 at 5:58 AM Nursing Assistant (NA) #1 was seen walking down the hallway carrying dirty linen in a plastic bag. A yellow isolation gown was hanging unbagged from her arm. She walked approximately 20 feet down the hallway and deposited the gown and bagged linen into a bin in the dirty utility room.

In an interview on 04/17/18 at 6:00 AM NA #1 confirmed that she had just exited room 242 after providing care. She indicated she had placed the soiled linens in a plastic bag but did not have...
### F 880

Continued From page 9

another bag to place the PPE in so she just
carried it out of the room. She stated she knew
she should have placed the PPE in a bag before
bringing it out of the room for disposal.

In an interview on 04/17/18 at 6:10 AM Nurse #1
stated it was her expectation that used PPE be
bagged before being carried out of an isolation
room. She indicated the aide should have made
sure she collected all the supplies she needed
prior to entering the isolation room to provide care
which would include bags to contain the soiled
linens and used PPE.

In an interview on 04/17/18 at 6:25 AM the
Director of Nursing (DON) indicated she expected
staff to understand the importance of isolation
and the containment of infectious organisms.
She stated she expected facility policy to be
followed with no shortcuts. The DON indicated
NA #1 should have placed any used PPE in a
receptacle in the isolation room before exiting the
room with it. She stated it was unacceptable that
the aide had carried soiled PPE out into the
hallway without being contained.

100% in-service was initiated on
4/17/2018 by the Staff Facilitator with all
nursing assistants to include NA # 1
regarding the facility policy on disposing of
PPE equipment before exiting an isolation
room by the Staff Facilitator to be
completed by 5/3/2017. All newly hired
nursing assistants will receive the
education during orientation by the Staff
Facilitator regarding the facility policy on
disposing of PPE equipment before
exiting an isolation room.

10% of all nursing assistants to include
Nursing Assistant # 1 will be observed by
the Staff Facilitator/quality improvement
nurse to ensure the facility policy on
disposing of PPE equipment before
exiting an isolation room is being followed
utilizing a Resident Care Audit tool weekly
x 8 weeks then monthly x 1 month. The
Staff Facilitator/Quality improvement
nurse will immediately retrain the nursing
assistant for any identified concerns
during the audit. The Director of Nursing
will review and initial the results of the
Resident Care Audit Tools weekly x 8
weeks then monthly x 1 month for
completion and to ensure all areas of
concerns were addressed.

The Director of Nursing will forward the
results of the Resident Care Audit tools to
the Executive Committee monthly X 3
months. The Executive committee will
meet monthly and review the Resident
Care Audit tools and address any issues,
concerns and/or trends to make changes
as needed, to include continued frequency
of monitoring x 3 months.