DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		TE SURVEY MPLETED
		345376	B. WING			C 7/03/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		1103/2010
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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	;	F 00			
	was conducted from After review of the SC state agency return to survey. This was cor	aplaint and follow-up survey 05/21/18 through 05/26/18. DD, CMS requested the to the facility for an extended apleted 07/02/18 through b Jeopardy was identified at:				
	of J	600 at a scope and severity 695 at a scope and severity				
	The tags F600 and F Quality of Care.	695 constituted substandard				
	Immediate Jeopardy removed on 07/03/18	began on 05/18/18 and was				
F 600 SS=J	Free from Abuse and CFR(s): 483.12(a)(1)	Neglect	F 600			7/11/18
	Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment,	involuntary seclusion and ical restraint not required to				
	§483.12(a) The facilit	y must-				
	physical abuse, corpo involuntary seclusion	-				
		SUPPLIER REPRESENTATIVE'S SIGNATUR		TITLE		(X6) DATE
	cally Signed	CONTRACTOR OF CONTRACTOR	~			07/03/2018

**Electronically Signed** 

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

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA				NO. 0938-03 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		PLE CONSTRUCTION		MPLETED
			A. DOILDING	J		С
		345376	B. WING			07/03/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
				2461 LEGION ROAD		
CUMBERI	AND NURSING AND RE	EHABILITATION CENTER		FAYETTEVILLE, NC 28306		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETIO DATE
F 600	Continued From page	e 1	F 60	00		
	Based on observation	on, record review and		Cumberland Nursing and I	Rehabilitation	
	resident and staff inte	erviews, the facility neglected		acknowledges receipt of th	e Statement of	
		omy care as ordered by the		Deficiencies and proposes		
		of 1 resident reviewed for		Correction to the extent the	•	
		sident #25) and the facility		of findings is factually corre		
		r obtain orders for indwelling nges for 1 of 1 resident		to maintain compliance with rules and provisions of qua		
		#25) resulting in a resident's		residents. The Plan of Corr		
	, ·	theter not being changed for		submitted as a written alleg		
		a hospitalization for a urinary		compliance.		
tr	tract infection (UTI).					
				Cumberland Nursing and F		
		for Resident #25 began on		response to this Statement		
		moved on 07/03/18 when the		does not denote agreemen		
		cceptable credible allegation facility will remain out of		Statement of Deficiencies r constitute an admission that		
		and severity of a G (actual		deficiency is accurate. Furt	•	
	harm that is not Imm			Cumberland Nursing and F		
	example 1b.			reserves the right to refute		
				deficiencies on this Statem	ent of	
	The Findings Include	ed:		Deficiencies through Inform		
				Resolution, formal appeal p		
		Imitted to the facility on		or any other administrative	or legal	
		al diagnoses included, in sis (MS), calculus (stone) in		proceeding.		
		idney, chronic obstructive				
		y infection), reflux uropathy				
		der toward the kidney),				
		story of urinary tract infection		F600		
		osis (MS), chronic obstructive				
	pulmonary disease a	nd tracheostomy status.		1a. The process that lead t		
				deficiency was the failure of		
		#25's quarterly Minimum		completely reading the Me		
		1/18, revealed Resident #25 intact and required total		Administration Record (MA resulted in not documenting		
		r her Activities of Daily Living		care provided. The failure of		
		licated Resident #25 had an		Nurse #2 to provide trache		
		theter and had obstructive		resident #25.		
		indicated the resident				

Facility ID: 953074

If continuation sheet Page 2 of 62

F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA					
	IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		TE SURVEY	
CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING	G			
		5.44440			C	
	345376	B. WING			07/03/2018	
OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
AND NURSING AND RE	HABILITATION CENTER		2461 LEGION ROAD			
			FAYETTEVILLE, NC 28306			
		ID			(X5)	
		PREFIX TAG			COMPLETIO DATE	
Continued From page	2	F 60	00			
received oxygen thera	apy and tracheostomy care.		On 5/17/18, Resident #25 was	s sent out to		
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
A review of Resident	#25's Care Plan revealed		dislodged G-Tube.			
the following:						
				•		
0	,					
	•					
	lity protocol (last revised			the trach		
,	furinary elimination with		site.			
			On 5/17/18 per hospital record	d at 6.58		
			oriented x 4, respiratory rate e	even and		
report any changes, c	change catheter per		unlabored, patient has trach a	ind wears		
	• •		O2 @ 2 liters. No mention of o	drainage,		
for signs and symptor 12/06/17).	ms of UTI (last revised		larvae, or foul-odor in tracheo	stomy.		
-	-			in stable		
•			position.			
• •	•		On E/17/19 per beer the sector	d at 10:40		
	-					
•			-	-		
	•					
-			On 5/18/18 per hospital record	d at 5:32		
revised 06/30/17).						
,	I for or actual ineffective					
breathing pattern rela	ted to her tracheostomy.					
			Therapist treatment assessme	ent.		
	· •					
needed or as ordered	I (last revised 12/28/17).					
	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page received oxygen thera A review of Resident the following: 1. At risk for recurred damage due to chron recurrent UTIs. Inter- catheter care per faci 12/06/17). 2. Altered pattern o indwelling catheter - a urinary retention. Re- tube and (indwelling of Interventions included facility protocol, moni report any changes, of physician orders and/ for signs and symptor 12/06/17). 3. Resistive to treat to shower, comb hair, nails cut, get out of be position, have facial h signs or weights take in part, to allow for fle accommodate the res the care being resisten notify the physician o to discuss the implica the therapeutic regim revised 06/30/17). 4. Had the potentia breathing pattern rela Interventions included tracheostomy care as and/or facility protoco stoma site frequently	AND NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 received oxygen therapy and tracheostomy care. A review of Resident #25's Care Plan revealed the following: 1. At risk for recurrent UTIs, urosepsis, or renal damage due to chronic UTIs or history or recurrent UTIs. Interventions included, in part, catheter care per facility protocol (last revised 12/06/17). 2. Altered pattern of urinary elimination with indwelling catheter - at risk for infection related to urinary retention. Resident with nephrostomy tube and (indwelling urinary) catheter. Interventions included, in part, catheter care per facility protocol, monitor nephrostomy tube and report any changes, change catheter per physician orders and/or facility protocol, monitor for signs and symptoms of UTI (last revised 12/06/17). 3. Resistive to treatment and care (did not want to shower, comb hair, turn off her back, have nails cut, get out of bed, have bed placed in low position, have facial hair removed, have vital signs or weights taken). Interventions included, in part, to allow for flexibility in ADL routine to accommodate the resident's mood, to document the care being resisted per facility protocol and to notify the physician of patterns in behaviors and to discuss the implications of not complying with the therapeutic regiment with the resident (last	OVIDER OR SUPPLIER         AND NURSING AND REHABILITATION CENTER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 2 received oxygen therapy and tracheostomy care.       F 6         A review of Resident #25's Care Plan revealed the following:       F 6         1. At risk for recurrent UTIs, urosepsis, or renal damage due to chronic UTIs or history or recurrent UTIs. Interventions included, in part, catheter care per facility protocol (last revised 12/06/17).       F 6         2. Altered pattern of urinary elimination with indwelling catheter - at risk for infection related to urinary retention. Resident with nephrostomy tube and (indwelling urinary) catheter. Interventions included, in part, catheter care per facility protocol, monitor nephrostomy tube and report any changes, change catheter per physician orders and/or facility protocol, monitor for signs and symptoms of UTI (last revised 12/06/17).       S. Resistive to treatment and care (did not want to shower, comb hair, turn off her back, have nails cut, get out of bed, have bed placed in low position, have facial hair removed, have vital signs or weights taken). Interventions included, in part, to allow for flexibility in ADL routine to accommodate the resident's mood, to document the care being resisted per facility protocol and to notify the physician of patterns in behaviors and to discuss the implications of not complying with the therapeutic regiment with the resident (last revised 06/30/17).       A. Had the potential for or actual ineffective breathing pattern related to her tracheostomy. Interventions included, in part, to provide tracheostomy care as ordered by the physician and/or facil	OWDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP COD           AND NURSING AND REHABILITATION CENTER         STREET ADDRESS, CITY, STATE, ZIP COD           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)         D           Continued From page 2         F 600           Contraint UTIs. Interventions included, in part, catheotory with page and p	OUDER OR SUPPLIER         STREET ADDRESS. CITY. STATE. 2P CODE           AND NURSING AND REHABILITATION CENTER         STREET ADDRESS. CITY. STATE. 2P CODE           SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST REPRECEDED BY FULL REGULATORY OR LSC DEMINIPYING INFORMATION)         ID PREFIX           Continued From page 2         F 600           Continue repretation of uninary elimination with indrwelling catheter.         F 600           12/06/17).         Continue repretation related to physician orders and/or facility protocol, monitor for signs and symptoms of UTI (last revised 12/06/17). <t< td=""></t<>	

Facility ID: 953074

		MEDICAID SERVICES				IO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	· · ·	TE SURVEY MPLETED	
	CONNECTION	IDENTIFICATION NOWDER.	A. BUILDIN	G			
			D 14/10			C	
		345376	B. WING			7/03/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (	CODE		
	LAND NURSING AND RE	HABILITATION CENTER		2461 LEGION ROAD			
				FAYETTEVILLE, NC 28306			
(X4) ID			ID			(X5) COMPLETIO	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	DATE	
F 600	Continued From page	e 3	F 60	00			
		of Resident #25's May 2018		registered nurse Patient	s tracheostomy		
	Medication Administr			with brownish drainage, fo			
		's order for "tracheostomy		site needs cleaning. Called			
		every day" and the dressing		Therapist (RT) to clean g-t			
		ed to be completed at 4:00		notified RN that pt has may			
	p.m. Prior to Resider	nt #25 leaving the facility on		tracheostomy. RN confirme	ed this by eye		
	05/17/18, there had b	peen 8 dates the order had		site. RN notified physician	via phone and		
	not been signed off b	y a nurse as having been		awaiting call back.			
		2, 4, 6, 7, 9, 10 and 15. Prior					
		o the hospital on 05/17/18,		On 5/18/18, the administra			
0		en documented as completed		aware by resident #25 frier			
		AR indicated the dressing		allegation that Resident #2			
	had not been comple	eted on 05/17/18.		observed with maggots in	her throat while		
	During an interview w	vith Nurse #7 on 05/25/18 at		at the hospital.			
		During an interview with Nurse #7 on 05/25/18 at 2:20 p.m., Nurse #7 stated she had worked the 3		On 5/18/18, an investigation	on was started		
	p.m. to 11 p.m. shift o			by the administrator to incl			
		ng the dressing on Resident		of an Initial Allegation Rep			
		and stated it had looked fine.		Care Personnel Investigati			
		worked the 3 p.m. to 11 p.m.			( )		
		had been one of the nurses		On 5/22/18, all alert and or	riented		
	who had assessed R	esident #25 when her PEG		residents were interviewed			
		When asked if she had		Worker (SW) in regards to			
		5's tracheostomy site prior		neglect. No areas of conce			
		g sent out, Nurse #7 stated		identified during the intervi	ews.		
		re had been no drainage					
	noted on the sheets.			On 5/25/18, the investigati			
				completed and the allegati			
	-	vith Nurse #2 on 05/26/18 at		unsubstantiated by the adr			
		had been asked why she had		Investigation Report was s			
	-	s on the MAR for Resident		HCPI by the administrator.			
		site dressing on May 2, 4, 6,					
		lurse #2 stated while she		Nurse #6 and #7 were rep			
		ng the dressing a couple of		Board of Nursing on 7/3/18			
		was going to be honest.		providing tracheostomy ca	ie by the DON.		
		n she came on duty she was		On 5/26/18 Desident #25	roturned to the		
	responsible for a med			On 5/26/18, Resident #25			
		to overseeing 2-3 medication ed she stayed stressed out		facility and was assessed nurse to include assessme	-		
	anco. muise #2 Stat	cu ane alayeu alleaseu uul					

Facility ID: 953074

		MEDICAID SERVICES				NO. 0938-03	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	. ,	OATE SURVEY	
		345376	B. WING			C 07/03/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E. ZIP CODE	07703/2010	
				2461 LEGION ROAD	,		
UMBERL	AND NURSING AND RE	HABILITATION CENTER		FAYETTEVILLE, NC 2830	6		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETIC DATE	
F 600	Continued From page	<u>م</u>	F 60				
1 000		ould come on duty she had	F 00		hich was clean dry		
		ere and there dealing with		tracheostomy site, w and covered with a d			
		behaviors. Nurse #2 stated it			nent for Resident #25		
		nging and stated she felt it		was documented by			
		why she did not always do		electronic medical re			
	the dressing change.						
				On 6/12/18, an obse	rvation of all		
		vith Nurse #6 on 05/26/18 at		residents to include I			
	10:40 a.m., Nurse #6			completed by the Dir	-		
		25's tracheostomy site		(DON), the Assistant	-		
	recall whether or not	out stated she could not		(ADON), and the Qu			
	dressing on 05/01/18			(QI) Nurse to physica residents with trache	· ·		
				resident was identifie			
	During an interview w	vith Nurse #7 on 05/26/18 at		tracheostomy.			
		stated 5/10/18 had been					
		yment at the facility. Nurse		On 6/12/18, an audit	of all Medication		
	#7 stated she recalled	d changing Resident #25's		Administration Recor	rd (MARs), including		
	tracheostomy site dre	essing on 05/10/18 and		MARs for Resident #	25, for the past 30		
	stated she had forgot	tten to sign off on the MAR.		days, was completed			
				the QI Nurse to ensu			
		vith the hospital ED nurse #2		respiratory care, incl			
		a.m., the hospital ED nurse		care were provided a documentation on th			
	#2 stated Resident #2	butes before the end of her 7			e MAR. There were eas of concern noted.		
		n 05/17/18. The hospital ED			cas of concern noted.		
		ident #25 smelled like she		On 6/12/18, an asse	ssment of all		
	needed a bath and he			residents with trache			
		heter were in need of some		Resident #25 was co	. 0		
	"tender loving care" h	nowever she had not		Nurse and the ADON	I to ensure		
		25's tracheostomy because		tracheostomy care w			
	her oxygen saturatior	n had been okay.		evidenced by observ	-		
				site and dressing wit			
		vith the hospital ED nurse #3		-	no identified areas of		
		a.m., the hospital ED nurse		concern during the a	uuit.		
		red for Resident #25 during shift on 05/17/18. The		On 6/12/18, an audit	of all residents □		
		stated Resident #25 had		physician orders to in			
		idition" and had focused her			QI nurse, the ADON,		

Facility ID: 953074

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	OMB NO. 09 (X3) DATE SUR	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	B	COMPLETE	Đ
					С	
		345376	B. WING	·····	07/03/2	2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
CUMBERI	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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AO CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE CC	(X5) DMPLETIC DATE
F 600	Continued From page	e 5	F 60	00		
	care to Resident #25			and the Staff Facilitator (S	SF) to identify all	
		heter secondary to Resident		residents with orders to re		
	#25 having had "reall	y bad smelling urine."		tracheostomy care. The a		
				completed on 6/13/18. Th		
	•	vith the hospital ED nurse #1		other identified residents		
		.m., the ED nurse #1, who		receive tracheostomy car	e.	
		7 p.m. shift on 5/18/18,			n democratica	
		entered the holding room en placed in she could smell		On 6/29/18, a 100% retur of tracheostomy care was		
		off of her and noted that her		licensed nurses to include		
		on it, her hair had been		and Nurse #6, and Nurse		
		kes and it appeared like it		and SF. Return demonstr	-	
		in a long time. The ED		tracheostomy care was co	ompleted on	
	nurse #1 stated she	ooked at Resident #25's		7/7/18. Retraining was co	mpleted by the	
	-	d had noted a substance on		ADON and/or SF during t		
		ich she compared to melted		audit for any nurse that co		
		ED nurse stated she called		demonstrate successful p		
		ist (RT) for tracheostomy ds. The ED nurse stated		tracheostomy care per po procedure.	and	
		un tracheostomy care, he		procedure.		
	-	he presence of maggots on		On 7/1/18, a contracted F	RT initiated	
	Resident #25's skin s			training on tracheostomy		
		he ED nurse stated she then		licensed nurses and ager		
	-	ce of maggots around the		include Nurse #6 and #7.		
	tracheostomy site.			was completed with all lic	ensed nurse and	
				agency nurses on 7/7/18.		
	-	vith the hospital's RT #1 on		all newly hired licensed n		
		n., the RT #1 stated he		contracted agency nurses	sauring	
		5 in the ED on 05/18/18. I been called to the ED to		orientation.		
		assess oxygen saturation		On 5/30/18, a 100 % in-se	ervice was	
		stomy care. The RT #1		initiated with all license nu		
	-	Resident #25's ED room,		agency nurses, and Nurs		
	-	odor emanating from the		#7 by the facility nurse co		
	resident. The RT #1	-		SF on providing tracheos		
		stomy, he noticed the		ordered by the physician		
	-	re dirty and there were		documentation of tracheo	-	
		ns on her tracheostomy. The		MAR. The in-service also		
	RI #1 stated he remo	oved the tracheostomy site		expectation that documer	ntation must be	

Facility ID: 953074

If continuation sheet Page 6 of 62

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULT	IPLE CONSTRUCTION	OMB NO. 09 (X3) DATE SUF	
	CORRECTION	IDENTIFICATION NUMBER:	` <i>'</i>		COMPLET	
					С	
		345376	B. WING		07/03/2	2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
				2461 LEGION ROAD		
	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 (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE CO	(X5) OMPLETIO DATE
F 600	Continued From page	2 6	F 6	:00		
		ing from the facility) and it		present on the MAR after	er providing	
		had secretions so old the		tracheostomy care. The		
	-	ne RT #1 stated Resident		completed on 6/28/18.		
		h the sponge was red and				
		ots under the tracheostomy		On 7/2/18, a 100 % in-s	ervice was	
	ties and the sponge.	The RT #1 stated he had		initiated with all licensed	I nurses to include	
		's odor was more prevalent		agency nurses and Nur	se #6, and Nurse	
		my care but could not state		#7 by the Facility Nursir		
		was coming from the		reading each tracheoste		
	-	not. The RT #1 stated he		MAR, following the phys		
		ggots off of Resident #25's		tracheostomy care, doc		
		tracheostomy however he		MAR tracheostomy care	-	
		change the inner cannula as		checking each page of t		
		be transferred to another		that no medications, tre documentation is misse		
		During a 2nd interview with 07/03/18 at 8:57 a.m., the		also included for license		
	-	he and another hospital RT		for additional assistance		
		sident #25's tracheostomy		ADON, QI Nurse, SF, o	,	
		8/18 and the hospital RT #2		nurse when feeling like		
	had documented the	-		needed to provide resid		
				tracheostomy care and		
	A review of the hospit	tal's records indicated		management. The in-se		
		ived at the Emergency		completed on 7/7/18. A		
		05/17/18 at 5:50 p.m. with a		agency or newly hired li	-	
	chief complaint of a d	islodged PEG tube.		be educated by the SF		
				in regards to reading ea		
		hospital record ED notes		order on the MAR, follow		
	revealed the following			order for tracheostomy		
		ed 5/18/18 8:33 a.m		on the MAR tracheostor		
		cheostomy collar (TC),		checking each page of t that no medications, tre		
		tygen (FIO2): 30, breath ote - pt placed on 30% TC		documentation is misse		
		al capillary oxygen saturation			u.	
	(SPO2) 97%"			On 6/29/18, an in-servic	e was initiated by	
		e, dated 05/18/18 2:02 p.m		the SF to administrator,	-	
		ny with brownish drainage,		payables, accounts rece		
		spiratory Therapist (RT) to		bookkeeper, AR assista		
		I that patient has maggots in		ADON, QI, treatment nu		
	tresheesterny DNLes	onfirmed this by eyesight."		licensed nurses to inclu		

Facility ID: 953074

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		ID HUMAN SERVICES MEDICAID SERVICES			F	TED: 08/21/2018 ORM APPROVED NO. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	IPLE CONSTRUCTION		DATE SURVEY
		345376	B. WING			C 07/03/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
		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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 600	on 05/17/18 at 9:15 p "tracheostomy tube is acute process" A review of a hospital Assessment note, da stated "called to patie assessment, upon my tracheostomy this RT around tracheostomy seen were wiped off she asked patient wh cleaned it at the nurs "they cleaned it 2 day During an interview w 05/24/18 at 11:35 a.m observed to be lying i and alert. Resident # and there had been a her body, possibly co was visibly dirty with noted in one part of it flakes, possibly skin f observed to have a tr Resident #25 stated to facility hardly ever go the nurses at the faci change it once a wee consistently change if stated it made her fee	ts of a chest x-ray performed o.m. revealed findings of a stable in positionno I's Tracheostomy ted 5/18/18 at 2:00 p.m., ent's room for tracheostomy ore detailed look at found maggots crawling r siteall maggots that were Once RN called to room en was the last time they ing facility and patient stated /s ago." //th Resident #25 on n., Resident #25 was in her hospital bed, awake #25's skin appeared clean a slight odor emanating off of ming from her hair which a dried brown substance a and areas full of dry white racheostomy in place. tracheostomy care at the t done. Resident #25 stated lity were supposed to	F 6	<ul> <li>nursing assistants, means assistant dietary manages housekeeping supervises staff, laundry staff, there therapy staff, supply clear activities director, and a on resident neglect.</li> <li>Examples of Nursing Hence Nursing home neglect:</li> <li>When a resident is repailed on the receive adequate cleaning, bathing, brus other forms of hygienic the nursing home negle reasonable food, water clean environment. When home fails to provide the adequate attention, predehydration, UTI □s an injuries to include fractions, cuts, diabeted diseases and mobility of Signs of Nursing Home Warning signs of nursing MAY include:</li> <li>Sudden weight loss, be pressure ulcers, injurie home fails or factures,</li> </ul>	dical records, ger, dietary staff, sor, housekeeping apy manager, erk, ward clerk, activities assistant lome Neglect can vary among elow are examples eatedly ignored, left napped at by any e. When a resident te help with laundry, hing their teeth, or practices. When ects to provide r, or a safe and ten the nursing acheostomy care, evention to include d infections, ures or medication ressure ulcers, es, cognitive concerns e Neglect ng home neglect edsores, or s from nursing dehydration,	
	05/26/18 at 2:42 p.m. expectation of nursing	vith the Administrator on , the Administrator stated his g staff, in regard to s to follow the residents' plan		changes in personal hy appearance efforts, cha behavior Prevention of Nursing I The nursing home resid	anges in mood or Home Neglect	

Facility ID: 953074

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		ND HUMAN SERVICES				FOR	D: 08/21/20
TATEMENT (	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION	(X3) DAT	O. 0938-03 E SURVEY PLETED
		345376	B. WING			С	
	ROVIDER OR SUPPLIER	545576		ST	REET ADDRESS, CITY, STATE, ZIP CODE	07	/03/2018
					161 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	K	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIC DATE
F 600	Continued From page	o 8	F 6	200			
1 000			FO	00			
	of care as directed by				monitored for changes in mobile, me		
		it was his expectation			physical ability, abnormal skin condit		
	training.	nt according to facility			pain, as well as any developing med concerns. Any changes noted in the	ICAI	
	u anning.				resident should be reported to the nu	Irea	
	The Assistant Directo	or of Nursing was notified of			The nurse must assess the change a		
		rdy on 06/29/18 at 3:10 p.m.			report the changes immediately to th		
		ity provided the following			and Resident Representative and pr		
		compliance and Immediate			appropriate interventions to address		
	Jeopardy removal:				change and prevent further decline a		
					document in the medical records. If a		
	A thorough investigat	tion was completed by the			resident has an acute medical chang		
		2/18 to ascertain the cause. It			the resident should be sent out via 9		
		ne administrator that the			with verbal notification to the physicia		
	-	of nurse #7 not completely					
		on Administration Record			In-service completed on 7/7/18.		
	-	documenting tracheostomy					
		g the interview, Nurse #6 and			On 7/11/18, the administrator spoke	with	
		that they did not provide			Quality Improvement Organization (0		
		resident #25 related to			for assistance in evaluation of specif	ic	
	being busy but could	not state the reason why			steps to be taken to address		
	they did not ask for a	ssistance.			tracheostomy care and training, staff		
					position/title designated to be respon	sible	
		t #25 was sent out to the			for the steps, timeline for accomplish		
	hospital for evaluation	n due to dislodged G-Tube.			of the steps, specific methodology to		
					used to evaluate the plan success		
		eostomy was assessed by			frequency of monitoring the effects o	f the	
		on 4/30/18, 5/7/18, and			plan initiation. The QIO staff are		
		mentation of larvae, foul			scheduled to visit the facility on 7/18		
	odor, or drainage aro	ound the tracheostomy site.			review current Plan of Correction, cu		
					systems, monitoring of tracheostomy		
		ital record at 6:50 pm, one			and make further recommendations	in	
	hour after resident wa				regards to tracheostomy care.		
	Department, the RN					•	
		Oriented x 4, respiration rate			10% of all residents with tracheostor		
		patient has tracheostomy			to include Resident #25 will be physi	-	
	and wears O2 @ 3 lit				observed and documentation of the		
	drainage, larvae, or f	oul-odor in tracheostomy.			and non-ulcer flow sheet assessmen		
					be monitored by the Assistant Direct	or of	

Event ID: EYQG11

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OLIVIEI		MEDICAID SERVICES			OMB NO. 09	938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		345376	B. WING		C 07/03/2	2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		2010
				2461 LEGION ROAD		
CUMBER	LAND 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 (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE CC	(X5) DMPLETIO DATE
F 600	Continued From page	e 0	EG	20		
1 000	-		F 60		the Quelity	
		ital record at 9:15 pm,		Nursing (ADON) and/or t	-	
	"Tracheostomy tube i	x-ray complete. Findings:		Improvement (QI) Nurse for 4 weeks, 3 days wee		
				then weekly for 4 weeks		
	On 5/17/18 per hospi	ital record at 10:42 pm, per		Care Audit tool. This auc	-	
		f the Registered nurse,		that tracheostomy care is		
	"tracheostomy tube in	n place. O2 @ 3 Liters via		per policy and procedure		
	tracheostomy mask."	•		documentation on the M	AR and an	
1				assessment has been co	-	
		ital record at 5:32 am, per		documentation in the ele		
		f the Registered nurse,		record and that the trach	-	
	"suction at bedside."			clean, odor-free, and dre	essing is dry and	
	On 5/18/18 per hospi	ital record at 8:33 am there is		intact.		
	documentation of a F			10% of all licensed nurse	es to include	
	treatment assessmer			agency nurses and Nurs		
				#7 will be observed utiliz		
	On 5/18/18 per the h	ospital record at 2:24 pm,		Pass Tracheostomy Aud	•	
		on of the registered nurse		weekly for 4 weeks, 3 da	ys weekly for 4	
	"Patient's tracheostor	my with brownish drainage,		weeks, then weekly for 4	weeks by the	
		e needs cleaning. Called RT		ADON and/or the QI Nur	se. This audit is	
		RT notified RN that patient		to ensure that nurses are	Ĵ.	
		eostomy. RN confirmed this		tracheostomy order on th		
		ed physician via phone and		the physician order for tr		
	awaiting call back."			documenting on the MAI	-	
	On 5/18/18 the admi	inistrator was made aware		care provided, and mana ensure tracheostomy car		
		nd of an allegation that		Any areas of concern ide	•	
		eserved with maggots in her		audits will be addressed		
	throat while at the ho			the ADON, QI Nurse, an		
		•		include providing additio		
	On 5/18/18, an invest	tigation was started by the			č	
	administrator to inclu	de submission of an Initial		The DON will present the	e findings of the	
		Health Care Personnel		Trach Care Audit tools a		
	Investigation (HCPI).			Pass Tracheostomy Aud		
				Executive Quality Assura		
		stigation was completed and		committee monthly for 3		
	the allegation was un			Executive QA Committee		
	auministrator. The In	vestigation Report was		monthly for 3 months an	a review the	

Facility ID: 953074

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						NO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	. ,	DATE SURVEY	
			A. DOILDING		-	С	
		345376	B. WING			07/03/2018	
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, S	STATE, ZIP CODE		
				2461 LEGION ROAD			
	AND NURSING AND RE	HABILITATION CENTER	FAYETTEVILLE, NC 28306				
(X4) ID		ATEMENT OF DEFICIENCIES	ID		'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	`	ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETIC DATE	
F 600	Continued From page	e 10	F 600				
	submitted to (HCPI) I	by the administrator.		Trach Care Audit	tools and the Medication		
				Pass Tracheostor			
		t #25 returned to the facility			and/or issues that may		
		y the hall nurse to include			ventions put into place		
		acheostomy site, which was			the need for further		
		ed with a dry dressing. On nent for Resident #25 was		frequency of mon	itoring.		
		all nurse in the electronic		The administrator	and DON will be		
	medical record.				e implementation of		
					to include all 100%		
	The care of the trach	ea was not documented to		audits, in services	s, and monitoring related		
		ctor's orders consistently.		to the plan of corr	rection.		
		vely educated nursing					
	•	Nurse # 2, #6, and #7 on			hat land to this		
	care.	ler and providing trachea		1b. The process t	etermined to be that the		
					staff failed to clarify an		
	Nurse #2 will be repo	orted to the Board of Nursing		-	elling urinary catheter for		
		umenting on the Medication			e indwelling urinary		
	Administration Recor	d by the Director of Nursing.		catheter was not	changed for Resident		
		r staffed at the facility			nospitalization for a		
		Nurse # 6 and #7 will be		Urinary Tract Infe	ction (UTI).		
	-	of Nursing on 7/3/18 for not					
	Nursing on 7/3/18.	my care by the Director		facility from the he	dent #25 returned to the		
				-	11-7 shift assigned hall		
	Corrective Action				observation of Resident		
		tory Therapist (RT) initiated		· · · · · · · · · · · · · · · · · · ·	theter and drainage bag,		
		omy care with licensed			on in the electronic		
		rse #6 and #7 on 7/1/18. The			concerns were noted		
		Staff Facilitator and eight		during the assess	sment.		
		rrently received the training					
	by the RT and will co	•			ssigned hall nurse ion orders for Resident		
	-	ntil the remaining nurses . There are ten licensed			ling urinary catheter to		
		be trained by the RT and			hly and as needed for		
		work until the training has			ment, and/or occlusion.		
		ontracted RT is on site as of		The order was tra			
	-	nd has initiated the remaining			nistration Record (MAR)		

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPI	LE CONSTRUCTION		<u>NO. 0938-03</u> TE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	MPLETED	
						С	
		345376	B. WING		(	7/03/2018	
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP (	CODE		
		HABILITATION CENTER		2461 LEGION ROAD			
	AND NORSING AND RE			FAYETTEVILLE, NC 28306			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 600	Continued From page	e 11	F 60	0			
	licensed nurse trainin			on 5/26/18 by the assigned	d hall nurse.		
	On 5/22/18, all alert a	and oriented residents were		A 100 % audit was comple	ted on		
	interviewed for negled	ct by the Social Worker with		7/13/2018 by the Assistant	Director of		
	no negative findings.			Nursing (ADON) of all resi			
	0 5/00/40			indwelling catheters to incl			
		vice was initiated with all		25 to assess for signs\sym No areas of concerns note			
	Nurse # 2, #6, and #7	ude agency nurse, and		audit.	a auning the		
		aff Facilitator (SF) on					
		ny care as ordered by the		On 6/14/18, an audit of all	residents with		
		vice also addressed the		indwelling catheters to incl			
	expectation that docu	mentation must be present		#25 was completed by the	e Quality		
		ministration Record (MAR)		Improvement (QI) Nurse, t			
		ostomy care. The in-service		Director of Nursing (ADON			
	was completed on 6/2	28/18.		to ensure all orders for ind			
	On 7/2/18 on in conv	ice was initiated with all		catheters were complete to parameters for changing th			
		clude agency nurses and		catheters. No areas of con	•		
		#7 by the Facility Nursing		identified during audit. The			
		g each tracheostomy order		completed on 6/14/2018.			
	on the MAR, following	g the physician order for					
	tracheostomy care, d	ocumenting on the MAR		On 6/14/18, a 100% audit	was initiated by		
		ovided, checking each page		the QI Nurse, the ADON, a			
	of the MAR to ensure			all residents with orders fo	-		
		nentation is missed. The ed for licensed nurses to ask		catheters to include reside were audited for the past 3			
		nce from the Director of		documentation was compl			
		rector of Nursing, Quality		indwelling urinary catheter			
	-	Staff Facilitator, or another		changed per physician ord			
		ng like assistance is needed		was completed on 6/28/18			
		are to include tracheostomy		concern identified during the			
		ement. No licensed nurse		immediately addressed by			
		k until the training has been		conducting an assessmen			
	completed.			to include the indwelling u			
	On 6/12/18 on obcor	vation of all residents to		for any abnormalities, sign UTI, notification of the phy			
		was completed by the		providing additional staff tr			
		OON), the Assistant Director					

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE	CONSTRUCTION	(X3) DAT	O. 0938-03 E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		COM	IPLETED
		345376	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	0/	7/03/2018
					461 LEGION ROAD		
CUMBERI	LAND NURSING AND RE	EHABILITATION CENTER	FAYETTEVILLE, NC 28306				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	[	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 600	Continued From page	e 12	F 6	00			
		and the Quality Improvement	10		On 5/29/18, an in-service was initiated	d by	
		ally identify all residents with			the Staff Facilitator (SF) for all license	-	
		re were no other residents			nurses and nursing assistants includir		
		identified during the audit.			agency to ensure urinary catheter car	-	
		Ũ			provided and documented in the		
	On 6/12/18, an audit	of all MARs, including MARs			electronic health record. Additionally,	any	
		the past 30 days, was			abnormalities observed at the insertio		
		ON and the QI Nurse to			site or in the drainage bag to include u	urine	
		piratory care, including			odor, color, or any drainage must be		
	-	ere provided as evidenced			reported immediately to the licensed		
	by documentation on the MAR. There were no other identified areas of concern noted during the			nurse. The in-service was completed 6/28/18. All newly hired licensed nurse			
	audit.	or concern noted during the			and nursing assistants to include age		
					will be in-serviced by the SF during	loy	
	On 6/12/18, an asses	ssment of all residents with			orientation to ensure urinary catheter	care	
		iding Resident #25 was			is provided and documented in the		
	completed by the QI	Nurse and the ADON to			electronic health record. Additionally,	any	
		care was provided as			abnormalities observed at the insertio		
		ing a clean insertion site and			site or in the drainage bag to include u	urine	
		nage present. There were no			odor, color, or any drainage must be		
	identified areas of co	ncern during the audit.			reported immediately to the licensed		
		of all registered aby sister			nurse and the licensed nurse must no	tity	
		of all residents' physician sident #25 was initiated by			the physician.		
		ON, and the Staff Facilitator			On 6/14/18, an in-service was initiated	d by	
		sidents with orders to receive			the SF for all licensed nurses to include	-	
		The audit was completed on			agency to ensure all orders for indwel	•	
		no other identified residents			urinary catheters are complete to inclu	-	
	with orders to receive	e tracheostomy care.			parameters for when to change the		
					urinary catheters. Additionally, the		
		return demonstration of			in-service informed all licensed nurses		
	-	as initiated with all licensed			notify the physician to clarify any orde		
		ency nurses to include Nurse			that did not contain instructions on wh		
		urse #7 by the Assistant ADON). Retraining will be			to change indwelling urinary catheters The in-service was completed on 6/28		
		ON during the time of the			All newly hired licensed nurses include		
		at cannot demonstrate			agency will be in-serviced by the SF	9	
	-	nce of tracheostomy care per			during orientation to ensure all orders	for	
		. No nurse will be allowed to			indwelling urinary catheters are comp		

Facility ID: 953074

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES				FOF	ED: 08/21/20 RM APPROVE O. 0938-039		
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345376	B. WING		0.	C 7/03/2018	
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
				2461 LEGION ROAD			
CUMBERI	AND NURSING AND RE	HABILITATION CENTER		FAYETTEVILLE, NC 28306			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 600	Continued From near	- 12	<b>_</b>				
F 000	Continued From page		F 60				
		y care on a resident until		to include parameters for whe			
	successful completio			the urinary catheters. If order			
		ensed nurse will be allowed n demonstration has been		include parameters on when the indwelling uripany esthete	•		
	completed.	n demonstration has been		the indwelling urinary cathete physician must be notified im			
	completed.				mediately.		
	On 6/29/18 an in-ser	vice for 100% of all staff was		On 7/13/2018, an in-service v	vas initiated		
		garding Neglect to include		by the SF with all licensed nu			
		heostomy care, signs of		include agency nurses in rega			
		g neglect. No staff will be		When the hall nurse receives			
		the in-service is completed.		for an indwelling catheter or a	a resident is		
				admitted with an order for an			
	The Quality Improver	ment Organization was		catheter the following must or	ccur: Hall		
	contacted by the Reg	ional Vice President of		nurse must write a telephone	order to		
	Operations on 7/03/1			identify parameters of when the	o change the		
	evaluation of specific	•		catheter to include size of cat			
		y care and training, staff		diagnosis of use. Hall Nurse	-		
		ed to be responsible for the		the catheter telephone order			
		complishment of the steps,		per the physician and block o			
		to be used to evaluate the		next catheter change per the			
		requency of monitoring the		order. Administrative nurses a			
	effects of the plan init			all new orders to include new			
	All residents with trac	cheostomies to include		orders 5 days a week to ensu new catheter orders are comp	•		
		physically observed and		include parameters of when t			
		MAR and non-ulcer flow		catheter and placed on the M	-		
		Il monitored by the Assistant		If any areas of concerns iden			
		ADON) and/or the Quality		order checks, the attending p			
		Irse 5 days weekly for 4		must be notified to get clarific	•		
		y for 4 weeks, then weekly		catheter order. In-service to b			
		a Trach Care Audit tool. This		by 7/17/2018	-		
		t tracheostomy care is being					
	performed per policy						
		e MAR and an assessment		10% of residents with indwell	0		
		with documentation in the		to include Resident #25 will b			
	electronic health reco			by the ADON and or QI Nurse	•		
	tracheostomy site is o			8 weeks, then monthly for 1 n			
		tact. A medication pass		utilizing a Catheter Monitoring	-		
	audit on tracheostom	y care will be completed by		ensure there is no signs\sym	ptoms of		

Facility ID: 953074

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TATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE	D. 0938-039 SURVEY PLETED
	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDIN	IG			C
		345376	B. WING				/03/2018
NAME OF P	ROVIDER OR SUPPLIER	1		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
CUMBERI	AND NURSING AND RE	HABILITATION CENTER			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 PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETIO DATE
F 600	the Assistant Director the Quality Improver licensed nurses to ind Nurse #6 and Nurse weeks, 3 days weekly for 4 weeks utilizing a Tracheostomy Audit that nurses are readin on the MAR, following tracheostomy care, d tracheostomy care pr to ensure tracheostor areas of concern ider be addressed immed Nurse, and/or the DC additional staff trainin The DON will present Care Audit tool and th Tracheostomy Audit Assurance (QA) com The Executive QA Co for 3 months and revi and the Medication P Tool to determine tree need further intervent determine the need for monitoring. Final date of complian The administrator and for the implementatio include all 100% audit monitoring related to	r of Nursing (ADON) and/or nent (QI) Nurse on 10% of all clude agency nurses and #7, 5 days weekly for 4 y for 4 weeks, then weekly a Medication Pass Tool. This audit is to ensure ng each tracheostomy order g the physician order for locumenting on the MAR rovided, and managing time my care is provided. Any ntified during the audits will liately by the ADON, QI DN to include providing ng. t the findings of the Trach he Medication Pass Tool to the Executive Quality mittee monthly for 3 months. committee will meet monthly iew the Trach Care Audit tool Pass Tracheostomy Audit nds and/or issues that may tions put into place and to or further frequency of nce 7/03/18. d DON will be responsible on of corrective actions to its, in services, and the plan of correction.	F 6	500	urinary tract infection and that all orde for indwelling urinary catheters are clarified to address parameters for changing the catheters, orders are transcribed correctly to the MAR, and documentation is completed on the M. when the indwelling urinary catheter is changed per the physician orders. An areas of concern identified during the review will be immediately addressed the DON to include obtaining an order clarification, notification of attending physician assessment of the resident and/or providing additional staff trainin The DON will present the findings of th Catheter Monitoring tools to the Exect QI committee monthly for 3 months. T Executive QI Committee will meet mon for 3 months and review the Catheter Monitoring tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequen of monitoring. The administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring rela- to the plan of correction.	AR by by ig. ne utive he nthly	
	removal was validate	on for Immediate Jeopardy d on 07/03/18, which ate Jeopardy on 07/03/18.					

Facility ID: 953074

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	
		345376	B. WING				C 03/2018
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	03/2010
CUMBERI	LAND NURSING AND RE	HABILITATION CENTER			2461 LEGION ROAD		
_	1			ł	FAYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Interviews were condupresent in the facility of confirmed the recent is related to tracheostomy care. records, audit tools, a assessments were matching by a sessment were were to a session of the sess track of the session of	ucted with nursing staff on 07/03/18. The staff in-services and trainings ny care and documentation . Reviews of the in-service nudits performed and facility ade. An interview with the 2:45 p.m. revealed the een reported to the North rsing. An interview with the ent of Operations on revealed he had contacted ent Organization for on of specific steps to be heostomy care and training. evealed Resident #25 had a 0/20/17 through 10/25/17. A 25's admission orders dated de any instructions o change her indwelling r of documentation of es the indwelling urinary anged - 10/11/17 and #25's physician orders revealed there had been no ange her indwelling urinary	F	600			

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CENTER	-	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		FORM	0: 08/21/2018 1 APPROVED 0: 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMP	LETED
		345376	B. WING				C 03/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	017	00/2010
CUMBERL	AND NURSING AND RE	HABILITATION CENTER		2461 LEGION ROAD FAYETTEVILLE, NC 28	306		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page tube.	9 16	F 60	0			
	(RN) notes revealed, "condition of patient's	al's ED registered nurse on 05/18/18 at 3:39 a.m., (indwelling urinary) catheter arge amounts of crystalized					
	Physical (H&P), dated Resident #25 "presen Facility (SNF) complatube. Patient denied nausea, vomiting, few in the ED, the PEG tu initial exam by ED pro- right nephrostomy tub material. Abdominal of scan was obtained an pyelonephritis. Patier denies abdominal p diarrhea, dysuria L positive urine analysis in this hospital for Pro- pyelonephritis in Octo of the H&P revealed a secondary to complication with planned replacer tube and indwelling un #25 being treated with	ts from Skilled Nursing ining of dislodged PEG					
	doctor (MD) on 05/25. stated it was his expe change residents' inde every 30 days. The M #25's indwelling urina changed 30 days since	/18 at 1:00 p.m., the MD					

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 08/21/2018 / APPROVED ). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345376	B. WING					C 03/2018
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE			
CUMBERI	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 PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD B		(X5) COMPLETION DATE
F 600	are at increased risk of During an interview w 12:30 p.m., Nurse #4 order to change the in Resident #25 had bee MARs in October 201 returned to the facility UTI and pyelonephritik knew Resident #25's had been changed sin could not prove it. During an interview w 12:35 p.m., Nurse #8 indwelling urinary cath replaced once a monto of the month depends the catheter was first she frequently had Re assignment and did in Resident #25's cathed #8 stated seeing the of on the MAR is a visual catheter needs to be During an interview w 05/26/18 at 1:20 p.m. could not remember ef urinary catheter had la facility. When she wai indicated 12/20/17, R sure it had been chan last 2 months.	hoses. The MD stated indwelling urinary catheters of UTIs. With Nurse #4 on 05/26/18 at stated she thought the indwelling urinary catheter for en inadvertently left off the 7 after Resident #25 of from a hospitalization for s. Nurse #4 stated she indwelling urinary catheter ince October 2017 but she with Nurse #8 on 05/26/18 at stated residents with heters have their catheters th. Nurse #8 stated the date is on the resident and when inserted. Nurse #8 stated esident #25 on her ot remember changing ter in the recent past. Nurse order to change the catheter al reminder to the nurse the changed.	F	600				

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If continuation sheet Page 18 of 62

TATEMENT	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		ATE SURVEY OMPLETED
		345376	B. WING			C
	ROVIDER OR SUPPLIER	040010		STREET ADDRESS, CITY, STATE, 2		07/03/2018
				2461 LEGION ROAD		
CUMBER	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	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETIO DATE
F 600	Continued From page	e 18	F 6	500		
	regard to indwelling u would expect the num of care as directed by Administrator stated I	irinary catheter changes, he sing staff to follow the plan				
F 641 SS=D		ients	F 6	41		7/11/18
	resident's status. This REQUIREMENT by: Based on medical re interviews, the facility the Quarterly Minimu assessment for 1 of 1 for hospice care (Res The findings included Resident #15 was ad 09/08/17. Cumulative pleural effusion, vasc behavior disturbance hypokalemia, cerebel ischemic heart diseas chronic obstructive por respiratory failure, mu renal disease, dyspha communication, seve status, dependence of neuromuscular dysfu tract infection.	<ul> <li>at accurately reflect the</li> <li>is not met as evidenced</li> <li>cord review and staff</li> <li>failed to accurately code</li> <li>m Data Set (MDS)</li> <li>I sampled resident reviewed</li> <li>sident #15).</li> <li>It:</li> <li>mitted to the facility on</li> <li>e diagnoses included</li> <li>cular dementia without</li> <li>diabetes mellitus,</li> <li>llar stroke syndrome, acute</li> <li>se, heart failure, pneumonia,</li> <li>ulmonary disease, acute</li> <li>uscle weakness, end stage</li> <li>agia, cognitive</li> <li>re sepsis, gastrostomy</li> <li>on renal dialysis, anemia,</li> <li>nction of bladder and urinary</li> </ul>		Cumberland Nursing a acknowledges receipt of Deficiencies and propose Correction to the extent of findings is factually of to maintain compliance rules and provisions of residents. The Plan of O submitted as a written a compliance. Cumberland Nursing ar response to this Statem does not denote agreen Statement of Deficienci constitute an admission deficiency is accurate. If Cumberland Nursing ar reserves the right to ref deficiencies on this State Deficiencies through Inf Resolution, formal appe or any other administrat proceeding.	of the Statement of ses this Plan of t that the summary orrect and in order with applicable quality of care of Correction is allegation of allegation of and Rehabilitation's ment of Deficiencies ment with the es nor does it that any Further, and Rehabilitation fute any of the tement of formal Dispute eal procedure and/	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/21/2018 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345376	B. WING				C 103/2018
	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 51 LEGION ROAD	•	
				FA	YETTEVILLE, NC 28306		1
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	Continued From page		F 6	41			
	resident having a cor	documented as no for Idition or chronic disease fe expectancy of less than 6			F 641		
		100 indicated the Resident			The process which led to this deficien was determined to be the Minimum D Set (MDS) Coordinator failed to accur code the MDS assessment for Reside	ata ately	
		15 care plan dated on at there was no care plan for			#15, resulting in Resident #15 being coded as receiving hospice services. On 5/24/18, Resident #15 MDS		
	(DON) on 05/24/18 a that the resident was	vith the Director of Nursing t 3:15 PM, she confirmed not receiving hospice care urther stated that it was her			assessment was modified by the MDS Coordinator to reflect Resident #15 wa not receiving hospice services.		
		MDS is coded accurately.			On 5/29/18, an in-service was conduct by the facility nurse consultant with th MDS Coordinator and the MDS nurse	е	
	05/24/18 at 5:15 PM,	vith the MDS Coordinator on she stated that it was a resident is not receiving			regards to coding residents for hospic services only when the resident has a physician □s order and receives hospi	e	
	05/26/18 at 2:40 PM,	vith the Administrator on he stated that it was his			services. All newly hired MDS coordinators and MDS nurses will rec the in-service during orientation by the		
	expectation that the M the resident.	IDS is coded accurately for			Staff Facilitator (SF) with regards to coding residents for hospice services when the resident has a physician □s order and receives hospice services.	only	
					On 6/11/18, a 100% audit of all reside current MDS assessments was initiated	ed	
					by the Quality Improvement (QI) Nurs the Assistant Director of Nursing (ADC and the Director of Nursing (DON), to completed by $6/28/18$ . The cudit will	ON),	
					completed by 6/28/18. The audit will ensure that all residents are accurated coded in the MDS assessment accord to the services received, to include	•	
					hospice services. Any areas of conce	ern	

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Facility ID: 953074

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 08/21/2018 APPROVED . 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		STRUCTION	(X3) DATE : COMPL	SURVEY LETED	
		345376	B. WING			07/0	, 03/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
CUMBERI	AND NURSING AND RE	HABILITATION CENTER			EGION ROAD TEVILLE, 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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 641	Continued From page	e 20	F	ide imi inc ass tra 10 inc the col the col and as init for mo ha Th ME Qu mo co and co co and co co co and co co co co co co co co co co co co co	entified during the audit will be mediately addressed by the DON t clude modification of the MDS sessment and providing additional ining. % of completed MDS assessments clude Resident #15 will be reviewed a ADON, the DON, and/or the MDS insultant to ensure accurate coding a MDS assessments, including for sidents receiving hospice services. dit will be conducted utilizing an MI curacy QI Tool three times weekly tecks, weekly for four weeks, then onthly for one month. Any identified as of concern will be immediately dressed by the DON and/or the MD insultant to include additional training d modifications to the MDS assess indicated. The DON will review an tial the MDS Accuracy QI Tool wee eight weeks and then monthly for onth to ensure any areas of concern we been addressed. e DON will present the findings of to DS Accuracy QI tool to the Executive inality Improvement (QI) committee onthly for 3 months. The Executive indicated will meet monthly for 3 mo d review the MDS Accuracy QI too termine trends and/or issues that n ed further interventions put into pla d to determine the need for further quency of monitoring. e administrator and the DON will b sponsible for the implementation of	staff s to d by of This DS for 4 U DS ng ment d kly one ns the ve QI onths I to nay ice		
	7(02-99) Previous Versions Obs	solete Event ID: EY	0011	Encility ID	: 953074 If conti		Page 21 of 62	

Event ID: EYQG11

Facility ID: 953074

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		MEDICAID SERVICES			OMB NO. 0	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION	(X3) DATE SUI COMPLET	
					С	
		345376	B. WING		07/03/	2018
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
CUMBERI	AND NURSING AND RE	HABILITATION CENTER		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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE C	(X5) COMPLETIO DATE
F 641	Continued From page	e 21	F 641	corrective actions to include all 100%		
				audits, in services, and monitoring related to the plan of correction.	ated	
F 675 SS=D			F 675		7/	11/18
	applies to all care and residents. Each residents. Each residents. Each residents facility must provide to necessary care and so the highest practicab psychosocial well-being resident's comprehender of care. This REQUIREMENT by:	damental principle that d services provided to facility dent must receive and the he services to attain or maintain le physical, mental, and ing, consistent with the nsive assessment and plan		F 675		
		erviews, the facility failed to cheduled for 1 of 3 residents		The process which led to this deficience		
	The findings included			was determined to be the nursing staff failed to provide showers as scheduled Resident #21.	F	
	08/13/15 with diagno weakness and chroni	mitted to the facility on ses which included muscle ic ischemic heart disease.		On 5/23/18, Resident #21 was provide with a shower by the assigned nursing assistant with documentation of the		
	(MDS), dated 02/21/2	#21's Minimum Data Set 8, revealed Resident #21 and required extensive		shower in the electronic health record. On 5/24/18, a questionnaire for all aler		
	assistance with bed r personal hygiene.	•		and oriented residents was completed the Social Worker and Minimum Data (MDS) nurse regarding shower	by	
	A review of Resident 09/29/17, indicated R assistance for persor			preferences to include preferences for baths and showers, or baths only. All o plans and care guides for alert and		

Event ID: EYQG11

Facility ID: 953074

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						<u>10. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			TE SURVEY MPLETED
			A. BUILDING	3		С
		345376	B. WING			
	ROVIDER OR SUPPLIER	040010		STREET ADDRESS, CITY, STATE, ZI		7/03/2018
				2461 LEGION ROAD	CODE	
CUMBERI	LAND NURSING AND RE	HABILITATION CENTER		FAYETTEVILLE, NC 28306		
				PROVIDER'S PLAN (		()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 675	Continued From page	e 22	F 67	75		
				oriented residents were u	updated as	
	During an interview w	vith Resident #21 on		applicable to indicate sho	•	
		, Resident #21 stated he				
	-	eceived showers on his		On 5/30/18, an in-service		
		ys. Resident #21 indicated		the facility nurse consulta		
		ular, do not give him a		Facilitator (SF) for all lice		
		1 stated he preferred getting		nursing assistants to incl		
	a shower on his sche	duled shower days.		regarding residents recei		
	A review of the Nurse	Assistant (NA) Bath Type		the scheduled shower da in-service includes docur	-	
	A review of the Nurse Assistant (NA) Bath Type documentation from 02/17/18 to 05/22/18 indicated nursing staff had documented 8			electronic health record t	•	
			were provided and if the			
	-	#21 during that timeframe.		a progress note docume		
		<b>3</b>		was completed, and the	-	
	A review of the facility	/ shower schedule indicated		DON was notified of the		
	Resident #21's showe	ers were scheduled twice		The in-service will be cor	npleted on	
	-	11pm shift on Wednesdays		6/28/18 by the SF. All ne	•	
		dent #21's next shower had		nurses and nursing assis		
		5/23/18 on the 3pm - 11pm		agency, will be in-service	-	
	shift.			during orientation regard	-	
	During on interview w	vith NIA #2 on 05/22/18 of		receiving showers on the		
		/ith NA #2 on 05/23/18 at ed he was an agency NA		shower days with review schedule book. The in-se		
		ed to care for Resident #21		documenting in the elect		
	•	hift. NA #2 stated he had		record that showers were		
		nower schedule notebook at		the resident refused, a pr	-	
		IA #2 stated there had been		documenting the refusal	•	
	times he had not bee	n able to provide residents		and the nurse and/or the	-	
		d because he got too busy.		notified of the refusal as	well.	
		esidents on his assignment				
		howers that evening, NA #2		On 5/30/18, a 100% aud	-	
		w. NA #2 stated the shower		the facility nurse consulta		
		onfused him stating it was		for the past 30 days on a		
		nine which resident had shower and on what day the		shower documentation to were provided to all resid		
	resident was to have			scheduled shower days.		
				completed by the facility		
	During an interview w	vith Nurse #4 on 05/24/18 at		by 6/20/18. Any areas of		
		stated the agencies the		identified during the audi		

Facility ID: 953074

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	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345376			C 07/03/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	07/03/2010
CUMBERI	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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE COMPLETION
F 675	facility contracted with sent to the facility on Living (ADLs) care an the training. Nurse #4 reports to the facility f shown the shower scl given instruction on d refusals of showers. Resident #21 got sho stated she could not p showers had not been During an interview w 05/24/18 at 9:08 a.m. facility staff would obt preferences in regard preferences on the re Administrator stated t	n trained the NAs who are basic Activities of Daily ad showers are included in 4 stated when an agency NA for the first time they are hedule notebook and are ocumentation of showers or Nurse #4 stated she knew wers more frequently but prove it because the n documented. with the Administrator on , the Administrator stated rain the residents' to bathing and then put the esidents' Care Guide. The he staff would be er documentation. The after these tasks had been expectation the nursing staff	F 67	5 addressed immediately by the f nurse consultant and/or the DC include providing additional train needed. On 6/14/18, the shower schedureviewed by the DON to ensure residents, including Resident # shower preferences were addet shower schedule. All areas of c identified during the review were addressed immediately by the include revision of the shower schedule revision of the shower schedule addressed include for F #21 will be reviewed by the QI Resource Nurse, and/or the As Director of Nursing (ADON) util Shower Audit tool weekly for 12 ensure all documentation is pre- electronic medical record indicas showers were provided as sche Any areas of concern identified review will result in immediate a the ADON and/or the QI Nurse will review and initial the Shower tools weekly for 12 weeks to ac completion of the audit. The administrator and/or the Di present the findings of the Show tools to the Executive Quality Improvement (QI) Committee in 3 months. Any issues, concern trends identified will be address	N to ning as all was a all 12, with d to the concern re DON to schedule to Resident Nurse, the sistant izing the 2 weeks to sent in the ating that eduled. during the action by . The DON er Audit cknowledge ON will wer Audit honthly for as, and/or

Event ID: EYQG11

Facility ID: 953074

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	-	ND HUMAN SERVICES			PRINTED: 08/21/20 FORM APPROVI OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345376	B. WING		C 07/03/2018
	ROVIDER OR SUPPLIER	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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIO
F 675 F 689	Continued From page	e 24 ards/Supervision/Devices	F 67	responsible for the implementation corrective actions to include all 100 audits, in-services, and monitoring to the plan of correction.	0%
SS=D	as free of accident ha §483.25(d)(2)Each re supervision and assis accidents.	S.			
	Based on observation interviews the facility interventions to prever multiple falls for 1 of (Resident #74) The findings included Record review reveal admitted to the facility diagnoses which include equarterly Minimum D 4/4/2018 revealed Re cognitively impaired a assistance with 2 per mobility. The MDS fu was not steady from standing. She was co with 1 person for loco	ent falls which resulted in 1 sampled resident. I: led Resident #74 was y on 6/24/2016 with uded dementia, anxiety, rtension. Review of the		F 689 The process which led to this defice was determined to be the facility fa implement interventions to prevent resulting in multiple falls for Reside On 6/12/18, a 100% audit of all pro- notes and incident reports to includ Resident #74 during the month of I was initiated by the facility nurse consultant and the Director of Nurse (DON) to ensure an intervention has put into place after a fall has occur The audit will be completed by 6/20 Any areas of concern identified dur audit will be immediately addresse Director of Nursing (DON) to include adding an intervention to the care and/or care guide as applicable an	ailed to t falls, ent #74. ogress de for May sing as been red. 8/18. ring the d by the de plan

Facility ID: 953074

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: ( FORMAI OMB NO. 0	PPROVE	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	(X3) DATE SURVEY COMPLETED	
		345376	B. WING		07/03/	2018	
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP COD			
CUMBERI	AND NURSING AND RE	HABILITATION CENTER	24	461 LEGION ROAD			
COMPEN			F	AYETTEVILLE, NC 28306			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE C E APPROPRIATE	(X5) OMPLETION DATE	
F 689	Continued From page	25	F 689				
	review.		1 000	providing additional staff train	ning.		
	5/8/2018 included a fe to a history of falls, co of safety awareness. would have no falls w review date of 6/12/20 implemented since 5/ therapy referral, ensu clutter and assist resi necessary. The care interventions before tf 5/9/2018 included pla position and have cor easy reach. The following fall inver- were reviewed: 3/2/2018 -Resident # locked unit and went The resident was obs her left side in another was assisted from the Bluish discoloration o Neurological checks of facility policy. No new documented. 4/27/2018 - Resident	9/2018 included rehab re environment is free of dent to negotiate barriers as plan indicated the he resident's last fall of cing the bed in the lowest nmonly used articles within estigations for Resident # 74 74 was ambulatory in the to another resident's room. erved lying on the floor on er resident's room. Resident e floor. Her body checked.		On 6/12/18, an in-service for licensed nurses to include ag initiated by the Staff Facilitato ensure all falls have an interv- into place immediately with d in the resident s medical rec the care guide. The in-service will be comple 6/28/18 by the SF. All newly I nurses including agency will I with this in-service by the SF orientation to ensure all falls intervention put into place im- with documentation in the res medical record and on the ca On 6/12/18, the Minimum Da Coordinator and MDS nurse in-serviced by the Facility Nu Consultant to ensure care pla guides are updated to reflect put into place for falls. All new MDS Coordinators and MDS be in-serviced by the SF duri on ensuring care plans and c are updated to reflect interven- into place for falls.	ency was or (SF) to vention put ocumentation cord and on ted on hired licensed be provided during have an mediately sident⊡s ure guide. ta Set (MDS) were rse ans and care interventions wly hired nurses will ng orientation care guides ntions put		
	found lying on the floo assessed injuries wer	or beside her bed. No re noted. Neurological		facility nurse consultant and t of Nursing (DON) to ensure fa			
		ed per the facility policy. No		interventions were document			
				On 6/14/18, Resident #74 roo			
		74 was walking around in locked unit and fell on the		inspected by the DON to ens interventions were implement			

Facility ID: 953074

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	OF DEFICIENCIES	MEDICAID SERVICES	עסיד וו אין גע <u>א</u>	LE CONSTRUCTION		NO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	l` ´			OMPLETED
			A DOILDING			С
		345376	B. WING			07/03/2018
NAME OF P	ROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
				2461 LEGION ROAD		
CUMBERLAND NURSING AND REHABILITATION 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	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETIO DATE
F 689	Continued From page	e 26	F 68	0		
1 000		n the sitting position and was	F 00	to the care plan and ca	re quide. No areas	
		ere noted. Neurological		of concern were identifi		
		ted per the facility policy. No		audit.		
	new interventions we					
	An observation of Re	sident # 74 was conducted				
		5 AM. The resident was				
	sitting in the activity r	oom in a chair.		On 6/14/18, the admini	strator, the DON,	
				the Assistant Director o	f Nursing (ADON),	
				the Quality Improvement		
		nducted on 5/ 23/2018 at 3:00		the Staff Facilitator (SF		
		Assurance (QA) nurse. The		the facility nurse consu		
	-	he was aware of Resident #		Fall Risk Protocol and I		
	-	he QA nurse indicated the at the facility daily by the		included ensuring an in into place on the care p		
		propriate interventions were		and that the interventio	-	
		A nurse further indicated		implemented after a fal		
		ident # 74 were difficult due				
	to the fact the resider	nt had decreased safety		All falls will be reviewed	d in clinical meeting	
	awareness and attem	npted to get up		5 times weekly for 12 w		
	independently.			Fall Intervention Monito		
				Quality Improvement (C		
		iducted on 5/23/2018 at 3:20		the Assistant Director o	- · · ·	
	-	istant (NA) # 1. NA # 1 amiliar with Resident #74 and		to ensure an intervention into place for each fall a	-	
		larly. NA # 1 reported the		and care guide has bee	-	
		up and would fall often. NA #1		reflect the intervention	-	
	-	know what would keep the		of concern identified du	-	
		ing. NA #1 further indicated		result in immediate acti		
	all the staff on the ha			Nurse, the ADON, and/		
		falls and would check on her		include adding an inter-		
	often.			necessary and/or provi	-	
	An interviewers	ducted with the Director of		training. The DON will r		
		nducted with the Director of		each Fall Intervention N	-	
		24/2018 at 1:20 PM. The as not familiar with Resident		weekly for 12 weeks to completion of the audit.		
		had just started working in				
	her new role as DON			The administrator and/	or the DON will	
		ation would be for an		present the findings of		

Facility ID: 953074

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TATEMENT	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OMB NO. 0938-( (X3) DATE SURVEY COMPLETED	
		345376	B. WING		C 07/03/2018	
	ROVIDER OR SUPPLIER	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 E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLE	
F 689 F 690 SS=G	intervention to be impresident had a fall at the Administrator on 5/24 Administrator on 5/24 Administrator reveale every day and discus Administrator indicate find appropriate interval Administrator reporte Resident # 74's repeat resident was not cogn directions the clinical else to offer as interval stated the expectation be appropriate and for to prevent accidents. Bowel/Bladder Incontt CFR(s): 483.25(e)(1): §483.25(e) Incontinent §483.25(e)(1) The fact resident who is contin admission receives so maintain continence to condition is or becom- not possible to maintate §483.25(e)(2)For a re- incontinence, based of comprehensive assess ensure that- (i) A resident who ent indwelling catheter is resident's clinical con- catheterization was n (ii) A resident who ent	blemented each time a the facility. ducted with the //2018 at 1:50 PM. The d the clinical team met sed each fall. The ed the clinical team tried to ventions for all falls. The d she was aware of ated falls and since the nitively able to follow team did not know what entions. The Administrator in was for fall interventions to or supervision to be provided tinence, Catheter, UTI -(3) nce. clility must ensure that nent of bladder and bowel on ervices and assistance to unless his or her clinical les such that continence is ain. esident with urinary on the resident's assment, the facility must ers the facility without an not catheterized unless the dition demonstrates that	F 68	Intervention Monitoring tool to the Executive Quality Improvement (QI) Committee monthly for 3 months. Any issues, concerns, and/or trends identif will be addressed by implementing changes as necessary, to include continued frequency of monitoring. The administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in-services, and monitoring rela- to the plan of correction.	ñed 9	

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: FORM A OMB NO. (	PPROVE
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SU COMPLE	
		345376	B. WING		C 07/03/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CUMBERI	AND NURSING AND RE	HABILITATION CENTER		2461 LEGION ROAD FAYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	CTION SHOULD BE COMPLET THE APPROPRIATE DATE	
F 690	as possible unless the demonstrates that car and (iii) A resident who is receives appropriate prevent urinary tract is continence to the external §483.25(e)(3) For a r incontinence, based comprehensive assess ensure that a resident receives appropriate restore as much norm possible. This REQUIREMENT by: Based on observation resident and staff inter clarify indwelling urinar resident reviewed (Re resident's indwelling urinar resident reviewed (Re resident's indwelling urinar for a urinary tract infer The Findings Include Resident #25 was ad 12/03/09. Her medic part, Multiple Scleros urethra, calculus of k pyelonephritis (kidney (urine flow from blador retention of urine and infection (UTI).	val of the catheter as soon e resident's clinical condition theterization is necessary; incontinent of bladder treatment and services to infections and to restore ent possible. esident with fecal on the resident's ssment, the facility must t who is incontinent of bowel treatment and services to nal bowel function as T is not met as evidenced on, record review and erviews, the facility failed to ary catheter orders for 1 of 1 esident #25) resulting in a urinary catheter not being months and a hospitalization ection (UTI). d: mitted to the facility on al diagnoses included, in is (MS), calculus (stone) in idney, chronic obstructive y infection), reflux uropathy der toward the kidney), I history of urinary tract	F 690	F 690 The process that lead to this deficie was determined to be that the licens nursing staff failed to clarify an orde an indwelling urinary catheter for Re #25. The indwelling urinary catheter not changed for Resident #25, resu hospitalization for a Urinary Tract In (UTI). On 5/25/18, Resident #25 returned facility from the hospital and was assessed by the 11-7 shift assigned nurse, to include observation of Res #25 indwelling catheter and drainag with documentation in the electronic health record. No concerns were no during the assessment.	sed er for esident r was lting in ifection to the d hall sident ge bag, c	
	Continued From page is assessed for remor as possible unless th demonstrates that ca and (iii) A resident who is receives appropriate prevent urinary tract is continence to the exter §483.25(e)(3) For a r incontinence, based comprehensive asses ensure that a residen receives appropriate restore as much norm possible. This REQUIREMENT by: Based on observation resident and staff inte clarify indwelling urinar resident reviewed (Re resident's indwelling urinar resident reviewed (Re resident's indwelling urinar resident reviewed (Re resident's indwelling urinar for a urinary tract infe The Findings Include Resident #25 was ad 12/03/09. Her medic part, Multiple Scleros urethra, calculus of k pyelonephritis (kidney (urine flow from blador retention of urine and infection (UTI). A review of Resident	e 28 val of the catheter as soon e resident's clinical condition theterization is necessary; incontinent of bladder treatment and services to infections and to restore ent possible. esident with fecal on the resident's ssment, the facility must t who is incontinent of bowel treatment and services to nal bowel function as T is not met as evidenced on, record review and erviews, the facility failed to ary catheter orders for 1 of 1 esident #25) resulting in a urinary catheter not being months and a hospitalization ection (UTI). d: mitted to the facility on al diagnoses included, in is (MS), calculus (stone) in idney, chronic obstructive y infection), reflux uropathy der toward the kidney),		F 690 The process that lead to this deficie was determined to be that the licens nursing staff failed to clarify an orde an indwelling urinary catheter for Re #25. The indwelling urinary catheter not changed for Resident #25, resu hospitalization for a Urinary Tract In (UTI). On 5/25/18, Resident #25 returned facility from the hospital and was assessed by the 11-7 shift assigned nurse, to include observation of Res #25 indwelling catheter and drainag with documentation in the electronic health record. No concerns were no	ency sed er for esident r was lting in ifection to the d hall sident ge bag, c oted	

Facility ID: 953074

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	(X3) DAT	IO. 0938-039 E SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED	
		345376	B. WING			C 07/03/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	//03/2018	
CUMBERLAND NURSING AND REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 690	Continued From page	29	F 69				
F 690	assistance of staff for (ADL). The MDS india indwelling urinary cat uropathy. A review of Resident 12/06/17, revealed th 1. At risk for recurred damage due to chrom recurrent UTIs. Inter- catheter care per faci 2. Altered pattern o indwelling catheter - a urinary retention. Re tube and (indwelling u Interventions included facility protocol, moni report any changes, o physician orders and/ for signs and symptor 3. Resistive to treat to shower, comb hair, nails cut, get out of be position, have facial h signs or weights take in part, to allow for fle accommodate the res the care being resisten notify the physician o to discuss the implicat the therapeutic regim revised 06/30/17).	intact and required total ther Activities of Daily Living cated Resident #25 had an heter and had obstructive #25's Care Plan, last revised e following: ent UTIs, urosepsis, or renal ic UTIs or history or ventions included, in part, lity protocol. f urinary elimination with at risk for infection related to sident with nephrostomy urinary) catheter. d, in part, catheter care per tor nephrostomy tube and change catheter per 'or facility protocol, monitor	F 69	<ul> <li>received clarification orders for #25 for the indwelling urinary carbe changed monthly and as neal leakage, dislodgement, and/or of The order was transcribed to the Medication Administration Reccords on 5/26/18 by the assigned hall</li> <li>A 100 % audit was completed of 7/13/2018 by the Assistant Diree Nursing (ADON) of all residents indwelling catheters to include r 25 to assess for signs\symptom No areas of concerns noted duraudit.</li> <li>On 6/14/18, an audit of all reside indwelling catheters to include F #25 was completed by the Qual Improvement (QI) Nurse, the Ast Director of Nursing (ADON) and to ensure all orders for indwellir catheters. No areas of concerns identified during audit. The audit completed on 6/14/2018.</li> <li>On 6/14/18, a 100% audit was if the QI Nurse, the ADON, and the all residents with orders for indwelling catheters to include resident #25 was completed on 6/14/2018.</li> </ul>	Atheter to eded for occlusion. e rd (MAR) nurse. n ctor of with esident # is of a UTI. ring the ents with Resident lity ssistant I the DON og urinary ude nary s were t was nitiated by ie DON of velling 5, MARs ths ensure nd		
	hospitalization from 1	0/20/17 through 10/25/17. A 25's admission orders dated		changed per physician orders. was completed on 6/28/18. Any concern identified during the au	The audit areas of		

Facility ID: 953074

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION		NO. 0938-03 ATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· /	G	· · /	OMPLETED	
						С	
		345376	B. WING			07/03/2018	
NAME OF PF	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		DE		
CUMBERL	AND NURSING AND RE	EHABILITATION CENTER		2461 LEGION ROAD FAYETTEVILLE, NC 28306			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	COMPLETIC	
F 690	Continued From page	e 30	F 69	00			
	urinary catheter.			conducting an assessment c	of the resident		
				to include the indwelling urin			
	Further record review	v documentation of revealed		for any abnormalities, signs\	symptoms of		
		lwelling urinary catheter had		UTI, notification of the physic			
	been changed - 10/1	1/17 and 12/20/17.		providing additional staff trai	ning.		
	A review of Resident	#25's physician orders		On 5/29/18, an in-service wa	as initiated by		
		revealed there had been no		the Staff Facilitator (SF) for a	-		
	physician order to ch	ange her indwelling urinary		nurses and nursing assistan			
	catheter.			agency to ensure urinary cat	theter care is		
				provided and documented in			
	A review of the hospi			electronic health record. Add			
	,	notes revealed Resident #25 ergency Department on		abnormalities observed at th site or in the drainage bag to			
		complaint of a dislodged		odor, color, or any drainage			
		copic gastrostomy (PEG)		reported immediately to the			
	tube.			nurse. The in-service was co			
				6/28/18. All newly hired licer			
		tal's ED registered nurse		and nursing assistants to inc			
		on 05/18/18 at 3:39 a.m.,		will be in-serviced by the SF	•		
	-	s (indwelling urinary) catheter		orientation to ensure urinary			
	sediment"	large amounts of crystalized		is provided and documented electronic health record. Add			
				abnormalities observed at th			
	A review of the hospi	tal's Admission History and		site or in the drainage bag to			
	Physical (H&P), date	d 05/18/18, indicated		odor, color, or any drainage			
	-	nts from Skilled Nursing		reported immediately to the			
		aining of dislodged PEG		nurse and the licensed nurse	e must notify		
	tube. Patient denied	•		the physician.			
		vers, chills. Upon evaluation ube was placed backupon		On 6/14/18, an in-service wa	as initiated by		
		ovider, it was noted that her		the SF for all licensed nurses			
		be was draining purulent		agency to ensure all orders t	•		
	material. Abdominal	computed tomography (CT)		urinary catheters are comple	ete to include		
		nd is suggestive of a right		parameters for when to char	-		
		nt denies any symptoms		urinary catheters. Additional	-		
	-	pain, nausea, vomiting,		in-service informed all licens			
		Labs remarkable for grossly		notify the physician to clarify	•		
	positive urine analysi	is Patient has been treated		that did not contain instruction	ons on when		

Facility ID: 953074

If continuation sheet Page 31 of 62

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			· /	e survey IPleted
			A. BOILDIN				С
		345376	B. WING			07	7/03/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
				2	461 LEGION ROAD		
CUMBERLAND NURSING AND REHABILITATION 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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 690	Continued From page	e 31	F 6	690			
		oteus pyelonephritis / UTI /			to change indwelling urinary catheters	5.	
		ober 2017" Further review			The in-service was completed on 6/28		
		an assessment of sepsis			All newly hired licensed nurses includ		
		ated UTI and pyelonephritis			agency will be in-serviced by the SF		
		ments of the nephrostomy			during orientation to ensure all orders		
		irinary catheter and Resident			indwelling urinary catheters are complete		
	#25 being treated wit	h intravenous antibiotics.			to include parameters for when to cha the urinary catheters. If orders did not		
	During an interview w	vith Resident #25's medical			include parameters on when to chang		
		5/18 at 1:00 p.m., the MD			the indwelling urinary catheter, the	0	
		ectation for nursing to			physician must be notified immediatel	у.	
	change residents' ind	welling urinary catheters					
		MD stated the fact Resident			On 7/13/2018, an in-service was initia	ted	
		ary catheter had not been			by the SF with all licensed nurse to		
		ce it had been inserted contributory factor to her			include agency nurses in regards to: When the hall nurse receives a new o	rdor	
		noses. The MD stated			for an indwelling catheter or a residen		
		ndwelling urinary catheters			admitted with an order for an indwellin		
	are at increased risk				catheter the following must occur: Hal	0	
					nurse must write a telephone order to		
	-	vith Nurse #4 on 05/26/18 at			identify parameters of when to change		
		stated she thought the			catheter to include size of catheter an		
		ndwelling urinary catheter for			diagnosis of use. Hall Nurse must place		
	MARs in October 201	en inadvertently left off the 17 after Resident #25			the catheter telephone order on the M per the physician and block of the dat		
		y from a hospitalization for			next catheter change per the physicia		
		is. Nurse #4 stated she			order. Administrative nurses are to rev		
		indwelling urinary catheter			all new orders to include new admission	on	
	-	ince October 2017 but she			orders 5 days a week to ensure that a	ny	
	could not prove it.				new catheter orders are complete to		
	During on interview w	with Nurses #8 on 05/26/19 of			include parameters of when to change		
	-	vith Nurse #8 on 05/26/18 at stated residents with			catheter and placed on the MAR correct If any areas of concerns identified dur	•	
		theters have their catheters			order checks, the attending physician	•	
		th. Nurse #8 stated the date			must be notified to get clarification of t		
		s on the resident and when			catheter order. In-service to be comple		
	the catheter was first	inserted. Nurse #8 stated			by 7/17/2018		
	she frequently had R						
	assignment and did r	not remember changing					

Facility ID: 953074

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION		TE SURVEY MPLETED
	CONTRACTION	DERTIFICATION DER.	A. BUILDING	i		C
		345376	B. WING		0	7/03/2018
AME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
		EHABILITATION CENTER		2461 LEGION ROAD		
0				FAYETTEVILLE, NC 28306		
(X4) ID		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC		(X5) COMPLETIO
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO TH	E APPROPRIATE	DATE
F 690	Continued From pag	le 32	F 69	0		
		eter in the recent past. Nurse		10% of residents with indwel	ling catheters	
	#8 stated seeing the	order to change the catheter		to include Resident #25 will I	be reviewed	
		al reminder to the nurse the		by the ADON and or QI Nurs	•	
	catheter needs to be	cnanged.		8 weeks, then monthly for 1 utilizing a Catheter Monitorin		
	During an interview	with Resident #25 on		ensure there is no signs/sym	•	
		n., the resident stated she		urinary tract infection and that	•	
		exactly when her indwelling		for indwelling urinary cathete		
	· ·	last been changed at the		clarified to address parameter		
	-	as told the medical record Resident #25 stated she felt		changing the catheters, orde transcribed correctly to the N		
		nged since but not for the		documentation is completed		
	last 2 months.			when the indwelling urinary of		
				changed per the physician o	rders. Any	
	-	with the Administrator on		areas of concern identified d		
	· · ·	n., the Administrator stated, in urinary catheter changes, he		review will be immediately a	•	
		rsing staff to follow the plan		the DON to include obtaining clarification, notification of at		
		y the physician. The		physician assessment of the	•	
	Administrator stated	he would expect the nursing cording to facility training.		and/or providing additional s		
				The DON will present the fin		
				Catheter Monitoring tools to		
				QI committee monthly for 3 r Executive QI Committee will		
				for 3 months and review the	•	
				Monitoring tools to determine		
				and/or issues that may need	further	
				interventions put into place a		
				determine the need for furthe of monitoring.	er trequency	
				The administrator and the D		
				responsible for the implement		
				corrective actions to include audits, in services, and moni		
				to the plan of correction.	ioning related	
F 695	Respiratory/Tracheo		F 69	-		7/11/18

TAG       REGULATORY OR LSC IDENTIFYING INFORMATION)       TAG       CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       DATE         F 695       Continued From page 33 CFR(s): 483.25(i)       F 695       <		MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
Image: Name of PROVIDER OR SUPPLIER     Street AdDRess, CITY, STATE, ZIP CODE       CUMBERL-IND NURSING AND REHABILITATION CENTER     STREET ADDRESS, CITY, STATE, ZIP CODE       (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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     (x5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE     (x5) COMPLETION DATE       F 695     Continued From page 33 CFR(s): 483.25(i)     F 695     F 695     F 695       § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered     F 695						COMPLETED
2461 LEGION ROAD FXETTEVILLE, 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 SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLETION DATE         F 695       Continued From page 33 CFR(s): 483.25(i)       F 695       F 695         § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered       F 695			345376	B. WING		-
EAVETTEVILLE, 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 SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH OEFICIENCY)       COMPLETION DATE         F 695       Continued From page 33 CFR(s): 483.25(i)       F 695       <	NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	·
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       (X5) COMPLETION DATE         F 695       Continued From page 33 CFR(s): 483.25(i)       F 695       F 695         § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered       F 695	CUMBER	LAND NURSING AND RE	HABILITATION CENTER			
PREFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAG(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)COMPLÉTION DATEF 695Continued From page 33 CFR(s): 483.25(i)F 695F 695F 695§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centeredF 695						
SS=J       CFR(s): 483.25(i)         § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	E COMPLETION
care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview and facility staff and hospital staff interview and facility staff and hospital staff interview, the facility failed to provide tracheostomy care as ordered by the medical doctor for 1 of 1 resident reviewed for respiratory care (Resident #25).F695Immediate Jeopardy began on 05/18/18 and was removed on 07/03/18 when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at scope and severity of D (not actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) to allow for ongoing in-servicing and monitoring to be accomplished.F695The findings included: Resident #25 was admitted to the facility on 12/03/09 with diagnoses which included Multiple Sclerosis, chronic obstructive pulmonary disease and tracheostomy status.F695A review of Resident #25's Minimum Data Set (MDS), dated 02/21/18, indicated Resident #25 was cognitively intact and required totalF695The section of the sect		CFR(s): 483.25(i) § 483.25(i) Respirator tracheostomy care and The facility must ensu- needs respiratory care care and tracheal suc- care, consistent with practice, the compreh- care plan, the resider and 483.65 of this sul- This REQUIREMENT by: Based on observation interview and facility sinterviews, the facility tracheostomy care asd doctor for 1 of 1 resid care (Resident #25). Immediate Jeopardy I removed on 07/03/18 an acceptable credibled The facility will remain and severity of D (not potential for more that Immediate Jeopardy) in-servicing and monit The findings included Resident #25 was add 12/03/09 with diagnoss and tracheostomy stat A review of Resident (MDS), dated 02/21/1	ry care, including d tracheal suctioning. Irre that a resident who e, including tracheostomy tioning, is provided such professional standards of tensive person-centered its' goals and preferences, opart. is not met as evidenced in, record review, resident staff and hospital staff failed to provide ordered by the medical ent reviewed for respiratory began on 05/18/18 and was when the facility provided e allegation of compliance. n out of compliance at scope actual harm with the n minimal harm that is not to allow for ongoing toring to be accomplished. : mitted to the facility on ses which included Multiple structive pulmonary disease tus. #25's Minimum Data Set 8, indicated Resident #25	F 69	<ul> <li>F695</li> <li>The process that lead to the deficiency was the failure of nurse #7 not comple reading the Medication Administration Record (MAR) which resulted in not documenting tracheostomy care provid The failure of Nurse #6 and Nurse #2 the provide tracheostomy care to resident #25. During the interview, Nurse #6 and Nurse #2 both stated that they did not provide tracheostomy care to resident related to being busy but could not stat the reason why they did not ask for assistance.</li> <li>On 5/17/18, Resident #25 was sent out the hospital for evaluation due to dislodged G-Tube.</li> <li>Resident #25 trach was assessed by the Treatment Nurse on 4/30/18, 5/7/18, a 5/14/18 with no documentation of larva foul odor, or drainage around the tracheostomy care to resident the tracheostomy care to resident with the tracheostomy care to resident with the tracheostomy care to resident with the hospital for evaluation due to dislodged G-Tube.</li> </ul>	tely ded. o d #25 te t t to

Facility ID: 953074

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IAIEMENI C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	(X3) DAT	E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	• •	B	. ,	PLETED
					С	
		345376	B. WING			//03/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE	
CUMBERLAND NURSING AND REHABILITATION CENTER				2461 LEGION ROAD FAYETTEVILLE, NC 28306		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN (		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	COMPLETIO
F 695	Continued From page	e 34	F 69	95		
		for her Activities of Daily		On 5/17/18 per hospital r	ecord at 6:58	
		IDS indicated resident		pm, one hour after reside		
		apy and tracheostomy care.		Emergency Department,		
				documented Patient cons		
		#25's Care Plan indicated		oriented x 4, respiratory r	ate even and	
		e potential for or actual		unlabored, patient has tra		
	ineffective breathing p			O2 @ 2 liters. No mentio	-	
	2	entions included, in part, to		larvae, or foul-odor in tra	cheostomy.	
	-	v care as ordered by the			accord at 0.15	
		ity protocol and to check		On 5/17/18 per hospital r		
	dressing to stoma site	e frequently and eeded or as ordered (last		pm, resident had a chest Findings: Tracheostomy		
	· •	ne Care Plan indicated		position.		
	,	en resistive to treatment and		position		
		shower, comb hair, turn off		On 5/17/18 per hospital r	ecord at 10:42	
	•	cut, get out of bed, have bed		pm, per the documentation		
		, have facial hair removed,		Registered nurse, trache		
		eights taken). Interventions llow for flexibility in ADL		place. O2 @ 3 Liters via	trach mask.	
	routine to accommoda	ate the resident's mood, to		On 5/18/18 per hospital r	ecord at 5:32	
		eing resisted per facility		am, per the documentation		
		the physician of patterns in		Registered nurse, suction	n at bedside.	
		uss the implications of not				
		erapeutic regiment with the		On 5/18/18 per hospital r		
	resident (last revised	06/30/17).		there is documentation of	· ·	
	A record review of Do	esident #25's May 2018		Therapist treatment asse	SSITIETIL.	
	Medication Administra	-		On 5/18/18 per the hospi	tal record at 2.02	
		s order for "tracheostomy		pm there is documentation		
		every day" and the dressing		registered nurse Patient		
	• •	ed to be completed at 4:00		with brownish drainage, f	•	
		nt #25 leaving the facility on		site needs cleaning. Calle		
		een 8 dates the order had		Therapist (RT) to clean g		
		y a nurse as having been		notified RN that pt has m		
		, 4, 6, 7, 9, 10 and 15. Prior		tracheostomy. RN confirm		
		o the hospital on 05/17/18,		site. RN notified physicia	n via phone and	
	-	n documented as completed		awaiting call back.		
	on 05/16/18. The MA had not been completed	R indicated the dressing		On 5/18/18, the administr		

Facility ID: 953074

CENTER				E CONSTRUCTION		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
			A. BUILDING		с	
		345376	B. WING		07/03/2018	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		07/03/2018	
CUMBERL	CUMBERLAND NURSING AND REHABILITATION CENTER			2461 LEGION ROAD FAYETTEVILLE, NC 28306		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	D 4 T	
F 695	Continued From page	e 35	F 69	5		
				aware by resident #25 friend of an		
	During an interview w	vith Nurse #7 on 05/25/18 at		allegation that Resident #25 was		
	•	stated she had worked the 3		observed with maggots in her throat v	while	
	p.m. to 11 p.m. shift o			at the hospital.		
	-	ig the dressing on Resident				
		and stated it had looked fine.		On 5/18/18, an investigation was star		
		worked the 3 p.m. to 11 p.m. and been one of the nurses		by the administrator to include submis		
		esident #25 when her PEG		of an Initial Allegation Report to Healt Care Personnel Investigation (HCPI).		
		When asked if she had				
	÷	5's tracheostomy site prior		On 5/25/18, the investigation was		
		g sent out, Nurse #7 stated		completed and the allegation was		
		re had been no drainage		unsubstantiated by the administrator.	The	
	noted on the sheets.	C C		Investigation Report was submitted to HCPI by the administrator.		
	During an interview w	vith Nurse #2 on 05/26/18 at				
		had been asked why she had		Nurse #6 and #7 were reported to the	•	
		on the MAR for Resident		Board of Nursing on 7/3/18 for not		
		site dressing on May 2, 4, 6,		providing tracheostomy care by the		
		urse #2 stated while she		Director of Nursing (DON).		
		ig the dressing a couple of		On E/26/19, Desident #25 returned to	the	
		was going to be honest.		On 5/26/18, Resident #25 returned to		
	responsible for a med	n she came on duty she was		facility and was assessed by the hall nurse to include assessment of the		
		to overseeing 2-3 medication		tracheostomy site, which was clean, o	drv.	
		ed she stayed stressed out		and covered with a dry dressing. On		
		ould come on duty she had		5/26/18, the assessment for Resident	t #25	
		ere and there dealing with		was documented by the hall nurse in		
	resident issues and b	ehaviors. Nurse #2 stated it		electronic medical record.		
	-	nging and stated she felt it				
		why she did not always do		On 6/12/18, an observation of all		
	the dressing change.			residents to include Resident #25 was		
	During on interview	ith Nurse #6 on 05/00/40 of		completed by the DON, the Assistant		
	10:40 a.m., Nurse #6	vith Nurse #6 on 05/26/18 at		Director of Nursing (ADON), and the Quality Improvement (QI) Nurse to		
		25's tracheostomy site		physically identify all residents with		
		but stated she could not		tracheostomies. One resident was		
	recall whether or not			identified with a tracheostomy.		

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	: 08/21/201 APPROVE . 0938-039
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		(X3) DATE COMPI	SURVEY LETED
		345376	B. WING			07/0	C 03/2018
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS	S, CITY, STATE, ZIP CODE		
				2461 LEGION RO	AD		
CUMBERI	AND NURSING AND RE	HABILITATION CENTER		FAYETTEVILLE	i, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	ROVIDER'S PLAN OF CORRECTIO H CORRECTIVE ACTION SHOULD S-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	Continued From page	e 36	F 6	95			
					8, an audit of all Medicatior	ר ר	
	During an interview w	vith Nurse #7 on 05/26/18 at			tion Record (MARs), includ		
	-	stated 5/10/18 had been			Resident #25, for the past	•	
	•	yment at the facility. Nurse			completed by the ADON a		
		d changing Resident #25's			se to ensure orders for		
	tracheostomy site dre	essing on 05/10/18 and		respiratory	care, including tracheosto	my	
	stated she had forgot	ten to sign off on the MAR.		care were	provided as evidenced by		
					ation on the MAR. There w		
	-	vith the hospital ED nurse #2		no other ide	entified areas of concern r	noted.	
		a.m., the hospital ED nurse					
	#2 stated Resident #2				B, an assessment of all	ina	
	• •	nutes before the end of her 7 n 05/17/18. The hospital ED			vith tracheostomies, includ 25 was completed by the (	-	
		ident #25 smelled like she			the ADON to ensure		
	needed a bath and he				my care was provided as		
		heter were in need of some			by observing a clean inser	rtion	
	"tender loving care" h				essing with no drainage		
		25's tracheostomy because			nere were no identified are	as of	
	her oxygen saturation	had been okay.		concern du	iring the audit.		
	During an interview w	vith the hospital ED nurse #3		On 6/12/18	B, an audit of all residents□	]	
		a.m., the hospital ED nurse		1.2	orders to include Resident		
		red for Resident #25 during			ed by the QI nurse, the AD		
		shift on 05/17/18. The			aff Facilitator (SF) to identi	fy all	
		stated Resident #25 had			vith orders to receive		
	care to Resident #25	idition" and had focused her			my care. The audit was on 6/13/18. There were no	<u> </u>	
		heter secondary to Resident		· ·	ified residents with orders		
		y bad smelling urine."			cheostomy care.	10	
	During an interview w	vith the hospital ED nurse #1		On 6/29/18	8, a 100% return demonstr	ation	
		o.m., the ED nurse #1, who			stomy care was initiated wi		
		7 p.m. shift on 5/18/18,			urses to include agency nu		
		entered the holding room			#6, and Nurse #7 by the A	DON	
		en placed in she could smell			eturn demonstration of		
		off of her and noted that her			my care was completed or		
	-	on it, her hair had been			training was completed by		
		kes and it appeared like it			/or SF during the time of the time of the time of the terms of terms o	ne	
-	nau not been washed	t in a long time. The ED		audit for an	ny nurse that could not		

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		MEDICAID SERVICES			OMB NO. 0938	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	PLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
					С	
		345376	B. WING		07/03/20	18
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIF	° CODE	
		HABILITATION CENTER		2461 LEGION ROAD		
	AND NORSING 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 ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE COMP O THE APPROPRIATE D,	(X5) PLETIC DATE
F 695	Continued From page	e 37	F 6	05		
1 000		ooked at Resident #25's	F U		orformonoo of	
		d had noted a substance on		demonstrate successful p tracheostomy care per po		
	-	ich she compared to melted		procedure.		
		ED nurse stated she called		On 7/1/18, a contracted F	RT initiated	
		sist (RT) for tracheostomy		training on tracheostomy		
		ds. The ED nurse stated		licensed nurses and age		
		un tracheostomy care, he		include Nurse #6 and #7.		
	-	he presence of maggots on		was completed with all lid		
	Resident #25's skin s	surrounding her		agency nurses on 7/7/18	.The RT will train	
		he ED nurse stated she then		all newly hired licensed n	nurse and	
		ce of maggots around the		contracted agency nurse	s during	
	tracheostomy site.			orientation.		
	During an interview w	vith the hospital's RT #1 on		On 5/30/18, a 100 % in-s	ervice was	
		n., the RT #1 stated he		initiated with all license n		
		5 in the ED on 05/18/18.		agency nurses, and Nurs		
	The RT stated he had	d been called to the ED to		#7 by the facility nurse co		
	assess the resident,	assess oxygen saturation		SF on providing tracheos	stomy care as	
		stomy care. The RT #1		ordered by the physician		
		Resident #25's ED room,		documentation of trached		
		odor emanating from the		MAR. The in-service also		
	resident. The RT #1			expectation that docume		
		ostomy, he noticed the		present on the MAR after		
		ere dirty and there were		tracheostomy care. The i	n-service was	
		ns on her tracheostomy. The oved the tracheostomy site		completed on 6/28/18.		
		ing from the facility) and it		On 7/2/18, a 100 % in-se	nvice was	
		d had secretions so old the		initiated with all licensed		
		he RT #1 stated Resident		agency nurses and Nurse		
		h the sponge was red and		#7 by the Facility Nursing		
		ots under the tracheostomy		reading each tracheostor		
		The RT #1 stated he had		MAR, following the physi	-	
		s's odor was more prevalent		tracheostomy care, docu		
		my care but could not state		MAR tracheostomy care	-	
		was coming from the		checking each page of th		
	tracheostomy site or	not. The RT #1 stated he		that no medications, trea		
		ggots off of Resident #25's		documentation is missed	. The in-service	
		tracheostomy however he		also included for licensed		
	did not have time to a	change the inner cannula as		for additional assistance	from the DON	

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ATEMENT O D PLAN OF		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIC	PI F	CONSTRUCTION	(X3) DATE	SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			<b>N</b> 7	PLETED
							С
		345376	B. WING			07/	03/2018
IAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
		HABILITATION CENTER		24	461 LEGION ROAD		
	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 .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIC DATE
F 695	Continued From page	2 38	F 69	95			
		be transferred to another	100	50	ADON, QI Nurse, SF, or another hall		
		During a 2nd interview with			nurse when feeling like assistance is		
	•	-07/03/18 at 8:57 a.m., the			needed to provide resident care to inclu	ude	
		he and another hospital RT			tracheostomy care and time		
	#2 had performed Re	sident #25's tracheostomy			management. The in-service was		
	care together on 05/1	8/18 and the hospital RT #2			completed on 7/7/18. All newly staffed		
	had documented the	care.			agency or newly hired licensed nurse v		
					be educated by the SF during orientation		
	A review of the hospit				in regards to reading each tracheoston	-	
		ived at the Emergency			order on the MAR, following the physic		
	• • • • •	05/17/18 at 5:50 p.m. with a			order for tracheostomy care, document	-	
	chief complaint of a d	Isloaged PEG lube.			on the MAR tracheostomy care provide checking each page of the MAR to ens		
	Further review of the	hospital record ED notes			that no medications, treatments, and	uie	
	revealed the following				documentation is missed.		
	1. An RT note, date						
		cheostomy collar (TC),			On 7/11/18, the administrator spoke wi	th	
		ygen (FIO2): 30, breath			Quality Improvement Organization (QI		
	sounds diminished; n	ote - pt placed on 30% TC			for assistance in evaluation of specific		
	at this time, periphera	al capillary oxygen saturation			steps to be taken to address		
	(SPO2) 97%"				tracheostomy care and training, staff		
		e, dated 05/18/18 2:02 p.m			position/title designated to be responsi		
		ny with brownish drainage,			for the steps, timeline for accomplishm		
		spiratory Therapist (RT) to			of the steps, specific methodology to b		
		I that patient has maggots in onfirmed this by eyesight."			used to evaluate the plan⊡s success, a frequency of monitoring the effects of t		
	-	is of a chest x-ray performed			plan initiation. The QIO staff are		
		.m. revealed findings of			scheduled to visit the facility on 7/18/18	3 to	
	-	s stable in positionno			review current Plan of Correction, curre		
	acute process"	····			systems, monitoring of tracheostomy c		
	·				and make further recommendations in		
	A review of a hospital	-			regards to tracheostomy care.		
		ted 5/18/18 at 2:00 p.m.,					
	-	ent's room for tracheostomy			10% of all residents with tracheostomic		
	assessment, upon mo				to include Resident #25 will be physica		
		found maggots crawling			observed and documentation of the MA		
		siteall maggots that were			and non-ulcer flow sheet assessment w		
	•	Once RN called to room en was the last time they			be monitored by the Assistant Director Nursing (ADON) and/or the Quality	UI	

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	PLE CONSTRUCTION	(X3) DAT	O. 0938-039	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	<u> </u>	CON	IPLETED	
		345376	B. WING		07	C 7/03/2018	
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE			
CUMBERI	LAND 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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 695	Continued From page	e 39	F 69	)5			
	<ul> <li>95 Continued From page 39</li> <li>cleaned it at the nursing facility and patient stated "they cleaned it 2 days ago."</li> <li>During an interview with Resident #25 on 05/24/18 at 11:35 a.m., Resident #25 was observed to be lying in her hospital bed, awake and alert. Resident #25's skin appeared clean and there had been a slight odor emanating off of her body, possibly coming from her hair which was visibly dirty with a dried brown substance noted in one part of it and areas full of dry white flakes, possibly skin flakes. Resident #25 was observed to have a tracheostomy in place. Resident #25 stated tracheostomy care at the facility hardly ever got done. Resident #25 stated the nurses at the facility were supposed to change it once a week and they did not consistently change it as ordered. Resident #25 stated it made her feel terrible knowing the state her tracheostomy site was in when she got to the hospital.</li> </ul>			<ul> <li>Improvement (QI) Nurse 5 days for 4 weeks, 3 days weekly for 4 then weekly for 4 weeks utilizing. Care Audit tool. This audit is to that tracheostomy care is being per policy and procedure, with documentation on the MAR and assessment has been complete documentation in the electronic record and that the tracheostom clean, odor-free, and dressing is intact.</li> <li>10% of all licensed nurses to imagency nurses and Nurse #6 ar #7 will be observed utilizing a M Pass Tracheostomy Audit Tool 8 weekly for 4 weeks, 3 days weeks, then weekly for 4 weeks</li> <li>ADON and/or the QI Nurse. The to ensure that nurses are readired.</li> </ul>	documentation on the MAR and an assessment has been completed with documentation in the electronic health record and that the tracheostomy site is clean, odor-free, and dressing is dry and		
	05/26/18 at 2:42 p.m. expectation of nursing tracheostomy care, is of care as directed by Administrator stated in nursing staff docume training. The Assistant Director the Immediate Jeopa On 07/03/18 at 2:46 g following credible alle Immediate Jeopardy A thorough investigat	s to follow the residents' plan the physician. The t was his expectation nt according to facility or of Nursing was notified of rdy on 06/29/18 at 3:10 p.m. o.m., the facility provided the egation of compliance and		documenting on the MAR trache care provided, and managing til ensure tracheostomy care is pre Any areas of concern identified audits will be addressed immed the ADON, QI Nurse, and/or the include providing additional staf The DON will present the findin Trach Care Audit tools and the I Pass Tracheostomy Audit Tools Executive Quality Assurance (C committee monthly for 3 months Executive QA Committee will m monthly for 3 months and review Trach Care Audit tools and the I	eostomy me to byided. during the iately by e DON to f training. gs of the Medication to the DA) s. The eet w the		

Facility ID: 953074

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TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	LE CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	<u> </u>	CO	MPLETED
		345376	B. WING			C
	ROVIDER OR SUPPLIER	545576		STREET ADDRESS, CITY, ST		7/03/2018
				2461 LEGION ROAD		
CUMBERI	AND NURSING AND RE	HABILITATION CENTER		FAYETTEVILLE, NC 283	06	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIATE IEFICIENCY)	(X5) COMPLETIO DATE
F 695	Continued From page	- 40	F 69	5		
1 000		e administrator that the	FO	Pass Tracheostomy	Audit Tools to	
		of nurse #7 not completely			nd/or issues that may	
		on Administration Record			entions put into place	
	which resulted in not	documenting tracheostomy		and to determine th	e need for further	
		the interview, Nurse #6 and		frequency of monito	oring.	
		that they did not provide		<b>T</b>		
		resident #25 related to		The administrator a		
	they did not ask for a	not state the reason why		responsible for the corrective actions to	-	
		ssistance.			and monitoring related	
	On 5/17/18, Residen	t #25 was sent out to the		to the plan of correc		
	hospital for evaluation	n due to dislodged G-Tube.				
	Resident #25's trache	eostomy was assessed by				
	the Treatment Nurse	on 4/30/18, 5/7/18, and				
		mentation of larvae, foul				
	odor, or drainage aro	und the tracheostomy site.				
	On 5/17/18 per hospi	tal record at 6:50 pm, one				
	hour after resident wa					
	Department, the RN					
		oriented x 4, respiratory rate				
	and wears O2 @ 3 lit	patient has tracheostomy				
		oul-odor in tracheostomy.				
	On 5/17/18 per hospi	tal record at 9:15 pm,				
	resident had a chest	x-ray complete. Findings:				
	"Tracheostomy tube i	in stable position."				
		tal record at 10:42 pm, per				
		the Registered nurse,				
	"tracheostomy tube in tracheostomy mask."	n place. O2 @ 3 Liters via				
	-	tal record at 5:32 am, per				
		the Registered nurse,				
	"suction at bedside."	J,				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345376	B. WING				C 103/2018
NAME OF P	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE		
CUMBER	LAND NURSING AND RE	HABILITATION CENTER			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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 695	On 5/18/18 per hospir documentation of a R treatment assessment On 5/18/18 per the ho there is documentation "Patient's tracheostor foul odor. G-tube site to clean g-tube and R maggots in tracheostor eye site. RN notified p awaiting call back." On 5/18/18, the admin by resident #25 friend Resident #25 was obs throat while at the host on 5/18/18, an invest administrator to inclue Allegation Report to F Investigation (HCPI). On 5/25/18, the invest the allegation was un administrator. The Inv submitted to (HCPI) b On 5/26/18, Resident and was assessed by assessment of the tra- clean, dry, and covere 5/26/18, the assessm documented by the ho medical record.	tal record at 8:33 am there is tespiratory Therapist at. ospital record at 2:24 pm on of the registered nurse my with brownish drainage, needs cleaning. Called RT RT notified RN that pt has omy. RN confirmed this by physician via phone and nistrator was made aware d of an allegation that served with maggots in her spital. tigation was started by the de submission of an Initial Health Care Personnel tigation was completed and substantiated by the vestigation Report was by the administrator. #25 returned to the facility of the hall nurse to include acheostomy site, which was ed with a dry dressing. On tent for Resident #25 was all nurse in the electronic ea was not documented to ctor's orders consistently.	F	695			

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CENTER STATEMENT ( AND PLAN OF NAME OF P CUMBERI (X4) ID	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER LAND NURSING AND RE SUMMARY STA	ATEMENT OF DEFICIENCIES	A. BUILD B. WING	ING	E CONSTRUCTION TREET ADDRESS, CITY, STATE, ZIP CODE 461 LEGION ROAD TAYETTEVILLE, NC 28306 PROVIDER'S PLAN OF CORRECTION	FORM OMB NC (X3) DATE COMP ( 07/	C: 08/21/2018 MAPPROVED D. 0938-0391 SURVEY PLETED C 03/2018
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		DATE
F 695	personnel to include N following doctor's orde care. Nurse #2 will be report on 7/3/18 for not docu Administration Record Nurse #2 is no longer through the Agency. N reported to the board providing tracheostom Nursing on 7/3/18. Corrective Action A contracted Respirat training on tracheoston nurses to include Nur Director of Nursing, S other nurses have cur by the RT and will cor tracheostomy care un complete the training. nurses that are left to will not be allowed to been completed. A cc 2:15 pm on 7/3/18 an licensed nurse training. On 5/30/18, an in-ser license nurses to inclu Nurse #6, and Nurse consultant and the Sta providing tracheostom physician. The in-serv expectation that docu on the Medication Administration	Nurse # 2, #6, and #7 on er and providing trachea	F	695			

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		ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 08/21/2018 RM APPROVED O. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345376	B. WING			07	C 7/ <b>03/2018</b>
NAME OF P	ROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CUMBERI	AND NURSING AND RE	HABILITATION CENTER		24	61 LEGION ROAD		
COMPERE				FA	YETTEVILLE, 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 CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 695	licensed nurses to inc Nurse #6, and Nurse Consultant on reading on the MAR, following tracheostomy care, d tracheostomy care pr of the MAR to ensure treatments, and docu in-service also includ for additional assistan Nursing, Assistant Di Improvement Nurse, hall nurse when feelin to provide resident ca care and time manag will be allowed to wor completed. On 6/12/18, an obser include Resident #25 Director of Nursing (D of Nursing (ADON), a (QI) Nurse to physica	ice was initiated with all clude agency nurses and #7 by the Facility Nursing g each tracheostomy order g the physician order for ocumenting on the MAR ovided, checking each page	F	695			
	for Resident #25, for completed by the AD ensure orders for res tracheostomy care we	of all MARs, including MARs the past 30 days, was ON and the QI Nurse to piratory care, including ere provided as evidenced the MAR. There were no of concern noted.					
	tracheostomies, inclu completed by the QI	ssment of all residents with Iding Resident #25 was Nurse and the ADON to r care was provided as					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	
		345376	B. WING				03/2018
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CUMBERL	AND NURSING AND RE	HABILITATION CENTER			461 LEGION ROAD 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 695	dressing with no drain identified areas of cor On 6/12/18, an audit of orders to include Ress the QI nurse, the ADC (SF) to identify all ress tracheostomy care. The 6/13/18. There were re- with orders to receive On 6/29/18, a 100% re- tracheostomy care was nurses to include age and Nurse #7 by the A (ADON). Retraining way ADON during the time that cannot demonstration of tracheostomy care No nurse will be allow care on a resident un- the return demonstration be allowed to work un- has been completed. The Quality Improven contacted by the Reg Operations on 7/03/18 evaluation of specific address tracheostomy position/title designate steps, timeline for acc specific methodology plan's success, and fr effects of the plan init All residents with trac	ng a clean insertion site and hage present. There were no incern during the audit. of all residents' physician ident #25 was initiated by DN, and the Staff Facilitator idents with orders to receive he audit was completed on no other identified residents tracheostomy care. return demonstration of as initiated with all licensed ncy nurses and Nurse #6, Assistant Director of Nursing <i>v</i> ill be completed by the e of the audit for any nurse ate successful performance per policy and procedure. ved to perform tracheostomy til successful completion of tion. No licensed nurse will ntil the return demonstration nent Organization was ional Vice President of 8 for assistance in steps to be taken to y care and training, staff ed to be responsible for the complishment of the steps, to be used to evaluate the requency of monitoring the iation. heostomies to include	F	695			
	Resident #25 will be p	physically observed and					

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		ND HUMAN SERVICES MEDICAID SERVICES					RINTED: 08/21/20 FORM APPROVE //B NO. 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ONSTRUCTION		3) DATE SURVEY COMPLETED
		345376	B. WING			C 07/03/2018	
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
CUMBERL	AND NURSING AND RE	EHABILITATION CENTER			1 LEGION ROAD YETTEVILLE, NC 28306		
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORF	PECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	COMPLETION
F 695	Continued From page	e 45	F	695			
		MAR and non-ulcer flow					
		Ill monitored by the Assistant					
		ADON) and/or the Quality					
	,	Irse 5 days weekly for 4					
	-	y for 4 weeks, then weekly					
		a Trach Care Audit tool. This tracheostomy care is being					
	performed per policy						
		e MAR and an assessment					
		with documentation in the					
	electronic health reco						
	tracheostomy site is dry and in	ntact. A medication pass					
	<b>u</b>	y care will be completed by					
		r of Nursing (ADON) and/or					
		nent (QI) Nurse on 10% of all					
		clude agency nurses and					
		#7, 5 days weekly for 4 y for 4 weeks, then weekly					
	for 4 weeks utilizing a						
	-	Tool. This audit is to ensure					
		ng each tracheostomy order					
		g the physician order for					
	•	locumenting on the MAR					
	• •	rovided, and managing time my care is provided. Any					
		ntified during the audits will					
		liately by the ADON, QI					
		ON to include providing					
	additional staff trainin	ng.					
	The DON will presen	t the findings of the Trach					
	Care Audit tools and	-					
		Tools to the Executive					
	•	A) committee monthly for 3					
		ve QA Committee will meet and review the Trach Care					
	Audit tools and the M						
		Tools to determine trends					

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	S FOR MEDICARE &				OMB NO. 0938-0
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
512410			A. BUILDING		
		345376	B. WING		С
		545576			07/03/2018
AME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	JDE
UMBERL	AND NURSING AND R	EHABILITATION CENTER		2461 LEGION ROAD FAYETTEVILLE, NC 28306	
			I		
(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 ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE COMPLET HE APPROPRIATE DATE
F 695	Continued From page	ge 46	F 69	5	
		ay need further interventions			
		determine the need for			
	further frequency of				
	Final date of complia	ance is 7/03/18.			
		nd DON will be responsible			
		on of corrective actions to dits, in-services, and			
		o the plan of correction.			
	The Credible Allega	tion for Immediate Jeopardy			
	-	ed on 07/03/18, which			
	removed the Immed	liate Jeopardy on 07/03/18.			
		ducted with nursing staff			
	-	y on 07/03/18. The staff			
		t in-services and trainings			
		omy care and documentation			
	-	e. Reviews of the in-service audits performed and facility			
		nade. An interview with the			
		2:45 p.m. revealed the			
		been reported to the North			
		ursing. An interview with the			
	Regional Vice Presi	dent of Operations on			
		n. revealed he had contacted			
		ment Organization for			
		ation of specific steps to be			
		cheostomy care and training.	<b>F 7 F</b>		7/44/40
F 759 SS=D	CFR(s): 483.45(f)(1)	Error Rts 5 Prcnt or More )	F 759	1	7/11/18
	§483.45(f) Medicatio	on Errors.			
	The facility must en				
	,				
		ation error rates are not 5			
	percent or greater;				
		IT is not met as evidenced			

Event ID: EYQG11

Facility ID: 953074

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPRON OMB NO. 0938-0
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED
		345376	B. WING		C 07/03/2018
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COI	
				2461 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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMPLETE E APPROPRIATE DATE
F 759	Continued From page	e 47	F 75	9	
		n, record reviews and staff 's medication error rate was		F 759	
	greater than 5% as e errors out of 25 oppo (Resident #90) review	videnced by 2 medication rtunities. 1 of 5 Residents wed had medication errors n of the medication pass. rate was 8 percent.		The process which led to this was determined to be that No to administer medications at time for Resident #90, resulti medication error rate greater	urse #3 failed the correct ing in a facility
	Review of medical re revealed she was add diagnoses of fracture diabetes, bipolar disc disorder, gastro-esop	cord for Resident #90		On 5/23/18, Resident #90 was by the assigned hall nurse ar reactions were noted from no administering the medication ordered time. On 5/23/18, the assigned nur	nd no adverse ot at the
	paraplegia, dysarthria Review of physician of administration record the following medicat	a, and osteoporosis. orders and the medication for Resident #90 revealed		the physician in the facility of assessment findings for Resi new orders were received. T reviewed chart for Resident # assessed Resident #90.	f the ident #90. No he physician
	milligrams (mg) by m disorder (8:00 AM & Depakote Sprinkles 5 at bedtime for bipolar 03/14/18 and Voltare topically to back and	outh twice daily for bipolar 12 noon) dated 03/14/18; 500 mg by mouth every night disorder (8:00 PM) dated n Gel 1 % apply 4 grams gel bilateral knees three times a 1, 12 noon, 8:00 PM) dated		On 5/23/18, Nurse #3 was pr retraining by the DON on me administration regarding adm medications at the correct tin on the resident s Medication Administration Record (MAR	dication ninistering ne specified า
	04/11/18. During observation of Nurse #3 on 5/23/18 observed administerii #90 that were schedu AM. During an interv PM on 5/23/18, when	f a medication pass with at 11:47 AM the nurse was ng medications to Resident Jled for 8:00 AM at 11:47 riew with Nurse #3 at 1:00		On 6/12/18, the Staff Facilita conducted a medication pass Nurse #3 to ensure all medic administered according to the physician s orders to include time specified on the MAR. On 6/12/18, a medication pass licensed nurses and medicat	s audit with ation was e e the correct ss audit for all

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
	CONTRECTION	BENTIFICATION NUMBER.	A. BUILDING	i	C	
		345376	B. WING		07/03/2018	
NAME OF P	ROVIDER OR SUPPLIER	•				
CUMBER	LAND 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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETIO	
F 759	stated she had a lot g had not been able to on time. She also sta the late administration medications to her Su She offered no resolu administration of Res In an interview with th 05/23/18 at 3:56 PM, expectation was that would be 0%. She ha administration until th The supervisor then y notified the physician orders for the omitted her expectation was t administered accordin and if there was a dis	going on this morning and get her medications passed ated she had not reported n of Resident #90's upervisor or to the physician. ution to the late ident #90's medications. ne Director of Nursing on	F 75		he DN), and all coording de the . The	

Event ID: EYQG11

Facility ID: 953074

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	MENT OF HEALTH AN S FOR MEDICARE &	MEDICAID SERVICES				RM APPROV 10. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	PLE CONSTRUCTION G	· · ·	TE SURVEY MPLETED C
		345376	B. WING		o	7/03/2018
AME OF PI	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP		
UMBERI	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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 759	Continued From page	2 49	F 7	59		
F 761 SS=D	Label/Store Drugs an CFR(s): 483.45(g)(h)	d Biologicals	F 70	<ul> <li>form, to ensure medication administered according to physician s orders to inclutime specified on the MAR concern identified during t immediately addressed by the ADON, and/or the SF notification of the physicia and/or providing additiona. The DON will review and i Medication Pass Audit form weeks, monthly for 1 mon acknowledge completion of the pass Audit forms to the Example the findings of the Pass Audit forms to the Example the findings of the pass Audit forms to the Examplementing changes as include continued frequen monitoring.</li> <li>The administrator and the responsible for the implement of the implement of the pass to include audits, in-services, and mutications.</li> </ul>	the ude the correct a Any areas of the audit will be the QI Nurse, to include in if applicable I staff training. nitial the ms weekly for 8 th to of the audit. the DON will Medication accutive Quality tee monthly for necens, and/or dressed by necessary, to cy of DON will be nentation of de all 100%	7/11/18
	§483.45(g) Labeling o Drugs and biologicals	of Drugs and Biologicals s used in the facility must be e with currently accepted s, and include the y and cautionary				

Facility ID: 953074

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	): 08/21/2018 / APPROVED ). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION		LETED
		345376	B. WING				C 03/2018
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				2	2461 LEGION ROAD		
COMBERI	AND NURSING AND RE	HABILITATION CENTER		F	FAYETTEVILLE, NC 28306		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		COMPLETION DATE
F 761	Continued From page	50	F	761			
			· ·	101			
	applicable.						
	§483.45(h) Storage o	f Drugs and Biologicals					
	\$483.45(h)(1) In acco	rdance with State and					
		lity must store all drugs and					
		compartments under proper					
		and permit only authorized					
	personnel to have acc	cess to the keys.					
	§483.45(h)(2) The fac	ility must provide separately					
		affixed compartments for					
		drugs listed in Schedule II of					
		orug Abuse Prevention and					
		nd other drugs subject to					
		he facility uses single unit					
		tion systems in which the					
		imal and a missing dose can					
	be readily detected.						
		is not met as evidenced					
	by: Based on observation	ns and staff interviews the			F 761		
		e a bottle of Humalog insulin					
		ulin syringe in a locked					
	medication cart (300 l				The process which led to this deficienc	v	
	medication carts.	-,			was determined to be that Nurse #2 fai	-	
					to secure a bottle of insulin and an		
	The findings included	:			unopened insulin syringe in the 300 ha	II	
					medication cart.		
		M Nurse # 2 was observed					
		s. The nurse locked the			On 6/15/18, Nurse #2 was in-serviced	-	
		ng a bottle of Humalog			the Director of Nursing (DON) on secu	-	
	-	art and an unopened insulin			medication to include insulin and insuli		
	syringe. She then en	tered a resident room.			syringes inside a locked medication ca when the cart is left unattended.	π	
		se #2 was conducted on					
		The nurse stated she should			On 5/29/18, a 100% audit of all		
	not have left the bottle				medication carts was completed by the		
	unopened insulin syri	nge on top of the medication			facility nurse consultant and the DON t	0	

Event ID: EYQG11

Facility ID: 953074

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DAT	O. 0938-039	
ND PLAN OI	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i	COM	PLETED	
		345376	B. WING		C 07/03/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
			2461 LEGION ROAD				
CUMBER	LAND NURSING AND RE	EHABILITATION 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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
F 761			F 76				
	<ul> <li>F 761 Continued From page 51</li> <li>cart unattended. The nurse then unlocked the medication cart and placed the medication and the insulin syringe into the cart.</li> <li>An interview with the Director of Nursing (DON) was conducted on 1/25/18 at 10:25 AM. The DON stated medications and syringes should be secured in the locked medication cart when unattended.</li> </ul>			<ul> <li>ensure all medication to include and insulin syringes were secur locked medication cart when lef unattended. There were no com noted during this audit.</li> <li>On 5/29/18, an in-service for 10 licensed nurses and medication including agency, was initiated Facilitator (SF) on medication s ensuring all medication to includ and insulin syringes were secur locked medication cart when lef unattended. The in-service will completed by 6/28/18. All newly licensed nurses and medication including agency, will be in-serv during orientation by the SF on storage and ensuring all medication include insulin and insulin syring secured in a locked medication left unattended.</li> </ul>	red inside a ft icerns 00% of all n aides, by the Staff torage and de insulin red in a ft be / hired n aides, //iced medication ation to ges were		
				All medication carts will be audi QI Nurse, the Resource Nurse, ADON twice weekly for 4 weeks weekly for 8 weeks, utilizing a M Storage Monitoring tool to ensu medications including insulin ar syringes are secured in the lock medication cart when left unatte areas of concern identified durin audit will be immediately addres QI Nurse, the Resource Nurse, ADON to include providing addi training. The DON will review and the Medication Storage Monitor acknowledge review and compl the audit.	and/or the s, then Medication are all and insulin ked ended. Any ng the ssed by the and/or the itional staff and initial ing tool to		

Event ID: EYQG11

Facility ID: 953074

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 08/21/2018 M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345376	B. WING				C / <b>03/2018</b>
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CUMBERI	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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 761	Continued From page	9 52	F	761			
F 812 SS=F	CFR(s): 483.60(i)(1)(2 §483.60(i) Food safet The facility must - §483.60(i)(1) - Procur approved or consider state or local authoriti (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using pr gardens, subject to co safe growing and food (iii) This provision doe from consuming foods	re food from sources ed satisfactory by federal, es. bod items obtained directly subject to applicable State ulations. s not prohibit or prevent roduce grown in facility ompliance with applicable d-handling practices. es not preclude residents s not procured by the facility. prepare, distribute and	F	812	The administrator and/or the DON will present the findings of the Medication Storage Monitoring tool to the Executive Quality Improvement (QI) committee monthly for 3 months. The Executive O Committee will meet monthly for 3 mor and review the Medication Storage Monitoring tool to determine trends and issues that may need further interventi put into place and to determine the need for further frequency of monitoring. The administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring rela- to the plan of correction.	QI hths d/or ons ed	7/11/18

Facility ID: 953074

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		ND HUMAN SERVICES MEDICAID SERVICES				RM APPROVE 10. 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345376	B. WING _		0	C 7/03/2018	
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE,			
			2461 LEGION ROAD				
CUMBERL	AND NURSING AND R	EHABILITATION CENTER		FAYETTEVILLE, NC 28306			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTIV CROSS-REFERENCE	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE	
F 812	Continued From pag	e 53	F	312			
	standards for food se						
		T is not met as evidenced					
	by:						
		ons and interviews, the facility		F 812			
		el food stored in the reach-in properly store scoops, failed			to this deficiency		
		food carts, failed to clean		The process which led was determined to be	•		
		arts, failed to clean open floor		implement processes	-		
		n table and failed to clean a		labeling of food in read	ch in refrigerator,		
	wall in the dishwashi	ing area.		proper storage of scoo			
	<b>T</b> I C II I I			sanitizing food carts, c			
	The findings included	d:		sanitizing utility carts, area below steam tabl	÷ .		
	A An observation of	f the reach-in refrigerator on		in the dish area.	e and cleaning wall		
		A revealed 2 unlabeled clear					
	plastic bags that con	tained a portion of bulk ham		On 5/21/18, the Dietar	y Manager		
		d cheese covered with clear		disposed and/or labele			
	wrap with no date.			food in the reach in rel			
	During an interview	with the Cortified Dictory		2/25/18, the dietary aid			
	-	with the Certified Dietary 8 at 4:25 PM, he stated it was		scoops in the proper a the dietary assistant cl			
	•	all open food items are dated		sanitized the food cart			
		ration date and name of food		5/23/18, the dietary as			
	item if removed from	the original container.		sanitized the utility car			
				dietary assistant clean			
		as made on 05/21/18 at		below the steam table			
		r, sugar and cornmeal bins ed directly in the food item.		dietary aide cleaned th area.	ie wall in the dish		
	During an interview	with the Certified Dietary		All dietary staff were ir	n serviced on		
		8 at 4:25 PM, he stated it was		5/25/18 by the Dietary	manager to ensure		
		scoops be stored in plastic		proper labeling of food	• • •		
	bags and labeled wit	h date on top of each bin.		scoops, cleaning and s			
	C An observation w	/as made on 05/21/18 at		carts, cleaning and sa cleaning open floor are			
		netal food delivery carts		table and cleaning wal			
		nch time to deliver meals to		All dietary staff, includ			
		cky brown substance and		Manager were re-train			
		The built up food debris		proper labeling of food			

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DA	NO. 0938-039 ATE SURVEY MPLETED
			A. BUILDING	<u> </u>		C
		345376	B. WING			07/03/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	P CODE	
CUMBERI	LAND 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 PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 812	Continued From page	e 54	F 81	2		
	covered approximate cart inside and outsid	ly 50 percent of metal food e.		scoops, cleaning and sar carts, cleaning and saniti cleaning open floor area	izing utility carts, below steam	
	Manager (CMD) on 0 stated it was his expe	vith the Certified Dietary 5/24/18 at 4:25 PM, he ectation that the food delivery and sanitized after breakfast,		table and cleaning wall ir utilizing the new Kitchen Tool.		
	that whoever was ass	als. The CDM further stated signed to unload the food sponsible for cleaning and livery carts.		On 6/13/18 the RVP train Administrator on how to a Kitchen Review Monitorin Dietary Manager, Assista	complete the ng tool. The	
	PM of 4 utility carts w food crumbs on the s			Manager and/or Adminis the kitchen for proper lab reach in refrigerator, prop scoops, cleaning and sar	peling of food in per storage of nitizing food	
	During an interview w Manager on 05/24/18 his expectation that th	rage containers were stored. vith the Certified Dietary at 4:25 PM, he stated it was ne utility carts be cleaned		carts, cleaning and saniti cleaning open floor area table and cleaning wall ir days a week for 4 weeks week for 4 weeks, then 2	below steam In the dish area 5 Is, then 3 days a	
	beverage containers			4 weeks. The Administrator and/or		
	12:40 PM of an open thick metal slotted co steam table containin and trash debris bene around the edges of o	as made on 05/21/18 at floor area covered with a ver (drain cover) below the g buildup of food particles eath the drain cover and drain cover. Observation		present the findings of th Monitoring tool to the Exc Improvement (QI) Comm 3 months. Any issues, co trends identified will be a implementing changes as	ecutive Quality nittee monthly for oncerns, and/or iddressed by s necessary, to	
		dor coming from the drain. 1 inches wide by 8 feet		include continued freque monitoring. The Administrator and th		
	Manager on 05/24/18 his expectation that the below the steam table weekly and as neede	with the Certified Dietary at 4:25 PM, he stated it was the floor area with drain cover be be thoroughly cleaned d. The CDM further stated of on the cleaning schedule.		responsible for the imple corrective actions to inclu audits, in-services, and n to the plan of correction.	mentation of ude all 100%	

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		345376	B. WING _				C 103/2018
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CUMBERI	AND NURSING AND RE	HABILITATION CENTER		24	61 LEGION ROAD		
COMBLICE				FA	YETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812	Continued From page	55	F8	812			
F 867 SS=F	PM of the wall behind dishwashing area of a on the wall and a sma from the wall. During an interview w Manager (CDM) on 00 stated it was his expe dishwashing area be needed. The CDM fur put in a work order to During an interview w 05/26/18 at 2:40 PM r expectation that the d sanitation guidelines t QAPI/QAA Improvem CFR(s): 483.75(g)(2)( §483.75(g) Quality as §483.75(g)(2) The qua assurance committee (ii) Develop and imple action to correct ident This REQUIREMENT by: Based on record revi	taught by the facility. ent Activities (ii) sessment and assurance. ality assessment and must: ement appropriate plans of ified quality deficiencies; is not met as evidenced ews, observations, and	F٤	867	F 867		7/11/18
	Assessment and Assu failed to maintain imp monitor the intervention place following the re- survey of 07/21/17 and	d the complaint survey of or 2 deficiencies originally			The process which led to this deficience was determined to be that the facility failed to maintain the implemented procedures and monitor the interventio and committee put into place for previo deficiencies:	ns	

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						O. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G		E SURVEY IPLETED
			A. BUILDING	J		С
		345376	B. WING		07	7/03/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		100/2010
				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	(EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETIC DATE
F 867	Continued From page	<del>2</del> 56	F 86	37		
		ese 3 deficiencies were	1.00	1.) 483.25: Free of Acci	dent	
		on the current recertification		Hazards/Supervision/De		
		5/26/18. The continued		failed to implement inter	-	
		uring 3 federal surveys of		prevent falls.		
		n of the facility's inability to		2.) 483.45: Free of Med	ication Error Rate	
		uality Assurance Program.		of 5% or More: The faci		
				error rate was greater th	nan 5% as	
	The findings included	:		evidenced by 2 medical	tion errors out of	
				25 opportunities during	observation of the	
	1. This tag is cross	referenced to:		medication pass.		
				3.) 483.60: Food and N		
	483.25: Free of Accid			The facility failed to pro		
	Hazards/Supervision/			failed to properly store s to clean and sanitize for		
		eview, and staff interviews, plement interventions to		clean open floor area be		
	-	sulted in multiple falls for 1		table and failed to clear		
	of 11 sampled resider	•		dishwashing area.		
	During the recertificat	tion and complaint survey of		On 6/13/18, the adminis	strator, Director of	
	07/21/17 the facility w	vas cited for failure to		Nursing (DON), Quality	Improvement (QI)	
	prevent 1 of 2 cognitiv	vely impaired residents with		Nurse, and the Dietary	Manager were	
		s from exiting a locked unit		educated by the facility	nurse consultant	
		n eloping from the facility via		regarding maintenance	-	
		he police found the resident		Assessment and Assura		
	on a busy street. The	e resident was not injured.		committee to include de		
	2 This too is cross	referenced to:		appropriate plans of act		
	2. This tag is cross			deficient areas and ens are implemented to ens	•	
	483 45° Free of Medi	ication Error Rate of 5% or		deficiencies are correct		
		ervation, record reviews and		administrators, DONs, (	•	
		cility's medication error rate		Dietary Managers will b		
	was greater than 5%			facility nurse consultant	-	
	-	of 25 opportunities for error		Regional Vice Presiden		
	during the observatio	n of the medication pass.		orientation regarding ma		
	During the compleint	auguar of 00/27/17 tha		Quality Assessment and		
		survey of 09/27/17 the ailure to assure morning		committee to include de		
		given per sliding scale order		appropriate plans of act deficient areas and ens		
		led residents, Resident #97,		are implemented to ens		

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345376	B. WING_				C 03/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	•	
	AND NURSING AND RE			24	61 LEGION ROAD		
CUIVIDERI	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 SC 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 867	Continued From page on five days.	2 57	F	367	deficiencies are corrected.		
	3. This tag is cross 483.60: Food and Nu observations and staf failed to properly labe refrigerator, failed to p to clean and sanitize and sanitize utility car area below the steam wall in the dishwashir During the recertificat 07/21/17 the facility w staff did not handle fo 1 of 1 meal observed During an interview co 3:33 PM the Administ multiple turnovers in H positions as well as so citations were different He continued by statist that they would re-exa	Attrition Services: Based on f interviews, the facility I food stored in the reach in properly store scoops, failed food carts, failed to clean ts, failed to clean open floor table and failed to clean a ng area. ion and complaint survey of vas cited for failure to ensure od with their bare hands for for Resident #52. onducted on 05/26/18 at rator stated they had key departmental staff ome of the aspects of the at that the previous citations . ng it was his expectation amine systems to find the es and address it with			deficiencies are corrected. On 6/13/18, the administrator, DON, Q Nurse, and the Dietary Manager were educated by the facility nurse consulta regarding the utilization of the Quality Assurance and Performance Improvement (QAPI) Plan to track and measure performance to include evaluation of each plan put into effect related to deficiencies and to ensure the concerns are resolved and do not reood All newly hired administrators, DONs, Q Nurses, and Dietary Managers will be educated by the facility nurse consulta and/or the RVP during orientation regarding the utilization of the Quality Assurance and Performance Improvement (QAPI) Plan to track and measure performance to include evaluation of each plan put into effect related to deficiencies and to ensure the concerns are resolved and do not reood On 6/14/18, the facility nurse consultar initiated a 100% audit of QI meeting minutes and action plans for past six months to ensure that the QI committe has maintained and monitored the interventions that were put into place. audit will be completed by 6/28/18. An concerns identified during the audit will immediately addressed by the facility consultant with the administrator and th DON to include revision of the QI actio plan, providing additional staff training needed, and increased monitoring is	nt aat cur. QI nt aat cur. t e The y I be ne n	

Event ID: EYQG11

Facility ID: 953074

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	-	ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 08/21/201 FORM APPROVE OMB NO. 0938-039
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345376	B. WING			C 07/03/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	
CUMBERL	AND NURSING AND RE	HABILITATION CENTER			I61 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 PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 867	Continued From page	58	F	367		
					All data collected for the areas of conc identified to include fall interventions, medication errors, and dietary services will be addressed by the Quality Assurance Committee (QA) with the administrator, DON, QI Nurse, and Dietary Manager in attendance, month for 3 months. The QA Committee will review the data and determine if the pl of corrections are being followed, if changes in plans of action are required improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the committee will be documented monthly each meeting by the QI Nurse. The Regional Vice President (RVP) wi ensure the facility is maintaining an effective QA program by reviewing the Executive Quality Improvement (QI) Committee meeting minutes and ensu implemented procedures and monitoring practices to address interventions, to include fall interventions, medication errors, and dietary services are followed and maintained Quarterly x2. The RVF the Facility Nurse consultant will immediately re-educate the administra DON, QI Nurse, and dietary manager any identified areas of concern. The results of the monthly QA committed meeting minutes will be presented by for administrator and/or the DON to the Executive QI committee quarterly x 2 for review and identification of trends,	s Ily an d to QA y at Il ring ng ed or tor, for tor, for
	7/02-99) Previous Versions Obs	olete Event ID: EV			development of action plans as indicat	

Event ID: EYQG11

Facility ID: 953074

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/21/20 FORM APPROV OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345376	B. WING		C 07/03/2018
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	·
CUMBERI	LAND NURSING AND RE	HABILITATION CENTER		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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETIO
F 867	Continued From page	e 59	F 867	to determine the need and/or frequen continued monitoring. The administrator and the DON will b responsible for the implementation of	e
F 908 SS=F		Safe Operating Condition	F 908	corrective actions to include all 100% audits, in services, and monitoring rel to the plan of correction.	
	and patient care equi condition. This REQUIREMENT by: Based on observatio interviews the facility commercial high temp temperature gauge w the manufacturer's in The findings included During the initial tour 1:00 PM the high tem dishwasher rinse tem 150 degrees Fahrenh During an observation indicated that the rins Fahrenheit with the u temperature test strip During an interview w on 05/24/18 at 4:02 F	failed to ensure the perature dishwasher rinse vas functioning according to struction. I: of the kitchen on 05/21/18 at perature commercial perature gauge was reading neit during the rinse cycle. In on 05/21/18 at 1:15 PM se cycle was at 180 degrees se of a dishwasher o.		F 908 The process which led to this deficient was determined to be the facility failed implement processes to ensure the commercial high temperature dishwas rinse temperature gauge was function according to manufacture instruction. On 5/25/18, the dish machine was inspected by Hobart and replacement parts were approved for the dish mac On 6/7/18, the facility began to use pa products based on the fact that the company made the decision to purcha a new dish machine instead of repairi existing unit. The facility will continue use paper products until new machine installed. On 6/13/18, all staff to include the Die Manager, were in serviced by the Administrator on the completion of wo	d to sher ning t thine. aper ase ng to e is etary

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DAT	OMB NO. 0938-03 (X3) DATE SURVEY		
		IDENTIFICATION NUMBER:	A. BUILDING	CON	COMPLETED			
		345376	B. WING		C 07/03/2018			
				STREET ADDRESS, CITY, STATE, ZIP CODE				
				2461 LEGION ROAD				
COMBLICE	MBERLAND NURSING AND REHABILITATION CENTER			FAYETTEVILLE, NC 28306				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE		
F 908	10:50 AM, he stated rinse and wash temp commercial dishwash stated that he was ra dishwasher. He was temperature gauge for functioning. Review of the "Food Report" completed by Section dated on 09/3 "Warewashing (clean and food-contact surf machines that provide rinse shall be equipped that measures and di the supply line immed warewashing machin not functioning according instructions. Warewas temperature measures strip to test temperature warewashing machin Review of a service r machine dated on 11 rinse pressure gauge booster heater. Review of a service r	with the DA #2 on 05/25/18 at that he was aware of the eratures on the high temp her. The DA #2 further rely assigned to the not aware that the or the rinse cycle was not Establishment Inspection y Environment Health 30/17 read in part hing and sanitizing of utensils faces of equipment) e a fresh hot water sanitizing ed with a pressure gauge isplays the water pressure in diately before entering the ne. The pressure gauge is ding to the date plate ashing machines, es device - Provide a test ure of the hot water in the ne." eport invoice for the dish /29/17 did not address the e and only addressed the	F 90		ete the cool. The ance will or 4 weeks, s, then 2 sure the properly. ON will nen e (QI) is. Any identified ting de ing. will be tion of 100%			
		ssure gauge was dated on or approval. facturer's instruction						
	An interview with the	Certified Dietary Manager						

Facility ID: 953074

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DEPART CENTER	PRINTED: 08/21/2018 FORM APPROVED OMB NO. 0938-0391								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345376	345376 B. WING				C 07/03/2018		8
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIF	P CODE			
CUMBERLAND NURSING AND REHABILITATION CENTER					2461 LEGION ROAD FAYETTEVILLE, NC 28306				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID		PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG		(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE		COMPLI DAT		
F 908	Continued From page	ntinued From page 61		= 908					
	(CDM) on 05/24/18 at 4:25 PM revealed that it was his expectation that the dietary staff use the			300					
	dishwasher temperati	ure test strips until the ssure gauge was							
	operational. He further stated that the dietary								
	in the notebook befor	ash and rinse temperatures e each cycle.							
	An interview with the	Administrator on 05/26/18 at							
		it it was his expectation that							
	the dishwasher be op manufacturer's guide								
		ines.							
FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: E			QG11	F	acility ID: 953074	If continu	ation sheet	Page 6	2 of 62