9104291710

11-09-2011

1 /10

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/28/2011 FORM APPROVED OMB NO. 0938-0391

CENTER	IS FOR MEDICARE &	MEDICAID SERVICES				OWR MC	) <u>. 0938-0391</u>
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDERSUPPLIERGUA IDENTIFICATION NUMBER;		ULTIPL LDING	LE CONSTRUCTION	(X3) DATE SUI COMPLET	ED
		345505	B. WAA	10		1	C 4/2011
MAUE OF DE	SALERTO AM PLINDITED			T.		1011	472411
KAME OF PE	ROUDER OR SUPPLIER				EET ADDRESS, GITY, STATE, ZIP COOE 500 CUMBERLAND ROAD		
CAROLIN	A REHAB CENTER OF C	UMBERLAND '		1	AYETTEVILLE, NC 28308		
				<del></del>		1011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LBC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAY OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REPERENCED TO THE APPRI DEFICIENCY)	LD BE OPRIATE	(X5) COMPLETION DATE
					The statements include		)
F 323			F	323	an admission and do no	ot	
SS=J	HAZARDS/SUPERVI	SION/DEVICES		1	constitute agreement w	ith the	
			-	1	alleged deficiencies he		
	The facility must ensu	as free of accident hazards	1	- 1	The plan of correction		
	as is possible; and ea			1			
		and assistance devices to		- 1	completed in the comp	nance of	
	prevent accidents.				state and federal regula	uons as	
				I	outlined. To remain in		
				- 1	compliance with all fed		
	`				state regulations the cer		
	This REOLIBEMENT	' is not met as evidenced			taken or will take the ac	tions set	
	by:	in the file on o vice in the		l	forth in the following p		
	Based on observatio	n, record review and staff			correction. The follow	กอ กโลก	•
		falled to ensure safe			of correction constitute	the Pint	
		Resident#1) sampled			center's allegation of	uic	
		in a wheelcheir in the facility				•	
	tan, that resulted in r floor of the van during	Resident #1 falling in the	1	l	compliance. All allege		
	liber of fite set only f	у напарин.		i	deficiencies cited have		
	Immediate Jeopardy	began on 7/5/11 and was		l	will be completed by th	e dates	
		at 12:36 PM, Immediate	l	l	indicated.		
		ed on 10/14/11 at 1:10PM,		ŀ			
		ided a credible allegation of			F323 How corrective a	ction	
	compliance. The facil		1	1	will be accomplished f		
		e and severily level of D (no ntiel for more than minimal			resident found to have	bass :	
		ediate jeopardy) the facility		1			
		full implementation and		- 1	affected by the deficien	IT	
		ctive action. Findings			practice —		7/5/2011
	include;	•		Ī	On 7/5/11, patient A.T. was		7/5/2011
		-112d 4 th fillt			transported from appointme	nt. During	
	Resideni #1 was adm 6/21/11. Cumulative d	litted to the facility on			transportation, patient slid f	rom chair.	
	Right/Left below Kne			I	Transportation alde immedia		
		knass, Cerebrovascular		-	called DON, who advised ald		
		menila, End Slage Renal			911 since the aide needed as		
	Disease and Alrial Fit	orliation (A-Flb).			In getting the patient back u	to the	
					chair and also to rule out po	sible	
ABORATORY,		SUPPLIER REPRESENTATIVES SIGNATURE	1		Injury. TITLE		(M) DATE
UU	in rriu	TW RN OON			Director of No	irsing	

Any deficiency statement ending with an extensk (\*) 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 periodipation.

FORM CMS-2587(02-99) Previous Versions Obsolete

Event10;0M8211

Facility 10; 980423

If continuation sheet Page 1 of 10

2/10

9104291710 03:46:41 p.m. 11-09-2011 2/10

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 10/28/2011 MAPPROVED D: 0938-0391
STATEMENT OF DEFICIENCIES (X1)		(X1) PROVIDENBUPPLIERCLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		345505	e, wi	NG_		ı	C 4/2011
		5,1025	l	Τ	WEST ABBRETT AME STATE WHARDS	1 1971	7,2911
NAMEOFIA	OVIDER OR SUPPLIER			0	TREET ADDRESS, CITY, STATE, ZIP CODE 4800 CUMBERLAND ROAD		
CAROLIN	A REHAB CENTER OF C	UMBERLAND			FAYETTEVILLE, NC 28308		i
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG	łΧ	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	DATE DATE
F 323	Continued From page	÷1	#	32	3 EMS arrived and transported	'natlent	
		sion.weight workeheet d Resident#j ' e welght			to emergency room to assess Patient returned to facility at approximately 10:30 PM on 1	patient. 7/5/11	
	form dated 6/22/11 in	aion fail risk assessment dicafed the resident was o a bilateral (both) emputes.	WWWWW.		and without complaints of pa injury. 24-hour and 5-day re submitted to state on transp alde for possible neglect.	oort	7/3/201
	short and long term n severely impaired will totally dependent will assistance for transfe one person physical unioff the unit. The M transition and welking	um Data Set (MDS)  i Indicated Resident #1 had namory problems, and was h decision making. He was n two plus person 's physical or and totally dependent with assistance with locomotion IDS indicated balance during y did not occur. He was nant to the lower extremity			Transportation aide was susp order for investigation to con cause of patient fall. Investiga concluded and did not warran termination of the employee not substantiate the neglect allegation.	clude on Itlon It the	
	and used a wheelche A review of the nurse 10:04 PM revealed R within the transportet to the facility from dia indicated). The reside location (where the re EMS (Emergency Me evaluated). A review of the emer-	Ir for mobility.  's notes dated 7/6/11 at esident #1 sustained a fall for van while in route back elysis (time of fall not ent was transferred from the esident fall) to the hospital by edical Services) to be			How corrective action y accomplished for those residents having the poto be affected by the saideficient practice—Facility owned van taken out Immediately and permanentl Transportation aide assumed CNA on the unit. Transportationger provided by the facility	tential ne of use y. rale of	
***************************************	Atrial Fibrillation (A-F EMS arrival at the loo presented to the eme complaints of a fall/a Indicated with a prim	dent #1 was disphorelle, in ib) with a pulse of 140, upon callon. The resident argency room with chief -fib. Discharge condition was ary diagnosis of A-Fib with lar Response) secondary to			contracted through Victory Trensportation, inc. Families encouraged to transport pati when possible. Completion		7/5/201

FORM CM8-2567(02-09) Provious Versions Obtolets

Event ID; 01/4211

Fadily 10: 060423

If continuation sheet Page 2 of 10

DEPARTMENT OF HEALTH AND HUMAN SERVICES

03:37:40 p.m. 11-09-2011 3 /10

PRINTED: 10/28/2011 FORM APPROVED OMB NO. 0938-0391

CENTER	S FUR MEDICARE &	MEDICAID SERVICES				Office 160	J. 11930-U38 I
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345505	B, WING	i			<i>4</i> /2011
•	NOVIDER OR SUPPLIER	UMBERLAND	1	460	ET ADDRESS, CITY, STATE, ZIP CODE 10 GUNBERLAND ROAD		
0,11,02	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			FAY	YETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST DE PRECEDED BY FULL LEC IDENTIFYING INFORMATION)	ID PREFI) TAG	•	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	DATE COMPLETION (X5)
F 323	overell clinical impression of the Resident #1 nursing facility on 7/5 prescription for potes milliequivalent sustain physical injuries were A review of the facility 7/5/11 indicated the fiby the Director of Nu with NA (Nurse Alde) telephone. The residificant the hospital on pain. As a result of the documented the residence of the employ the DON on 7/6/1 suspended due to resident during transport as a secured in ven. * The corrective action was unsubstantiated by the Toler of the employ of the post of the post indicated Resident # Injury with abrasion with 4x4 gauze covered to the post 8/24/11 revealed a c	elemia (low potessium). The sisten revealed the A-Fib was was discharged back to the 7/11 in stable condition, with a sium chloride 20 med-release tablets. No bindicated.  y investigation completed on all incident was investigated raing (DON) and discussed #1 (transporter) via ent returned to the facility 1/6/11 at 10:30 PM with no he incident, it was dent returned with a skin KA.  Dyee corrective action taken 1 stated NA#1 was Foliure to assure sefety of portation, performance of the resulting in a situation fere of a patient. Resident fell result of being improperly a documented as the administrator dated  aled 7/14/11 at 4:50 PM 1 "Did have a new skin noted to left BKA anteriory	F3	323	Victory Transport can transport Chair and 1 small Whee (20in) at the same time. An requiring a Wheelchair greatinches will be transported be EMS.  Completion 4/25/2  Patients that require transporte assessed on admission using the "Ticket to Ride asform" (see attached) for the appropriate type of transported to Victory Transport. Dono Managers will audit Ticket to form completion, and verificiate to Victory transport, are sident was transported appropriately based on asseneds, 2 patients per week Audits will be reviewed at with management meeting and round the propriately based on the completion of	ches) or 1 clchair y resident ter than 30 y County col1 cortation and PRN sessment e ortation, oe provided or Unit co Ride y a copy and that essment X 4 weeks. yeekly risk nonthly or concern clon ager or	10/14/

FORM CMS-2557(02-00) Previous Versions Obsolele

Event ID; OM6211

Facility 10: 060423

If continuation sheet Page 3 of 10

٠,

9104291710

4/10

4 / 10

03:38:47 p.m. 11-09-2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE/SCUA IDENTIFICATION NUMBER;

AND PLAN OF CORRECTION

NAME OF PROVIDER OF SUPPLIER

PRINTED: 10/28/2011
FORM APPROVED
OMB NO. 0938-0391

[X2] MULTIPLE CONSTRUCTION
A BUILDING

C

10/14/2011

NAME OF PROVIDER OF SUPPLIER

B. WANG		(	C				
		345505	B. VAN	G	10/14		4/2011
NAME OF PROVIDER OR SUPPLIER CAROLINA REHAB CENTER OF CUMBERLAND			STREET ADDRESS, CITY, STATE, ZIP CODE  4500 CUMBERLAND ROAD  FAYETTEVILLE, NC 28305				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSG IDENTIFYING INFORMATION]	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CHOSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	CONSTRUCTION CONSTRUCTION
F 323	fall) to transport reside appointments to prevent appointments to prevent appointments to prevent appointments to prevent appointments to free appointment of the facility van been used Resident #1 's fell in previously (no date gives a facility van been used Resident #1 twice wit resident positioned a center of the facility viocated in the van. Nothe dialysis canter the needed to be transported to transported to transported in the positioned Resident #1 and Realtempted to transported in the positioned Resident #1 in the had difficulty get due to the wideness Resident #1. She ele was positioned in the enough to make a laput the lap belt across shoulder. She also in positioned in the whole in the wideness and the put the lap belt across shoulder. She also in positioned in the whole in the wideness and the put the lap belt across shoulder. She also in positioned in the whole in the whole in the wideness and the put the lap belt across shoulder. She also in positioned in the whole i	ents to all future dialysis ent further fall occurrences.  11/11 at 11:55 AM, NA#1 d she had transported continents for the facility for s. She stated she was no or the facility, nor had the d to transport residents since July 2011, NA#1 added liven) she had transported shout any problems, with the and securely strapped in the an, with no other residents A#1 added upon arrival at are were two residents that arted back to the facility	F	323	Facility transportation needs vereviewed by the QA committee Victory Transportation was confor their safety requirements a result, Victory provided the following for transportation safety.  Cond/25/2011  Any driver found negligent or compliance with company's sapplicles and procedures will be immediately terminated.  In the event of an accident or emergency the following steps taken:  If any injury occurs to a patient driver should immediately call regardless if they can visualize injuries, and notify health care.  Wait for law enforcement. Do move vehicle until authorized enforcement or the situation of the conforcement or the situation of the conforcement or the situation of the situation of the conforcement of the supervisor upon return to official accident record.	e and nsidered and as a llowing npletion not in afety a an s will be t the 911, any a facility, not by law dictates as soon on to	4/25/11

FORM CMS-2687(02-99) Previous Versions Obtolele

EventID: DM8211

Fadity ID: 080423

if continuation sheet Page 4 of 10

DEPARTMENT OF HEALTH AND HUMAN SERVICES

03:39:53 p.m. 11-09-2011 5/10

PRINTED: 10/28/2011 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391	
OF DEFICIENCIES	(XI) PROVIDENSUFFLIENCLIA IDENTIFICATION NUMBER:	' '			COMPLETE	ED C
345505		B. WA	IG	<del></del>	_	; ;;2011
			48	600 CUMBERLAND ROAD		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSG IDENTIFYING INFORMATION)			iX.	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO	SHOULD BE COUPLETICE	
of the lower frame of hooks boiled to the fi revealed while in rou she made a left turn was positioned in the He is falling. "Upon Indicated she saw Redownward. Then, she observed the resident his bultocks in front obeit positioned under neck, with his head p She added she push lap beit. Thereafter, it back to the facility an happened. She state (DON) called her bac instructed and Resid hospital to be evalual proceeded back to the facility van. Muncomfortable for two large residents/large van due to the lap be support the resident stated she did not rebecause she was fer (transporter) added a the former Oirector of in the facility van hir her how to securely wheelcheir, She indicate return demonst competency with safe	the wheelchair to the metal cor of the van. NA#1 te back to the facility when she heard Resident #11 who center of the van state, " looking in the rear mirror she stdent #1 's head going a pulled the van over and it positioned on the floor on of the wheelcheir, with the lap habit arm, across his resilioned leaning backward, ed the button to release the YA#1 indicated she called informed what had he Director of Nursing is and instructed her to call she then colled 911 as ent #1 was transported to the led. Afterwards, she has facility with Resident #11 with concluded she felt or years while transporting wheelchairs in the facility old was not tight enough to during transport. NA#1 port this concern to anyone arful of losing her job. NA#1 approximately 4 years ago if Nursing installed seat belts have a gerichair and cated she was not asked to ration to validate her rely securing a wheelchair or	F	323	by management or the heal facility to be a first ald resp driver will not provide first the patient as comfortable until medical help arrives.  Upon Health Care Facility in Nurse Manager, DON or At will notify Responsible partemergency contact.  Mensures to be put in systemic changes made ensure practice will in re-occur facility suspended use of fowned van immediately as permanently.  7/5/2011  Transportation provided to Victory Transportation, incompletion 4/25/2011  Implementation of a driver reward/incentive program safe driving an integral partemponsibilities, including stresponsibilities, including stresponsibilities.	ith care onder, the ald. Make as possible  notification, iministrator ty or  a place or de to not  acility ad  Completion hrough Victory s policies:  to make t of the  raining and safety strap	4/25/10 4/25/10
	CONTECTION  TOWOER OR SUPPLIER  A REHAB CENTER OF CONTENT OR SUMMARY STREET OR SUMMARY STREET OF CONTENT OR SUMMARY STREET OR SUMMARY OR SUMM	OF DEFICIENCIES CORRECTION  (X1) PROMDER/SUPPLIER/CLIA IDENTIFICATION MUMBER:  345505  ROYDER OR SUPPLIER A REHAB CENTER OF CUMBERLAND  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FIAL	TOP DEFICIENCIES CORRECTION  (X1) PROVIDENSUPPLENCIA (DENTIFICATION NUMBER:  345505  ROMOBER OR SUPPLIER  A REHAB CENTER OF CUMBERLAND  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FIAL REGULATORY OR LSG IDENTIFYING INFORMATION)  Continued From page 4  of the lower frame of the wheelchair to the matal hooks boiled to the floor of the van. NA#1 revealed while in route back to the facility when she made a left turn she heard Resident #11 who was positioned in the center of the van stale,  He is falling. ** Upon looking in the rear mirror she indicated she sew Resident #1 *s heard going downward. Then, she pulled the van over and observed the resident positioned on the floor on his buttocks in front of the wheelcheir, with the lap belt positioned under his left arm, across his neck, with his head positioned leaning backward. She added she pushed the button to release the lap belt. Thereafter, NA#1 indicated she called back to the facility and informed what had happened. She stated the Director of Nursing (DON) called her back and instructed her to call 911. NA#1 revealed she then colled 911 as instructed and Resident #1 was transported to the hospital to be evaluated. Afterwards, she proceeded back to the facility with Resident #11 in the facility van, NA#1 concluded she felt uncomfortable for two years while transporting large residents/large wheelchairs in the facility van due to the lap belt was not tight enough to support the resident during transport. NA#1 stated she did not report this concern to anyone because she was fearful of losing her job. NA #1 (transporter) added approximately 4 years ago the former Director of Nursing installed seat belts in the facility van himself and verbally indicated to her how to securely strap a gerichair and wheelchair. She indicated she was not asked to do a return demonstration to velidate her competency with safely securing a wheelchair or	TO DEFICIENCIES CORRECTION  (X1) PROVIDERUSUPPLIERCLIA DENTIFICATION NUMBER:  345505  ROMDER OR SUPPLIER  A REHAB CENTER OF CUMBERLAND  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PALL REGULATORY OR ISC IDENTIFYING INFORMATION)  Continued From page 4  of the lower frame of the wheelchair to the metal hooks bolled to the floor of the van. NA#1 revealed while in route back to the facility when she made a left turn she heard Resident #11 who was positioned in the center of the van stale, " He is falling, " Upon looking in the rear mirror she indicated she saw Resident #1 's haad going downward. Then, she pulled the van over and observed the resident positioned on the floor on his bultocks in front of the wheelcheir, with the lap belt positioned under his left arm, across his neck, with his head positioned leaning backward. She added she pushed the button to release the lap belt. Thereafier, NA#1 indicated she called back to the facility and informed what had happened. She stated the Director of Nursing (DON) called her back and instructed her to call 911, NA#1 revealed she then colled 911 as instructed and Resident #1 was transported to the hospital to be evaluated, Afterwards, she proceeded back to the facility with Resident #11 in the facility van, NA#1 concluded she felt uncomfortable for two years while transporting large residenta/large wheelchairs in the facility van due to the lap belt was not tight enough to support the resident during transport. NA#1 stated she did not report this concern to anyone because she was fearful of losing her job. NA#1 (transporter) added approximately 4 years ago the former Director of Nursing installed seat belts in the facility van himself and verbally indicated to her how to securely strap a gerichair and wheelchair, She indicated she was not asked to do a return demonstration to validale her compotency with safely securing a wheelchair or	DEFINITE HORSE TO BE THE CAND HUNDER TO BE PRECISE TO BE STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306  SUMMARY STATEMENT OF DEFICIENCIES (CANDER PRECISE) THAT REGULATORY OR IS SIDE/THYNIO INFORMATION TAGE (CANDER PRECISE) THAT REGULATORY OR IS SIDE/THYNIO INFORMATION TAGE (CANDER PRECISE) TO THE AFM DEFICIENCY)  Continued From page 4 of the lower frame of the wheelchair to the metal hooks belied to the floor of the van. NA #1 revealed while in route back to the facility when she made a left turn she heard Resident #11 who was positioned in the center of the van stelo." He is falling. "Upon looking in the rear rithror she indicated she saw Resident #1 * heard going downward. Then, she pulled the van over and observed the resident positioned on the floor on his buttocks in front of the wheelchair, with the lap bell positioned under his left arm, across his neck, with his head positioned on the floor on his buttocks in front of the wheelchair, with the lap bell. Thereafter, NA #1 indicated she colled back to the facility and informed what had happened. She stated the Director of Nursing (DON) colled her back and instructed her to call grow and to the lap bell was not light enough to support the resident during transport and tight enough to support the resident during transport and tight enough to support the resident during transport and wheelchair, she indicated she was not asked to a return demonstration to validate her composency with safely a years ago the former Director of Nursing installed seat bells in the facility van himself and varbally indicated to her how to securely strps a gerichair and wheelchair, she indicated she was not asked to a return demonstration to validate her composency with safely accurring a wheelchair or responsibilities, including a responsibilities, including transportion of driver to responsibilities.	TO DEPOINT INCOMPLES TO DEPOIN

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/28/2011 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES						Civilo 190	, uaaa-uaa i
	of Deficiencies Correction	(XI) PHOVIDER/SUPPLIER/CUA  DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SUI COMPLETI	
					· · · · · · · · · · · · · · · · · · ·	(	;
		345505	B. WIN	G		10/1	1/2011
NAME OF PR	OVIDER OR SUPPLIER			err	EET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
		·			DO CUMBERLAND ROAD		
CAROLINA	CAROLINA REHAB CENTER OF CUMBERLAND			F/	ayetteville, NC 28306		
IVIND	TP VGAULUS	ATEMENT OF DEFICIENCIES	(i)		PROVIDERS PLAN OF CORRECT	ON	0(5)
(X4) IO PREFIX		Y MUST BE PRECEDED BY FULL	PREF	X	(EACH CORRECTIVE ACTION SHOU	LD BE	CONSTELLON CONSTELLON DATE
DAT	regulatory or i	BC IDENTIFYING INFORMATION)	TAG		Cross-referenced to the Appro Deficiency)	PHATE	DATE
			<del> </del>				
F 222	O	. r	_	202	Frequently communicate safe	ty to	
F 323			F	323	drivers via email and training		
Ì		e positioned Resident #1 in	Ī				
		day of the fell on 7/5/11.	[		Education of drivers upon hir	a. nnce	
		n in the facility van, NA#1 used for demonstration was			per month for 3 months and		
		t #1 's wheelcheir. The			quarterly thereafter		
		int #1 was positioned behind	[		descent menories		
		ne 'a faft arm facing the			Upon hire each driver is requi	red to	
		o bench seat). The lower		1	learn how to safely get a path		
		air was secured to the floor			and out of the vehicle and ho		
		points (left front, right front			properly secure the patient in		
		ower back frame of the			wheelchair inside the vehicle,		
		was not secured to the floor			<u>.                                      </u>		
		ended a long (single) lap belt			to use the FE500 Series Syste		
		he floor of the van (left side or the back wheel) and was			Applications, which includes t		
		wheelchair arm rest, under			and rear tie-downs that are u		
		e chest/ight shoulder and	l		securing the wheelchair and t		
		le buckle belt that dangled	]		and shoulder belt that is used		
		the resident (suspended			secure the patient. Victory Ti		
		an). The lap belt was			uses the operation instruction		
	observed to be loose		1		are <u>recommended by</u> the con	' ' 21	
	tightness or resistanc	e if one leaned forward,			SURE_LOK. A copy of the ope	ration "	
	Highes on Liberton -	n 40149144 nt 9:40 AM with			instructions is attached,		•
		n 10/12/11 at 8:10 AM with N regarding NA #1 ' s					
	employee's file rave				In the event that an incident :	occurs,	
		mpetency/validation training			.Any deficient practice or con		
		ents in the facility van. The			be addressed at the time of t	ne	
	administrator indicate	d she would have the			occurrence. These results will	l be	
	former DON who pre	sently worked at the			presented to the Quality Assu	rance &	
		all her a stalement regarding			Assessment committee risk		
		copy of the training was not			management weekly, and mo	nthly for	[
	provided during the s	prvey investigation).	1		any additional recommendati		
	In an inlandaus an 471	/12/11 at 8:15 AM, the			Administrator responsible.		1
		d she was unable to locale				- 1	
	the facility 's van ope		ł		1	1	
		secure the seat belts in the				+	
							<u> </u>

FORM CMS-2587(02-99) Previous Versions Obsolets

Event ID: 01/0211

Facility ID: 080423

If continuation sheet Page 6 of 10

03:42:06 p.m. 11-09-2011

7 /10

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**  PRINTED: 10/28/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION DENTIFICATION NUMBER:  A BUILDING		(X3) DATE SUF COMPLET			
		345605	B. WNG	<del></del>		3
	on agen on assets left	340005			10/1	4/2011
NAME OF P	ROVIDER OR SUPPLIER		1	et address, city, state, zip code 90 Cumberland Road		
CAROLIN	A REHAB CENTER OF C	UMBERLAND	1	YETTEVILLE, NC 28308		
(X4) IO PREFIX TAG	(EAC) DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST DE PRECEDED BY FULL BC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAY OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCE) TO THE APPRO DEFICIENCY)	DBE	CONSTE
F 323	In an interview on 10/ (transporter) indicated to transport two residing callity van back from the size of Resident in her to secure the resident intoughts the straps were not tight, hopeful have far to go " prior back to the facility, from the facility in the facility in the facility added she discussed after Resident in the facility and the f	12/11 at 11:55 AM, NA#1 If It was not unusual for her ents at one time in the dialysis. She added it was that made if difficult for dent. NA#1 stated "I had sere not secure, the streps sily it will work, we don't to transport of the resident on the dialysis center.  13/11 at 8:10 AM, the two revealed the corporate copy of the operational 's van. The administrator with the corporate office fail, the van needed to be fon to prevent any potential it administrator) revealed she her transport of Resident #1 administrator) revealed she her and parellel to the bench belt streps were loose when the dialysis center.  of the interviewed due to the skied in the facility. It is notified of the immediate of compliance on 10/13/11	F 323	How facility will monito corrective action(s) to endeficient practice will not occur- Facility no longer uses facility van.  Completion 7/5/2011 Transportation provided thro Victory Transportation, inc. Vi Transport has the following procompletion 4/25/2011  Implementation of a driver reward/incentive program to safe driving an integral part of company  Documentation of driver train responsibilities, including safe checklist (done quarterly and Frequently communicate safe drivers via email and training Education of drivers upon himper month for 3 months and quarterly thereafter Upon hire each driver is required in how to safely get a pation of the vehicle and he properly secure the patient in	nsure of re- owned  ugh ctory olicles: make f the ling and ety strap prn ety to sessions e, once then ired to ent in w to	4/25/11

FORM CM5-2667(02-99) Pravious Versions Obsolets

EventID: ON0211

Facility (0: 980423

If continuation sheet Page 7 of 10

03:43:02 p.m. 11-09-2011 8/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/28/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION ID	DENTIFICATION NUMBER:	A BUILDING			1
		7. 00.00,110		l c	
	345505	B, WING		10/14/2011	
NAME OF PROVIDER OR SUPPLIER  CAROLINA REHAB CENTER OF CUMBERLAND		48	ESTADDRESS, CITY, STATE, ZIP CODE 100 CUMBERLAND ROAD NYETTEVILLE, NO. 28306		:
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY DR LEC IDE	BE PRECEDED BY FULL	ID PREFIX YAG	PROVIDER'S PLAY OF CORRECT (EACH CORRECTIVE AUTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TO BE CONFLET	TIOH
F 323 Continued From page 7 Indicated: Address how the corrective accomplished for those resibeen affected by the deficie On 7/5/11, patient was bein appointment. During transp from chair. Transportation acailed DON, who advised a the alde needed assistance back up to the chair and als injury.  EMS arrived and transported emergency room to assess returned to facility at approx 7/5/11 and denied pain. 24-submitted to state on transpossible neglect. Transport suspended in order for inversion cause of patient fail. Invend did not warrant the term employee and did not substallegation.  How corrective action will be those resident having potenthe same deficient practice. Facility owned van taken of Transportation aide assum unit. Transportation aide assum unit. Transportation no long facility-owned van, and is contracted transpossible. Completion 7/6/2  (Contracted transportation statement that they can transpossible. Completion 7/6/2	Idents found to have ent practice:  Ing transported from portation, patient slid elde immediately elde to call 911 since en getting the patient so to rule out possible ed patient to a patient. Patient eximately 10:30 PM on the control of the estigation to conclude estigation to conclude estigation to conclude mination of the eleminate the abuse estigation to be effected by estigation to the eleminate the abuse estigation to entitle to be effected by estigation to conclude mination of the eleminate the abuse estigation to entitle to be effected by estimated through esportation company), ensport patients when eleminated through esportation company).  Company) provided ensport 2 Wheelcheirs	F 323	wheelchair inside the vehicle, to use the FE500 Series Syster Applications, which includes the and rear tie-downs that are used securing the wheelchair and the and shoulder belt that is used secure the patient. Victory Truses the operation instruction are recommended by the consumer of the operation instructions is attached.  In the event that an incident of the event that the time of the event that the event that the event of the event of the event that victory the event that victory that in the event that victory that unable to transport, County be contacted to provide transportation.	ns-Track the front, sed in the lap to ansport as that apany ration  cccurs, cern will le l be larance & anthly for ons.  ry river ong and drs' safety written de ver quarterly mas. asport is	

FORM CMS-2507(02-89) Previous Versions Obselete

Eventio; Oliezti

Fadily ID: 980423

If continuation sheet Page 8 of 10

/10

PRINTED: 10/28/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (XZ) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C B. WNG 346605 10/14/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4500 CUMBERLAND ROAD CAROLINA REHAB CENTER OF CUMBERLAND PAYETTEVILLE, NC 28306 BUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION CONSTELLON (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY Patients that require transportation F 323 F 323 | Conlinued From page 8 are assessed on admission and PRN Wheelchelr (20 in) at the same time. Any resident using the "Ticket to Ride assessment requiring a wheelchair greater than 30 inches will form" (see attached) for the be transported by County EMS. Completion appropriate type of transportation. 10/14/11 Copy of Ticket to Ride will be provided Patients that require transportation will be to Victory Transport. Don or Unit assessed on admission and PRN (as needed) Managers will audit Ticket to Ride using the "Ticket to Ride assessment form" for form completion, and verify a copy the appropriate type of transportation. Copy of given to Victory transport, and that assessment will be provided to (contracted resident was transported transportátion company). DON or Unit Managers appropriately based on assessment will audit assessment completion, and verify a needs, 2 patients per week X 4 weeks. copy given to (contracted transportation company), and that was transported appropriately Audits will be reviewed at weekly risk based on assessment needs. 2 patients per week management meeting and monthly X 4 weeks. Audits will be reviewed at weekly risk QA X 1. Any deficit practice or concern management meeting and monthly QA (Quality will be discussed for further Assurance) X 1. Any deficit practice or concern recommendations. Completion will be discussed for further recommendations. 10/14/2011 Don, Unit Manager or DON, Unit Manager or House Supervisor House Supervisor responsible. responsible, Completion 10/14/2011 Address what measures will be put in place or systemic changes made to ensure that the delicient practice will not occur: Facility no longer uses transportation facility owned van. Completion 7/5/2011 Indicate how the facility plans to monitor its performance to make sure solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and eustained. The plan must be implemented and the corrective action evaluated for its

FORM CUB-2567(02-99) Prayious Versions Obsole(s

effectiveness. The POC is integrated into the quality assurance system of the facility:

Event(D:OM821)

Facility 10: 980423

If continuation sheet Page 8 of 10

10/10

PRINTED: 10/28/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C D. WING 346505 10/14/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4800 GUNBERLAND ROAD CAROLINA REHAB CENTER OF CUMBERLAND **FAYETTEVILLE, NC 28308** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (XII) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY Continued From page 9 F 323 Facility no longer uses facility owned ven. Completion 7/6/2011 The allegation of compliance was verified on 10/14/11 at 1:10PM, as evidence by interviews with facility stelf/contracted transportation agency staff related to: the maximum size wheelchair a resident could be transported in, the facility procedure for residents who regulred transport in a wheelchair greater than 30 inches, the facility process for the ticket to ride when transportation arrived at the facility for transport of the residents to appointments. Observations of the pick up process included observing the contracted agency arrival at the facility, pick up the ticket to ride form from the nurses station (prior to transport of the resident). Each nurse 's station had a ticket to ride binder located at each nurse 's station with specific information how the resident was to be transported. The ticket to ride identified the resident, room number, type of transport, any special considerations and a signature by the nurse and initial of the transporter. A copy was given to the transporter upon initial for transport in the presence of the nurse releasing the resident.

FORM CMS-2567(02-99) Previous Versions Obsolets

Eventin; OMA211

Facility IO: 850423

If continuation sheet Page 10 of 10