CENTERS	OR MEDICARE & MEDICAID SERVICES			"A" FORM
STATEMENT C	F ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER#	MULTIPLE CONSTRUCTION	DATE SURVEY
NO HARM WIT	H ONLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	COMPLETE:
FOR SNFs AND	NFs	345505	B. WING	5/9/2013
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, S	•	
CAROLINA REHAB CENTER OF CUMBERLAND		4600 CUMBERLAND FAYETTEVILLE, NC		
ID PREFIX				

TAG

SUMMARY STATEMENT OF DEFICIENCIES

F 157

483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)

A facility must immediately inform the resident consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in \\$83.15(e) (2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the residents legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:

Based on record review, staff interviews, and family interview, the facility failed to notify the legal representative that while care was provided the staff lowered 1 of 1 resident (Resident #81) on to the floor. The findings included:

Resident #81 was admitted into the facility on admitted 12/9/08. Diagnoses included Abnormal Posture and Dementia. The annual minimum data assessment dated 3/12/13 indicated Resident #81's short and long term memory was impaired Extensive assistance of one person physical assist was required with transfers

A review of the nurse's note completed by Nurse #1 written on 5/1/13 at 4:31 pm read in part "All activities of daily living by staff, resident usually stand for changes - did not do today. Unable to stand with one or three assist."

In an interview on 5/8/13 at 12:29 pm, NA #2 accompanied by the director of nursing (DON) revealed that toward the end of April 2013 - beginning of May 2013 (could not recall the specific date) between 11:00 am - 11:30 am, she provided incontinence care to Resident #81 by herself while standing Resident #81 up at the foot of the bed. NA #2 stated Resident #81 became resistant; the broda chair was positioned too far away from Resident #81; so she lowered Resident #81 on to the floor on her buttocks while yelling for help due to she could no longer hold the resident.

In an interview on 5/8/13 at 12:39 pm, Nurse #2 stated that she was notified on 5/1/13 by Nurse #1 that Resident #81 "was sat down on the floor so that NA#2 could get a better grip" Nurse #2 indicated that she

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 stifient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable90 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 disclosable14 days following the date these documents are made available to the facility If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs 345505	# MULTIPLE CONSTRUCTION A. BUILDING: B. WING DDRESS, CITY, STATE, ZIP CODE MBERLAND ROAD	DATE SURVEY COMPLETE: 5/9/2013					
FOR SNFs AND NFs 345505	B. WING						
345505	DDRESS, CITY, STATE, ZIP CODE	5/9/2013					
		•					
	MBERLAND ROAD						
ALDAINI BUILD ADSODD AD AUGDDD IND	EVILLE, NC						
ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES							
F 157 Continued From Page 1							
did not notify the legal representative because she eas the primary nurse and communicated also via the							
In an interview on 5/8/13 at 12:41 pm, Nurse #1 inc she assessed Resident #81 with no injuries, gait belt was assisted on to the floor and did not fall on to th	was intact, and NA #2 conveyed to her						
stated she expected the legal representative to have	In an interview on 5/8/13 at 2:12 pm, the DON accompanied by the administrator and the regional consultant stated she expected the legal representative to have been notified of Resident #81 being lowered on to the floor by NA #2. The DON indicated she was notified that Resident #81 had been lowered on to the floor but could not recall when or who informed her.						
During an interview on 5/10/13 at 5:45 pm, the legal lift pad underneath Resident #81 during her visitation occurred and she had not been notified immediately #3 during her visit why there was a mechanical lift that the mechanical lift pad was in place due to report representative elaborated in the past (no specific dat was the legal guardian and wanted to be notified imporm. The legal representative concluded that she explace, and informed of exactly what had happened	on on 5/1/13 at 6:30 pm, with suspicion on 5/1/13 at 6:30 pm, with suspicion of the legal representative stated she inquipad underneath Resident#81 and Nurse ort that Resident#81 had trouble standing the indicated) she had informed the nursing mediately regarding any concerns of ca	that a fall had uired from Nurse #3 informed her g up. The legal ng staff that she re outside of the					
•							
		,					
·							

06-24-2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILU	LTIPLI DING (E CONSTRUCTION Of - MAIN BUILDING OF DECETOR	
		345505	B. WING		JUN 2 4 28631	3/2013
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZP CODE	_
CAROLIN	IA REHAB CENTER	OF CUMBERLAND	-	F	AYETTEVILLE, NC 28306NSTRUCTION SEC	TION
(X4) ID PREFIX TAG	(FACH OFFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000 K 038 SS≃E	Surveyor: 27871 This Life Safety Coconducted as per at 42 GFR 483.70(Health Care section publications. This construction, one automatic sprinkle The deficiencies dare as follows: NFPA 101 LIFE Surveyors is arrest.	ode (LSC) survey was I'he Code of Federal Register a); using the 2000 Existing in of the LSC and its referenced building is Type III story, with a complete		038	admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed	
K 076 SS=E	Surveyor: 27871 Based on observe approximately 9:0 items were noncolinclude: when stale emergency release system(nurse stalknowledge of local 42 CFR 483.70(altimately 100 KFPA 101 LIFE 5) Medical gas storal protected in accolinations of the stalknowledge of local field in accoling the stal) SAFETY CODE STANDARD age and administration areas are rdance with NFPA 99, alth Care Facilities.	* K	(070	completed for all employees on the unit on how to release the mag lock doors in case of emergency. Completion 6/13/13. How you will identify other life safety issues having the potential to affect residents by the same deficient practice and what corrective action will be taken.	6.13.13
		VIDER/SUPPLIER BEPRESENTATIVE'S S	IGNATUR	E.	Administrator 6	.24.13
•	a harror	2 # Qum			HOUNNING CO	

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.

If continuation sheet Page 3 larg

12:17:01 p.m.

06-24-2013

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 AND PLAN OF CORRECTION 06/13/2013 345505 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4800 CUMBERLAND ROAD CAROLINA REHAB CENTER OF CUMBERLAND **FAYETTEVILLE, NC 28308** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREPIX TAG CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) included how the mag locks K 000 were released, where the release K 000 INITIAL COMMENTS switches were located, and that when the release button was Surveyor: 27871 This Life Safety Code (LSC) survey was pushed, all mag locks would be conducted as per The Code of Federal Register released, therefore extra at 42 CFR 483.70(a); using the 2000 Existing surveillance of wandering Health Care section of the LSC and its referenced patients would be needed. publications. This building is Type III 6.21.13 construction, one story, with a complete Completion 6/21/13. automatic sprinkler system. Measures to be put in place or The deficiencies determined during the survey systemic changes made to are as follows: ensure practice will not NFPA 101 LIFE SAFETY CODE STANDARD K 038 K 038 re-occur — SS≂E Exit access is arranged so that exits are readily Each month the center holds a accessible at all times in accordance with section safety meeting, Prior to the 7.1. 19.2.1 safety meeting, the maintenance director will randomly ask employees throughout the facility if they know how to release the mag locks in case of This STANDARD is not met as evidenced by: emergency. Immediate Surveyor: 27871 Based on observations and staff interview at education will be provided to approximately 9:00 am onward, the following any employee who does not items were noncompliant, specific findings know. The SDC will provide include; when staff was interviewed on location of facility-wide education on how emergency release switch for mag locking to release the locks if needed at system(nurse station) they did not have 6.21.13 that time. Completion 6/21/13. knowledge of location. 42 CFR 483.70(a) How facility will monitor NFPA 101 LIFE SAFETY CODE STANDARD K 076 K 076 corrective action(s) to ensure SS=E deficient practice will not re-Medical gas storage and administration areas are protected in accordance with NFPA 99, occur-

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.

If continuation sheet Page 1 lar 3

TITLE

Standards for Health Care Facilities.

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

12:18:19 p.m.

06-24-2013

DEPARTMENT OF HEA	LTH AND	HUMAN	SERVICES
CENTERS FOR MEDIC	ARE & ME	DICAID	SERVICES_

OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 06/13/2013 B. WING 345505 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER

CAROLIN	IA REHAB CENTER OF CUMBERLAND			D CUMBERLAND ROAD YETTEVILLE, NC 28306	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Surveyor. 27871 This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows: NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K (000	Education to the staff on how to release the mag locks will be done quarterly and presented in the quarterly QA meeting, led by the administrator. Any issues will be discussed and a plan of correction implemented immediately. In-services or correction will be discussed and presented as needed. Completion 6/21/13.	6.21.13
K 076 SS≒E	1	Andreas and Andrea	076		VAL DATE

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

TITLE :

(X6) DATE

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.

12:19:25 p.m.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

06-24-2013 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING 0	CONSTRUCTION 1 - MAIN BUILDING 01	(X3) DATE COMP	SURVEY LETED
	•	346505	B. WING		06/1	3/2013
	ROVIDER OR SUPPLIER	OF CUMBERLAND	46	ET ADDRESS, CITY, STATE, ZIP CODE 00 CUMBERLAND ROAD YETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREPIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFIC ENCY)	OULD BE	(X5) COMPLETION DATE
K 076	3,000 cu.ft. are enseparation. (b) Locations for s 3,000 cu.ft. are ve 4.3.1.1.2, 19.3.2.4 This STANDARD Surveyor: 27871 Based on observation and 700 hall oxyg cylinders were no 42 CFR 483.70(a) NFPA 101 LIFE S Electrical wiring a with NFPA 70, N This STANDARD Surveyor: 27871 Based on observation of the surveyor o	e locations of greater than closed by a one-hour upply systems of greater than need to the outside. NFPA 99 is not met as evidenced by: litions and staff interview at 0 am onward, the following impliant, specific findings forage room on 100 hall had aix in with full ones. Also on 100 en storage room, three oxygen it in a rack or cart. AFETY CODE STANDARD in a equipment is in accordance ational Electrical Code. 9.1.2 is not met as evidenced by: ations and staff interview at 100 em onward, the following ompliant, specific findings it cords(2) were being used in	K 076	K076 What corrective will be accomplished be facility to correct the correct the corrective. An in-service was immediately a month of the sprage of the spr	ediately elity, on proper ede: full from te storage tility oxygen floor or eletion other g the dents by ectice ction will a which storage: rated ropriate e clearly etility oxygen	6.13.13

12:20:31 p.m.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

06-24-2013 7/10 3 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				(X3) DATE	SHBAEA
STATEMEN AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILD	TIPLE ING 0	CONSTRUCTION 11 - MAIN BUILDING 01	COMPL	
		345505	B. WING			06/13	3/2013
	PROVIDER OR SUPPLIER NA REHAB CENTER	OF CUMBERLAND	-,	46	EET ADDRESS, CITY, STATE, ZIP CODE 600 CUMBERLAND ROAD AYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	JEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 076	3,000 cu.ft. are en	age 1 e locations of greater than closed by a one-hour	К	076	in patient rooms. Each unit manager audited each patie room on their unit. Comple 6/21/13.	nt	6.21.13
K 14 SS=	separation. (b) Locations for s 3,000 cu.ft. are ve 4.3.1.1.2, 19.3.2.4 This STANDARD Surveyor: 27871 Based on observe approximately 9:0 Items were noncoinclude: oxygen s empty cylinders mand 700 hall oxyg cylinders were no 42 CFR 483.70(a NFPA 101 LIFE S Electrical wiring a with NFPA 70, N This STANDARD Surveyor: 27871	upply systems of greater than need to the outside. NFPA 99 is not met as evidenced by: its not met as evidenced by: ations and staff interview at 0 am onward, the following mpliant, specific findings torage room on 100 hall had nix in with full ones. Also on 100 en storage room, three oxygen t in a rack or cart. SAFETY CODE STANDARD and equipment is in accordance ational Electrical Code. 9.1.2		(147	Measures to be put in plansystemic changes made to ensure practice will not re-occur— The central supply coordinator) make daily rounds in each utility room to ensure the oxygen tanks are properly stored. Any issues will be immediately reported to the administrator or DON in absence of the administrator Completion 6/13/13. How facility will monitor corrective action(s) to end deficient practice will not occur— The central supply coordinator, make daily rounds in each utility room to ensure the	ator of will clean e or. sure t re- nator e of) will	6. (3.13
Additional and the state of the	Based on observ approximately 9: items were none	ations and staff interview at 00 am onward, the following ompliant, specific findings or cords(2) were being used in			oxygen tanks are properly stored. Any issues will be immediately reported to the administrator or DON in	ie	

12:21:37 p.m. 06-24-2013

8/103

FORM APPROVED OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 06/13/2013 B. WING 345505 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4600 CUMBERLAND ROAD CAROLINA REHAB CENTER OF CUMBERLAND FAYETTEVILLE, NC 28308 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) absence of the administrator. 6-13-13 K 076 K 076 | Continued From page 1 Completion 6/13/13. All leadership team members (a) Oxygen storage locations of greater than were educated on proper storage 3,000 cu.ft. are enclosed by a one-hour of oxygen. All leadership team separation. members have specific hall assignments to round on daily, (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 and have been instructed to 4.3.1.1.2, 19.3.2.4 make sure there is no oxygen stored in patient rooms and they are also required to check proper storage within clean utility rooms. Any issues identified This STANDARD is not met as evidenced by: will be immediately brought to Surveyor: 27871 the attention of the Based on observations and staff interview at administrator. Completion approximately 9:00 am onward, the following 6-13-13 items were noncompliant, specific findings 6/13/13. include: oxygen storage room on 100 hall had empty cylinders mix in with full ones. Also on 100 K147 What corrective action and 700 hall oxygen storage room, three oxygen will be accomplished by the cylinders were not in a rack or cart. facility to correct the deficient 42 CFR 483.70(a) practice -NFPA 101 LIFE SAFETY CODE STANDARD K 147 Extension cord found in patient K 147 room 108 was immediately SS≍E Electrical wiring and equipment is in accordance taken out. The unit manager with NFPA 70. National Electrical Code. 9.1.2 called the family to make them aware that the extension cord brought in was a fire hazard and This STANDARD is not met as evidenced by: explained the hazard to them at Surveyor: 27871 that time. Completion 6/13/13. 6-13-13 Based on observations and staff interview at approximately 9:00 am onward, the following items were noncompliant, specific findings How you will identify other include: extenson cords(2) were being used in life safety issues having the

residents bedroom 108 bed #1.

12:22:43 p.m.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

06-24-2013 9710 PKINTED: U6/13/2013 FORM APPROVED OMB NO. 0938-0391

			(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		345505	B. WING		<u> </u>	06/	13/2013
1	ROVIDER OR SUPPLIER	OF CUMBERLAND		46	EET ADDRESS, CITY, STATE, ZIP CODE 00 CUMBERLAND ROAD AYETTEVILLE, NC 28306		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
K 147	Continued From pa	age 2	K		potential to affect resider the same deficient practice and what corrective actions to be taken — All patient rooms checked extension cords. No other identified. Completion 6/1 Measures to be put in playstemic changes made to ensure practice will not re-occur— All employees were educated the hazard of extension cords are not to used within the facility an identified, to immediately the administrator so proper follow up with the patient family can take place and extension cord(s) will be immediately removed. Leadership team members been educated to look for during their daily rounds patient rooms and will not administrator if any issued identified. Identified issued be discussed in the month meeting. Completion 6/13 How facility will monito	for issues 3/13. ace or o tted on ords. be diff notify or and/or the this in the tify the sare as will ly QA 1/13.	6.13.13
					corrective action(s) to en		<u> </u>

12:23:29 p.m.

06-24-2013

1-2013 10/10 PKINTED. U0/13/2013 FORM APPROVED OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

345505

(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

06/13/2013

NAME OF PROVIDER OR SUPPLIER

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

CAROLINA REHAB CENTER OF CUMBERLAND

STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CUMBERLAND ROAD

CAROLI	NA REHAB CENTER OF CUMBERLAND	_	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
K 147	Continued From page 2	K 14	deficient practice will not re-			
	 	-	All employees were educated on	}		
	42 CFR 483.70(a)	[the hazard of extension cords.			
			In-service included that			
			extension cords are not to be			
	·		used within the facility and if			
			identified, to immediately notify			
			the administrator so proper			
			follow up with the patient and/or			
			family can take place, and the extension cord(s) will be			
			immediately removed.			
			Leadership team members have			
			been educated to look for this			
			during their daily rounds in the			
			patient rooms and will notify the			
			administrator if any issues are			
			identified. Identified issues will	1		
			be discussed in monthly QA	1		
			meeting. Completion 6/13/13.	6:13.1		
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	and the state of t					
			•			
			,			

B. WING