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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345505	A. BUILDING ______ B. WING ______	C 04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA REHAB CENTER OF CUMBERLAND	4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation conducted on 04/26/18. Event ID# MSDB11.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) to reflect the Preadmission Screening and Resident Review (PASRR) Level II Preadmission Screening for 2 of 2 residents (Residents #8 and #101) identified as PASRR Level II. The findings included: 1. Resident #8 was admitted to the facility on 7/16/15 with diagnoses including Depression, Anxiety and Unspecified Psychotic Disorder. A review of Resident #8's Annual Minimum Data Set (MDS) assessment dated 04/17/17 indicated the resident was considered by the State PASRR Level II process to have a serious mental illness and/or intellectual disability that resulted in the screening and review to determine need and recommendations for appropriate care, and formulate a set of recommendations to develop Resident #8's plan of care. During an interview with the Social Worker #1 (SW) on 04/25/18 at 5:28 PM, the SW stated	F 641	The statements included are not an 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 by the dates indicated. F641 The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. The facility failed to accurately code the Minimum Data Set (MDS) to reflect the Preadmission Screening and Resident Review (PASRR) Level II Preadmission Screening for 2 of 2 residents (Residents	5/24/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 05/17/2018

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

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F 641	Continued From page 1 Social Workers were responsible for coding Section A1500 from the Minimum Data Set's PASRR Level II. During an interview with the Administrator on 04/25/18 at 5:37 PM, the Administrator stated her expectations were for her staff to code the MDS dated 04/17/17 correctly and accurately to reflect Resident #8's PASRR Level II status. During an interview with the Director of Nursing (DON) on 04/26/18 at 1:26 PM, the DON stated she expected the staff to correctly code section A1500 from the Minimum Data Set's PASRR Level II. 2. Resident #101 was admitted to the facility on 1/09/18 with a diagnosis of Intellectual Disability. A review of Resident #101's Admission Minimum Data Set (MDS) assessment dated 01/18/18 indicated the resident was not considered by the State PASRR (Preadmission Screening Resident Review) Level II process to have a serious mental illness and/or intellectual disability that resulted in the screening and review to determine need and recommendations for appropriate care, and formulate a set of recommendations to develop Resident #101's plan of care. Review of Resident #101's PASRR Level II Determination Notification dated on 04/08/15 revealed that the nursing facility placement was appropriate and there was no expiration date. During an interview with the MDS Nurse #2 on 04/25/18 at 11:20 AM revealed that the Social Worker (SW) is responsible for completing Section A1500 of the MDS. The MDS Coordinator further stated that the SW that	F 641	#8 and #101) identified as PASRR Level II. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. The MDSC Consultant provided education to the MDSC and DC Planner that any resident with a Level II PASRR must be coded in Section A of their Comprehensive Minimum Data Set per the RAI Manual. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The MDSC or designee will audit 5 residents comprehensive MDS who have a Level II PASRR completed in Section A by the DC Planner, 1 time a week for 4 weeks, 2 times a month for 1 month, and monthly for 4 months. Any coding issue identified on the audits will be immediately corrected with coaching/discipline as needed to the MDSC or DC Planner. Results of the audits will be presented to be reviewed at the quarterly QAPI meeting. The MDSC Consultant is responsible for implementing the acceptable plan of correction by May 24, 2018.	

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F 641	Continued From page 2 completed that assessment is no longer employed at the facility. During an interview with the Social Worker #1 on 04/25/18 at 5:28 PM, the SW stated Social Workers were responsible for coding Section A1500 of the Minimum Data Set PASRR Level II. During an interview with the Administrator on 04/25/18 at 5:37 PM, the Administrator stated her expectations were for her staff to code the MDS accurately. During an interview with the Director of Nursing (DON) on 04/26/18 at 1:26 PM, the DON stated she expected the staff to correctly code section A1500 of the Minimum Data Set PASRR Level II.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		5/24/18

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F 656	Continued From page 3 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to develop a comprehensive plan of care directing measurable goals and interventions for pressure ulcers for 1 of 3 residents reviewed for pressure ulcers (Resident #476). The findings included: Resident #476 was admitted to the facility on 11/07/17 with diagnoses which included intestinal obstruction, muscle weakness and type 2 diabetes mellitus. The Minimum Data Set (MDS), dated 11/14/17, indicated Resident #476 was moderately cognitively impaired and required limited assistance with bed mobility and toileting and	F 656	F656 The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. The facility failed to develop a comprehensive plan of care directing measurable goals and interventions for pressure ulcers for resident #476. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. The MDSC Consultant provided education to the MDSC on ensuring a care plan is	

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F 656	Continued From page 4 extensive assistance with transfers. The MDS indicated Resident #476 had been occasionally incontinent of urine and had been admitted with a Stage 2 Pressure Ulcer. The Care Area Assessment (CAA), dated 11/14/17, revealed Resident #476's MDS assessment had triggered a care plan for pressure ulcers as he had been admitted to the facility with a pressure ulcer to his sacrum and had been receiving pressure ulcer care. A review of Resident #476's Care Plan, last revised 11/20/17, revealed the facility did not care plan Resident #476's sacral pressure ulcer and treatment. During an interview with MDS Coordinator #2 on 04/26/17 at 9:45 AM, MDS Coordinator #2 confirmed Resident #476 did not have a care plan for pressure ulcers. MDS Coordinator stated she had completed Resident #476's MDS and CAA and had care planned all care areas that triggered for care planning except pressure ulcers. When asked why she did not care plan the pressure ulcer, MDS Coordinator #2 stated she did not know why and related it to human error. During an interview with the Director of Nursing (DON) on 04/26/18 at 10:25 AM, the DON stated it was her expectation nursing staff care plan all care areas that trigger for care planning from the MDS assessment.	F 656	developed for each resident with a pressure ulcer as indicated by the Care Area Assessment, when completing a comprehensive Minimum Data Set. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The MDS Consultant or designee will audit 5 current residents□ comprehensive Minimum Data Sets, who have a pressure ulcer to ensure the item was care planned if the CAA addressed that the item will be care planned, 1 week for 4 weeks, 2 times a month for 1 month, and monthly for 4 months. Any coding issue identified on the audits will be immediately corrected with coaching/discipline as needed to the MDSC. Results of the audit will be presented at the quarterly QAPI meeting. The MDSC Consultant is responsible for implementing the acceptable plan of correction by May 17, 2018.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F 657		5/24/18

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F 657	Continued From page 5 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to revise a resident's care plan after a change in the resident's condition for 1 of 4 residents reviewed for accidents (Resident #39). The findings included: Resident #39 was admitted to the facility on 04/29/16 with diagnoses which included Multiple Sclerosis, generalized muscle weakness, repeated falls, other neurologic disorders in Lyme disease and dementia with behavioral disturbance. The Minimum Data Set (MDS), dated 02/17/18,	F 657	F657 The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. The facility failed to revise a resident's care plan, for accidents, after a change in the resident's condition for Resident #39. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. The MDSC Consultant and Nurse consultant provided education to the MDSC and DON that any care plans need	

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F 657 Continued From page 6

indicated Resident #39 was severely cognitively impaired and required extensive assistance with her Activities of Daily Living (ADLs). The MDS indicated Resident #39 had impairment to both sides of her upper and lower extremities.

A review of the falls Care Area Assessment (CAA), dated 02/17/18, indicated Resident #39 had memory and decision making impairment and had been at risk for falls related to her history of repeated falls, confusion, and need for assistance with ADLs. The CAA indicated Resident #39 had multiple falls without injury since the last assessment.

A review of Resident #39's falls Care Plan included the following interventions:
1. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed (last revised 05/02/16)
2. Re-educate the resident if she would like to ambulate to ask for assistance and verbalize an understanding (last revised 12/20/16)

During an interview with MDS Coordinator #1 and MDS Coordinator #2 on 04/25/18 at 10:30 AM, MDS Coordinator #1 stated Care Plans are updated with each MDS assessment. MDS Coordinator #2 stated Resident #39 had not walked in a long time. MDS Coordinator #1 confirmed Resident #39's falls interventions were not current. MDS Coordinator #1 stated Resident #39 had MDS assessments completed since December 2016 and the falls interventions had not been updated because they had been overlooked.

During an interview with the Director of Nursing (DON) on 04/26/18 at 10:25 AM, the DON stated

F 657

to reflect current resident status and should be reviewed with each quarterly or annual assessment.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.

The MDS Consultant or designee will audit 5 current residents comprehensive Minimum Data Sets fall care plans to ensure interventions are current and accurate, 1 week for 4 weeks, 2 times a month for 1 month, and monthly for 4 months. Any coding issue identified on the audits will be immediately corrected with coaching/discipline as needed to the MDS. Results of the audits will be presented in the quarterly QAPI meeting.

The DON is responsible for implementing the acceptable plan of correction by May 17, 2018.

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F 657	Continued From page 7 it was her expectation nursing staff revise residents' Care Plans during the MDS assessment and as needed.	F 657		