STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 000	INITIAL COMMENTS A recertification, complaint and follow-up survey was conducted from 05/21/18 through 05/26/18. After review of the SOD, CMS requested the state agency return to the facility for an extended survey. This was completed 07/02/18 through 07/03/18. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity of J CFR 483.25 at tag F695 at a scope and severity of J The tags F600 and F695 constituted substandard Quality of Care. Immediate Jeopardy began on 05/18/18 and was removed on 07/03/18.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 600		7/11/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/03/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 600	Continued From page 1 Based on observation, record review and resident and staff interviews, the facility neglected to provide tracheostomy care as ordered by the medical doctor for 1 of 1 resident reviewed for respiratory care (Resident #25) and the facility neglected to clarify or obtain orders for indwelling urinary catheter changes for 1 of 1 resident reviewed (Resident #25) resulting in a resident's indwelling urinary catheter not being changed for several months and a hospitalization for a urinary tract infection (UTI). Immediate Jeopardy for Resident #25 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 a G (actual harm that is not Immediate Jeopardy) for example 1b. The Findings Included: Resident #25 was admitted to the facility on 12/03/09. Her medical diagnoses included, in part, Multiple Sclerosis (MS), calculus (stone) in urethra, calculus of kidney, chronic obstructive pyelonephritis (kidney infection), reflux uropathy (urine flow from bladder toward the kidney), retention of urine, history of urinary tract infection (UTI), Multiple Sclerosis (MS), chronic obstructive pulmonary disease and tracheostomy status. A review of Resident #25's quarterly Minimum Data Set, dated 02/21/18, revealed Resident #25 had been cognitively intact and required total assistance of staff for her Activities of Daily Living (ADL). The MDS indicated Resident #25 had an indwelling urinary catheter and had obstructive uropathy. The MDS indicated the resident	F 600	Cumberland Nursing and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Cumberland Nursing and Rehabilitation's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Cumberland Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceeding. F600 1a. The process that lead to the deficiency was the failure of nurse #7 not completely reading the Medication Administration Record (MAR) which resulted in not documenting tracheostomy care provided. The failure of Nurse #6 and Nurse #2 to provide tracheostomy care to resident #25.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 600	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 revised 06/30/17). 4. 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 facility protocol and to check dressing to stoma site frequently and replace/change as needed or as ordered (last revised 12/28/17).	F 600	On 5/17/18, Resident #25 was sent out to the hospital for evaluation due to dislodged G-Tube. Resident #25 trach was assessed by the Treatment Nurse on 4/30/18, 5/7/18, and 5/14/18 with no documentation of larvae, foul odor, or drainage around the trach site. On 5/17/18 per hospital record at 6:58 pm, one hour after resident was in the Emergency Department, the RN documented Patient conscious, alert and oriented x 4, respiratory rate even and unlabored, patient has trach and wears O2 @ 2 liters. No mention of drainage, larvae, or foul-odor in tracheostomy. On 5/17/18 per hospital record at 9:15 pm, resident had a chest x-ray complete. Findings: Tracheostomy tube in stable position. On 5/17/18 per hospital record at 10:42 pm, per the documentation of the Registered nurse, tracheostomy tube in place. O2 @ 3 Liters via trach mask. On 5/18/18 per hospital record at 5:32 am, per the documentation of the Registered nurse, suction at bedside. On 5/18/18 per hospital record at 8:33 am there is documentation of a Respiratory Therapist treatment assessment. On 5/18/18 per the hospital record at 2:02 pm there is documentation of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 600	Continued From page 3 1a. A record review of Resident #25's May 2018 Medication Administration Record (MAR) revealed a physician's order for "tracheostomy site dressing change every day" and the dressing change was scheduled to be completed at 4:00 p.m. Prior to Resident #25 leaving the facility on 05/17/18, there had been 8 dates the order had not been signed off by a nurse as having been completed - May 1, 2, 4, 6, 7, 9, 10 and 15. Prior to being discharged to the hospital on 05/17/18, the dressing had been documented as completed on 05/16/18. The MAR indicated the dressing had not been completed on 05/17/18. During an interview with Nurse #7 on 05/25/18 at 2:20 p.m., Nurse #7 stated she had worked the 3 p.m. to 11 p.m. shift on 05/16/18 and had remembered changing the dressing on Resident #25's tracheostomy and stated it had looked fine. Nurse #7 stated she worked the 3 p.m. to 11 p.m. shift on 5/17/18 and had been one of the nurses who had assessed Resident #25 when her PEG tube had dislodged. When asked if she had checked Resident #25's tracheostomy site prior to Resident #25 being sent out, Nurse #7 stated she remembered there had been no drainage noted on the sheets. During an interview with Nurse #2 on 05/26/18 at 9:56 a.m., Nurse #2 had been asked why she had not signed her initials on the MAR for Resident #25's tracheostomy site dressing on May 2, 4, 6, 7, 9 and 15, 2018. Nurse #2 stated while she remembered changing the dressing a couple of times she stated she was going to be honest. Nurse #2 stated when she came on duty she was responsible for a medication cart and 30 residents in addition to overseeing 2-3 medication aides. Nurse #2 stated she stayed stressed out	F 600	registered nurse Patient□s tracheostomy with brownish drainage, foul odor. G-tube site needs cleaning. Called Respiratory Therapist (RT) to clean g-tube and RT notified RN that pt has maggots in tracheostomy. RN confirmed this by eye site. RN notified physician via phone and awaiting call back. On 5/18/18, the administrator was made aware by resident #25 friend of an allegation that Resident #25 was observed with maggots in her throat while at the hospital. On 5/18/18, an investigation was started by the administrator to include submission of an Initial Allegation Report to Health Care Personnel Investigation (HCPI). On 5/22/18, all alert and oriented residents were interviewed by the Social Worker (SW) in regards to abuse and neglect. No areas of concern were identified during the interviews. On 5/25/18, the investigation was completed and the allegation was unsubstantiated by the administrator. The Investigation Report was submitted to HCPI by the administrator. Nurse #6 and #7 were reported to the Board of Nursing on 7/3/18 for not providing tracheostomy care by the DON. On 5/26/18, Resident #25 returned to the facility and was assessed by the hall nurse to include assessment of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 600	Continued From page 4 because when she would come on duty she had always been pulled here and there dealing with resident issues and behaviors. Nurse #2 stated it had been very challenging and stated she felt it could be the reason why she did not always do the dressing change. During an interview with Nurse #6 on 05/26/18 at 10:40 a.m., Nurse #6 stated she recalled changing Resident #25's tracheostomy site dressing in the past but stated she could not recall whether or not she had changed the dressing on 05/01/18. During an interview with Nurse #7 on 05/26/18 at 12:49 p.m., Nurse #7 stated 5/10/18 had been her first day of employment at the facility. Nurse #7 stated she recalled changing Resident #25's tracheostomy site dressing on 05/10/18 and stated she had forgotten to sign off on the MAR. During an interview with the hospital ED nurse #2 on 07/03/18 at 9:33 a.m., the hospital ED nurse #2 stated Resident #25 arrived in the ED approximately 15 minutes before the end of her 7 a.m. to 7 p.m. shift on 05/17/18. The hospital ED nurse #2 stated Resident #25 smelled like she needed a bath and her nephrostomy and indwelling urinary catheter were in need of some "tender loving care" however she had not assessed Resident #25's tracheostomy because her oxygen saturation had been okay. During an interview with the hospital ED nurse #3 on 07/03/18 at 11:30 a.m., the hospital ED nurse #3 stated she had cared for Resident #25 during her 7 p.m. to 7 a.m. shift on 05/17/18. The hospital ED nurse #3 stated Resident #25 had been in "real bad condition" and had focused her	F 600	tracheostomy site, which was clean, dry, and covered with a dry dressing. On 5/26/18, the assessment for Resident #25 was documented by the hall nurse in the electronic medical record. On 6/12/18, an observation of all residents to include Resident #25 was completed by the Director of Nursing (DON), the Assistant Director of Nursing (ADON), and the Quality Improvement (QI) Nurse to physically identify all residents with tracheostomies. One resident was identified with a tracheostomy. On 6/12/18, an audit of all Medication Administration Record (MARs), including MARs for Resident #25, for the past 30 days, was completed by the ADON and the QI Nurse to ensure orders for respiratory care, including tracheostomy care were provided as evidenced by documentation on the MAR. There were no other identified areas of concern noted. On 6/12/18, an assessment of all residents with tracheostomies, including Resident #25 was completed by the QI Nurse and the ADON to ensure tracheostomy care was provided as evidenced by observing a clean insertion site and dressing with no drainage present. There were no identified areas of concern during the audit. On 6/12/18, an audit of all residents physician orders to include Resident #25 was initiated by the QI nurse, the ADON,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 600	Continued From page 5 care to Resident #25's nephrostomy and indwelling urinary catheter secondary to Resident #25 having had "really bad smelling urine." During an interview with the hospital ED nurse #1 on 05/23/18 at 4:25 p.m., the ED nurse #1, who worked the 7 a.m. to 7 p.m. shift on 5/18/18, stated when she had entered the holding room Resident #25 had been placed in she could smell the "stench" coming off of her and noted that her face had dried spittle on it, her hair had been matted with white flakes and it appeared like it had not been washed in a long time. The ED nurse #1 stated she looked at Resident #25's tracheostomy site and had noted a substance on the tracheostomy which she compared to melted malt chocolate. The ED nurse stated she called a Respiratory Therapist (RT) for tracheostomy care and oxygen needs. The ED nurse stated once the RT had begun tracheostomy care, he had informed her of the presence of maggots on Resident #25's skin surrounding her tracheostomy site. The ED nurse stated she then observed the presence of maggots around the tracheostomy site. During an interview with the hospital's RT #1 on 05/25/18 at 11:15 a.m., the RT #1 stated he recalled Resident #25 in the ED on 05/18/18. The RT stated he had been called to the ED to assess the resident, assess oxygen saturation and perform tracheostomy care. The RT #1 stated upon arrival to Resident #25's ED room, he had noticed a foul odor emanating from the resident. The RT #1 stated when he had assessed the tracheostomy, he noticed the tracheostomy ties were dirty and there were visible dried secretions on her tracheostomy. The RT #1 stated he removed the tracheostomy site	F 600	and the Staff Facilitator (SF) to identify all residents with orders to receive tracheostomy care. The audit was completed on 6/13/18. There were no other identified residents with orders to receive tracheostomy care. On 6/29/18, a 100% return demonstration of tracheostomy care was initiated with all licensed nurses to include agency nurses and Nurse #6, and Nurse #7 by the ADON and SF. Return demonstration of tracheostomy care was completed on 7/7/18. Retraining was completed by the ADON and/or SF during the time of the audit for any nurse that could not demonstrate successful performance of tracheostomy care per policy and procedure. On 7/1/18, a contracted RT initiated training on tracheostomy care with licensed nurses and agency nurses to include Nurse #6 and #7. 100 % training was completed with all licensed nurse and agency nurses on 7/7/18.The RT will train all newly hired licensed nurse and contracted agency nurses during orientation. On 5/30/18, a 100 % in-service was initiated with all license nurses to include agency nurses, and Nurse #6 and Nurse #7 by the facility nurse consultant and the SF on providing tracheostomy care as ordered by the physician and documentation of tracheostomy care on MAR. The in-service also addressed the expectation that documentation must be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 600	Continued From page 6 sponge (gauze dressing from the facility) and it had been so dirty and had secretions so old the sponge was hard. The RT #1 stated Resident #25's skin underneath the sponge was red and he had noticed maggots under the tracheostomy ties and the sponge. The RT #1 stated he had noticed Resident #25's odor was more prevalent during the tracheostomy care but could not state whether the foul odor was coming from the tracheostomy site or not. The RT #1 stated he cleaned all of the maggots off of Resident #25's skin and cleaned the tracheostomy however he did not have time to change the inner cannula as Resident #25 had to be transferred to another part of the hospital. During a 2nd interview with the hospital RT #1 on -07/03/18 at 8:57 a.m., the hospital RT #1 stated he and another hospital RT #2 had performed Resident #25's tracheostomy care together on 05/18/18 and the hospital RT #2 had documented the care. A review of the hospital's records indicated Resident #25 had arrived at the Emergency Department (ED) on 05/17/18 at 5:50 p.m. with a chief complaint of a dislodged PEG tube. Further review of the hospital record ED notes revealed the following: 1. An RT note, dated 5/18/18 8:33 a.m. - "oxygen device = tracheostomy collar (TC), fraction of inspired oxygen (FIO2): 30, breath sounds diminished; note - pt placed on 30% TC at this time, peripheral capillary oxygen saturation (SPO2) 97%" 2. An ED nurse note, dated 05/18/18 2:02 p.m. - "patient's tracheostomy with brownish drainage, foul odor ...called Respiratory Therapist (RT) to clean. RT notified RN that patient has maggots in tracheostomy. RN confirmed this by eyesight."	F 600	present on the MAR after providing tracheostomy care. The in-service was completed on 6/28/18. On 7/2/18, a 100 % in-service was initiated with all licensed nurses to include agency nurses and Nurse #6, and Nurse #7 by the Facility Nursing Consultant on reading each tracheostomy order on the MAR, following the physician order for tracheostomy care, documenting on the MAR tracheostomy care provided, checking each page of the MAR to ensure that no medications, treatments, and documentation is missed. The in-service also included for licensed nurses to ask for additional assistance from the DON, ADON, QI Nurse, SF, or another hall nurse when feeling like assistance is needed to provide resident care to include tracheostomy care and time management. The in-service was completed on 7/7/18. All newly staffed agency or newly hired licensed nurse will be educated by the SF during orientation in regards to reading each tracheostomy order on the MAR, following the physician order for tracheostomy care, documenting on the MAR tracheostomy care provided, checking each page of the MAR to ensure that no medications, treatments, and documentation is missed. On 6/29/18, an in-service was initiated by the SF to administrator, accounts payables, accounts receivables (AR) bookkeeper, AR assistant, SW, DON, ADON, QI, treatment nurse, scheduler, licensed nurses to include agency nurses,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 600	Continued From page 7 3. Final order results of a chest x-ray performed on 05/17/18 at 9:15 p.m. revealed findings of "tracheostomy tube is stable in position ...no acute process" A review of a hospital's Tracheostomy Assessment note, dated 5/18/18 at 2:00 p.m., stated "called to patient's room for tracheostomy assessment, upon more detailed look at tracheostomy this RT found maggots crawling around tracheostomy site ...all maggots that were seen were wiped off ...Once RN called to room she asked patient when was the last time they cleaned it at the nursing facility and patient stated "they cleaned it 2 days ago." 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. During an interview with the Administrator on 05/26/18 at 2:42 p.m., the Administrator stated his expectation of nursing staff, in regard to tracheostomy care, is to follow the residents' plan	F 600	nursing assistants, medical records, assistant dietary manager, dietary staff, housekeeping supervisor, housekeeping staff, laundry staff, therapy manager, therapy staff, supply clerk, ward clerk, activities director, and activities assistant on resident neglect. Examples of Nursing Home Neglect Nursing home neglect can vary among individual cases, but below are examples of neglect: When a resident is repeatedly ignored, left alone, or accidentally snapped at by any overstressed employee. When a resident do not receive adequate help with laundry, cleaning, bathing, brushing their teeth, or other forms of hygienic practices. When the nursing home neglects to provide reasonable food, water, or a safe and clean environment. When the nursing home fails to provide tracheostomy care, adequate attention, prevention to include dehydration, UTI□s and infections, injuries to include fractures or medication for concerns such as pressure ulcers, infections, cuts, diabetes, cognitive diseases and mobility concerns Signs of Nursing Home Neglect Warning signs of nursing home neglect MAY include: Sudden weight loss, bedsores, or pressure ulcers, injuries from nursing home falls or factures, dehydration, changes in personal hygiene or appearance efforts, changes in mood or behavior Prevention of Nursing Home Neglect The nursing home resident should be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 600	Continued From page 8 of care as directed by the physician. The Administrator stated it was his expectation nursing staff document according to facility training. The Assistant Director of Nursing was notified of the Immediate Jeopardy on 06/29/18 at 3:10 p.m. On 07/03/18 the facility provided the following credible allegation of compliance and Immediate Jeopardy removal: A thorough investigation was completed by the administrator on 7/02/18 to ascertain the cause. It was determined by the administrator that the cause was the failure of nurse #7 not completely reading the Medication Administration Record which resulted in not documenting tracheostomy care provided. During the interview, Nurse #6 and nurse #2 both stated that they did not provide tracheostomy care to resident #25 related to being busy but could not state the reason why they did not ask for assistance. On 5/17/18, Resident #25 was sent out to the hospital for evaluation due to dislodged G-Tube. Resident #25's tracheostomy was assessed by the Treatment Nurse on 4/30/18, 5/7/18, and 5/14/18 with no documentation of larvae, foul odor, or drainage around the tracheostomy site. On 5/17/18 per hospital record at 6:50 pm, one hour after resident was in the Emergency Department, the RN documented "Patient Conscious Alert and Oriented x 4, respiration rate even and unlabored, patient has tracheostomy and wears O2 @ 3 liters." No mention of drainage, larvae, or foul-odor in tracheostomy.	F 600	monitored for changes in mobile, mental, physical ability, abnormal skin conditions, pain, as well as any developing medical concerns. Any changes noted in the resident should be reported to the nurse. The nurse must assess the change and report the changes immediately to the MD and Resident Representative and provide appropriate interventions to address the change and prevent further decline and document in the medical records. If a resident has an acute medical change, the resident should be sent out via 911 with verbal notification to the physician. In-service completed on 7/7/18. On 7/11/18, the administrator spoke with Quality Improvement Organization (QIO) for assistance in evaluation of specific steps to be taken to address tracheostomy care and training, staff position/title designated to be responsible for the steps, timeline for accomplishment of the steps, specific methodology to be used to evaluate the plan□s success, and frequency of monitoring the effects of the plan initiation. The QIO staff are scheduled to visit the facility on 7/18/18 to review current Plan of Correction, current systems, monitoring of tracheostomy care and make further recommendations in regards to tracheostomy care. 10% of all residents with tracheostomies to include Resident #25 will be physically observed and documentation of the MAR and non-ulcer flow sheet assessment will be monitored by the Assistant Director of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 600	Continued From page 9 On 5/17/18 per hospital record at 9:15 pm, resident had a chest x-ray complete. Findings: "Tracheostomy tube in stable position." On 5/17/18 per hospital record at 10:42 pm, per the documentation of the Registered nurse, "tracheostomy tube in place. O2 @ 3 Liters via tracheostomy mask." On 5/18/18 per hospital record at 5:32 am, per the documentation of the Registered nurse, "suction at bedside." On 5/18/18 per hospital record at 8:33 am there is documentation of a Respiratory Therapist treatment assessment. On 5/18/18 per the hospital record at 2:24 pm, there is documentation of the registered nurse "Patient's tracheostomy with brownish drainage, foul odor. G-tube site needs cleaning. Called RT to clean g-tube and RT notified RN that patient has maggots in tracheostomy. RN confirmed this by eye site. RN notified physician via phone and awaiting call back." On 5/18/18, the administrator was made aware by resident #25's friend of an allegation that Resident #25 was observed with maggots in her throat while at the hospital. On 5/18/18, an investigation was started by the administrator to include submission of an Initial Allegation Report to Health Care Personnel Investigation (HCPI). On 5/25/18, the investigation was completed and the allegation was unsubstantiated by the administrator. The Investigation Report was	F 600	Nursing (ADON) and/or the Quality Improvement (QI) Nurse 5 days weekly for 4 weeks, 3 days weekly for 4 weeks, then weekly for 4 weeks utilizing a Trach Care Audit tool. This audit is to ensure that tracheostomy care is being performed per policy and procedure, with 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 intact. 10% of all licensed nurses to include agency nurses and Nurse #6 and Nurse #7 will be observed utilizing a Medication Pass Tracheostomy Audit Tool 5 days weekly for 4 weeks, 3 days weekly for 4 weeks, then weekly for 4 weeks by the ADON and/or the QI Nurse. This audit is to ensure that nurses are reading each tracheostomy order on the MAR, following the physician order for tracheostomy care, documenting on the MAR tracheostomy care provided, and managing time to ensure tracheostomy care is provided. Any areas of concern identified during the audits will be addressed immediately by the ADON, QI Nurse, and/or the DON to include providing additional staff training. The DON will present the findings of the Trach Care Audit tools and the Medication Pass Tracheostomy Audit Tools to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 600	Continued From page 10 submitted to (HCPI) by the administrator. On 5/26/18, Resident #25 returned to the facility and was assessed by the hall nurse to include assessment of the tracheostomy site, which was clean, dry, and covered with a dry dressing. On 5/26/18, the assessment for Resident #25 was documented by the hall nurse in the electronic medical record. The care of the trachea was not documented to show we followed doctor's orders consistently. Therefore we proactively educated nursing personnel to include Nurse # 2, #6, and #7 on following doctor's order and providing trachea care. Nurse #2 will be reported to the Board of Nursing on 7/3/18 for not documenting on the Medication Administration Record by the Director of Nursing. Nurse #2 is no longer staffed at the facility through the Agency. Nurse # 6 and #7 will be reported to the board of Nursing on 7/3/18 for not providing tracheostomy care by the Director Nursing on 7/3/18. Corrective Action A contracted Respiratory Therapist (RT) initiated training on tracheostomy care with licensed nurses to include Nurse #6 and #7 on 7/1/18. The Director of Nursing, Staff Facilitator and eight other nurses have currently received the training by the RT and will complete all resident's tracheostomy care until the remaining nurses complete the training. There are ten licensed nurses that are left to be trained by the RT and will not be allowed to work until the training has been completed. A contracted RT is on site as of 2:15 pm on 7/3/18 and has initiated the remaining	F 600	Trach Care Audit tools and the Medication Pass Tracheostomy Audit Tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. The administrator and DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction. 1b. The process that lead to this deficiency was determined to be that the licensed nursing staff failed to clarify an order for an indwelling urinary catheter for Resident #25. The indwelling urinary catheter was not changed for Resident #25, resulting in hospitalization for a Urinary Tract Infection (UTI). On 5/25/18, Resident #25 returned to the facility from the hospital and was assessed by the 11-7 shift assigned hall nurse, to include observation of Resident #25 indwelling catheter and drainage bag, with documentation in the electronic health record. No concerns were noted during the assessment. On 5/26/18, the assigned hall nurse received clarification orders for Resident #25 for the indwelling urinary catheter to be changed monthly and as needed for leakage, dislodgement, and/or occlusion. The order was transcribed to the Medication Administration Record (MAR)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 600	Continued From page 11 licensed nurse training. On 5/22/18, all alert and oriented residents were interviewed for neglect by the Social Worker with no negative findings. On 5/30/18, an in-service was initiated with all license nurses to include agency nurse, and Nurse # 2, #6, and #7 by the facility nurse consultant and the Staff Facilitator (SF) on providing tracheostomy care as ordered by the physician. The in-service also addressed the expectation that documentation must be present on the Medication Administration Record (MAR) after providing tracheostomy care. The in-service was completed on 6/28/18. On 7/2/18, an in-service was initiated with all licensed nurses to include agency nurses and Nurse #6, and Nurse #7 by the Facility Nursing Consultant on reading each tracheostomy order on the MAR, following the physician order for tracheostomy care, documenting on the MAR tracheostomy care provided, checking each page of the MAR to ensure that no medications, treatments and documentation is missed. The in-service also included for licensed nurses to ask for additional assistance from the Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Staff Facilitator, or another hall nurse when feeling like assistance is needed to provide resident care to include tracheostomy care and time management. No licensed nurse will be allowed to work until the training has been completed. On 6/12/18, an observation of all residents to include Resident #25 was completed by the Director of Nursing (DON), the Assistant Director	F 600	on 5/26/18 by the assigned hall nurse. A 100 % audit was completed on 7/13/2018 by the Assistant Director of Nursing (ADON) of all residents with indwelling catheters to include resident # 25 to assess for signs\symptoms of a UTI. No areas of concerns noted during the audit. On 6/14/18, an audit of all residents with indwelling catheters to include Resident #25 was completed by the Quality Improvement (QI) Nurse, the Assistant Director of Nursing (ADON) and the DON to ensure all orders for indwelling urinary catheters were complete to include parameters for changing the urinary catheters. No areas of concerns were identified during audit. The audit was completed on 6/14/2018. On 6/14/18, a 100% audit was initiated by the QI Nurse, the ADON, and the DON of all residents with orders for indwelling catheters to include resident #25, MARs were audited for the past 3 months ensure documentation was complete and indwelling urinary catheters had been changed per physician orders. The audit was completed on 6/28/18. Any areas of concern identified during the audit were immediately addressed by the DON by conducting an assessment of the resident to include the indwelling urinary catheter for any abnormalities, signs\symptoms of UTI, notification of the physician, and/or providing additional staff training.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 600	Continued From page 12 of Nursing (ADON), and the Quality Improvement (QI) Nurse to physically identify all residents with tracheostomies. There were no other residents with tracheostomies identified during the audit. On 6/12/18, an audit of all MARs, including MARs for Resident #25, for the past 30 days, was completed by the ADON and the QI Nurse to ensure orders for respiratory care, including tracheostomy care were provided as evidenced by documentation on the MAR. There were no other identified areas of concern noted during the audit. On 6/12/18, an assessment of all residents with tracheostomies, including Resident #25 was completed by the QI Nurse and the ADON to ensure tracheostomy care was provided as evidenced by observing a clean insertion site and dressing with no drainage present. There were no identified areas of concern during the audit. On 6/12/18, an audit of all residents' physician orders to include Resident #25 was initiated by the QI nurse, the ADON, and the Staff Facilitator (SF) to identify all residents with orders to receive tracheostomy care. The audit was completed on 6/13/18. There were no other identified residents with orders to receive tracheostomy care. On 6/29/18, a 100% return demonstration of tracheostomy care was initiated with all licensed nurses to include agency nurses to include Nurse #2, Nurse #6, and Nurse #7 by the Assistant Director of Nursing (ADON). Retraining will be completed by the ADON during the time of the audit for any nurse that cannot demonstrate successful performance of tracheostomy care per policy and procedure. No nurse will be allowed to	F 600	On 5/29/18, an in-service was initiated by the Staff Facilitator (SF) for all licensed nurses and nursing assistants including agency to ensure urinary catheter care is provided and documented in the electronic health record. Additionally, any abnormalities observed at the insertion site or in the drainage bag to include urine odor, color, or any drainage must be reported immediately to the licensed nurse. The in-service was completed on 6/28/18. All newly hired licensed nurses and nursing assistants to include agency will be in-serviced by the SF during orientation to ensure urinary catheter care is provided and documented in the electronic health record. Additionally, any abnormalities observed at the insertion site or in the drainage bag to include urine odor, color, or any drainage must be reported immediately to the licensed nurse and the licensed nurse must notify the physician. On 6/14/18, an in-service was initiated by the SF for all licensed nurses to including agency to ensure all orders for indwelling urinary catheters are complete to include parameters for when to change the urinary catheters. Additionally, the in-service informed all licensed nurses to notify the physician to clarify any orders that did not contain instructions on when to change indwelling urinary catheters. The in-service was completed on 6/28/18. All newly hired licensed nurses including agency will be in-serviced by the SF during orientation to ensure all orders for indwelling urinary catheters are complete	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 600	Continued From page 13 perform tracheostomy care on a resident until successful completion of the return demonstration. No licensed nurse will be allowed to work until the return demonstration has been completed. On 6/29/18, an in-service for 100% of all staff was initiated by the SF regarding Neglect to include failure to provide tracheostomy care, signs of neglect, and reporting neglect. No staff will be allowed to work until the in-service is completed. The Quality Improvement Organization was contacted by the Regional Vice President of Operations on 7/03/18 for assistance in evaluation of specific steps to be taken to address tracheostomy care and training, staff position/title designated to be responsible for the steps, timeline for accomplishment of the steps, specific methodology to be used to evaluate the plan's success, and frequency of monitoring the effects of the plan initiation. All residents with tracheostomies to include Resident #25 will be physically observed and documentation of the MAR and non-ulcer flow sheet assessment will monitored by the Assistant Director of Nursing (ADON) and/or the Quality Improvement (QI) Nurse 5 days weekly for 4 weeks, 3 days weekly for 4 weeks, then weekly for 4 weeks utilizing a Trach Care Audit tool. This audit is to ensure that tracheostomy care is being performed per policy and procedure, with 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 intact. A medication pass audit on tracheostomy care will be completed by	F 600	to include parameters for when to change the urinary catheters. If orders did not include parameters on when to change the indwelling urinary catheter, the physician must be notified immediately. On 7/13/2018, an in-service was initiated by the SF with all licensed nurse to include agency nurses in regards to: When the hall nurse receives a new order for an indwelling catheter or a resident is admitted with an order for an indwelling catheter the following must occur: Hall nurse must write a telephone order to identify parameters of when to change the catheter to include size of catheter and diagnosis of use. Hall Nurse must place the catheter telephone order on the MAR per the physician and block of the date of next catheter change per the physicians order. Administrative nurses are to review all new orders to include new admission orders 5 days a week to ensure that any new catheter orders are complete to include parameters of when to change the catheter and placed on the MAR correctly. If any areas of concerns identified during order checks, the attending physician must be notified to get clarification of the catheter order. In-service to be completed by 7/17/2018 10% of residents with indwelling catheters to include Resident #25 will be reviewed by the ADON and\or QI Nurse weekly for 8 weeks, then monthly for 1 month, utilizing a Catheter Monitoring tool to ensure there is no signs\symptoms of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 600	Continued From page 14 the Assistant Director of Nursing (ADON) and/or the Quality Improvement (QI) Nurse on 10% of all licensed nurses to include agency nurses and Nurse #6 and Nurse #7, 5 days weekly for 4 weeks, 3 days weekly for 4 weeks, then weekly for 4 weeks utilizing a Medication Pass Tracheostomy Audit Tool. This audit is to ensure that nurses are reading each tracheostomy order on the MAR, following the physician order for tracheostomy care, documenting on the MAR tracheostomy care provided, and managing time to ensure tracheostomy care is provided. Any areas of concern identified during the audits will be addressed immediately by the ADON, QI Nurse, and/or the DON to include providing additional staff training. The DON will present the findings of the Trach Care Audit tool and the Medication Pass Tracheostomy Audit Tool to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the Trach Care Audit tool and the Medication Pass Tracheostomy Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. Final date of compliance 7/03/18. The administrator and DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction. The Credible Allegation for Immediate Jeopardy removal was validated on 07/03/18, which removed the Immediate Jeopardy on 07/03/18.	F 600	urinary tract infection and that all orders 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 MAR when the indwelling urinary catheter is changed per the physician orders. Any areas of concern identified during the review will be immediately addressed by the DON to include obtaining an order clarification, notification of attending physician assessment of the resident and/or providing additional staff training. The DON will present the findings of the Catheter Monitoring tools to the Executive QI committee monthly for 3 months. The Executive QI Committee will meet monthly 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 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 related to the plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 600	Continued From page 15	F 600		

Interviews were conducted with nursing staff present in the facility on 07/03/18. The staff confirmed the recent in-services and trainings related to tracheostomy care and documentation of tracheostomy care. Reviews of the in-service records, audit tools, audits performed and facility assessments were made. An interview with the DON on 07/03/18 at 2:45 p.m. revealed the named nurses had been reported to the North Carolina Board of Nursing. An interview with the Regional Vice President of Operations on 07/03/18 at 2:50 p.m. revealed he had contacted the Quality Improvement Organization for assistance in evaluation of specific steps to be taken to address tracheostomy care and training.

1b. A record review revealed Resident #25 had a hospitalization from 10/20/17 through 10/25/17. A review of Resident #25's admission orders dated 10/25/17 did not include any instructions regarding how often to change her indwelling urinary catheter.

Further record review of documentation of revealed two instances the indwelling urinary catheter had been changed - 10/11/17 and 12/20/17.

A review of Resident #25's physician orders 10/25/17 to 05/17/18 revealed there had been no physician order to change her indwelling urinary catheter.

A review of the hospital's Emergency Department's (ED's) notes revealed Resident #25 presented to the Emergency Department on 05/17/18 with a chief complaint of a dislodged percutaneous endoscopic gastrostomy (PEG)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 600	Continued From page 16	F 600		

tube.

A review of the hospital's ED registered nurse (RN) notes revealed, on 05/18/18 at 3:39 a.m., "condition of patient's (indwelling urinary) catheter noted with hardened large amounts of crystalized sediment ..."

A review of the hospital's Admission History and Physical (H&P), dated 05/18/18, indicated Resident #25 "presents from Skilled Nursing Facility (SNF) complaining of dislodged PEG tube. Patient denied any abdominal pain, nausea, vomiting, fevers, chills. Upon evaluation in the ED, the PEG tube was placed back ...upon initial exam by ED provider, it was noted that her right nephrostomy tube was draining purulent material. Abdominal computed tomography (CT) scan was obtained and is suggestive of a right pyelonephritis. Patient denies any symptoms ...denies abdominal pain, nausea, vomiting, diarrhea, dysuria ... Labs remarkable for grossly positive urine analysis ... Patient has been treated in this hospital for Proteus pyelonephritis / UTI / pyelonephritis in October 2017 ..." Further review of the H&P revealed an assessment of sepsis secondary to complicated UTI and pyelonephritis with planned replacements of the nephrostomy tube and indwelling urinary catheter and Resident #25 being treated with intravenous antibiotics.

During an interview with Resident #25's medical doctor (MD) on 05/25/18 at 1:00 p.m., the MD stated it was his expectation for nursing to change residents' indwelling urinary catheters every 30 days. The MD stated the fact Resident #25's indwelling urinary catheter had not been changed 30 days since it had been inserted certainly had been a contributory factor to her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 600	Continued From page 17	F 600		

current hospital diagnoses. The MD stated residents who have indwelling urinary catheters are at increased risk of UTIs.

During an interview with Nurse #4 on 05/26/18 at 12:30 p.m., Nurse #4 stated she thought the order to change the indwelling urinary catheter for Resident #25 had been inadvertently left off the MARs in October 2017 after Resident #25 returned to the facility from a hospitalization for UTI and pyelonephritis. Nurse #4 stated she knew Resident #25's indwelling urinary catheter had been changed since October 2017 but she could not prove it.

During an interview with Nurse #8 on 05/26/18 at 12:35 p.m., Nurse #8 stated residents with indwelling urinary catheters have their catheters replaced once a month. Nurse #8 stated the date of the month depends on the resident and when the catheter was first inserted. Nurse #8 stated she frequently had Resident #25 on her assignment and did not remember changing Resident #25's catheter in the recent past. Nurse #8 stated seeing the order to change the catheter on the MAR is a visual reminder to the nurse the catheter needs to be changed.

During an interview with Resident #25 on 05/26/18 at 1:20 p.m., the resident stated she could not remember exactly when her indwelling urinary catheter had last been changed at the facility. When she was told the medical record indicated 12/20/17, Resident #25 stated she felt sure it had been changed since but not for the last 2 months.

During an interview with the Administrator on 05/26/18 at 2:42 p.m., the Administrator stated, in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 600	Continued From page 18 regard to indwelling urinary catheter changes, he would expect the nursing staff to follow the plan of care as directed by the physician. The Administrator stated he would expect the nursing staff to document according to facility training.	F 600		
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 medical record review and staff interviews, the facility failed to accurately code the Quarterly Minimum Data Set (MDS) assessment for 1 of 1 sampled resident reviewed for hospice care (Resident #15). The findings included: Resident #15 was admitted to the facility on 09/08/17. Cumulative diagnoses included pleural effusion, vascular dementia without behavior disturbance, diabetes mellitus, hypokalemia, cerebellar stroke syndrome, acute ischemic heart disease, heart failure, pneumonia, chronic obstructive pulmonary disease, acute respiratory failure, muscle weakness, end stage renal disease, dysphagia, cognitive communication, severe sepsis, gastrostomy status, dependence on renal dialysis, anemia, neuromuscular dysfunction of bladder and urinary tract infection. Review of the Quarterly Minimum Data Set (MDS) assessment dated 02/15/18 indicated Resident #15 was cognitively intact. Section	F 641	Cumberland Nursing and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Cumberland Nursing and Rehabilitation's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Cumberland Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceeding.	7/11/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 641	Continued From page 19 JI400 prognosis was documented as no for resident having a condition or chronic disease that may result in a life expectancy of less than 6 months. Section O0100 indicated the Resident #15 received hospice care during this assessment period. Review of Resident #15 care plan dated on 02/15/18 revealed that there was no care plan for hospice care. During an interview with the Director of Nursing (DON) on 05/24/18 at 3:15 PM, she confirmed that the resident was not receiving hospice care services. The DON further stated that it was her expectation that the MDS is coded accurately. During an interview with the MDS Coordinator on 05/24/18 at 5:15 PM, she stated that it was a coding error and the resident is not receiving hospice care. During an interview with the Administrator on 05/26/18 at 2:40 PM, he stated that it was his expectation that the MDS is coded accurately for the resident.	F 641	F 641 The process which led to this deficiency was determined to be the Minimum Data Set (MDS) Coordinator failed to accurately code the MDS assessment for Resident #15, resulting in Resident #15 being coded as receiving hospice services. On 5/24/18, Resident #15 MDS assessment was modified by the MDS Coordinator to reflect Resident #15 was not receiving hospice services. On 5/29/18, an in-service was conducted by the facility nurse consultant with the MDS Coordinator and the MDS nurse with regards to coding residents for hospice services only when the resident has a physician□s order and receives hospice services. All newly hired MDS coordinators and MDS nurses will receive the in-service during orientation by the Staff Facilitator (SF) with regards to coding residents for hospice services only when the resident has a physician□s order and receives hospice services. On 6/11/18, a 100% audit of all residents□ current MDS assessments was initiated by the Quality Improvement (QI) Nurse, the Assistant Director of Nursing (ADON), and the Director of Nursing (DON), to be completed by 6/28/18. The audit will ensure that all residents are accurately coded in the MDS assessment according to the services received, to include hospice services. Any areas of concern	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 641	Continued From page 20	F 641	identified during the audit will be immediately addressed by the DON to include modification of the MDS assessment and providing additional staff training. 10% of completed MDS assessments to include Resident #15 will be reviewed by the ADON, the DON, and/or the MDS consultant to ensure accurate coding of the MDS assessments, including for residents receiving hospice services. This audit will be conducted utilizing an MDS Accuracy QI Tool three times weekly for 4 weeks, weekly for four weeks, then monthly for one month. Any identified areas of concern will be immediately addressed by the DON and/or the MDS consultant to include additional training and modifications to the MDS assessment as indicated. The DON will review and initial the MDS Accuracy QI Tool weekly for eight weeks and then monthly for one month to ensure any areas of concerns have been addressed. The DON will present the findings of the MDS Accuracy QI tool to the Executive Quality Improvement (QI) committee monthly for 3 months. The Executive QI Committee will meet monthly for 3 months and review the MDS Accuracy QI tool to determine trends and/or issues that may need further interventions 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 641	Continued From page 21	F 641	corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	
F 675 SS=D	Quality of Life CFR(s): 483.24 § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews, the facility failed to provide showers as scheduled for 1 of 3 residents reviewed (Resident #21). The findings included: Resident #21 was admitted to the facility on 08/13/15 with diagnoses which included muscle weakness and chronic ischemic heart disease. A review of Resident #21's Minimum Data Set (MDS), dated 02/21/18, revealed Resident #21 was cognitively intact and required extensive assistance with bed mobility, dressing and personal hygiene. A review of Resident #21's Care Plan, last revised 09/29/17, indicated Resident #21 required assistance for personal hygiene.	F 675	F 675 The process which led to this deficiency was determined to be the nursing staff failed to provide showers as scheduled to Resident #21. On 5/23/18, Resident #21 was provided with a shower by the assigned nursing assistant with documentation of the shower in the electronic health record. On 5/24/18, a questionnaire for all alert and oriented residents was completed by the Social Worker and Minimum Data Set (MDS) nurse regarding shower preferences to include preferences for baths and showers, or baths only. All care plans and care guides for alert and	7/11/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 675	Continued From page 22 During an interview with Resident #21 on 05/21/18 at 2:47 p.m., Resident #21 stated he had not consistently received showers on his scheduled shower days. Resident #21 indicated agency staff, in particular, do not give him a shower. Resident #21 stated he preferred getting a shower on his scheduled shower days. A review of the Nurse Assistant (NA) Bath Type documentation from 02/17/18 to 05/22/18 indicated nursing staff had documented 8 showers for Resident #21 during that timeframe. A review of the facility shower schedule indicated Resident #21's showers were scheduled twice weekly on the 3pm - 11pm shift on Wednesdays and Saturdays. Resident #21's next shower had been scheduled for 05/23/18 on the 3pm - 11pm shift. During an interview with NA #2 on 05/23/18 at 3:50 p.m., NA #2 stated he was an agency NA and had been assigned to care for Resident #21 for the 3pm - 11pm shift. NA #2 stated he had known there was a shower schedule notebook at the nurses' station. NA #2 stated there had been times he had not been able to provide residents showers as scheduled because he got too busy. When asked which residents on his assignment were scheduled for showers that evening, NA #2 stated he did not know. NA #2 stated the shower schedule notebook confused him stating it was hard for him to determine which resident had been scheduled for a shower and on what day the resident was to have the shower. During an interview with Nurse #4 on 05/24/18 at 8:05 a.m., Nurse #4 stated the agencies the	F 675	oriented residents were updated as applicable to indicate shower preferences. On 5/30/18, an in-service was initiated by the facility nurse consultant and the Staff Facilitator (SF) for all licensed nurses and nursing assistants to include agency, regarding residents receiving showers on the scheduled shower days. The in-service includes documenting in the electronic health record that showers were provided and if the resident refused, a progress note documenting the refusal was completed, and the nurse and/or the DON was notified of the refusal as well. The in-service will be completed on 6/28/18 by the SF. All newly hired licensed nurses and nursing assistants, including agency, will be in-serviced by the SF during orientation regarding residents receiving showers on the scheduled shower days with review of the shower schedule book. The in-service includes documenting in the electronic health record that showers were provided and if the resident refused, a progress note documenting the refusal was completed, and the nurse and/or the DON was notified of the refusal as well. On 5/30/18, a 100% audit was initiated by the facility nurse consultant and the DON for the past 30 days on all residents shower documentation to ensure showers were provided to all residents on scheduled shower days. The audit will be completed by the facility nurse consultant by 6/20/18. Any areas of concern identified during the audit will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 675	Continued From page 23 facility contracted with trained the NAs who are sent to the facility on basic Activities of Daily Living (ADLs) care and showers are included in the training. Nurse #4 stated when an agency NA reports to the facility for the first time they are shown the shower schedule notebook and are given instruction on documentation of showers or refusals of showers. Nurse #4 stated she knew Resident #21 got showers more frequently but stated she could not prove it because the showers had not been documented. During an interview with the Administrator on 05/24/18 at 9:08 a.m., the Administrator stated facility staff would obtain the residents' preferences in regard to bathing and then put the preferences on the residents' Care Guide. The Administrator stated the staff would be re-educated on proper documentation. The Administrator stated after these tasks had been completed it was his expectation the nursing staff follow the residents' bathing preference.	F 675	addressed immediately by the facility nurse consultant and/or the DON to include providing additional training as needed. On 6/14/18, the shower schedule was reviewed by the DON to ensure all residents, including Resident #12, with shower preferences were added to the shower schedule. All areas of concern identified during the review were addressed immediately by the DON to include revision of the shower schedule to reflect resident preferences. 10% of showers to include for Resident #21 will be reviewed by the QI Nurse, the Resource Nurse, and/or the Assistant Director of Nursing (ADON) utilizing the Shower Audit tool weekly for 12 weeks to ensure all documentation is present in the electronic medical record indicating that showers were provided as scheduled. Any areas of concern identified during the review will result in immediate action by the ADON and/or the QI Nurse. The DON will review and initial the Shower Audit tools weekly for 12 weeks to acknowledge completion of the audit. The administrator and/or the DON will present the findings of the Shower Audit tools to the Executive Quality Improvement (QI) Committee monthly for 3 months. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include continued frequency of monitoring. The administrator and the DON will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 675	Continued From page 24	F 675	responsible for the implementation of corrective actions to include all 100% audits, in-services, and monitoring related to the plan of correction.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to implement interventions to prevent falls which resulted in multiple falls for 1 of 1 sampled resident. (Resident #74) The findings included: Record review revealed Resident #74 was admitted to the facility on 6/24/2016 with diagnoses which included dementia, anxiety, depression and hypertension. Review of the quarterly Minimum Data Set (MDS) dated 4/4/2018 revealed Resident # 74 was severely cognitively impaired and required extensive assistance with 2 person with transfer and bed mobility. The MDS further revealed the resident was not steady from moving from seated to standing. She was coded for limited assistance with 1 person for locomotion on the unit. The Resident was coded for 1 fall for the quarterly	F 689	F 689 The process which led to this deficiency was determined to be the facility failed to implement interventions to prevent falls, resulting in multiple falls for Resident #74. On 6/12/18, a 100% audit of all progress notes and incident reports to include for Resident #74 during the month of May was initiated by the facility nurse consultant and the Director of Nursing (DON) to ensure an intervention has been put into place after a fall has occurred. The audit will be completed by 6/28/18. Any areas of concern identified during the audit will be immediately addressed by the Director of Nursing (DON) to include adding an intervention to the care plan and/or care guide as applicable and/or	7/11/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 689	Continued From page 25 review. Review of the Care Plan for Resident # 74 dated 5/8/2018 included a focus of risk for falls related to a history of falls, cognitive impairment and lack of safety awareness. The goal was the resident would have no falls with injury through the next review date of 6/12/2018. Interventions implemented since 5/9/2018 included rehab therapy referral, ensure environment is free of clutter and assist resident to negotiate barriers as necessary. The care plan indicated the interventions before the resident's last fall of 5/9/2018 included placing the bed in the lowest position and have commonly used articles within easy reach. The following fall investigations for Resident # 74 were reviewed: 3/2/2018 -Resident # 74 was ambulatory in the locked unit and went to another resident's room. The resident was observed lying on the floor on her left side in another resident's room. Resident was assisted from the floor. Her body checked. Bluish discoloration observed to left elbow. Neurological checks were completed per the facility policy. No new fall interventions were documented. 4/27/2018 - Resident # 74 was trying to get up from bed without assistance. The resident was found lying on the floor beside her bed. No assessed injuries were noted. Neurological checks were completed per the facility policy. No new fall interventions were documented. 5/3/2018-Resident # 74 was walking around in the sitting area of the locked unit and fell on the	F 689	providing additional staff training. On 6/12/18, an in-service for 100% of all licensed nurses to include agency was initiated by the Staff Facilitator (SF) to ensure all falls have an intervention put into place immediately with documentation in the resident□s medical record and on the care guide. The in-service will be completed on 6/28/18 by the SF. All newly hired licensed nurses including agency will be provided with this in-service by the SF during orientation to ensure all falls have an intervention put into place immediately with documentation in the resident□s medical record and on the care guide. On 6/12/18, the Minimum Data Set (MDS) Coordinator and MDS nurse were in-serviced by the Facility Nurse Consultant to ensure care plans and care guides are updated to reflect interventions put into place for falls. All newly hired MDS Coordinators and MDS nurses will be in-serviced by the SF during orientation on ensuring care plans and care guides are updated to reflect interventions put into place for falls. On 6/14/18, the care guide and care plan for Resident #74 was reviewed by the facility nurse consultant and the Director of Nursing (DON) to ensure fall interventions were documented. On 6/14/18, Resident #74 room was inspected by the DON to ensure all interventions were implemented according	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 689	Continued From page 26 floor. Resident was in the sitting position and was crying. No injuries were noted. Neurological checks were completed per the facility policy. No new interventions were documented. An observation of Resident # 74 was conducted on 5/23/2018 at 10:55 AM. The resident was sitting in the activity room in a chair. An interview was conducted on 5/ 23/2018 at 3:00 PM with the Quality Assurance (QA) nurse. The QA nurse reported she was aware of Resident # 74's repeated falls. The QA nurse indicated the falls were reviewed at the facility daily by the clinical team and appropriate interventions were put into place. The QA nurse further indicated interventions for Resident # 74 were difficult due to the fact the resident had decreased safety awareness and attempted to get up independently. An interview was conducted on 5/23/2018 at 3:20 PM with Nursing Assistant (NA) # 1. NA # 1 confirmed she was familiar with Resident #74 and worked with her regularly. NA # 1 reported the resident tried to get up and would fall often. NA #1 indicated she did not know what would keep the resident from not falling. NA #1 further indicated all the staff on the hall were aware of the resident's numerous falls and would check on her often. An interview was conducted with the Director of Nursing (DON) on 5/24/2018 at 1:20 PM. The DON revealed she was not familiar with Resident # 74's falls since she had just started working in her new role as DON 3 weeks ago. DON indicated her expectation would be for an	F 689	to the care plan and care guide. No areas of concern were identified during the audit. On 6/14/18, the administrator, the DON, the Assistant Director of Nursing (ADON), the Quality Improvement (QI) Nurse, and the Staff Facilitator (SF) were educated by the facility nurse consultant regarding the Fall Risk Protocol and Procedure, which included ensuring an intervention was put into place on the care plan and care guide and that the intervention was implemented after a fall. All falls will be reviewed in clinical meeting 5 times weekly for 12 weeks utilizing a Fall Intervention Monitoring tool by the Quality Improvement (QI) Nurse and/or the Assistant Director of Nursing (ADON) to ensure an intervention has been put into place for each fall and the care plan and care guide has been updated to reflect the intervention added. Any areas of concern identified during the audit will result in immediate action by the QI Nurse, the ADON, and/or the DON to include adding an intervention if necessary and/or providing additional staff training. The DON will review and initial each Fall Intervention Monitoring tool weekly for 12 weeks to acknowledge completion of the audit. The administrator and/or the DON will present the findings of the Fall	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 689	Continued From page 27 intervention to be implemented each time a resident had a fall at the facility. An interview was conducted with the Administrator on 5/24/2018 at 1:50 PM. The Administrator revealed the clinical team met every day and discussed each fall. The Administrator indicated the clinical team tried to find appropriate interventions for all falls. The Administrator reported she was aware of Resident # 74's repeated falls and since the resident was not cognitively able to follow directions the clinical team did not know what else to offer as interventions. The Administrator stated the expectation was for fall interventions to be appropriate and for supervision to be provided to prevent accidents.	F 689	Intervention Monitoring tool to the Executive Quality Improvement (QI) Committee monthly for 3 months. Any issues, concerns, and/or trends identified 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 related to the plan of correction.	
F 690 SS=G	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one	F 690		7/17/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 690	Continued From page 28 is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interviews, the facility failed to clarify indwelling urinary catheter orders for 1 of 1 resident reviewed (Resident #25) resulting in a resident's indwelling urinary catheter not being changed for several months and a hospitalization for a urinary tract infection (UTI). The Findings Included: Resident #25 was admitted to the facility on 12/03/09. Her medical diagnoses included, in part, Multiple Sclerosis (MS), calculus (stone) in urethra, calculus of kidney, chronic obstructive pyelonephritis (kidney infection), reflux uropathy (urine flow from bladder toward the kidney), retention of urine and history of urinary tract infection (UTI). A review of Resident #25's quarterly Minimum Data Set, dated 02/21/18, revealed Resident #25	F 690	F 690 The process that lead to this deficiency was determined to be that the licensed nursing staff failed to clarify an order for an indwelling urinary catheter for Resident #25. The indwelling urinary catheter was not changed for Resident #25, resulting in hospitalization for a Urinary Tract Infection (UTI). On 5/25/18, Resident #25 returned to the facility from the hospital and was assessed by the 11-7 shift assigned hall nurse, to include observation of Resident #25 indwelling catheter and drainage bag, with documentation in the electronic health record. No concerns were noted during the assessment. On 5/26/18, the assigned hall nurse	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 690	Continued From page 29	F 690		

had been cognitively intact and required total assistance of staff for her Activities of Daily Living (ADL). The MDS indicated Resident #25 had an indwelling urinary catheter and had obstructive uropathy.

A review of Resident #25's Care Plan, last revised 12/06/17, 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.
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.
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 revised 06/30/17).

A record review revealed the resident had a hospitalization from 10/20/17 through 10/25/17. A review of Resident #25's admission orders dated 10/25/17 did not include any instructions regarding how often to change her indwelling

received clarification orders for Resident #25 for the indwelling urinary catheter to be changed monthly and as needed for leakage, dislodgement, and/or occlusion. The order was transcribed to the Medication Administration Record (MAR) on 5/26/18 by the assigned hall nurse.

A 100 % audit was completed on 7/13/2018 by the Assistant Director of Nursing (ADON) of all residents with indwelling catheters to include resident # 25 to assess for signs\symptoms of a UTI. No areas of concerns noted during the audit.

On 6/14/18, an audit of all residents with indwelling catheters to include Resident #25 was completed by the Quality Improvement (QI) Nurse, the Assistant Director of Nursing (ADON) and the DON to ensure all orders for indwelling urinary catheters were complete to include parameters for changing the urinary catheters. No areas of concerns were identified during audit. The audit was completed on 6/14/2018.

On 6/14/18, a 100% audit was initiated by the QI Nurse, the ADON, and the DON of all residents with orders for indwelling catheters to include resident #25, MARs were audited for the past 3 months ensure documentation was complete and indwelling urinary catheters had been changed per physician orders. The audit was completed on 6/28/18. Any areas of concern identified during the audit were immediately addressed by the DON by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 690	Continued From page 30 urinary catheter. Further record review documentation of revealed two instances the indwelling urinary catheter had been changed - 10/11/17 and 12/20/17. A review of Resident #25's physician orders 10/25/17 to 05/17/18 revealed there had been no physician order to change her indwelling urinary catheter. A review of the hospital's Emergency Department's (ED's) notes revealed Resident #25 presented to the Emergency Department on 05/17/18 with a chief complaint of a dislodged percutaneous endoscopic gastrostomy (PEG) tube. A review of the hospital's ED registered nurse (RN) notes revealed, on 05/18/18 at 3:39 a.m., "condition of patient's (indwelling urinary) catheter noted with hardened large amounts of crystalized sediment ..." A review of the hospital's Admission History and Physical (H&P), dated 05/18/18, indicated Resident #25 "presents from Skilled Nursing Facility (SNF) complaining of dislodged PEG tube. Patient denied any abdominal pain, nausea, vomiting, fevers, chills. Upon evaluation in the ED, the PEG tube was placed back ...upon initial exam by ED provider, it was noted that her right nephrostomy tube was draining purulent material. Abdominal computed tomography (CT) scan was obtained and is suggestive of a right pyelonephritis. Patient denies any symptoms ...denies abdominal pain, nausea, vomiting, diarrhea, dysuria ... Labs remarkable for grossly positive urine analysis ... Patient has been treated	F 690	conducting an assessment of the resident to include the indwelling urinary catheter for any abnormalities, signs\symptoms of UTI, notification of the physician, and/or providing additional staff training. On 5/29/18, an in-service was initiated by the Staff Facilitator (SF) for all licensed nurses and nursing assistants including agency to ensure urinary catheter care is provided and documented in the electronic health record. Additionally, any abnormalities observed at the insertion site or in the drainage bag to include urine odor, color, or any drainage must be reported immediately to the licensed nurse. The in-service was completed on 6/28/18. All newly hired licensed nurses and nursing assistants to include agency will be in-serviced by the SF during orientation to ensure urinary catheter care is provided and documented in the electronic health record. Additionally, any abnormalities observed at the insertion site or in the drainage bag to include urine odor, color, or any drainage must be reported immediately to the licensed nurse and the licensed nurse must notify the physician. On 6/14/18, an in-service was initiated by the SF for all licensed nurses to including agency to ensure all orders for indwelling urinary catheters are complete to include parameters for when to change the urinary catheters. Additionally, the in-service informed all licensed nurses to notify the physician to clarify any orders that did not contain instructions on when	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 690	Continued From page 31 in this hospital for Proteus pyelonephritis / UTI / pyelonephritis in October 2017 ..." Further review of the H&P revealed an assessment of sepsis secondary to complicated UTI and pyelonephritis with planned replacements of the nephrostomy tube and indwelling urinary catheter and Resident #25 being treated with intravenous antibiotics. During an interview with Resident #25's medical doctor (MD) on 05/25/18 at 1:00 p.m., the MD stated it was his expectation for nursing to change residents' indwelling urinary catheters every 30 days. The MD stated the fact Resident #25's indwelling urinary catheter had not been changed 30 days since it had been inserted certainly had been a contributory factor to her current hospital diagnoses. The MD stated residents who have indwelling urinary catheters are at increased risk of UTIs. During an interview with Nurse #4 on 05/26/18 at 12:30 p.m., Nurse #4 stated she thought the order to change the indwelling urinary catheter for Resident #25 had been inadvertently left off the MARs in October 2017 after Resident #25 returned to the facility from a hospitalization for UTI and pyelonephritis. Nurse #4 stated she knew Resident #25's indwelling urinary catheter had been changed since October 2017 but she could not prove it. During an interview with Nurse #8 on 05/26/18 at 12:35 p.m., Nurse #8 stated residents with indwelling urinary catheters have their catheters replaced once a month. Nurse #8 stated the date of the month depends on the resident and when the catheter was first inserted. Nurse #8 stated she frequently had Resident #25 on her assignment and did not remember changing	F 690	to change indwelling urinary catheters. The in-service was completed on 6/28/18. All newly hired licensed nurses including agency will be in-serviced by the SF during orientation to ensure all orders for indwelling urinary catheters are complete to include parameters for when to change the urinary catheters. If orders did not include parameters on when to change the indwelling urinary catheter, the physician must be notified immediately. On 7/13/2018, an in-service was initiated by the SF with all licensed nurse to include agency nurses in regards to: When the hall nurse receives a new order for an indwelling catheter or a resident is admitted with an order for an indwelling catheter the following must occur: Hall nurse must write a telephone order to identify parameters of when to change the catheter to include size of catheter and diagnosis of use. Hall Nurse must place the catheter telephone order on the MAR per the physician and block of the date of next catheter change per the physicians order. Administrative nurses are to review all new orders to include new admission orders 5 days a week to ensure that any new catheter orders are complete to include parameters of when to change the catheter and placed on the MAR correctly. If any areas of concerns identified during order checks, the attending physician must be notified to get clarification of the catheter order. In-service to be completed by 7/17/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 690	Continued From page 32 Resident #25's catheter in the recent past. Nurse #8 stated seeing the order to change the catheter on the MAR is a visual reminder to the nurse the catheter needs to be changed. During an interview with Resident #25 on 05/26/18 at 1:20 p.m., the resident stated she could not remember exactly when her indwelling urinary catheter had last been changed at the facility. When she was told the medical record indicated 12/20/17, Resident #25 stated she felt sure it had been changed since but not for the last 2 months. During an interview with the Administrator on 05/26/18 at 2:42 p.m., the Administrator stated, in regard to indwelling urinary catheter changes, he would expect the nursing staff to follow the plan of care as directed by the physician. The Administrator stated he would expect the nursing staff to document according to facility training.	F 690	10% of residents with indwelling catheters to include Resident #25 will be reviewed by the ADON and\or QI Nurse weekly for 8 weeks, then monthly for 1 month, utilizing a Catheter Monitoring tool to ensure there is no signs\symptoms of urinary tract infection and that all orders 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 MAR when the indwelling urinary catheter is changed per the physician orders. Any areas of concern identified during the review will be immediately addressed by the DON to include obtaining an order clarification, notification of attending physician assessment of the resident and/or providing additional staff training. The DON will present the findings of the Catheter Monitoring tools to the Executive QI committee monthly for 3 months. The Executive QI Committee will meet monthly 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 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 related to the plan of correction.	
F 695	Respiratory/Tracheostomy Care and Suctioning	F 695		7/11/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 695 SS=J	Continued From page 33 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 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 interviews, the facility failed to provide tracheostomy care as ordered by the medical doctor for 1 of 1 resident reviewed for respiratory care (Resident #25). Immediate 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. The 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. A review of Resident #25's Minimum Data Set (MDS), dated 02/21/18, indicated Resident #25 was cognitively intact and required total	F 695	F695 The process that lead to the deficiency was the failure of nurse #7 not completely reading the Medication Administration Record (MAR) which resulted in not documenting tracheostomy care provided. The failure of Nurse #6 and Nurse #2 to 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 #25 related to being busy but could not state the reason why they did not ask for assistance. On 5/17/18, Resident #25 was sent out to the hospital for evaluation due to dislodged G-Tube. Resident #25 trach was assessed by the Treatment Nurse on 4/30/18, 5/7/18, and 5/14/18 with no documentation of larvae, foul odor, or drainage around the trach site.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 695	Continued From page 34 dependence on staff for her Activities of Daily Living (ADLs). The MDS indicated resident received oxygen therapy and tracheostomy care. A review of Resident #25's Care Plan indicated Resident #25 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 facility protocol and to check dressing to stoma site frequently and replace/change as needed or as ordered (last revised 12/28/17). The Care Plan indicated Resident #25 had been 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 record review of Resident #25's May 2018 Medication Administration Record (MAR) revealed a physician's order for "tracheostomy site dressing change every day" and the dressing change was scheduled to be completed at 4:00 p.m. Prior to Resident #25 leaving the facility on 05/17/18, there had been 8 dates the order had not been signed off by a nurse as having been completed - May 1, 2, 4, 6, 7, 9, 10 and 15. Prior to being discharged to the hospital on 05/17/18, the dressing had been documented as completed on 05/16/18. The MAR indicated the dressing had not been completed on 05/17/18.	F 695	On 5/17/18 per hospital record at 6:58 pm, one hour after resident was in the Emergency Department, the RN documented Patient conscious, alert and oriented x 4, respiratory rate even and unlabored, patient has trach and wears O2 @ 2 liters. No mention of drainage, larvae, or foul-odor in tracheostomy. On 5/17/18 per hospital record at 9:15 pm, resident had a chest x-ray complete. Findings: Tracheostomy tube in stable position. On 5/17/18 per hospital record at 10:42 pm, per the documentation of the Registered nurse, tracheostomy tube in place. O2 @ 3 Liters via trach mask. On 5/18/18 per hospital record at 5:32 am, per the documentation of the Registered nurse, suction at bedside. On 5/18/18 per hospital record at 8:33 am there is documentation of a Respiratory Therapist treatment assessment. On 5/18/18 per the hospital record at 2:02 pm there is documentation of the registered nurse Patient□s tracheostomy with brownish drainage, foul odor. G-tube site needs cleaning. Called Respiratory Therapist (RT) to clean g-tube and RT notified RN that pt has maggots in tracheostomy. RN confirmed this by eye site. RN notified physician via phone and awaiting call back. On 5/18/18, the administrator was made	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 695	Continued From page 35 During an interview with Nurse #7 on 05/25/18 at 2:20 p.m., Nurse #7 stated she had worked the 3 p.m. to 11 p.m. shift on 05/16/18 and had remembered changing the dressing on Resident #25's tracheostomy and stated it had looked fine. Nurse #7 stated she worked the 3 p.m. to 11 p.m. shift on 5/17/18 and had been one of the nurses who had assessed Resident #25 when her PEG tube had dislodged. When asked if she had checked Resident #25's tracheostomy site prior to Resident #25 being sent out, Nurse #7 stated she remembered there had been no drainage noted on the sheets. During an interview with Nurse #2 on 05/26/18 at 9:56 a.m., Nurse #2 had been asked why she had not signed her initials on the MAR for Resident #25's tracheostomy site dressing on May 2, 4, 6, 7, 9 and 15, 2018. Nurse #2 stated while she remembered changing the dressing a couple of times she stated she was going to be honest. Nurse #2 stated when she came on duty she was responsible for a medication cart and 30 residents in addition to overseeing 2-3 medication aides. Nurse #2 stated she stayed stressed out because when she would come on duty she had always been pulled here and there dealing with resident issues and behaviors. Nurse #2 stated it had been very challenging and stated she felt it could be the reason why she did not always do the dressing change. During an interview with Nurse #6 on 05/26/18 at 10:40 a.m., Nurse #6 stated she recalled changing Resident #25's tracheostomy site dressing in the past but stated she could not recall whether or not she had changed the dressing on 05/01/18.	F 695	aware by resident #25 friend of an allegation that Resident #25 was observed with maggots in her throat while at the hospital. On 5/18/18, an investigation was started by the administrator to include submission of an Initial Allegation Report to Health Care Personnel Investigation (HCPI). On 5/25/18, the investigation was completed and the allegation was unsubstantiated by the administrator. The Investigation Report was submitted to HCPI by the administrator. Nurse #6 and #7 were reported to the Board of Nursing on 7/3/18 for not providing tracheostomy care by the Director of Nursing (DON). On 5/26/18, Resident #25 returned to the facility and was assessed by the hall nurse to include assessment of the tracheostomy site, which was clean, dry, and covered with a dry dressing. On 5/26/18, the assessment for Resident #25 was documented by the hall nurse in the electronic medical record. On 6/12/18, an observation of all residents to include Resident #25 was completed by the DON, the Assistant Director of Nursing (ADON), and the Quality Improvement (QI) Nurse to physically identify all residents with tracheostomies. One resident was identified with a tracheostomy.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 695	Continued From page 36 During an interview with Nurse #7 on 05/26/18 at 12:49 p.m., Nurse #7 stated 5/10/18 had been her first day of employment at the facility. Nurse #7 stated she recalled changing Resident #25's tracheostomy site dressing on 05/10/18 and stated she had forgotten to sign off on the MAR. During an interview with the hospital ED nurse #2 on 07/03/18 at 9:33 a.m., the hospital ED nurse #2 stated Resident #25 arrived in the ED approximately 15 minutes before the end of her 7 a.m. to 7 p.m. shift on 05/17/18. The hospital ED nurse #2 stated Resident #25 smelled like she needed a bath and her nephrostomy and indwelling urinary catheter were in need of some "tender loving care" however she had not assessed Resident #25's tracheostomy because her oxygen saturation had been okay. During an interview with the hospital ED nurse #3 on 07/03/18 at 11:30 a.m., the hospital ED nurse #3 stated she had cared for Resident #25 during her 7 p.m. to 7 a.m. shift on 05/17/18. The hospital ED nurse #3 stated Resident #25 had been in "real bad condition" and had focused her care to Resident #25's nephrostomy and indwelling urinary catheter secondary to Resident #25 having had "really bad smelling urine." During an interview with the hospital ED nurse #1 on 05/23/18 at 4:25 p.m., the ED nurse #1, who worked the 7 a.m. to 7 p.m. shift on 5/18/18, stated when she had entered the holding room Resident #25 had been placed in she could smell the "stench" coming off of her and noted that her face had dried spittle on it, her hair had been matted with white flakes and it appeared like it had not been washed in a long time. The ED	F 695	On 6/12/18, an audit of all Medication Administration Record (MARs), including MARs for Resident #25, for the past 30 days, was completed by the ADON and the QI Nurse to ensure orders for respiratory care, including tracheostomy care were provided as evidenced by documentation on the MAR. There were no other identified areas of concern noted. On 6/12/18, an assessment of all residents with tracheostomies, including Resident #25 was completed by the QI Nurse and the ADON to ensure tracheostomy care was provided as evidenced by observing a clean insertion site and dressing with no drainage present. There were no identified areas of concern during the audit. On 6/12/18, an audit of all residents physician orders to include Resident #25 was initiated by the QI nurse, the ADON, and the Staff Facilitator (SF) to identify all residents with orders to receive tracheostomy care. The audit was completed on 6/13/18. There were no other identified residents with orders to receive tracheostomy care. On 6/29/18, a 100% return demonstration of tracheostomy care was initiated with all licensed nurses to include agency nurses and Nurse #6, and Nurse #7 by the ADON and SF. Return demonstration of tracheostomy care was completed on 7/7/18. Retraining was completed by the ADON and/or SF during the time of the audit for any nurse that could not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 695	Continued From page 37	F 695		

nurse #1 stated she looked at Resident #25's tracheostomy site and had noted a substance on the tracheostomy which she compared to melted malt chocolate. The ED nurse stated she called a Respiratory Therapist (RT) for tracheostomy care and oxygen needs. The ED nurse stated once the RT had begun tracheostomy care, he had informed her of the presence of maggots on Resident #25's skin surrounding her tracheostomy site. The ED nurse stated she then observed the presence of maggots around the tracheostomy site.

During an interview with the hospital's RT #1 on 05/25/18 at 11:15 a.m., the RT #1 stated he recalled Resident #25 in the ED on 05/18/18. The RT stated he had been called to the ED to assess the resident, assess oxygen saturation and perform tracheostomy care. The RT #1 stated upon arrival to Resident #25's ED room, he had noticed a foul odor emanating from the resident. The RT #1 stated when he had assessed the tracheostomy, he noticed the tracheostomy ties were dirty and there were visible dried secretions on her tracheostomy. The RT #1 stated he removed the tracheostomy site sponge (gauze dressing from the facility) and it had been so dirty and had secretions so old the sponge was hard. The RT #1 stated Resident #25's skin underneath the sponge was red and he had noticed maggots under the tracheostomy ties and the sponge. The RT #1 stated he had noticed Resident #25's odor was more prevalent during the tracheostomy care but could not state whether the foul odor was coming from the tracheostomy site or not. The RT #1 stated he cleaned all of the maggots off of Resident #25's skin and cleaned the tracheostomy however he did not have time to change the inner cannula as

demonstrate successful performance of tracheostomy care per policy and procedure.
On 7/1/18, a contracted RT initiated training on tracheostomy care with licensed nurses and agency nurses to include Nurse #6 and #7. 100 % training was completed with all licensed nurse and agency nurses on 7/7/18.The RT will train all newly hired licensed nurse and contracted agency nurses during orientation.

On 5/30/18, a 100 % in-service was initiated with all license nurses to include agency nurses, and Nurse #6 and Nurse #7 by the facility nurse consultant and the SF on providing tracheostomy care as ordered by the physician and documentation of tracheostomy care on MAR. The in-service also addressed the expectation that documentation must be present on the MAR after providing tracheostomy care. The in-service was completed on 6/28/18.

On 7/2/18, a 100 % in-service was initiated with all licensed nurses to include agency nurses and Nurse #6, and Nurse #7 by the Facility Nursing Consultant on reading each tracheostomy order on the MAR, following the physician order for tracheostomy care, documenting on the MAR tracheostomy care provided, checking each page of the MAR to ensure that no medications, treatments, and documentation is missed. The in-service also included for licensed nurses to ask for additional assistance from the DON,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 695	Continued From page 38 Resident #25 had to be transferred to another part of the hospital. During a 2nd interview with the hospital RT #1 on -07/03/18 at 8:57 a.m., the hospital RT #1 stated he and another hospital RT #2 had performed Resident #25's tracheostomy care together on 05/18/18 and the hospital RT #2 had documented the care. A review of the hospital's records indicated Resident #25 had arrived at the Emergency Department (ED) on 05/17/18 at 5:50 p.m. with a chief complaint of a dislodged PEG tube. Further review of the hospital record ED notes revealed the following: 1. An RT note, dated 5/18/18 8:33 a.m. - "oxygen device = tracheostomy collar (TC), fraction of inspired oxygen (FIO2): 30, breath sounds diminished; note - pt placed on 30% TC at this time, peripheral capillary oxygen saturation (SPO2) 97%" 2. An ED nurse note, dated 05/18/18 2:02 p.m. - "patient's tracheostomy with brownish drainage, foul odor ...called Respiratory Therapist (RT) to clean. RT notified RN that patient has maggots in tracheostomy. RN confirmed this by eyesight." 3. Final order results of a chest x-ray performed on 05/17/18 at 9:15 p.m. revealed findings of "tracheostomy tube is stable in position ...no acute process" A review of a hospital's Tracheostomy Assessment note, dated 5/18/18 at 2:00 p.m., stated "called to patient's room for tracheostomy assessment, upon more detailed look at tracheostomy this RT found maggots crawling around tracheostomy site ...all maggots that were seen were wiped off ...Once RN called to room she asked patient when was the last time they	F 695	ADON, QI Nurse, SF, or another hall nurse when feeling like assistance is needed to provide resident care to include tracheostomy care and time management. The in-service was completed on 7/7/18. All newly staffed agency or newly hired licensed nurse will be educated by the SF during orientation in regards to reading each tracheostomy order on the MAR, following the physician order for tracheostomy care, documenting on the MAR tracheostomy care provided, checking each page of the MAR to ensure that no medications, treatments, and documentation is missed. On 7/11/18, the administrator spoke with Quality Improvement Organization (QIO) for assistance in evaluation of specific steps to be taken to address tracheostomy care and training, staff position/title designated to be responsible for the steps, timeline for accomplishment of the steps, specific methodology to be used to evaluate the plan□s success, and frequency of monitoring the effects of the plan initiation. The QIO staff are scheduled to visit the facility on 7/18/18 to review current Plan of Correction, current systems, monitoring of tracheostomy care and make further recommendations in regards to tracheostomy care. 10% of all residents with tracheostomies to include Resident #25 will be physically observed and documentation of the MAR and non-ulcer flow sheet assessment will be monitored by the Assistant Director of Nursing (ADON) and/or the Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 695	Continued From page 39 cleaned it at the nursing facility and patient stated "they cleaned it 2 days ago." 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. During an interview with the Administrator on 05/26/18 at 2:42 p.m., the Administrator stated his expectation of nursing staff, in regard to tracheostomy care, is to follow the residents' plan of care as directed by the physician. The Administrator stated it was his expectation nursing staff document according to facility training. The Assistant Director of Nursing was notified of the Immediate Jeopardy on 06/29/18 at 3:10 p.m. On 07/03/18 at 2:46 p.m., the facility provided the following credible allegation of compliance and Immediate Jeopardy removal: A thorough investigation was completed by the administrator on 7/02/18 to ascertain the cause. It	F 695	Improvement (QI) Nurse 5 days weekly for 4 weeks, 3 days weekly for 4 weeks, then weekly for 4 weeks utilizing a Trach Care Audit tool. This audit is to ensure that tracheostomy care is being performed per policy and procedure, with 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 intact. 10% of all licensed nurses to include agency nurses and Nurse #6 and Nurse #7 will be observed utilizing a Medication Pass Tracheostomy Audit Tool 5 days weekly for 4 weeks, 3 days weekly for 4 weeks, then weekly for 4 weeks by the ADON and/or the QI Nurse. This audit is to ensure that nurses are reading each tracheostomy order on the MAR, following the physician order for tracheostomy care, documenting on the MAR tracheostomy care provided, and managing time to ensure tracheostomy care is provided. Any areas of concern identified during the audits will be addressed immediately by the ADON, QI Nurse, and/or the DON to include providing additional staff training. The DON will present the findings of the Trach Care Audit tools and the Medication Pass Tracheostomy Audit Tools to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the Trach Care Audit tools and the Medication	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 695	Continued From page 40 was determined by the administrator that the cause was the failure of nurse #7 not completely reading the Medication Administration Record which resulted in not documenting tracheostomy care provided. During the interview, Nurse #6 and nurse #2 both stated that they did not provide tracheostomy care to resident #25 related to being busy but could not state the reason why they did not ask for assistance. On 5/17/18, Resident #25 was sent out to the hospital for evaluation due to dislodged G-Tube. Resident #25's tracheostomy was assessed by the Treatment Nurse on 4/30/18, 5/7/18, and 5/14/18 with no documentation of larvae, foul odor, or drainage around the tracheostomy site. On 5/17/18 per hospital record at 6:50 pm, one hour after resident was in the Emergency Department, the RN documented "Patient conscious, alert and oriented x 4, respiratory rate even and unlabored, patient has tracheostomy and wears O2 @ 3 liters." No mention of drainage, larvae, or foul-odor in tracheostomy. On 5/17/18 per hospital record at 9:15 pm, resident had a chest x-ray complete. Findings: "Tracheostomy tube in stable position." On 5/17/18 per hospital record at 10:42 pm, per the documentation of the Registered nurse, "tracheostomy tube in place. O2 @ 3 Liters via tracheostomy mask." On 5/18/18 per hospital record at 5:32 am, per the documentation of the Registered nurse, "suction at bedside."	F 695	Pass Tracheostomy Audit Tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. The administrator and DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 695	Continued From page 41	F 695		

On 5/18/18 per hospital record at 8:33 am there is documentation of a Respiratory Therapist treatment assessment.

On 5/18/18 per the hospital record at 2:24 pm there is documentation of the registered nurse "Patient's tracheostomy with brownish drainage, foul odor. G-tube site needs cleaning. Called RT to clean g-tube and RT notified RN that pt has maggots in tracheostomy. RN confirmed this by eye site. RN notified physician via phone and awaiting call back."

On 5/18/18, the administrator was made aware by resident #25 friend of an allegation that Resident #25 was observed with maggots in her throat while at the hospital.

On 5/18/18, an investigation was started by the administrator to include submission of an Initial Allegation Report to Health Care Personnel Investigation (HCPI).

On 5/25/18, the investigation was completed and the allegation was unsubstantiated by the administrator. The Investigation Report was submitted to (HCPI) by the administrator.

On 5/26/18, Resident #25 returned to the facility and was assessed by the hall nurse to include assessment of the tracheostomy site, which was clean, dry, and covered with a dry dressing. On 5/26/18, the assessment for Resident #25 was documented by the hall nurse in the electronic medical record.

The care of the trachea was not documented to show we followed doctor's orders consistently. Therefore we proactively educated nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 695	Continued From page 42	F 695		

personnel to include Nurse # 2, #6, and #7 on following doctor's order and providing trachea care.

Nurse #2 will be reported to the Board of Nursing on 7/3/18 for not documenting on the Medication Administration Record by the Director of Nursing. Nurse #2 is no longer staffed at the facility through the Agency. Nurse # 6 and #7 will be reported to the board of Nursing on 7/3/18 for not providing tracheostomy care by the Director Nursing on 7/3/18.

Corrective Action
A contracted Respiratory Therapist (RT) initiated training on tracheostomy care with licensed nurses to include Nurse #6 and #7 on 7/1/18. The Director of Nursing, Staff Facilitator and eight other nurses have currently received the training by the RT and will complete all resident's tracheostomy care until the remaining nurses complete the training. There are ten licensed nurses that are left to be trained by the RT and will not be allowed to work until the training has been completed. A contracted RT is on site as of 2:15 pm on 7/3/18 and has initiated the remaining licensed nurse training.

On 5/30/18, an in-service was initiated with all license nurses to include agency nurse, and Nurse #6, and Nurse #7 by the facility nurse consultant and the Staff Facilitator (SF) on providing tracheostomy care as ordered by the physician. The in-service also addressed the expectation that documentation must be present on the Medication Administration Record (MAR) after providing tracheostomy care. The in-service was completed on 6/28/18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 695	Continued From page 43	F 695		

On 7/2/18, an in-service was initiated with all licensed nurses to include agency nurses and Nurse #6, and Nurse #7 by the Facility Nursing Consultant on reading each tracheostomy order on the MAR, following the physician order for tracheostomy care, documenting on the MAR tracheostomy care provided, checking each page of the MAR to ensure that no medications, treatments, and documentation is missed. The in-service also included for licensed nurses to ask for additional assistance from the Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Staff Facilitator, or another hall nurse when feeling like assistance is needed to provide resident care to include tracheostomy care and time management. No licensed nurse will be allowed to work until the training has been completed.

On 6/12/18, an observation of all residents to include Resident #25 was completed by the Director of Nursing (DON), the Assistant Director of Nursing (ADON), and the Quality Improvement (QI) Nurse to physically identify all residents with tracheostomies. One resident was identified with a tracheostomy.

On 6/12/18, an audit of all MARs, including MARs for Resident #25, for the past 30 days, was completed by the ADON and the QI Nurse to ensure orders for respiratory care, including tracheostomy care were provided as evidenced by documentation on the MAR. There were no other identified areas of concern noted.

On 6/12/18, an assessment of all residents with tracheostomies, including Resident #25 was completed by the QI Nurse and the ADON to ensure tracheostomy care was provided as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 695	Continued From page 44	F 695		

evidenced by observing a clean insertion site and dressing with no drainage present. There were no identified areas of concern during the audit.

On 6/12/18, an audit of all residents' physician orders to include Resident #25 was initiated by the QI nurse, the ADON, and the Staff Facilitator (SF) to identify all residents with orders to receive tracheostomy care. The audit was completed on 6/13/18. There were no other identified residents with orders to receive tracheostomy care.

On 6/29/18, a 100% return demonstration of tracheostomy care was initiated with all licensed nurses to include agency nurses and Nurse #6, and Nurse #7 by the Assistant Director of Nursing (ADON). Retraining will be completed by the ADON during the time of the audit for any nurse that cannot demonstrate successful performance of tracheostomy care per policy and procedure. No nurse will be allowed to perform tracheostomy care on a resident until successful completion of the return demonstration. No licensed nurse will be allowed to work until the return demonstration has been completed.

The Quality Improvement Organization was contacted by the Regional Vice President of Operations on 7/03/18 for assistance in evaluation of specific steps to be taken to address tracheostomy care and training, staff position/title designated to be responsible for the steps, timeline for accomplishment of the steps, specific methodology to be used to evaluate the plan's success, and frequency of monitoring the effects of the plan initiation.

All residents with tracheostomies to include Resident #25 will be physically observed and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 695	Continued From page 45	F 695		

documentation of the MAR and non-ulcer flow sheet assessment will monitored by the Assistant Director of Nursing (ADON) and/or the Quality Improvement (QI) Nurse 5 days weekly for 4 weeks, 3 days weekly for 4 weeks, then weekly for 4 weeks utilizing a Trach Care Audit tool. This audit is to ensure that tracheostomy care is being performed per policy and procedure, with 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 intact. A medication pass audit on tracheostomy care will be completed by the Assistant Director of Nursing (ADON) and/or the Quality Improvement (QI) Nurse on 10% of all licensed nurses to include agency nurses and Nurse #6 and Nurse #7, 5 days weekly for 4 weeks, 3 days weekly for 4 weeks, then weekly for 4 weeks utilizing a Medication Pass Tracheostomy Audit Tool. This audit is to ensure that nurses are reading each tracheostomy order on the MAR, following the physician order for tracheostomy care, documenting on the MAR tracheostomy care provided, and managing time to ensure tracheostomy care is provided. Any areas of concern identified during the audits will be addressed immediately by the ADON, QI Nurse, and/or the DON to include providing additional staff training.

The DON will present the findings of the Trach Care Audit tools and the Medication Pass Tracheostomy Audit Tools to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the Trach Care Audit tools and the Medication Pass Tracheostomy Audit Tools to determine trends

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 695	Continued From page 46 and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. Final date of compliance is 7/03/18. The administrator and DON will be responsible for the implementation of corrective actions to include all 100% audits, in-services, and monitoring related to the plan of correction. The Credible Allegation for Immediate Jeopardy removal was validated on 07/03/18, which removed the Immediate Jeopardy on 07/03/18. Interviews were conducted with nursing staff present in the facility on 07/03/18. The staff confirmed the recent in-services and trainings related to tracheostomy care and documentation of tracheostomy care. Reviews of the in-service records, audit tools, audits performed and facility assessments were made. An interview with the DON on 07/03/18 at 2:45 p.m. revealed the named nurses had been reported to the North Carolina Board of Nursing. An interview with the Regional Vice President of Operations on 07/03/18 at 2:50 p.m. revealed he had contacted the Quality Improvement Organization for assistance in evaluation of specific steps to be taken to address tracheostomy care and training.	F 695		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced	F 759		7/11/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 759	Continued From page 47 by: Based on observation, record reviews and staff interviews the facility's medication error rate was greater than 5% as evidenced by 2 medication errors out of 25 opportunities. 1 of 5 Residents (Resident #90) reviewed had medication errors during the observation of the medication pass. The Medication error rate was 8 percent. The findings included: Review of medical record for Resident #90 revealed she was admitted 07/09/15 with diagnoses of fracture of lower end of femur, diabetes, bipolar disorder, major depressive disorder, gastro-esophageal reflux disease, pseudobulbar affect, convulsions, cerebral palsy, paraplegia, dysarthria, and osteoporosis. Review of physician orders and the medication administration record for Resident #90 revealed the following medications and medication administration times: Depakote Sprinkles 375 milligrams (mg) by mouth twice daily for bipolar disorder (8:00 AM & 12 noon) dated 03/14/18; Depakote Sprinkles 500 mg by mouth every night at bedtime for bipolar disorder (8:00 PM) dated 03/14/18 and Voltaren Gel 1 % apply 4 grams gel topically to back and bilateral knees three times a day for pain (8:00 AM, 12 noon, 8:00 PM) dated 04/11/18. During observation of a medication pass with Nurse #3 on 5/23/18 at 11:47 AM the nurse was observed administering medications to Resident #90 that were scheduled for 8:00 AM at 11:47 AM. During an interview with Nurse #3 at 1:00 PM on 5/23/18, when asked about the discrepancy in the administration time Nurse #3	F 759	F 759 The process which led to this deficiency was determined to be that Nurse #3 failed to administer medications at the correct time for Resident #90, resulting in a facility medication error rate greater than 5%. On 5/23/18, Resident #90 was assessed by the assigned hall nurse and no adverse reactions were noted from not administering the medication at the ordered time. On 5/23/18, the assigned nurse notified the physician in the facility of the assessment findings for Resident #90. No new orders were received. The physician reviewed chart for Resident #90 chart and assessed Resident #90. On 5/23/18, Nurse #3 was provided with retraining by the DON on medication administration regarding administering medications at the correct time specified on the resident□s Medication Administration Record (MAR). On 6/12/18, the Staff Facilitator (SF) conducted a medication pass audit with Nurse #3 to ensure all medication was administered according to the physician□s orders to include the correct time specified on the MAR. On 6/12/18, a medication pass audit for all licensed nurses and medication aides to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 759	Continued From page 48 stated she had a lot going on this morning and had not been able to get her medications passed on time. She also stated she had not reported the late administration of Resident #90's medications to her Supervisor or to the physician. She offered no resolution to the late administration of Resident #90's medications. In an interview with the Director of Nursing on 05/23/18 at 3:56 PM, she revealed her expectation was that the medication error rate would be 0%. She had no knowledge of the late administration until the surveyor informed her. The supervisor then verified with Nurse #3, notified the physician and received additional orders for the omitted medications. She stated her expectation was that medications would be administered according to the physician's orders and if there was a discrepancy the staff would notify her and the physician immediately for new orders.	F 759	include agency, was initiated by the Quality Improvement (QI) Nurse, the Assistant Director of Nursing (ADON), and the Staff Facilitator (SF) to ensure all medications were administered according to the physician□s orders to include the correct time specified on the MAR. The audit will be completed by 6/28/18. Any areas of concern identified during the audits will be immediately addressed by the QI Nurse, the ADON, and/or the SF to include additional staff training and increased monitoring of medication passes. On 5/29/18, an in-service was initiated by the facility nurse consultant, DON, and the SF for all licensed nurses and medication aides, including agency, to ensure medications were administered correctly utilizing the 5 Rights of Medication Administration, including administering medications according to the physician□s orders to include the correct time specified on the MAR. The in-service will be completed by 6/28/18. All newly hired licensed nurses and medication aides to include agency will be provided with this in-service by the Staff Facilitator (SF) during orientation regarding the 5 Rights of Medication Administration, including administering medications according to the physician□s orders to include the correct time specified on the MAR. 10% of Licensed Nurses and medication aides, to include Nurse #3, will be audited by the QI Nurse, the ADON, and/or the SF weekly for 8 weeks, then monthly for 1 month, utilizing a Medication Pass Audit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 759	Continued From page 49	F 759	form, to ensure medications are administered according to the physician□s orders to include the correct time specified on the MAR. Any areas of concern identified during the audit will be immediately addressed by the QI Nurse, the ADON, and/or the SF to include notification of the physician if applicable and/or providing additional staff training. The DON will review and initial the Medication Pass Audit forms weekly for 8 weeks, monthly for 1 month to acknowledge completion of the audit. The administrator and/or the DON will present the findings of the Medication Pass Audit forms to the Executive Quality Improvement (QI) Committee monthly for 3 months. Any issues, concerns, and/or trends identified 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 related to the plan of correction.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761		7/11/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 761	Continued From page 50 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to secure a bottle of Humalog insulin and an unopened insulin syringe in a locked medication cart (300 hall cart) for 1 of 3 medication carts. The findings included: On 5/23/18 at 4:44 PM Nurse # 2 was observed preparing medications. The nurse locked the medication cart, leaving a bottle of Humalog insulin on top of the cart and an unopened insulin syringe. She then entered a resident room. An interview with Nurse #2 was conducted on 5/23/18 at 4:45 PM. The nurse stated she should not have left the bottle of insulin and the unopened insulin syringe on top of the medication	F 761	F 761 The process which led to this deficiency was determined to be that Nurse #2 failed to secure a bottle of insulin and an unopened insulin syringe in the 300 hall medication cart. On 6/15/18, Nurse #2 was in-serviced by the Director of Nursing (DON) on securing medication to include insulin and insulin syringes inside a locked medication cart when the cart is left unattended. On 5/29/18, a 100% audit of all medication carts was completed by the facility nurse consultant and the DON to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 761	Continued From page 51 cart unattended. The nurse then unlocked the medication cart and placed the medication and the insulin syringe into the cart. 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.	F 761	ensure all medication to include insulin and insulin syringes were secured inside a locked medication cart when left unattended. There were no concerns noted during this audit. On 5/29/18, an in-service for 100% of all licensed nurses and medication aides, including agency, was initiated by the Staff Facilitator (SF) on medication storage and ensuring all medication to include insulin and insulin syringes were secured in a locked medication cart when left unattended. The in-service will be completed by 6/28/18. All newly hired licensed nurses and medication aides, including agency, will be in-serviced during orientation by the SF on medication storage and ensuring all medication to include insulin and insulin syringes were secured in a locked medication cart when left unattended. All medication carts will be audited by the QI Nurse, the Resource Nurse, and/or the ADON twice weekly for 4 weeks, then weekly for 8 weeks, utilizing a Medication Storage Monitoring tool to ensure all medications including insulin and insulin syringes are secured in the locked medication cart when left unattended. Any areas of concern identified during the audit will be immediately addressed by the QI Nurse, the Resource Nurse, and/or the ADON to include providing additional staff training. The DON will review and initial the Medication Storage Monitoring tool to acknowledge review and completion of the audit.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 761	Continued From page 52	F 761	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 QI Committee will meet monthly for 3 months and review the Medication Storage Monitoring tool to determine trends and/or issues that may need further interventions 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 related to the plan of correction.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		7/11/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 812	Continued From page 53 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to properly label food stored in the reach-in refrigerator, failed to properly store scoops, failed to clean and sanitize food carts, failed to clean and sanitize utility carts, failed to clean open floor area below the steam table and failed to clean a wall in the dishwashing area. The findings included: A. An observation of the reach-in refrigerator on 05/21/18 at 12:20 PM revealed 2 unlabeled clear plastic bags that contained a portion of bulk ham and 2 blocks of sliced cheese covered with clear wrap with no date. During an interview with the Certified Dietary Manager on 05/24/18 at 4:25 PM, he stated it was his expectation that all open food items are dated with open date, expiration date and name of food item if removed from the original container. B. An observation was made on 05/21/18 at 12:25 PM of the flour, sugar and cornmeal bins with the scoops stored directly in the food item. During an interview with the Certified Dietary Manager on 05/24/18 at 4:25 PM, he stated it was his expectation that scoops be stored in plastic bags and labeled with date on top of each bin. C. An observation was made on 05/21/18 at 12:30 PM of 3 dirty metal food delivery carts being used during lunch time to deliver meals to the residents with sticky brown substance and built up food debris. The built up food debris	F 812	F 812 The process which led to this deficiency was determined to be the facility failed to implement processes to ensure proper labeling of food in reach in refrigerator, proper storage of scoops, cleaning and sanitizing food carts, cleaning and sanitizing utility carts, cleaning open floor area below steam table and cleaning wall in the dish area. On 5/21/18, the Dietary Manager disposed and/or labeled the unlabeled food in the reach in refrigerator. On 2/25/18, the dietary aide stored the scoops in the proper area. On 5/21/18, the dietary assistant cleaned and sanitized the food carts. On 5/21/18 and 5/23/18, the dietary assistant cleaned and sanitized the utility carts. On 5/24/18, the dietary assistant cleaned the open area below the steam table. On 5/25/18 the dietary aide cleaned the wall in the dish area. All dietary staff were in serviced on 5/25/18 by the Dietary manager to ensure proper labeling of food, proper storage of scoops, cleaning and sanitizing food carts, cleaning and sanitizing utility carts, cleaning open floor area below steam table and cleaning wall in the dish area. All dietary staff, including the Dietary Manager were re-trained on 6/13/18 on proper labeling of food, proper storage of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 812	Continued From page 54 covered approximately 50 percent of metal food cart inside and outside. During an interview with the Certified Dietary Manager (CMD) on 05/24/18 at 4:25 PM, he stated it was his expectation that the food delivery carts were cleaned and sanitized after breakfast, lunch and dinner meals. The CDM further stated that whoever was assigned to unload the food delivery carts was responsible for cleaning and sanitizing the food delivery carts. D. An observation was made on 5/21/18 at 12:35 PM of 4 utility carts with a sticky substance and food crumbs on the surface where clean dinnerware and beverage containers were stored. During an interview with the Certified Dietary Manager on 05/24/18 at 4:25 PM, he stated it was his expectation that the utility carts be cleaned and sanitized before storing clean dinnerware and beverage containers on them. E. An observation was made on 05/21/18 at 12:40 PM of an open floor area covered with a thick metal slotted cover (drain cover) below the steam table containing buildup of food particles and trash debris beneath the drain cover and around the edges of drain cover. Observation was made of a foul odor coming from the drain. The area measured 11 inches wide by 8 feet long. During an interview with the Certified Dietary Manager on 05/24/18 at 4:25 PM, he stated it was his expectation that the floor area with drain cover below the steam table be thoroughly cleaned weekly and as needed. The CDM further stated that floor area was not on the cleaning schedule.	F 812	scoops, cleaning and sanitizing food carts, cleaning and sanitizing utility carts, cleaning open floor area below steam table and cleaning wall in the dish area utilizing the new Kitchen Review Audit Tool. On 6/13/18 the RVP trained the Administrator on how to complete the Kitchen Review Monitoring tool. The Dietary Manager, Assistant Dietary Manager and/or Administrator will monitor the kitchen for proper labeling of food in reach in refrigerator, proper storage of scoops, cleaning and sanitizing food carts, cleaning and sanitizing utility carts, cleaning open floor area below steam table and cleaning wall in the dish area 5 days a week for 4 weeks, then 3 days a week for 4 weeks, then 2 days a week for 4 weeks. The Administrator and/or the DON will present the findings of the Kitchen Review Monitoring tool to the Executive Quality Improvement (QI) Committee monthly for 3 months. Any issues, concerns, and/or trends identified 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 related to the plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 812	Continued From page 55 F. Observation was made on 05/21/18 at 12:45 PM of the wall behind the clean dish rack in the dishwashing area of a brown substance splashed on the wall and a small area had paint peeling from the wall. During an interview with the Certified Dietary Manager (CDM) on 05/24/18 at 4:25 PM, he stated it was his expectation that the wall in the dishwashing area be cleaned weekly and as needed. The CDM further stated that he would put in a work order to have the wall painted. During an interview with the Administrator on 05/26/18 at 2:40 PM revealed that it was his expectation that the dietary staff follow the sanitation guidelines taught by the facility.	F 812		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and resident and staff interviews the facility Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put in place following the recertification/complaint survey of 07/21/17 and the complaint survey of 09/27/17. This was for 2 deficiencies originally cited in July 2017 and 1 deficiency cited in	F 867	F 867 The process which led to this deficiency was determined to be that the facility failed to maintain the implemented procedures and monitor the interventions and committee put into place for previous deficiencies:	7/11/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 867	Continued From page 56 September 2017. These 3 deficiencies were subsequently recited on the current recertification complaint survey of 05/26/18. The continued failure of the facility during 3 federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: 1. This tag is cross referenced to: 483.25: Free of Accident Hazards/Supervision/Devices: Based on observation, record review, and staff interviews, the facility failed to implement interventions to prevent falls which resulted in multiple falls for 1 of 11 sampled resident (Resident #74). During the recertification and complaint survey of 07/21/17 the facility was cited for failure to prevent 1 of 2 cognitively impaired residents with exit seeking behaviors from exiting a locked unit in the facility and then eloping from the facility via an unsecured door. The police found the resident on a busy street. The resident was not injured. 2. This tag is cross referenced to: 483.45: Free of Medication Error Rate of 5% or More: Based on observation, record reviews and staff interviews the facility's medication error rate was greater than 5% as evidenced by 2 medication errors out of 25 opportunities for error during the observation of the medication pass. During the complaint survey of 09/27/17 the facility was cited for failure to assure morning insulin coverage was given per sliding scale order for one of three sampled residents, Resident #97,	F 867	1.) 483.25: Free of Accident Hazards/Supervision/Devices: the facility failed to implement interventions to prevent falls. 2.) 483.45: Free of Medication Error Rate of 5% or More: The facility□s medication error rate was greater than 5% as evidenced by 2 medication errors out of 25 opportunities during observation of the medication pass. 3.) 483.60: Food and Nutrition Services: The facility failed to properly label food, failed to properly store scoops, and failed to clean and sanitize food carts, failed to clean open floor area below the steam table and failed to clean a wall in the dishwashing area. On 6/13/18, the administrator, Director of Nursing (DON), Quality Improvement (QI) Nurse, and the Dietary Manager were educated by the facility nurse consultant regarding maintenance of the Quality Assessment and Assurance (QAA) committee to include developing appropriate plans of action to monitor deficient areas and ensuring interventions are implemented to ensure quality deficiencies are corrected. All newly hired administrators, DONs, QI Nurses, and Dietary Managers will be educated by the facility nurse consultant and/or the Regional Vice President (RVP) during orientation regarding maintenance of the Quality Assessment and Assurance (QAA) committee to include developing appropriate plans of action to monitor deficient areas and ensuring interventions are implemented to ensure quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 867	Continued From page 57 on five days. 3. This tag is cross referenced to: 483.60: Food and Nutrition Services: Based on observations and staff interviews, the facility failed to properly label food stored in the reach in refrigerator, failed to properly store scoops, failed to clean and sanitize food carts, failed to clean and sanitize utility carts, failed to clean open floor area below the steam table and failed to clean a wall in the dishwashing area. During the recertification and complaint survey of 07/21/17 the facility was cited for failure to ensure staff did not handle food with their bare hands for 1 of 1 meal observed for Resident #52. During an interview conducted on 05/26/18 at 3:33 PM the Administrator stated they had multiple turnovers in key departmental staff positions as well as some of the aspects of the citations were different that the previous citations. He continued by stating it was his expectation that they would re-examine systems to find the root cause of the issues and address it with continuous monitoring and improvements.	F 867	deficiencies are corrected. On 6/13/18, the administrator, DON, QI Nurse, and the Dietary Manager were educated by the facility nurse consultant 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 that concerns are resolved and do not reoccur. All newly hired administrators, DONs, QI Nurses, and Dietary Managers will be educated by the facility nurse consultant 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 that concerns are resolved and do not reoccur. On 6/14/18, the facility nurse consultant initiated a 100% audit of QI meeting minutes and action plans for past six months to ensure that the QI committee has maintained and monitored the interventions that were put into place. The audit will be completed by 6/28/18. Any concerns identified during the audit will be immediately addressed by the facility consultant with the administrator and the DON to include revision of the QI action plan, providing additional staff training if needed, and increased monitoring is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 867	Continued From page 58	F 867	All data collected for the areas of concern 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, monthly for 3 months. The QA Committee will review the data and determine if the plan of corrections are being followed, if changes in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the QA committee will be documented monthly at each meeting by the QI Nurse. The Regional Vice President (RVP) will ensure the facility is maintaining an effective QA program by reviewing the Executive Quality Improvement (QI) Committee meeting minutes and ensuring implemented procedures and monitoring practices to address interventions, to include fall interventions, medication errors, and dietary services are followed and maintained Quarterly x2. The RVP or the Facility Nurse consultant will immediately re-educate the administrator, DON, QI Nurse, and dietary manager for any identified areas of concern. The results of the monthly QA committee meeting minutes will be presented by the administrator and/or the DON to the Executive QI committee quarterly x 2 for review and identification of trends, development of action plans as indicated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 867	Continued From page 59	F 867	to determine the need and/or frequency of continued monitoring. The administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	
F 908 SS=F	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews the facility failed to ensure the commercial high temperature dishwasher rinse temperature gauge was functioning according to the manufacturer's instruction. The findings included: During the initial tour of the kitchen on 05/21/18 at 1:00 PM the high temperature commercial dishwasher rinse temperature gauge was reading 150 degrees Fahrenheit during the rinse cycle. During an observation on 05/21/18 at 1:15 PM indicated that the rinse cycle was at 180 degrees Fahrenheit with the use of a dishwasher temperature test strip. During an interview with the Dietary Aide #1 (DA) on 05/24/18 at 4:02 PM, she stated that she was aware that the rinse temperature gauge on the dishwasher was not functioning properly.	F 908	F 908 The process which led to this deficiency was determined to be the facility failed to implement processes to ensure the commercial high temperature dishwasher rinse temperature gauge was functioning according to manufacture instruction. On 5/25/18, the dish machine was inspected by Hobart and replacement parts were approved for the dish machine. On 6/7/18, the facility began to use paper products based on the fact that the company made the decision to purchase a new dish machine instead of repairing existing unit. The facility will continue to use paper products until new machine is installed. On 6/13/18, all staff to include the Dietary Manager, were in serviced by the Administrator on the completion of work	7/11/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 908	Continued From page 60 During an interview with the DA #2 on 05/25/18 at 10:50 AM, he stated that he was aware of the rinse and wash temperatures on the high temp commercial dishwasher. The DA #2 further stated that he was rarely assigned to the dishwasher. He was not aware that the temperature gauge for the rinse cycle was not functioning. Review of the "Food Establishment Inspection Report" completed by Environment Health Section dated on 09/30/17 read in part "Warewashing (cleaning and sanitizing of utensils and food-contact surfaces of equipment) machines that provide a fresh hot water sanitizing rinse shall be equipped with a pressure gauge that measures and displays the water pressure in the supply line immediately before entering the warewashing machine. The pressure gauge is not functioning according to the date plate instructions. Warewashing machines, temperature measures device - Provide a test strip to test temperature of the hot water in the warewashing machine." Review of a service report invoice for the dish machine dated on 11/29/17 did not address the rinse pressure gauge and only addressed the booster heater. Review of a service report invoice job estimate for the dish machine pressure gauge was dated on 05/23/18 submitted for approval. There were no manufacturer's instruction available at the facility. An interview with the Certified Dietary Manager	F 908	orders to ensure notification of broken/improper functioning equipment. On 6/13/18 the RVP trained the Administrator on how to complete the Kitchen Equipment Monitoring tool. The Maintenance Director, Maintenance assistant, and/or Administrator will complete the Kitchen Equipment Monitoring Tool 5 day a week for 4 weeks, then 3 days a week for 4 weeks, then 2 days a week for 4 weeks to ensure the kitchen equipment functioning properly. The Administrator and/or the DON will present the findings of the Kitchen Equipment Monitoring tool to the Executive Quality Improvement (QI) Committee monthly for 3 months. Any issues, concerns, and/or trends identified 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 related to the plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD 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
F 908	Continued From page 61 (CDM) on 05/24/18 at 4:25 PM revealed that it was his expectation that the dietary staff use the dishwasher temperature test strips until the dishwasher rinse pressure gauge was operational. He further stated that the dietary staff document the wash and rinse temperatures in the notebook before each cycle. An interview with the Administrator on 05/26/18 at 2:45 PM revealed that it was his expectation that the dishwasher be operating according to manufacturer's guidelines.	F 908		