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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345505	A. BUILDING ______ B. WING ______	C 05/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA REHAB CENTER OF CUMBERLAND	4600 CUMBERLAND 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 SS=E	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 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 observation and staff interviews the facility failed to keep unattended medications stored in a locked medication cart for 3 of 6 medication carts observed (Magnolia Unit Medication Cart #2, Dogwood Unit Medication Cart #2 and Independence Unit Medication Cart #1) and failed to keep an unattended medication secured by leaving it on top of a medication cart for 1 of 6 medication carts observed (Dogwood Unit Medication Cart #1). Findings included:	F 761	The statements included in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The	6/14/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/14/2019

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

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F 761	Continued From page 1 1. A. In an observation on 05/23/19 beginning at 2:35 PM a medication cart was seen unattended at the Magnolia Unit nurse's station. The drawers and lock of the medication cart were facing into the hallway. The lock of the medication cart did not appear to be engaged. A continuous observation of the medication cart was conducted until 2:41 PM when Nurse #1 approached the medication cart. During the six minutes of the continuous observation eleven staff members and a visitor walked past the medication cart. In an interview on 05/23/19 at 2:41 PM Nurse #1 verified that the medication cart was unlocked. She stated she had stepped away from the cart and into the clean utility room to discuss a resident with another staff member. Nurse #1 stated that she should not have left the medication cart unlocked. She indicated that anything could have happened to the medications and she would not have known about it. In an interview on 05/24/19 at 10:39 AM the Regional Nurse Consultant stated that she expected medications to be secured at all times to protect the residents. B. In an observation on 05/23/19 at 4:12 PM two bubble pack cards of medication were seen on top of the locked Dogwood Unit Medication Cart #2. No staff or residents were seen on the hall, but Nurse #2 approached the cart within approximately 30 seconds. In an interview on 05/23/19 at 4:13 PM Nurse #2 confirmed that the two bubble pack cards of medication on top of the medication cart contained a medication called clonidine (used to	F 761	following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F761 How the corrective action will be accomplished for the residents found to have been affected by the deficient practice □ On May 23, 2019 three medication carts were noted to be unlocked and unattended and one cart had unsecured medications left on top of it. No residents were affected by deficient practice and nurses locked the carts and stored medications immediately at time of discovery. How the facility will identify other residents having the potential to be affected by the same deficient practice □ All medication carts were checked immediately to ensure locks were working properly and ensure that there were no other unsecured medications. Training began with all nursing staff on 5/23/19 about proper storage of medications to protect the residents. Measure to be put in place or systemic changes made to ensure practice will not re-occur □ All nurses were educated on proper storage of medication to protect the residents. Training was completed on June 14, 2019. All new hires will also receive the training during orientation. Nurses found to be non-compliant will receive disciplinary action as needed.	

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F 761	Continued From page 2 treat high blood pressure) with a dosage of 0.2 mg (milligrams). Each card contained 30 doses of the medication for a total of 60 doses. Nurse #2 indicated she had been in a room across the hall with the door shut and that she should not have left the medications on top of the cart because anyone could have taken them. In an interview on 05/24/19 at 10:39 AM the Regional Nurse Consultant stated that she expected medications to be secured inside the medication carts at all times to protect the residents. C. In an observation on 05/23/19 at 4:22 PM a medication cart was seen unattended at the Independence Unit nurse's station. The drawers and the lock of the medication cart were facing into the hallway. The lock of the medication cart did not appear to be engaged. After approximately 20 seconds Nurse #3 approached the cart and pushed in the lock on the medication cart. In an interview on 05/23/19 at 4:22 PM Nurse #3 confirmed that the medication cart had been left unlocked. She stated she had gone to fill a water pitcher and had looked back at the medication cart and saw that it was unlocked so she came back to lock it. She stated the medication carts should always be locked so that no one could get into the medications. In an interview on 05/24/19 at 10:39 AM the Regional Nurse Consultant stated that she expected medications to be secured at all times to protect the residents. 2. During an observation on 5/23/19 at 5:05 PM a medication cart located on Dogwood Hall was	F 761	How the facility plans to monitor its performance to make sure that solutions are sustained Director of Nursing or designee will audit 5 medication carts weekly x 4 weeks and then monthly times 3 months to ensure compliance of medication storage. Results of the audits will be reviewed at the quarterly Quality Assurance meeting x 2 to ensure solutions are sustained. Date of compliance: June 14, 2019	

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F 761	Continued From page 3	F 761		

observed unlocked and unattended. The medication cart was located near the end of the hallway, with several staff members walking by the cart. A continuous observation was conducted until 5:10 PM when Nurse # 4 was observed leaving a resident ' s room across the hallway and returned to the medication cart.

An interview was conducted on 5/23/19 at 5:10 PM with the assigned nurse (Nurse #4). She stated she thought she had locked the cart before entering the resident ' s room, and that it was an error on her part. She stated she typically double checks to assure the cart is locked before leaving it unattended.

An interview was conducted on 5/24/19 at 10:39 AM with the Regional Nurse Consultant. She stated its her expectation that medications are always secured to protect the residents.