PRINTED: 11/15/2019 FORM APPROVED OMB NO. 0938-0391

| NAME OF PROVIDER CAROLINA REHAI (X4) ID PREFIX TAG | SUMMARY STA (EACH DEFICIENC' REGULATORY OR I | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | B. WING _ ID PREFIX TAG | (EACH CORRECTIVE ACTION SH | CTION DULD BE | C (X5) COMPLETION DATE |
|--|--|--|-------------------------|---|------------------|------------------------|
| CAROLINA REHAI | SUMMARY STA (EACH DEFICIENC' REGULATORY OR I | UMBERLAND ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX | 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHICK CROSS-REFERENCED TO THE APP | CTION OULD BE | (X5) COMPLETION |
| (X4) ID PREFIX | SUMMARY ST, (EACH DEFICIENC' REGULATORY OR L | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHICK CROSS-REFERENCED TO THE APP | OULD BE | COMPLETION |
| PREFIX | (EACH DEFICIENC' REGULATORY OR I | Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | PREFIX | (EACH CORRECTIVE ACTION SHOOT CROSS-REFERENCED TO THE APP | OULD BE | COMPLETION |
| | | | | PREFIX (EACH CORRECTIVE ACTION SHOL TAG CROSS-REFERENCED TO THE APPRI | | B/IIE |
| F 000 INITIA | | | F 0 | 00 | | |
| to confacility obtains returned for a number of the confusion of the confu | iduct a complair on 10/5/19. Ad ied through 10/5 ed to the facility new allegation. diate Jeopardy 483.12 at tag F 600 constituted diate Jeopardy yed on 10/11/19 icted on 10/15/1 of thirteen allegation at the sident has the ct, misappropriation esident has the ct, misappropriation appropriation as de es but is not lim ral punishment, hysical or chem | ations were substantiated. Neglect m Abuse, Neglect, and right to be free from abuse, tion of resident property, efined in this subpart. This lited to freedom from involuntary seclusion and ical restraint not required to edical symptoms. | F 6 | 00 | | 11/1/19 |
| ABORATORY DIRECTOR | | | | | | |

11/05/2019 **Electronically Signed**

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.

| CENTER | 3 FOR WEDICARE & | WEDICAID SERVICES | | | | OIVID INC | 7. 0930-0391 |
|---------------|-------------------------------|---|---------------|-----|--|------------------------|-------------------------|
| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
| | | | | | | | o |
| | | 345505 | B. WING _ | | | | 15/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | • | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 46 | 600 CUMBERLAND ROAD | | |
| CAROLIN | A REHAB CENTER OF C | CUMBERLAND | | F | AYETTEVILLE, NC 28306 | | |
| (X4) ID | SUMMARY ST | FATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | S PLAN OF CORRECTION (| |
| PREFIX TAG | (EACH DEFICIENC | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFI) TAG | X | (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | COMPLETION DATE |
| F 600 | Continued From pag | e 1 | Fé | 300 | | | |
| | _ | e verbal, mental, sexual, or | | | | | |
| | physical abuse, corp | | | | | | |
| | involuntary seclusion | | | | | | |
| | • | Γ is not met as evidenced | | | | | |
| | by: | | | | | | |
| | _ · | riew, resident, staff and | | | This Plan of Correction is submitted in | | |
| | family interviews, phy | ysician and physician | | | compliance with applicable law and | | |
| | assistant (PA) intervi | ews, paramedic interview, | | | regulation. To demonstrate continuing | | |
| | medical examiner int | erview, emergency | | | compliance with applicable law, the ce | nter | |
| | telecommunication m | nanager interview, pest | | | has taken or will take the actions set for | rth | |
| | | erview, police interview, and | | | in the following allegation of complianc | e. | |
| | _ | w the facility neglected to | | | The following Plan of Correction | | |
| | | tering a resident's rooms, | | | constitutes the center □s allegation of | | |
| | _ | mediately call 911 and keep | | | compliance. All alleged deficiencies ha | | |
| | | n and cardiac vest in place, | | | been, or will be completed by the dates | • | |
| | | vide complete information condition to Emergency | | | indicated. | | |
| | | MS) staff who responded to | | | F600 | | |
| | | ncy for one (Resident # 1) of | | | 1 000 | | |
| | _ | ents whose death was | | | The plan of correcting the specific | | |
| | • | 11 was found in her bed | | | deficiency. The plan should address th | e | |
| | | ncluding her face, mouth and | | | processes that lead to the deficiency | | |
| | | 911 staff removed the | | | cited; | | |
| | | st and oxygen and the | | | ¿ Resident # 1 was found covered in a | nts | |
| | resident went into ca | rdiac arrest. Resident #1 | | | on 9/15/19 at 1:00 AM. She was | | |
| | | us fire ant bites and was | | | breathing but not responding appropria | - 1 | |
| | | o the hospital for evaluation | | | to the situation. The facility immediately | | |
| | | lent #1 expired while in the | | | took resident to the shower in an attern | pt | |
| | | interview revealed fire ant | | | to remove the ants. During this time | | |
| | | ontributed to her death. The | | | resident #1 stopped breathing, CPR wa | | |
| | findings include: | | | | initiated and 911 was notified. The facil | ιτy | |
| | Immediate leanard: | hagan on 0/15/10 when | | | failed to immediately notify 911 while | ility | |
| | | began on 9/15/19 when found Resident # 1 covered | | | simultaneously removing ants. The fact failed to ensure resident who was oxyg | | |
| | | nouth, nose and "all over her | | | dependent received oxygen during the | | |
| | | sident #1 was found staff | | | emergency. The facility failed to show | | |
| | - | before they removed the | | | has a system to identify the type of ant | | |
| | | st, oxygen and provided the | | | getting into the building, that they have | | |
| | | er. The immediate jeopardy | | | assessed all rooms and filled holes/cra | | |
| | Toolacht with a show | or. The initioulate jeopardy | | | accessed an rooms and inica noics/cra | UNU | |

PRINTED: 11/15/2019 FORM APPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---------------|-------------------------------|--|--------------|-----|--|-------------------------------|--------------------|
| | | | A. BOILDI | _ | | ١, | С |
| | | 345505 | B. WING | | | l | |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | 10/ | 10/2013 |
| | | | | | 600 CUMBERLAND ROAD | | |
| CAROLIN | A REHAB CENTER OF C | CUMBERLAND | | | AYETTEVILLE, NC 28306 | | |
| (X4) ID | SUMMARY ST | TATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFI TAG | | (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | COMPLETION DATE |
| F 600 | Continued From page | e 2 | F | 600 | | | |
| | was removed on 10/ | 11/19 when the facility | | | which might allow entry; and that they | | |
| | | ole credible allegation of | | | have established a protocol in how to | | |
| | 1 - | removal. The facility will | | | respond if fire ants are found to have | | |
| | remain out of complia | ance at a scope and severity | | | swarmed a resident who needs both | | |
| | level of D (not actual | harm with the potential for | | | emergency help and help removing the | : | |
| | more than minimal ha | arm that is not immediate | | | ants; and a system to assure that | | |
| | • • • • • | lity to complete staff training | | | information about fire ant stings is | | |
| | | oring systems put in place | | | conveyed to all medical personnel to | | |
| | are effective. | | | | assure proper treatment and evaluation | | |
| | | | | | How the facility will identify other reside | | |
| | | al discharge summary, dated | | | having the potential to be affected by the | ne | |
| | 8/30/19, revealed she | | | | same deficient practice; | | |
| | · · | or an exacerbation of her | | | ¿ All residents have the potential to be | | |
| | While hospitalized a | Pulmonary Disease (COPD). | | | affected by this deficient practice The measures that will be put into place | 2 | |
| | · · | ompleted. This showed the | | | or systemic changes made to ensure the | | |
| | | kages but had experienced a | | | the deficient practice will not recur; | iat | |
| | | of "demand ischemia (not | | | " All certified nursing assistants will | be | |
| | | e resident was fitted and | | | educated on reporting all sightings of a | | |
| | | (a personal device which | | | on a patient immediately to a nurse. Th | | |
| | - | ontinuously and delivers a | | | education was completed 10/11/2019 to | | |
| | | detects a life threatening | | | Director of Nursing or designee. | • | |
| | abnormal heart rhyth | m) prior to discharge to the | | | " The Director of Nursing (DON) and | t | |
| | facility where she wa | s to receive therapy for | | | nursing administration completed traini | ng | |
| | strengthening. | | | | with all nurses about what information | | |
| | | | | | should be given to all EMS personnel | | |
| | | nitted to the facility on | | | when they are called to assist in | | |
| | | es which included a history | | | emergency situations. The training | | |
| | | omplications, hyperlipidemia, | | | included providing all pertinent medica | | |
| | - | erosclerotic heart disease | | | information including abnormal health | | |
| | without angina, and (| JUFU. | | | concerns for any resident from the previous 24-72 hours. This was | | |
| | According to 8/30/10 | facility admission orders the | | | completed 10/09/2019 | | |
| | | ve oxygen continuously at 3 | | | " All nurse education was completed | 4 | |
| | Liters/minute. | ve exygen continuously at a | | | 10/11/2019 by director of nursing or | 4 | |
| | Enorominato. | | | | designee that upon discovery of a resid | lent | |
| | During an interview w | vith Facility Nurse Consultant | | | with fire ants on them we will assess vi | | |
| | | AM, the consultant confirmed | | | signs, protect airways, instruct a staff | | |
| | | ardiac vest while she resided | | | member to notify 911, have a staff | | |

Facility ID: 980423

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|--|---------------------|--|--|-------------------------------|--|
| | 345505 | B. WING _ | | 10 | C 0/ 15/2019 | |
| NAME OF PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO | • | | |
| | | | 4600 CUMBERLAND ROAD | | | |
| CAROLINA REHAB CENTER OF C | UMBERLAND | | FAYETTEVILLE, NC 28306 | | | |
| PREFIX (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | |
| and took care of mair communication needs the consultant stated an order for it or doct facility notes. Resident #1's admiss Set) assessment, dat resident was cognitive independent with her bathing. She needed A nursing note entry of AM specified Resider with intermittent confirmake her needs known bell to do so. No commoted. Her respiration with no shortness of a The resident had been nostrils intermittently to let the nurse apply clean up her face and with blood. The resident was noted to be filled one point from her bles aturation dropped to bloody oxygen cannut oxygen saturation incommunication. On 9/14/19 at 3:00 P specified the resident person and place, he were 95 percent, and had stopped. The resmore labored breathing. | e resident was responsible ntaining the battery and any ed regarding it. Therefore, there would not have been amentation about it in the sion MDS (Minimum Data ed 9/6/19, revealed the ely intact. She was dressing, hygiene, and supervision for ambulating. Written on 9/14/19 at 11:48 at #1 was alert and oriented usion noted. She was able to wn to staff and utilized a call plaints or discomfort were as were even and unlabored breath noted during shift. In bleeding from her bilateral throughout shift but refused pressure to the nose or discomfort where as unrounding areas messed ent's oxygen nasal cannula and clotted with blood at eeding nose. Her oxygen of 5 percent but when the alla tubing was changed her creased to 91 percent. My another nursing entry it was alert and oriented to roxygen saturation levels the bleeding from her nose edident was noted to have | F6 | member retrieve a crash car oxygen as needed while sim attempting to remove fire an "All staff education bega 10/2/2019. Administrator ed department managers who reducation to their respective on the following components. Understanding fire ants as pasheet provided on Red importants, removing patients from room if suspect fire ants, imcontact maintenance directs activity is suspected, when it rooms inspect floor, linen ar for ant activity. This education completed on 10/3/2019. "Any employee that did reducation will be removed fit schedule until education is completed until education is completed in the above topics during rorientation by director of nurdesignee. "On 10/10/2019 all resid base on the wall the leads to was removed and inspected cracks/holes and sealed if for cove base in all rooms was ensured no gaps exist. This completed 10/10/2019 "EcoLab pest control seperformed bi-weekly ant treat November 1 and will resume through the late spring and spest control recommendation on 9/17/2019. | nultaneously ints. In on ducated provided de departments s: Der information orted fire ants: dentifying fire in affected mediately or if any in resident ind window sill on was not receive the rom the completed. be educated new hire rsing or dent room cove of the exterior of for ound. The inspected and s was rvices atments until e April 1 summer per | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | PLE CONSTRUCTION IG | · , | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---------------------|--|--|-------------------------------|--|
| | | | 5 | | | С | |
| | | 345505 | B. WING _ | | | 10/15/2019 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO | DDE | | |
| CAROLIN | A DELIAR CENTER O | E CUMPEDI AND | | 4600 CUMBERLAND ROAD | | | |
| CAROLINA | A REHAB CENTER O | F CUMBERLAND | | FAYETTEVILLE, NC 28306 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICI | Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | |
| F 600 | during the 7:00 AN was interviewed by and reported the form profusely from the and would not let apply ice. There we her clothes. The resident was very some trouble bread (Physician Assistate what the resident was ordered left, the resident wongen level had oxygen cannula cloth oxygen cannula cloth oxygen was ordered left, the resident work oxygen level had oxygen cannula cloth oxygen cannula cloth oxygen was call company and the to perform it that of the perform of the performance of the performanc | M to 3:00 PM shift. Nurse # 1 y phone on 10/3/19 at 2:30 PM ollowing. The resident bled nose that day after breakfast the nurse pinch her nose or was blood on the sheets and on esident reported she had nose did not want to go to the ch the bleeding stopped. The alert that day but did have withing. She had talked to the PA ant), who had informed her to do would allow them to do. A chest and done. When Nurse # 1 was still alert and oriented with blood pressure was fine. Her "picked back up" after the hange. 5 PM it was noted the chest essible aspiration of blood due to led into the mobile imaging imaging company would be out day. est x-ray findings, dated the resident had a minimal nce denser than air such as tein in the lung). 5 PM, the Physician Assistant ter for Avelox 400 milligrams (an treat bacterial infections) every | F6 | | nitor its hat solutions d exterior maintenance ally provided or fire ant had will weekly x 4 y pest the eatment and s will be called d at the 2 for further mber 1, 2019 sible for | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDI | TIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|------------------------|--|-------------------------------|------------------------|---|
| | | 345505 | B. WING _ | | | C 10/15/2019 | |
| | ROVIDER OR SUPPLIER | UMBERLAND | | STREET ADDRESS, CITY, STATE, 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | ZIP CODE | 16/16/2016 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | EFIX (EACH CORRECTIVE ACTION SHOULD | | | N |
| F 600 | statements regarding resident being transfer 9/15/19. Noted below and interviews conduct Resident # 1 prior to 9/15/19. Nurse Aide (NA) # 3 of 9/14/19 from 3:00 PM interviewed on 10/3/1 the following. Usually independent. On the drowsy. Her family can hot. The last time she "walking rounds" between she and the one around to look in on repeked in on her and and appeared okay. Such the room that day, but "three times total and were five or six ants and 1 and the roommate in, kill the ants, and the duty. She did not knowere. They appeared NA # 5 cared for Resibegan at 11:00 PM of statement read, "Star 12:35 AM, went in (R looked at her and tho changing colors, then I put her cup down ar | M the facility provided written the events prior to the erred to the hospital on are some of the statements of the terred with staff who cared for the hospital transfer on | F | 500 | | | |
| | the nurse. When called | ed her I said can you come dent #1's room)? I think she | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED C | | |
|---|---|---|---------------------|---|------------------------------|--|--|
| | | 345505 | B. WING | | 10/15/2019 | | |
| | ROVIDER OR SUPPLIER A REHAB CENTER OF | CUMBERLAND | | STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | , | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | O BE COMPLETION | | |
| F 600 | 4:03 PM and reports was making rounds the resident was blated because she had so resident was Cauca and realized the blated She got Nurse # 3 and her. The resident's ants." They were "a mouth was open, are was not moving or took her to the show did not take her oxy. They went to get and shower, and when to resident had stoppe ants in the room on had not reported the roommate had been drop food on the flocation had been swapped roommate's bed wa unit. When Resident her, they appeared air conditioning unit. Nurse # 3's written and read, "At appro (#5) reported to me in (Resident # 1's room in (Resident # 1's room in the resident # 1's | wed by phone on 10/3/19 at ed the following. When she around 1:00 AM she thought ack when she first saw her many ants on her. (The isian). She got closer to her ck things were moving on her. and returned to the room with mouth and nose were "full of all over her upper body." Her and she was breathing. She alking. She remembered e # 5 coming to help. They wer to wash off the ants. They gen with her to the shower. They gen with her to the shower. They gen with her to the shower. They gen with her on the bed the did breathing. She had seen the time before that date but the ants. Resident # 1's he messy with food and would for. Resident # 1's bed position at some time to be where the shear the air conditioning that # 1 was found with ants on to be coming from around the area of the room. Statement was dated 9/15/19 eximately 0100 (1:00 AM), CNA that she 'thought the resident from) may have ants on her | F 600 | | | | |
| | face.' I immediately light switch and wer (Resident # 1). On t significant amount of | nom) may have ants on her went to room -turned on the not to bed B to assess resident, his assessment, I observed a of red ants, of various sizes to dent's face, in her nose and | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | CONSTRUCTION | (X3) DATE COMP | SURVEY |
|---|---|---|----------------------|-----|--|-------------------|----------------------------|
| | | | A. BOILD | _ | | Ι, | С |
| | | 345505 | B. WING | | | | 15/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | • | S | STREET ADDRESS, CITY, STATE, ZIP CODE | - | |
| CAROLIN | A DELIAD CENTED OF | CUMPERIAND | | 4 | 600 CUMBERLAND ROAD | | |
| CAROLIN | A REHAB CENTER OF | CUMBERLAND | | F | FAYETTEVILLE, NC 28306 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 600 | upper extremities. noted on floor, to b the air conditioning the blanket; which I immediately sent cloths' (to try to ren possible). The resignon-verbal. Respira unlabored. CNA ar wash cloths and wa remove as many a at that time that we and I instructed CN many ants as poss station and page or (unit) STAT (right a resident's room and shirt vertically from middle. Additional: 4, Nurse #5) and wa removed the rest of the 'Life Vest'). We (wheelchair) and (I) pushed the W/C qu on (unit) hall- Nurse the shower onto luit (Nurse #5) were or shower stall and we device to rinse as r resident's body. I to swabbed ants from process went fairly notice resident was 'not breathing.' I as check her 'code sta information that she | Age 7 A, upper torso and bilateral There was a clear 'trail' of ants e coming from the wall next to unit. The ants were coming up was slightly touching the floor. the CNA to 'go get some wash nove as many ants as dent was awake, however was ations were shallow-but even & rived back to the room with the as attempting with myself to ints as possible. I determined would need additional help IA to continue removing as ible, while I ran to the nurse's werhead for (Nurse # 4) to way) then returned back to d used my scissors to cut her her neck straight down the staff arrived (Nurse # 4, NA # with their assistance we f resident's clothing (including transferred resident to w/c NA # 4) held her feet up while I uickly down to the shower room the # 4 had ran ahead and cut the warm water. Myself and the either side of resident in the the used the handheld shower many ants as possible from took 4X 4 guaze pads and the resident's mouth as well. This and the returned with the was a 'full code.' I instructed | F | 600 | | | |

PRINTED: 11/15/2019 FORM APPROVED OMB NO. 0938-0391

| OLIVILIY | OT OIL MEDIO, ILL A | WEDIO/ ND OLIVIOLO | | | | OWID ITC | 7. 0000 000 1 |
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| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | | | | | (| C |
| | | 345505 | B. WING | | | 10/ | 15/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | <u></u> | |
| 04501111 | 4 DELLAD OFNITED OF (| NIMPERI AND | | 40 | 600 CUMBERLAND ROAD | | |
| CAROLINA | A REHAB CENTER OF C | JUMBERLAND | | F. | AYETTEVILLE, NC 28306 | | |
| (X4) ID | SUMMARY ST | TATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PRÉFIX | , | CY MUST BE PRECEDED BY FULL | PREFIX | | (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA | | COMPLETION DATE |
| TAG | REGULATORT OR | LSC IDENTIFYING INFORMATION) | TAG | | DEFICIENCY) | AIE. | |
| | | | | | | | |
| F 600 | Continued From page | e 8 | F | 600 | | | |
| | Nurse # 2) and I tran | sferred resident to the bed, | | | | | |
| | · ' | neath resident and I began | | | | | |
| | | after determining she was in | | | | | |
| | | atory arrest. (Nurse # 5 and | | | | | |
| | Nurse #2) were settir | ng up ambu bag with high | | | | | |
| | , , , | d Nurse #4 went to (hall) | | | | | |
| | | emergency services. I | | | | | |
| | | (Nurse # 5) giving rescue | | | | | |
| | | g and (Nurse # 4) printed off | | | | | |
| | resident's paperwork | • | | | | | |
| | | CNA to the front door to | | | | | |
| | | personnel to enter building. | | | | | |
| | · · | y eventually took over instructed the two CNAs | | | | | |
| | | make a check of all of the | | | | | |
| | | ne unit) to ensure there were | | | | | |
| | no additional issues | • | | | | | |
| | | is was an isolated incident. | | | | | |
| | _ | ook over resident's care-l | | | | | |
| | immediately notified | DON (Director of Nursing) | | | | | |
| | regarding this situation | on. 911 personnel were | | | | | |
| | | each other regarding | | | | | |
| | | rom resident; however, they | | | | | |
| | - | aff if we had noticed the ants. | | | | | |
| | | gh their departure from | | | | | |
| | | orso remained without | | | | | |
| | | ed a gross amount of 'bites' ck-torso and bilat. upper | | | | | |
| | | was very pale white in color | | | | | |
| | | obvious with dark pink to red | | | | | |
| | | eparture from facility I called | | | | | |
| | | s daughter via phone that | | | | | |
| | | ory distress and had been | | | | | |
| | | ital). She verbalized her | | | | | |
| | | ppreciation for nurse having | | | | | |
| | called." | j | | | | | |
| | | | | | | | |
| | Nurse # 3 was interv | iewed on 10/3/19 at 4:45 PM | | | | | |

and again on 10/4/19 at 3:15 PM. Nurse # 3

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|-----------------------|--|--------------|-----|---|-------------------------------|--------------------|
| | | | | | | 1 (| С |
| | | 345505 | B. WING | | | 1 | 15/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 10/ | 10/2010 |
| | | | | 4 | 4600 CUMBERLAND ROAD | | |
| CAROLIN | A REHAB CENTER OF | CUMBERLAND | | F | FAYETTEVILLE, NC 28306 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | (EACH DEFICIEN | NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | PREFI TAG | | (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | COMPLETION DATE |
| F 600 | Continued From pa | ge 9 | F | 600 | | | |
| | <u> </u> | events from her statement and | | 000 | | | |
| | | ation. Prior to 1:00 AM she | | | | | |
| | _ | lent # 1 at 11:40 PM. She had | | | | | |
| | | d, from the light of the hall, | | | | | |
| | | and fall of her chest which | | | | | |
| | | atory distress at that time. She | | | | | |
| | · · | her oxygen was on. She | | | | | |
| | | ne, because she was working | | | | | |
| | | night. She had left the previous | | | | | |
| | | Resident # 1's unit at 11:40 | | | | | |
| | PM. At that time Nu | rse # 2 was still there, and | | | | | |
| | she (Nurse # 3) we | nt around to check on her new | | | | | |
| | residents. When NA | A# 1 called her to the room | | | | | |
| | | ne went into the room, flipped | | | | | |
| | on the light, and fou | and the resident had ants on | | | | | |
| | | k, bilateral arms, and all over | | | | | |
| | | ere red ants of various sizes. | | | | | |
| | | d her eyes and seemed to | | | | | |
| | | as if she was aware the nurse | | | | | |
| | _ | She was breathing at the time. | | | | | |
| | | g or talking. Nurse # 3 directed | | | | | |
| | _ | ashcloths so they could wash | | | | | |
| | | nile the NA ran for the ached in her pocket to grab | | | | | |
| | i i | r to cut away the resident's | | | | | |
| | | se # 3 reached in her pocket, | | | | | |
| | _ | n the same pocket. It occurred | | | | | |
| | | ntation would never describe | | | | | |
| | | that had covered Resident # | | | | | |
| | | e grabbed her phone and | | | | | |
| | | econds went "boom-boom;" | | | | | |
| | | res for documentation | | | | | |
| | | e phone aside, and went to | | | | | |
| | | he resident's clothing. She | | | | | |
| | | resident while she worked, | | | | | |
| | | e okay. We are going to get | | | | | |
| | | u are going to be okay." When | | | | | |
| | | the room with the washcloths, | | | | | |
| | she realized she ne | eded more help and they | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUIL | | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|---|--|-------------------|-----|---|-------------------------------|----------------------------|
| | | | A. BOILD | | | Ι, | C |
| | | 345505 | B. WING | | | | 15/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | - | | ξ | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| CAROLIN | A REHAB CENTER OF | CUMPERI AND | | 4 | 1600 CUMBERLAND ROAD | | |
| CAROLIN | A REHAD CENTER OF | COMBERLAND | | F | FAYETTEVILLE, NC 28306 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 600 | paged stat (right av When she did this, and also Nurse # 5 resident's cardiac voxygen was also reportable oxygen be fast with her. They ran with her to the with the ants were bathroom to contain shower, they were away" from Reside many to estimate the Resident # 1 was chad leaned forward had passed by while and showered. She bed. She recalled N facility and was als was in the shower. The majority of the ants them. EMS worker and she did not tell Resident # 1's room contained in the bathe resident's room stated she could not the resident who roommate did not shad occurred. She (DON) that night ar Her nursing training her to deal with me | esident in the shower. She vay) for Nurse # 4 to come. Nurse # 4 arrived with NA # 4, came. She removed the rest and all of her clothing. Her emoved and they didn't get any reause they were working so got her to the wheelchair and hallway shower. Her linens thrown into the resident's in the ants in them. While in the "just wiping and wiping ants int # 1's body. There were too ine number. Nurse # 5 said trashing and they saw her head if About three to five minutes they had been getting her up to directed staff to get a clean shurse # 2 had still been in the into helping while the resident in Nurse # 4 quickly placed a room door and they started that to call 911. EMS arrived by had been able to get the rooff in the shower but not all of its did not ask about the ants, them. When she returned to in, she bagged the linen throom. The rest of the ants in the were "just gone." Nurse #3 but understand that because back of ants" going towards in they had walked in. The seem cognizant about what called the Director of Nursing and she sent the pictures to her. It is an experience had prepared dical emergencies but she had go a resident covered with fire | F | 600 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|-------------------|--|---|-----|-------------------------------|--|
| | | | | _ | | (| c | |
| | | 345505 | B. WING | | | 10/ | 15/2019 | |
| NAME OF PROVIDER OR SUPE | | UMBERLAND | | 4 | TREET ADDRESS, CITY, STATE, ZIP CODE 600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | | | |
| PREFIX (EACH D | EFICIENC' | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | |
| resident's roo problem prior found Reside seemed to ge still breathing nurse did not stepped up or while they we recalled seeir and arms. Sh the resident's due to the and pneumonia. Si delayed her re Nurse # 2 wa at 2:50 PM. A 9/14/19, she I She had beer heard the page Resident # 1 to the room. N Resident # 1's was breathing body; mostly She could not knew there w Nurse # 3 dire about two or the her into the w hallway show # 5 and she w resident. She resident had i did recall they She did not re | d not seed and we to the ir not # 1, the the and in the structure in with an in in the structure in the interval i | en ants before in the was not aware of any ant incident. When she first he urgent matter to her had its off her because she was not she was breathing the repulse. As the paramedic etcher to continue CPR in Resident # 1 out, the nurse it is on her torso, face, neck, for realized at the time that cory failure might have been not to her recently diagnosed aking the pictures had it is by seconds and not longer. Bewed by phone on 10/3/19 second shift ended on ained to chart and help. In the resident when she help. Because she had known been well earlier, she went he entered Nurse # 3 was in Resident # 1 looked like she he had "insects" all over her bdomen, face, and thighs. The number of insects but in the interest in the shower together with the recall exactly when the er pulse or respirations. She is even bed and placed her in it. Here were bites, and she did staff had been told. | F | 600 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|---------------------|--|------------------------------|-------------------------------|--|
| | | 345505 | B. WING | B. WING | | C 1 0/15/2019 | |
| | ROVIDER OR SUPPLIER A REHAB CENTER OF | CUMBERLAND | | STREET ADDRESS, CITY, STATE, ZIP CO. 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| F 600 | 7:00 AM. NA # 4 repinterview. When she help, she went also the nurses trying to the resident was "or "hair to feet." They mouth, and private a but she was not talk them off her. Once twheelchair, she pick backwards as the nuthe shower room. SI Nurse # 4, Nurse # 8 and trying to get the recall when the resider recall they put her in started to perform C that unit in awhile ar seen any ants in the Nurse # 5's, (who wis began on 9/14/19 at read, "I (Nurse # 5) shift on 9/15/19. Aro over the intercom a to (name of unit) ST ran to the unit. After (Nurse # 3) with one wheelchair rushed in # 3) attempted to reithings resembled an resident's nares and mouth). Then I notice pale, and unconscious bed, CPR administer took over the situation. | wed via phone on 10/4/19 at worted the following in her heard the page for STAT and entered the room to find get the resident out of bed. Overed with ants" from her were also in her ears, nose, areas. Her eyes were open, and not reying to move and get the resident was in the led up her legs and ran areas pushed the wheelchair to the remembered Nurse # 3, 5, and NA # 5 all being there ants off her. She did not dent stopped breathing but did the bed after the shower and PR. She had not worked on the shad not personally room. Torked on the third shift which the shad not so when I heard page from the nurse to come AT. I took the crash cart and I have reached and noted of the resident who sat in a not the shower room. (Nurse move some small black ts which came from the buccal areas (inside the ed the resident very lethargic, us. (Nurse # 3) requested a red until EMS arrived and | F 60 | 00 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | I ` ′ | FIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---------------------|--|--|-------------------------------|--|
| | | 345505 | B. WING _ | | 1, | C 10/15/2019 | |
| | ROVIDER OR SUPPLIER | F CUMBERLAND | | STREET ADDRESS, CITY, STATE, Z 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | | 110/2013 | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION) | ID PREFII TAG | PROVIDER'S PLAN X (EACH CORRECTIVE CROSS-REFERENCED DEFICE | ACTION SHOULD BE TO THE APPROPRIATE | (X5) COMPLETION DATE | |
| F 600 | the interview. At 1: "stat" help which merash cart to Reside on the unit, Nurse the shower stall. The closed and was brootherwise. There we she had a sheet at one or two ants on from her mouth an were black, and the Once in the shower her. Nurse # 5 was noticed the resider Nurse # 3 they need gotten from across | the following information in 200 AM she heard a call for reant code to her. She took the ent # 1's unit. When she got # 3 was taking Resident # 1 to be resident had her eyes eathing but was not responding that it is no expected to a compart of the resident's face coming the resident was showering for the showering her. Nurse # 5 at stopped breathing and told field to start CPR. A bed was the hall, the resident was the started CPR. She did not | F | 600 | | | |
| | 0105 (1:05 AM) the asking for me to co (another room) chafeed. I immediately (name of unit). Upo was attempting to assisted with trans ahead and cut the (Nurse # 3). I cut the instructed to get archeck patient's "co transferred from what unresponsive. I was print off patient inforeturned to patient' perform CPR. EMS on scene and relie | a statement read, "At around intercom system came on ome to (name of unit). I was in anging out a patient's tube of left the room and ran to on arrival to unit nursing staff transfer patient to wheelchair. I fer and was instructed to go shower on luke warm water by the shower on and was in empty bed. I was asked to de status" as well. Patient was instructed to call 911 and to ormation. After doing so I is side and helped nursing staff is and Fire Department arrived wed nursing staff. Patient was (automated external | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|---------------------|---|-------------------------------|----------------------------|
| | | 345505 | B. WING _ | | | C 10/15/2019 |
| | ROVIDER OR SUPPLIER | CUMBERLAND | | STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | | 10/10/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 600 | Continued From pag | ge 14 | F 6 | 00 | | |
| | defibrillator) and EK | G (electrocardiogram) by d that she had abnormal ued CPR while exiting | | | | |
| | at 6:45 AM. Nurse # his interview. He we he heard them page When he entered the was in the room tryir wheelchair. The resishe was breathing. Stalking. He remembe around her shoulder arms to help lift her idirected him to go tu he ran to get a new nursing desk to view he pulled the code shit the print button fo out. Then other staff the resident had stol | riewed by phone on 10/4/19 4 reported the following in into Resident # 1's unit when there was an emergency. The resident's room, Nurse # 3 ing to get the resident in the dent's eyes were open and she was not moving or ered seeing a "cluster" of ants is. He grabbed around her into the wheelchair. Nurse # 3 irrn on the shower, and then bed. He then went to the interest her code status and, while tatus up on the computer, he is paperwork to transfer her imembers called to him that oped breathing, and he called iminutes elapsed while they | | | | |
| | called. He had not so 1's room. During a for # 4 on 10/5/19 at 6:4 that he printed out the medication record postated when he pulled automatically printed. Interview by phone of 10/10/19 at 11:25 All received the resident information which shaden in the resident was in the second of the property of the president was in the second of the property of the president was in the second of the property of the president was in the property of the pro | the ants off of her and 911 een ants before in Resident # bllow up interview with Nurse 15 AM, it was verified with him he resident's face sheet and rior to calling 911. The nurse ed up the code status, he just dit out to be ready to go. with a police detective on M revealed the police had t's recorded Cardiac Vest howed on 9/14/19 at 12:56:19 bradycardia with a heartbeat as per minute. At 1:10 AM on | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLI A. BUILDING | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--|---|--|---------------------|---|-----------------|
| | | 345505 | B. WING | | C 10/15/2019 |
| | ROVIDER OR SUPPLIER | CUMBERLAND | 4 | STREET ADDRESS, CITY, STATE, ZIP CODE 1600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | 10.70.20.0 |
| (X4) ID PREFIX TAG | EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | D BE COMPLETION |
| F 600 | Continued From pag | e 15 Vest was removed from her | F 600 | | |
| | or turned off. Review of EMS reco | rds revealed the 911 call received at 1:11:53 AM. EMS | | | |
| | scene at 1:16:00 AM | • | | | |
| | oversees the county' interviewed by phone reported the following have protocol instructions are sovering a resid them, the facility staff was non-responsive. There was nothing mould have dispatch | munication's Manager, who s 911 call center, was e on 10/7/19 at 1:50 PM and g. The call center does not stions to give a caller for fire lent. When the call came into f had reported the resident and CPR had been initiated. The nentioned about ants. They ed the crew with the same of the same of the control of the contro | | | |
| | were first found, ther the scene sooner. The instructions about re- asked over the dispat have been referred to As an emergency tel | n they would have arrived on ney would not have given moving oxygen or life vest if the call. The facility would to their protocol or physician. ecommunications manager, oppropriate response would be | | | |
| | | order to get the paramedics | | | |
| | call, was interviewed 10:02 AM and report arrived Resident # 1 her room. He remove staff did not mention They reported she haminutes prior. She hapulseless electrical ri | by phone on 10/7/19 at ed the following. When EMS was in the hallway and not in ed 5-8 ants from her, but the anything about the ants. ad been seen about 20 to 30 ad a "very, very slow hythm" (no pulse but slow ore was warm, and her | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE A. BUILDING | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|---|---|---------------------|---|-----------------|--|
| | | 345505 | B. WING | | C 10/15/2019 | |
| | NAME OF PROVIDER OR SUPPLIER CAROLINA REHAB CENTER OF CUMBERLAND | | | TREET ADDRESS, CITY, STATE, ZIP CODE 600 CUMBERLAND ROAD AYETTEVILLE, NC 28306 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY) | D BE COMPLETION | |
| F 600 | from her thoracic are appeared to be red of the EMS crew that is then he would have opened her airway to not report any informing give her epinephrine would have been on bites as well. The Paramedic Man was interviewed by and reported the foll county 911 call cent was dispatched. In odispatched and four ants and in distress paramedics are "greet trained to clean and while dealing with a Emergency Room (Frevealed the resider arrest and expired in noted, "Multiple small on face and trunk. Non patient's skin included." The ER Physician was 10/7/19 at 3:15 PM. The following. When conveyed to him in toon her by the paramit was a rash on her her trunk was literall crawled out of her neworking with her. According with her. According to the paramit was a rash on her her trunk was literall crawled out of her neworking with her. According to the paramit working with her. | d and blue. There was a rash ea to her pelvis which dots. If the staff had informed he had been covered in ants, used a laryngoscope and to look further down. They did nation about ants. EMS did to for the cardiac arrest, which to e of the treatments for ant agger of the responding crew belone on 10/7/19 at 12:50 PM owing. The call went to the er, and then his EMS crew general, if his crew were to be do a resident covered with or cardiac failure, then his tat multitaskers." They are decontaminate a resident coding or declining resident. ER) records for 9/15/19 at entered the ER with cardiac in the ER. The ER physician all flat erythematous lesions lote occasional ants crawling uding head and face." as interviewed by phone on The ER Physician reported Resident # 1 arrived it was the report that she had ants edics. At first, he also thought trunk, but then he realized y covered with bites. One ant ose while the ER staff were cording to the ER physician if red in ants to the point that | F 600 | | | |

| , , | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|---------------------|---|----------------------------|--|
| | | 345505 | B. WING | | C 10/15/2019 | |
| | ROVIDER OR SUPPLIER A REHAB CENTER OF | CUMBERLAND | | STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | 10/13/2013 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY) | D BE COMPLETION | |
| F 600 | a black resident, the the overwhelming finer death but stated According to the EF received hundreds overwhelming immushich can contribute the extent of the answould have used extreatment. They had cardiac arrest, so sistem used for the answould have used extreatment. They had cardiac arrest, so sistem used for the answould have used extreatment. They had cardiac arrest, so sistem used for the answould have used for the answord for the cause of death with contributing fact and chronic respirate. Resident # 1's Faminterviewed by phore reported the following 1 on 9/14/19. He and and stayed until 4:3 seemed pale and helabored, but "otherwishe wanted to go to not wanted to do so of her bed to the win roommate's and family and found the roommate had kept always closed. On so brushed a "sugar and "did not think and "di | stake a Caucasian resident for en there was a "good chance" re ant venom did contribute to d he could not say for sure. It is physician when an individual of bites the body can have an une response to the venom the to death. If he had been told to coverage of her body, he binephrine or steroids in her did used epinephrine to treat the the got a drug that would have not bites. # 1's death certificate # 1's PA signed on 9/18/19 that was cardiopulmonary arrest extors of pneumonia, COPD, tory failure. | F 600 | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|---|-----|---|-------------------------------|----------------------------|
| | | 345505 | B. WING | | | | C 15/2019 |
| | ROVIDER OR SUPPLIER | UMBERLAND | | 46 | REET ADDRESS, CITY, STATE, ZIP CODE 00 CUMBERLAND ROAD AYETTEVILLE, NC 28306 | 1 10/ | 10/2013 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 600 | signs were okay, and when they called him know she had passed because of her medic facility had mentioned the resident. Resident # 1's Family interviewed by phone She received a phone (which was 2:07 AM time) from someone a member told her Resident the entrance way do and they had to push to get to her. She was and they sent her to thospital and the physhad come into the EF to do their best, but is had said anything about 10 money 16/19 she received Administrator who told investigation." She had investigation and ask was told Resident # 1 she had "like two bite Administrator if this heath and was inform been low and in the 7 not been doing well. Sextent of the ant cover until a police officer in week. | ass away. He knew her vital she was coherent. But later that night to let him d away, he was not surprised cal history. No one from the d ants had been found on | F | 600 | | | |
| | 10/5/19 at 11:44 AM | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|---------------------|--|---|-----------------|-------------------------------|--|
| | | 345505 | B. WING | | | C 10/15/2019 | | |
| NAME OF PI | ROVIDER OR SUPPLIER | 0.0000 | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | 1 10/ | 15/2019 | |
| | | | | 4 | 600 CUMBERLAND ROAD | | | |
| CAROLIN | A REHAB CENTER OF (| CUMBERLAND | | F | AYETTEVILLE, NC 28306 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 600 | Continued From pag | e 19 | F 6 | 300 | | | | |
| | anytime a resident is EMS should be calle | found covered in ants, then d right away. | | | | | | |
| | and reported the follo | ewed on 10/5/19 at 9:30 AM owing. She had worked on | | | | | | |
| | 12:45 AM on 9/15/19 | nd left the facility around . She received a phone call | | | | | | |
| | still in the building. N | Nurse # 3 while EMS was urse # 3 informed her they | | | | | | |
| | | # 1 with ants on her, Nurse # , and then Nurse # 3 and the | | | | | | |
| | staff had showered ti | ne resident. After they got e resident coded. Nurse # 3 | | | | | | |
| | texted pictures at the | same time she talked to the | | | | | | |
| | | y didn't look at the pictures deleted them right away. | | | | | | |
| | | the resident had not been | | | | | | |
| | doing well on the eve | _ | | | | | | |
| | | ad informed her of this had been at the facility on | | | | | | |
| | | DN) informed Nurse # 3 to | | | | | | |
| | , | # 1's roommate was moved | | | | | | |
| | | to check all of the resident's | | | | | | |
| | · · | make sure there were no | | | | | | |
| | - | told Nurse # 3 to gather | | | | | | |
| | statements from staff | _ | | | | | | |
| | | ght and informed her of the | | | | | | |
| | 1 | ministrator was to talk to her | | | | | | |
| | corporate supervisor | . She did not call EMS to | | | | | | |
| | | ner about the ants herself | | | | | | |
| | although Nurse # 3 h | ad not told them. She did | | | | | | |
| | | PA on 9/16/19 and told him | | | | | | |
| | 1 | gnificant amount" of ants on | | | | | | |
| | | nad responded that he was | | | | | | |
| | | e statements that were | | | | | | |
| | • | Administrator. She never | | | | | | |
| | | ht have been part of the | | | | | | |
| | | ause the resident had not //14/19. The DON had never | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | FIPLE CONSTRUCTION NG | ` ' | (X3) DATE SURVEY COMPLETED C 10/15/2019 | |
|---|---|---|--------------------|--|--|--|--|
| | | 345505 | 345505 B. WING | | | | |
| | NAME OF PROVIDER OR SUPPLIER CAROLINA REHAB CENTER OF CUMBERLAND | | | STREET ADDRESS, CITY, STATE, ZIF 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | | 0/10/2013 | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | ' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN (X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE | ACTION SHOULD BE TO THE APPROPRIATE | (X5) COMPLETION DATE | |
| F 600 | On 10/5/19 at 11:0 interviewed and recalled her around know about the an coded. She made statements, make was permanently rinspected, and verchecked. The next establish a timelinstatements and reresident had been being found with the knew there needed because Nurse #3 and the other staff black ants. They pon 9/16/19. They sthemselves because could not come out the candy bar on 9 the Pest Control To He treated for fire been made aware the facility althoug ants. The facility of to a Professor of Expertise in the anterned about the ability to conglome prevent problems travel one to two in wondered if the rehave attracted the her staff had done the emergency or | age 20 s in the room before. O AM the Administrator was ported the following. The DON 1:30 AM on 9/15/19 and let her ts and then a resident had sure the DON knew to get sure Resident #1's roommate removed, all the unit rooms iffy when Resident # 1 was last morning of 9/16/19 she tried to and she received the ad them. She found that the checked on frequently prior to be ants. In investigating, she do to be more clarification as referred to them as red ants members described them as laced a candy bar in the room sprayed the room on 9/16/19 see the pest control company to that day. Ants did come to 9/17/19, and it was verified with echnician they were fire ants. ants on 9/17/19. She had never of fire ants before 9/17/19 in the there had been some sugar proporate office had reached out entomology who had some ear of fire ants. They had nature of the fire ants, their erate, their habits, and how to with them in future. They can naches per second. She had sident's bloody nose could m. She never questioned that anything wrong in reacting to that the ants could have | F | 600 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|---------------------|--|--|-------------------------------|--|
| | | 345505 | 345505 B. WING | | | C 10/15/2019 | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZII 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | • | 0/13/2019 | |
| (X4) ID PREFIX TAG | (EACH DEFICI | Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN (X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE | ACTION SHOULD BE TO THE APPROPRIATE | (X5) COMPLETION DATE | |
| F 600 | thereby removed a never saw the pick knew there had be not necessary bed statements she had presented a picture body was covered had also discussed medical director. The monitoring for antiand practices to a created a daily mone checked the room the staff on responsible to the staff on the st | the resident from danger. She tures that had been taken but the some. She knew they were cause of HIPPA. She felt the ad received from her staff had the of the extent the resident's land thus she was aware. She do the incident with the facility of they had educated their staff on same reporting ants, and cleaning word ants. They also had conitoring tool where they as for ants. They did not educate anding to a fire ant emergency taken steps to avoid an | F | 600 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | PLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED C 10/15/2019 | |
|---|---|---|---------------------|---|-----------|--|--|
| | | 345505 B. V | | | | | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | | 0/13/2019 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| F 600 | response to the eme therefore she had do in regards to steps t | is not focused on the staff ergency situation and one no retraining to the staff hey should take when a vered with fire ants. She also for the pest control | F 60 | 00 | | | |
| | by phone on 10/4/19 following information Resident # 1 had a she had been resist remembered she had hospital for treatmenther care there. He wincident. When he wincident, it was convants. As time passe became more award covering her body. A certificate, he had be her and in her mouth could have caused a her body. He though had some type of might which did not allow them off her. He wooxygen be removed level of alertness be think it advisable to resident who was not had been a tough can he likened it to finding Typically, you would and then assess the was important to alw possible when deali | sident's Physician Assistant at 12:41 PM revealed the h. He had been aware hose bleed on 9/14/19 and live to some care. He also d not wanted to go to the ht and he had left orders for livas not called the night of the livas first told about the leved to him there were a few d and he learned more he le of the extent of the ants lafter he had signed the death leen told the ants were all over h. A large number of bites an inflammatory response in hit it possible she could have ledical event prior to the ants her to call for help or try to get build not advise a resident's luntil vitals, oxygen level, and lassessed. He would also not remove a cardiac vest from a lot responding. He stated it last for the staff involved, and ling someone in a fire. I remove someone from a fire lir status. The PA did say it livays call 911 as soon as ling with an emergency, and libe given as much information | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION NG | 1, , | (X3) DATE SURVEY COMPLETED | |
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| | | 345505 | B. WING _ | NG | | C 10/15/2019 | |
| | ROVIDER OR SUPPLIER | F CUMBERLAND | | STREET ADDRESS, CITY, STATE, ZIF 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | • | 0/10/2013 | |
| (X4) ID PREFIX TAG | (EACH DEFICI | Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE | ACTION SHOULD BE O THE APPROPRIATE | (X5) COMPLETION DATE | |
| F 600 | phone on 10/5/19 following. It had be Resident # 1 had later after the incideresident had not be symptoms of pneutohecking on her. It ants could have concerned to the According and her was some leeway be a prolonged tin understanding the "relatively shortly" make a quick judg "complete rarity" a protocol to refer to It "did not make so not communicated of ant coverage, a been done. Review of an inverse Administrator into revealed no mention prior to the incident that exterior and con 9/15/19 to ensign the summary also inspection of all reaffected by this issue continues to received. | _ | F | 500 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) BUILDING (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) BUILDING (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTR | | (X3) DATE COMP | SURVEY LETED | | | | |
|--|---|--|---------------------|--|---------------------------------|-----|----------------------------|
| | | 345505 | B. WING _ | | | 10/ |) 15/2019 |
| | ROVIDER OR SUPPLIER A REHAB CENTER OF C | CUMBERLAND | | STREET ADDRESS, CITY, STATE, ZIP 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | CODE | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIA | | (X5) COMPLETION DATE |
| F 600 | ants." The summary second contractor where the facility on 9/20/19. The Maintenance Dir 10/4/19 at 9:00 AM at PM and reported the started work in July 2 some "pop ups of sugthere, and the staff were more than one and get rid of the ant reoccurring problem of 9/15/19, and he has to 9/17/19 in the build records left for him from aintenance director started in July, 2019. System where they of themselves and make them. He did not recapointed out to him sir 2019. The day (9/16/sent to the hospital thempty room. They was date of 9/17/19 they had come to the candolack with a little she Control Technician care | for ants. Prior to this o other sightings of fire also noted the facility had a no came to the facility after control company and treated of the facility after control company and treated on 10/5/19 at 1:25 following. He had just 10/19. Sometimes there were gar ants" since he had been rould let him know if there for two. They would clean as. He was not aware of a with ants prior to the incident and never seen fire ants prior ding. There had been no om the previous about a problem when he They have a maintenance | F | | CY) | | |
| | and they had not obs courtyard. They talke Technician and got a They thought the ant | backed up to a courtyard, served mounds in the ed to their Pest Control second opinion as well. s could be burrowing under f the building and coming in | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|--|---|---|---|-------------------------------|--|
| | | 345505 | B. WING | | C 10/15/2019 | |
| | ROVIDER OR SUPPLIER | CUMBERLAND | STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | | 1 10/10/2010 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLETION | |
| F 600 | building. Because or residents' rooms, you the sheetrock where had ordered new bat the baseboard in rescracks at the bottom the replacement bas staff member had se in a room, then he wabout it prior to 9/17. The facility's Pest Cointerviewed by phone at 1:35 PM. He routi of the facility which it pesticide solution will the facility. Additional sprayed a liquid pesmonths around the had been called out maintenance treatment two times was in Ma fire ants in the winder the baseboards of the sheet of the baseboards of the sheet of the baseboards of the same transport of the sheet of the baseboards of th | the the foundation met the fithe glued baseboard in u could not see all the way to the wall met the floor. They seboard but had not taken off sidents' rooms to look for of the sheetrock because seboard had not come in. If a seen more than five or six ants yould have wanted to know | F 600 | , | | |
| | write down the room had directed them the need to be fixed. He baseboards himself Directors took note adding recall he had ide baseboards but did which dates. He valid to the candy bar tes Fire ants secrete ph | not recall which rooms and on dated that the ants that came ton 9/17/19 were fire ants. | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | , , | I ' ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--|--|--|---------------------|---|-------------------------------|--|
| | | 345505 | B. WING | | C 10/15/2019 | |
| | ROVIDER OR SUPPLIER A REHAB CENTER OF | CUMBERLAND | ' | STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | 10/10/2013 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE COMPLETION | |
| F 600 | follow the trail. Also identify two fire ant outside of Resident activity when he loo On 10/7/19 at 2:40 interview was conducted. He had May, 2019 treatmen had not billed the fatreatment, but he win May, 2019 in the stated the facility wo room they were identified. Review of pest contumentation of find Interview with a polito/5/19 at 6:14 PM responded to a call prior to Resident # During the August, member had been of police officer had of the police officer had of the police officer had of the report noted the different stories whe asking for Resident removed because the disruptive. When the 8's family member is | hours, other fire ants can on the date of 9/17/19 he did mounds in the courtyard # 1's room, but they had no ked at them on 9/17/19. PM a follow up phone acted with the Pest Control checked his records for the act of fire ants. The company cility extra for the in between as sure he had identified them window sill of a resident. He build have kept a record of the ntified in. Fol records supplied to the facility revealed no e ants prior to 9/17/19. The detective by phone on revealed the police had at the facility in August 2019 at the facility in August 2019 police call another family concerned about ants, and the | F 600 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | IPLE CONSTRUCTION | , , , | TE SURVEY |
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| | | 345505 | B. WING | | | C |
| | ROVIDER OR SUPPLIER A REHAB CENTER OF C | | | STREET ADDRESS, CITY, STATE, ZIP C 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | | 10/15/2019 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT | ION SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 600 | 8's room. Police Offithat she (the officer) near Resident # 8's roofficer noted in her restaff there were ants maintenance was aw the following day. Police Officer # 1 wa 10/9/19 at 7:38 PM. following. She saw al floor along the wall w Resident # 7's side of the window side of the sugar ants at first to I sure. She saw them is he moved the shoes ants on that wing and take care of it. A review of Resident was admitted on 7/3' longer resided at the Resident # 8's admis the resident was cog total staff assistance. Resident #8's family phone on 10/8/19 at following. She had w two occasions in Resoccasion, they were staff could do becaus needed was locked u corner of the room ne later someone sprays seemed to scatter the They were later informafter they left that every staff that every left that every later information in the staff could following sprays seemed to scatter the They were later informafter they left that every later information in the staff could following sprays seemed to scatter the they were later information. | cer # 1 noted in her report observed ants along the wall commate (Resident #7). The sport that she was told by in other resident rooms, are, and they would be in sinterviewed by phone on The officer reported the cout 40 to 50 ants on the chich was near the corner of f the room (which was near e room). They looked like ner, but she did not know for n Resident # 7's shoes and s. Staff told her there were it maintenance was going to #8's record revealed she 1/19 to the 400 hall and no facility. According to sion MDS, dated 8/13/19, nitively impaired and needed | F | 600 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDII | TIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
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| | | 345505 | B. WING _ | | | C 10/15/2019 |
| | ROVIDER OR SUPPLIER A REHAB CENTER OF C | UMBERLAND | | STREET ADDRESS, CITY, STATE, 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | , ZIP CODE | 10/10/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | X (EACH CORRECTIVI CROSS-REFERENCE | AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIA' CIENCY) | |
| F 600 | family member saw to The baseboard was and they seemed to be She was concerned to not call for help. She got stung by them and kind of ants they were officer left, the facility shortly there after Research A review of Resident was admitted on 8/2/the facility. The resided atted 8/13/19, coded cognition on a scale of Resident # 7 was interested in hall she had seen browere "all over the rocabout them. The antibite her feet. She did but knew they bit her covers off the floor, be were "all over the rocabout them. The antibite her feet. She did but knew they bit her covers off the floor, be since Resident #8's be since Resident #8's be since Resident #8 co and changed the resist sprayed and it "slowes stop them." Then one into her room and she area. After she was an problem, and she we | Resident #8's bed. The ne ants again on 8/11/19. Not sealed near the AC unit, be coming from that area. Decause Resident # 8 could was not aware Resident #8 d she did not know what he. That night after the police moved Resident #8. Then sident # 8 was discharged. #7's record revealed she and no longer resided at tent's MDS assessment, the resident as a 15 for of 1 to 15. This indicated | F | 600 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING | | (X3) DATE SURVEY COMPLETED | | | |
|--|---|---|---------------------|--|-----------------|
| | | 345505 | B. WING | | C 10/15/2019 |
| | ROVIDER OR SUPPLIER | CUMBERLAND | | STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | 10/10/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLETION |
| F 600 | following. He visited week. At first, he did first few visits when 8/2/19, but then on "they just came out He would see more on the walls and the to be little black anteresident a new room. The facility's ant mostarted following the reviewed. This reviewed. This reviewed. This reviewed identified in the 10/3/19 in Room 40 which Resident #7, 1 resided. The audit 9/18/19 that the root the window side of maintenance director made aware. On 10 was sprayed and cl. An audit for Room 40 been found in this reand been sprayed a water. | t 7:25 PM and reported the dabout three to four times a do not notice the ants during his Resident # 7 was admitted on his next visits it seemed like of nowhere all of the sudden." than 20 at a time. They were defloors and appeared to him is. They finally gave the in and then she went home. Initioring sheets they had define incident of 9/17/19 were leaved revealed "sugar ants" had deir audits on 9/18/19 and leaved and the same hall on Resident # 8, and Resident # 100 to the room, sprayed, and the loor and Administrator had been look of the room leaned with soap and water. How the revealed sugar ants had soom on 10/2/19. The room and cleaned with soap and | F 60 | | |
| | Resident # 7, Resid sheets. The Adminis aware the police residuals thought it was becan there was a need to very upset. She was had complained of a understanding they | the Administrator to discuss lent #8, and the ant monitoring strator reported she was sponded on 8/11/19 but she use of a domestic issue and oremove the family who was a aware Resident #8's family lents, but it was her were sugar ants, the ed on the night of 8/11/19, the | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPI A. BUILDING | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED C | |
|---|---|--|-----------------------------|--|------------------------------|--|
| | | 345505 | B. WING | | 10/15/2019 | |
| | ROVIDER OR SUPPLIER | CUMBERLAND | | STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY) | D BE COMPLETION | |
| F 600 | room was sprayed a aware of any report Resident # 8's bed. # 7 had been exper was her understand also because she g so well. They had n company to deal wire would have only do repetitious thing or and it had not been the case. Regarding stated it was her un on the facility audits Administrator stated maintenance directed. On 10/9/19 at 10:51 information by emaithe email, the first s was on 9/18/19; a docompany had been told there might be hours after the sprathey did not reach company. They spracontrol company habeen about 2 dozer did tell the pest confor a biweekly visit of the room. On 10/3/1 couple black ants. Tagain, and the Pest scheduled for 10/9/1. | and cleaned. She was not as the ants had crawled into She was not aware Resident iencing any problems and it ing Resident # 7 had moved of along with her roommate of called their pest control the the 8/11/19 issue. They he so if it had been a there were a large number her understanding this was the audits, the Administrator derstanding that ants noted were tiny sugar ants. The she would check with her or and follow back up. AM the Administrator sent I to the surveyor. According to ighting of ants in Room 408 ay after the pest control in on 9/17/19. They had been sightings of ants up to 24 y on 9/17/19 and therefore out to the pest control ayed with spray the pest d left them. The ants had a tiny black ants in a cup. They trol technician when he came on 9/23/19, and he sprayed in 19 in Room 408 there were a They sprayed and cleaned Control Technician was | F 600 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | 345505 | B. WING | | C 10/15/2019 |
| | VIDER OR SUPPLIER | CUMBERLAND | | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE COMPLETION |
| cainn the broad state of the second state of t | ncident. The technicat bit people were uilding on 9/23/19 toom 408 to be fire even of them. He sacility that day (10/aseboards were looms were 407 and the baseboard or ne corner behind the ble to detect that the fire sheetrock why getting down on sing a flashlight. Information provide intomology, who have all the sheetrock why getting down on sing a flashlight. Information provide intomology, who have intomology, who have intomology, who have intomology in the information provide intomology, who have in the information in the infor | ge 31 ervice to address the 8/11/19 cian stated the only local ants if fire ants. When he was in the he had identified the ants in e ants. There were six or sprayed. While he was in the 9/19) he had identified the ose in two rooms. These d 408. Approximately ½ to 1/8 in the window wall was loose at the nightstands. He had been there were cracks at the base ere the baseboard was loose his hands and knees and d by the Professor of ad been contacted by the 9/15/19 incident, was mation noted the following. a facility consist of stained ody fluids. When one of these by even a single scout ant, a veen the food source and the nel of the colony. As soon as the rest are cruit on the borders of ous recruits are ready to to trail back to the food and The more ants on a trail, the pecomes, and the more uited. Fire ants are relatively by 1 to 2 inches per second. onservatively) hundreds of fire tited to a patients' bed. | F 600 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | PLE CONSTRUCTION | | TE SURVEY MPLETED | |
|---|---|--|---------------------|--|--------------------------------|----------------------------|--|
| | | 345505 | B. WING | | | C 1 0/15/2019 | |
| | ROVIDER OR SUPPLIER | 1 | | STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | | 10/13/2019 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | |
| F 600 | Fire ants sting and in creates a fiery sensal sting is highly individed individuals, they can two bites, whereas owithstand a lot of bite be painful in order to stated many nursing the gravity of the three needs to be bethem. On 10/9/19 at 7:29 Finformed of the Immer provided a credible as Jeopardy removal or Immediate Jeopardy F600 Carolina Rehab Cen Credible Allegation or Removal Identify those recipies are likely to suffer, a a result of the nonco 1. Deficient practicon 9/15/19 at 1:00 A her mouth, in her noobody. The resident were sponding verbally or removed, and her ox take her to the show although the residen had a history of recewhich were conducted. | are getting into the building. hject a toxin at the site that tition. The response to their ualized. For some have a reaction with one or ther people might be able to es. The toxin is intended to ward animals from them. He homes do not understand eat fire ants might pose, and etter protocols to deal with PM the Administrator was ediate Jeopardy. The facility allegation of Immediate 10/11/19. The allegation of removal indicated: ter of Cumberland of Immediate Jeopardy ents who have suffered, or serious adverse outcome as | F 60 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION NG | (X3) DATE S COMPL | |
|---|---|--|--------------------|--|--------------------------------------|----------------------------|
| | | 345505 | B. WING | | C | 5/2019 |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | | 5/2019 |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN C X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE | CTION SHOULD BE O THE APPROPRIATE | (X5) COMPLETION DATE |
| F 600 | with the removal of Resident # 1 on the she was not responsion movement. The nuremoved her oxyge checking the reside signs of life while in initiated a code and The facility failed to simultaneously rento ensure resident received oxygen defacility failed to show the type of ants gehave assessed all which might allow established a proto ants are found to heeds both emerge the ants; and a systabout fire ant sting personnel to assure evaluation. 2. Facility Action 1. Resident #1 etc. 2. The facility improvement in another room to att. 3. On 9/15/2019 incident. The room for ants and removing another room. 4. No resident of services came out 9/17/2019. 5. On 9/15/2019 | sponded and were assisting the fire ants found on a date of 9/15/19 at the time anding verbally or with rese who responded first an and life vest without ent's pulse. Resident # 1 lost in the shower, and the staff diactivation of 911 at that point. In immediately notify 911 while moving ants. The facility failed who was oxygen dependent uring the emergency. The low it has a system to identify thing into the building, that they arooms and filled holes/cracks entry; and that they have locol in how to respond if fire lave swarmed a resident who ency help and help removing them to assure that information is is conveyed to all medical the proper treatment and expired on 9/15/2019 mediately took resident to the lempt to remove the ants immediately following the mate in the room was checked the definition on the later of the later o | F | 500 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | PLE CONSTRU | | · / | TE SURVEY MPLETED |
|---|--|--|---------------------|-------------|--|----------|----------------------------|
| | | 345505 | B. WING _ | | | | C 0/15/2019 |
| | ROVIDER OR SUPPLIER | UMBERLAND | | 4600 CUMBE | DRESS, CITY, STATE, ZIP CODE ERLAND ROAD //ILLE, NC 28306 | <u> </u> | 0/10/2013 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHO PROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 600 | ant activity. 6. All staff education Administrator educate who provided educate departments on the for Understanding fire an | f 1 was found to ensure no n began on 10/2/2019. ed department managers on to their respective | F 6 | 00 | | | |
| | nursing homes, ident patients from affected immediately contact ractivity is suspected, inspect floor, linen an proper food storage, containers, and remo promptly. This educa 10/3/2019. 7. On 9/17/2019 the | fying fire ants, removing I room if suspect fire ants, maintenance director if any when in resident rooms d window sill for ant activity availability of storage ving trash in resident rooms tion was completed on e facility's pest control | | | | | |
| | for ants and also spra Facility also moved s bi-weekly ant treatme 8. On 9/20/2019 an | implete exterior treatment ayed internally in room 405. ervices from monthly to ints to reduce ant activity. other pest control company and completed an external ant | | | | | |
| | director was educated erase pheromones in per the direction of a 10. All resident room inspected daily by madesignee that has be control technician for 9/16 and will continue 4 weeks and monthly be reported to the Material Personner in the material series of the Material Personner in the person | d on using soap and water to room after ant activity noted university entomologist. It is and exterior grounds an initially provided by pest fire ant activity beginning on the daily x 4 weeks bi weekly x x 1. Any pest sightings will unintenance Director for ility's pest control company | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | I ` ′ | IPLE CONSTRUCTION IG | | TE SURVEY MPLETED |
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| | | 345505 | B. WING | | | C |
| | ROVIDER OR SUPPLIER A REHAB CENTER OF C | | | STREET ADDRESS, CITY, STATE, 2 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | | 0/15/2019 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE CROSS-REFERENCED | N OF CORRECTION : ACTION SHOULD BE TO THE APPROPRIATE :IENCY) | (X5) COMPLETION DATE |
| F 600 | these deficient practi Specify the action the | e potential to be affected by | F 6 | 000 | | |
| | adverse outcome from | m occurring or recurring, and | | | | |
| | educated on reporting patient immediately to began 10/11/2019 by designee. | g all sightings of ants on a o a nurse. This education Director of Nursing or | | | | |
| | administration compl about what information EMS personnel wher | Nursing (DON) and nursing eted training with all nurses on should be given to all not they are called to assist in they are training included | | | | |
| | providing all pertinen including abnormal h resident from the pre completed 10/09/201 | t medical information ealth concerns for any vious 24-72 hours. This was | | | | |
| | director of nursing or discovery of a reside will assess vital signs staff member to notify | designee that upon nt with fire ants on them we s, protect airways, instruct a y 911, have a staff member | | | | |
| | while simultaneously ants. 4. All staff education | apply oxygen as needed attempting to remove fire on began on 10/2/2019. | | | | |
| | who provided educat departments on the f Understanding fire ar provided on Red imp nursing homes, ident | ed department managers ion to their respective ollowing components: nts as per information sheet orted fire ants: a threat to ifying fire ants, removing d room if suspect fire ants, | | | | |
| | immediately contact | maintenance director if any when in resident rooms | | | | |

| NAME OF PROVIDER OR SUPPLIER CAROLINA REHAB CENTER OF CUMBERLAND (X4) ID (EACH DERICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 600 Continued From page 36 (EACH DESIGNATION IN This education was completed on 10/3/2019. 5. Any employee that did not receive the education is completed. 6. All new employees will be educated on the above topics during new hire orientation by director of nursing or designee. 7. As per the recommendation of pest control technician maintenance department began on 10/10/2019 removing all resident room cove base on the wall the leads to the exterior inspecting for cracks/holes and sealing if found. The cove base in all rooms was inspected and ensured no gaps exist. This will be completed 10/10/2019 8. All resident rooms and exterior grounds inspected for integrating the provided by pest control technician for fire ant activity beginning on 9/16 and will continue daily x 4 weeks and monthly x 1. Any pest sightings will be reported to the Maintenance Director for treatment and the facility's pest control company | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--|---|--|--|---------|----------------------|---|-------------------------------|--|
| NAME OF PROVIDER OR SUPPLIER CAROLINA REHAB CENTER OF CUMBERLAND SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) | | | | | | _ | С | |
| CAROLINA REHAB CENTER OF CUMBERLAND (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 600 Continued From page 36 inspect floor, linen and window sill for ant activity. This education was completed on 10/3/2019. 5. Any employee that did not receive the education will be removed from the schedule until education is completed. 6. All new employees will be educated on the above topics during new hire orientation by director of nursing or designee. 7. As per the recommendation of pest control technician maintenance department began on 10/10/2019 removing all resident room cove base on the wall the leads to the exterior inspecting for cracks/holes and sealing if found. The cove base in all rooms was inspected and ensured no gaps exist. This will be completed 10/10/2019 8. All resident rooms and exterior grounds inspected daily by maintenance department or designee initially provided by pest control technician for fire ant activity beginning on 9/16 and will continue daily x 4 weeks bi weekly x 4 weeks and monthly x 1. Any pest slightings will be reported to the Maintenance Director for treatment and the facility's pest control company | | | 345505 | B. WING | | <u> </u> | 10/15/2019 | |
| CAROLINA REHAB CENTER OF CUMBERLAND SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PROVIDER'S PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY | NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY | , STATE, ZIP CODE | | |
| CX4] ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREF | CAROLIN | IA DELIAD CENTED O | E CLIMPEDI AND | | 4600 CUMBERLAND R | OAD | | |
| F 600 Continued From page 36 inspect floor, linen and window sill for ant activity. This education was completed on 10/3/2019. 5. Any employee that did not receive the education will be removed from the schedule until education is completed. 6. All new employees will be educated on the above topics during new hire orientation by director of nursing or designee. 7. As per the recommendation of pest control technician maintenance department began on 10/10/2019 removing all resident room cove base on the wall the leads to the exterior inspecting for cracks/holes and sealing if found. The cove base in all rooms was inspected and ensured no gaps exist. This will be completed 10/10/2019 8. All resident rooms and exterior grounds inspected daily by maintenance department or designee initially provided by pest control technician for fire ant activity beginning on 9/16 and will continue daily x 4 weeks bi weekly x 4 weeks and monthly x 1. Any pest sightings will be reported to the Maintenance Director for treatment and the facility's pest control company | CAROLIN | IA KENAD CENTER O | FCOMBERLAND | | FAYETTEVILLE, NC | 28306 | | |
| inspect floor, linen and window sill for ant activity. This education was completed on 10/3/2019. 5. Any employee that did not receive the education will be removed from the schedule until education is completed. 6. All new employees will be educated on the above topics during new hire orientation by director of nursing or designee. 7. As per the recommendation of pest control technician maintenance department began on 10/10/2019 removing all resident room cove base on the wall the leads to the exterior inspecting for cracks/holes and sealing if found. The cove base in all rooms was inspected and ensured no gaps exist. This will be completed 10/10/2019 8. All resident rooms and exterior grounds inspected daily by maintenance department or designee initially provided by pest control technician for fire ant activity beginning on 9/16 and will continue daily x 4 weeks bi weekly x 4 weeks and monthly x 1. Any pest sightings will be reported to the Maintenance Director for treatment and the facility's pest control company | PREFIX | (EACH DEFICIE | ENCY MUST BE PRECEDED BY FULL | PREFI | X (EACH COR | RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE | COMPLETION | |
| will be called for follow up as needed. 9. The facility's pest control company will perform bi-weekly ant treatments until November 1 and will resume April 1 through the late spring and summer per pest control recommendation. This began on 9/17/2019. Date of immediate jeopardy removal is October 11, 2019. The Administrator is responsible for implementing the acceptable immediate jeopardy removal plan. On 10/15/19 the facility's plan for immediate jeopardy removal was validated by the following. Multiple residents were interviewed and stated | F 600 | inspect floor, linen This education wa 5. Any employed education will be reducation is comp 6. All new employed above topics durin director of nursing 7. As per the reducation mainter 10/10/2019 remove on the wall the lead cracks/holes and sin all rooms was in exist. This will be 8. All resident rowinspected daily by designee initially put technician for fire a and will continue of weeks and monthal be reported to the treatment and the will be called for for 9. The facility's purform bi-weekly 1 and will resume and summer per put This began on 9/1. Date of immediate 11, 2019. The Administrator the acceptable immediate improved in the proportion of the facility's purform bi-weekly 1 and will resume and summer per put This began on 9/1. The Administrator the acceptable immediate 11, 2019. The Administrator the acceptable immediate 11, 2019 and 10/15/19 the facility's propardy removal in the propagation of the prop | and window sill for ant activity. It is completed on 10/3/2019. It is that did not receive the emoved from the schedule until leted. It is is equal to the growth if it is that did not receive the emoved from the schedule until leted. It is is equal to the growth if is that did not receive the emoved from the schedule until leted. It is is equal to the extended on the growth if is equal to the growth if is equal to the extended on the growth is equal to the growth is equal to the extended on the growth is equal to the extended on the growth is equal to the growth is equal to the extended on the growth is equal to the growth is extended on the growth is extended | F | 600 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | | | |
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| | | | 7 55.125. | _ | | (| c |
| | | 345505 | B. WING | | | 10/ | 15/2019 |
| | ROVIDER OR SUPPLIER A REHAB CENTER OF C | UMBERLAND | | 40 | TREET ADDRESS, CITY, STATE, ZIP CODE 600 CUMBERLAND ROAD AYETTEVILLE, NC 28306 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | X | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 600 | fire ant education. Rathroughout the facility clean and without any were observed to be to bottom of the sheet roduring their interviews within the past week, and caulked before rethe window side of the revealed there had be in the past week within documented evidence exterior grounds per to compliance plan. The documentation of insecredible allegation of were conducted with nurse aides on 10/15, included staff on diffe shifts. During these in had received training allegation of compliar knowledgeable about monitoring for fire ant ants were seen, and I had fire ants on them the Maintenance Direct 10/15/19 revealed the sightings of fire ants, correction would be on Develop/Implement A | rom the facility in regards to indom room observations revealed the rooms were to type of ants. Baseboards tight against the floor at the lock. Residents reported is that staff had been in removed the baseboard, replacing the baseboard at the room. Staff interviews the room in sightings of fire ants in the facility. The facility had the of daily room audits and their credible allegation of a facility also had revice training per their compliance plan. Interviews thousekeepers, nurses, and interviews staff validated they per the facility's credible interviews staff validated they per the facility's credible ince plan. They were recognizing fire ants, is, measures to take if fire now to respond if a resident. Interviews conducted with cotor and Administrator on the had been no further and the facility's plan of ingoing. buse/Neglect Policies | | 607 | | | 11/1/19 |
| SS=D | CFR(s): 483.12(b)(1)- §483.12(b) The facilit implement written pol | | | | | | |
| | §483.12(b)(1) Prohibi | t and prevent abuse, | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBED: | |) MULTIPLE CONSTRUCTION BUILDING | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---|---|---|-------------------------------|--|
| | | 345505 | B. WING | | C 10/15/2019 | | |
| | ROVIDER OR SUPPLIER | 1 | | STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | | 10710/2010 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTI REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO TI | | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | | |
| F 607 | substigate any sure \$483.12(b)(3) Include paragraph \$483.95, This REQUIREMEN' by: Based on record revinterview, police interview, procedures in the arcreporting when staff in her bed covered with (Resident # 1) of threviewed for abuse a included: The facility's "Abuse Crime" policy, dated statement that there neglect, and that all sresult in an internal infurther indicated the thorough and "the invinclude, but will not be evidence, interviewing witnesses, and involvindividuals, agents, or process and determing stipulated that the factors. | tion of residents and esident property, ish policies and procedures ch allegations, and e training as required at It is not met as evidenced riew, resident interview, staff rview, physician interview, neterview the facility failed to be and neglect policies and resident was found | F 60 | | dress the ciency ete a cour report igation of Resident uation of ad taken ency of the fire ants. In of any implaining eng to pest 5/19 at cour report ent #1 no | | |
| | could not say what h witnessed to the stat | appened or which was not e agency. A 24 hour report report would be filed. | | having the potential to be affect same deficient practice; " Any resident with a current | ted by the | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | IPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--|--|--|---------------------|---|--|
| | | 345505 | B. WING | | C |
| NAME OF D | ROVIDER OR SUPPLIER | 0-2000 | 1 | STREET ADDRESS, CITY, STATE, ZI | 10/15/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | , , , | P CODE |
| CAROLIN | A REHAB CENTER O | F CUMBERLAND | | 4600 CUMBERLAND ROAD | |
| | | | | FAYETTEVILLE, NC 28306 | |
| (X4) ID PREFIX TAG | (EACH DEFICI | / STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN ((EACH CORRECTIVE A | ACTION SHOULD BE COMPLETION DATE |
| F 607 | Continued From page 39 | | | 607 | |
| F 607 | A 1:15 AM nursing noted Resident # approximately 1:1 distress. NA # 5 was interviand reported the fraking rounds are resident was black because she had resident was Caucand realized the b She got Nurse # 3 her. The resident's ants." They were mouth was open, was not moving on Nurse # 4 and Nurtook her to the she did not take her on They went to get a shower, and when resident had stoppants in the room of had not reported to roommate had been where the roommate conditioning unit. with ants on her, to from around the aroom. | ewed on 10/3/19 at 4:03 PM collowing. When she was bund 1:00 AM she thought the when she first saw her so many ants on her. (The casian). She got closer to her lack things were moving on her. It and returned to the room with something. She remembered reset as been talking. She remembered reset as the state of the ants. They was nother bed for her after the at they put her on the bed the ped breathing. She had seen ne time before that date but he ants. Resident # 1's en "pretty nasty" with food and in the floor. Resident # 1 was found hey appeared to be coming in conditioning unit area of the | F | occurrence have the pot affected by the same de " All incident reports to days were reviewed to e weren to utstanding unit that weren to investigate timely manner. The measures that will be or systemic changes may the deficient practice will " Administrator and Designed by Regional Nurse Conscompleting a thorough in Training included: collect interviewing alleged victic witnesses, and involving individuals, agents, or and in the process and deter " Administrator and Designed Nurse Constant Process and was filed within the stime frame. How the facility plans to performance to make sure sustained; " The Regional Nurse designee will review all in weekly for four weeks, a reports monthly for five refindings will be reviewed." | ficient practice. for the past 30 Insure there usual occurrences d or reported in a e put into place de to ensure that not recur; ON were trained ultant on investigation. Iting evidence, ms and other appropriate uthorities to assist minations. ON were trained ultant on ensuring ompleted timely specified 24 hour monitor its re that solutions e Consultant or incident reports ind 5 incident months. The |
| | and again on 10/4 interview Nurse # found around 1:00 | erviewed on 10/3/19 at 4:45 PM /19 at 3:15 PM. During the 3 reported Resident # 1 was 0 AM on 9/15/19 with fire ants trunk, bilateral arms, and all | | QAPI meetings. Date of compliance is Not The Administrator is respingly implementing the accept correction. | oonsible for |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | | |
|---|---|---|--------------------------------|---|---|-------------------------------|--|--|
| | | 345505 | B. WING | | | C 10/15/2019 | | |
| | ROVIDER OR SUPPLIER | 1 1111 | | STREET ADDRESS, CITY, STATE, ZIP CO 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | • | 10/13/2013 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | ON SHOULD BE IE APPROPRIATE | (X5) COMPLETION DATE | | | | |
| F 607 | taken when she was Nurse # 5, NA # 4 ar # 3's call for help wit these staff members when they initially ar 1 although the reside when they arrived. T shower and most of to showering, the rescardiac vest were re The resident stopped cardiopulmonary resstarted by staff. Emewere called after the breathing. Once paraover the resuscitation were not told by the had been covered with ants on hospital transfer. Emergency Room (Erevealed the residen arrest and expired in noted, "Multiple sma on face and trunk. Non patient's skin inclination of the ER Physician with 3:15 PM. This intervit multiple bites on her could have contributed." | tures of the resident were found. Nurse # 2, Nurse # 4, and NA #5 responded to Nurse in Resident # 1. None of called emergency services rived to help with Resident # ent was not moving or talking the resident was taken to the the fire ants removed. Prior sident's oxygen and her moved because of the ants. If breathing in the shower and suscitation efforts were regency medical services resident had stopped amedics arrived and took an efforts of Resident # 1, they staff members the resident tith fire ants. The entation in the resident's at the resident being found 109/15/19 prior to her TR) records for 9/15/19 at entered the ER with cardiac the ER. The ER physician and flat erythematous lesions onto occasional ants crawling and head and face." The interviewed on 10/7/19 at the resident had body and that fire ant venom the to the resident's death. The sident's death. | F 60 | 07 | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION IG | (X3) DATE SURVEY COMPLETED | | |
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| | | 345505 | B. WING _ | | | C 10/15/2019 | |
| | ROVIDER OR SUPPLIER A REHAB CENTER OF | CUMBERLAND | | STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | | 10/10/2010 | |
| (X4) ID PREFIX TAG | FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EAC | | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETION DATE | | |
| F 607 | prior to the incident that exterior and dai on 9/15/19 to ensure The summary also r inspection of all resi affected by this issu continues to receive for pest control and specifically designed incident there were ants." The summary second contractor we their contracted pest the facility on 9/20/1. The investigation surinto Resident # 1's in evaluation of the steaten when respond finding Resident # 1 summary made no rother residents com that loose baseboar pest entry. Interview with a police: 1.14 PM revealed the call at the facility in a summary in a call at the facility in a call | in of ants being problematic with Resident # 1. It noted by room rounds were started at the facility was free of ants. Indeed, "The facility did and dent rooms that could be at the facility has had and a monthly treatment services biyearly treatments and for ants. Prior to this and other sightings of fire also noted the facility had a arthocame to the facility after at control company and treated 9. Immary by the Administrator incident revealed no aps each staff member had being to the emergency of covered with fire ants. The mention of any problems of plaining of any type of ants or discould be contributing to the edetective on 10/5/19 at the police had responded to a August 2019 because a family | F 6 | 07 | | | |
| | incident of 9/15/19. call another family n about ants, and the ants. The police report, da and reviewed on 10, 1 had responded on | prior to Resident # 1's fire ant During the August 2019 police nember had been concerned police officer had observed ated 8/11/19, was obtained /8/19. It noted police officer # 8/11/19 to a call in a room on 00 hall) to which Resident # 1 | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | 1 ' ' | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | | |
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| | | 345505 | B. WING _ | | | C | |
| | ROVIDER OR SUPPLIER | | B. Wille _ | STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | 1 1 | 10/15/2019 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | |
| F 607 | report that she was to other resident rooms and they would be in Police Officer # 1 wa 7:38 PM. The officer saw about 40 to 50 a wall which was near side of the room (who of the room) when sl 8/11/19. They looked her, but she did not hin Resident # 7's shoes. Staff told her and maintenance was A review of Resident was admitted on 8/2 cognitively intact resinterviewed on 10/8/ the following. While so the 400 hall she hiday. They were "all of telling staff about the shoes and bite her fewere fire ants but kn aware to keep her coroommate (Resident because she was cothe ants crawl up into called for help since Staff came in and chinens. Staff sprayed but it did not stop the officer came into her another area. After se | The officer noted in her old by staff there were ants in maintenance was aware, | F 6 | 07 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 ' ' | PLE CONSTRUCTION 3 | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|---|--|------------------|--|
| | | 345505 | B. WING | | C 10/15/2019 | |
| | ROVIDER OR SUPPLIER A REHAB CENTER OF | | STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | | 10/13/2019 | |
| (X4) ID PREFIX TAG | (EACH DEFICIE) | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE COMPLETION | |
| F 607 | Continued From pa | ge 43 | F 60 | 07 | | |
| | Technician on 10/5. PM revealed he had the window sill of a According to a follo Control Technician only local ants that he had not been can Resident #7 and Resident #7 and Resident #7 and Resident #7 at 11:00 identified through the with fire ants prior to the control of the | acility's Pest Control (19 at 12:43 PM and at 1:35 d seen and treated fire ants in resident's room in May 2019. w up interview with the Pest on 10/9/19 at 12:26 PM the bit people were fire ants, and illed in for an extra service for esident #8's room in August ce had responded. erview with the Administrator of AM the facility had not heir investigation a problem to the incident of 9/15/19. Of AM the Administrator was corted the following. The DON 1:30 AM on 9/15/19 and let her and then a resident had sure the DON knew to get sure Resident #1's roommate sure Resident #1's roommate sure Resident #1 was last morning of 9/16/19 she tried to and she received the d them. She found that the checked on frequently prior to the ants. In investigating, she to be more clarification referred to them as red ants members described them as faced a candy bar in the room to brayed the room on 9/16/19 the the pest control company that day. Ants did come to 117/19, and it was verified with | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | SURVEY PLETED |
|---|--|--|--------------------|--|---|----------|----------------------------|
| | | | | | | (| С |
| | | 345505 | B. WING | | | 10/ | 15/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | _ | STRE | EET ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| CAROLIN | A DELIAD CENTED O | E CUMPERI AND | | 4600 | CUMBERLAND ROAD | | |
| CAROLIN | A REHAB CENTER O | FCUMBERLAND | | FAY | ETTEVILLE, NC 28306 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES SNCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFI TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 607 | been made aware the facility although ants. The facility of to a professor of Expertise in the arrival and she had wond nose could have a questioned that he wrong in reacting that and she had wond nose could have a questioned that he wrong in reacting that she wrong in reacting that she was and thereby reaction that he wrong in reacting that she was and thereby reaction that he was and thereby resident's body was aware. She had all the facility medical their staff on moniting and cleaning and palso had created at they checked the reducate the staff of emergency because avoid an emergency linterview with the 10/5/19 at 10:00 A asked by the corporinvestigate the incommon that is a supplementation. | ants on 9/17/19. She had never of fire ants before 9/17/19 in there had been some sugar orporate office had reached out intomology who had some ea of fire ants. They had nature of the fire ants, their erate, their habits, and how to with them in future. They can inches per second. The resident is bloody nose earlier in the day, ered if the resident's bloody thracted them. She never it staff had done anything to the emergency or that the aused the resident's death. She orked together to remove the emoved the resident from it saw the pictures that had ewither had been some. She of the extent had eave there had been some. She of the extent the inscrease of HIPPA. In the second of the extent the inscrease of the extent the | F | 607 | | | |

| | ITATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) PROVIDER/SUPPLIER/CLIA (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) A. BUILDING (X7) PROVIDER/SUPPLIER/CLIA (X8) MULTIPLE CONSTRUCTION (X9) MULTIPLE CONSTRUCTION (X9) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) PROVIDER/SUPPLIER/CLIA (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) PROVIDER/SUPPLIER/CLIA (X7) MULTIPLE CONSTRUCTION (X7) PROVIDER/SUPPLIER/CLIA (X8) MULTIPLE CONSTRUCTION (X9) MULTIPLE CONSTRUCT | | (X3) DATE SURVEY COMPLETED | | | |
|--------------------------|--|--|-------------------------------|---|---------------------------------------|----------------------------|
| | | 345505 | B. WING _ | | | C 10/15/2019 |
| | ROVIDER OR SUPPLIER | CUMBERLAND | | STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | , , , , , , , , , , , , , , , , , , , | 10/13/2013 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 607 | to the hospital on 9/1 covered with fire ants the resident was weat was brought to her at on 10/4/19, and that was aware there were but had not been aware them but had she had not been aware sponded. She did a still in the building. So and Nurse # 4 and of the only nursing staff emergency in the fact found. The Corporate she had concentrate resident's medical stabeling found with the checking on her. Her focused on the staff and the time it took to the covered with the covered with the checking on the staff and the time it took to the staff and the time it took to the same was supported to the staff and the time it took to the staff and t | g transferred from the facility 5/19 which showed her s. She had not been aware aring a cardiac vest until it tention by the survey team it had been removed. She se some written statements are of all of them. She had d talked to some of the staff. Ware that four nurses had not know that Nurse # 2 was the had thought Nurse # 3 ne of the nurse aides were a responding to the sility when the resident was the Nurse Consultant stated do her investigation on the latus prior to the resident ants to assure they had been are investigation was not response to the emergency them to call for emergency ther investigation did not | F 6 | 07 | | |
| F 686 SS=D | by the facility revealed investigation was represented in the state and the filed with the state and the filed with the state and the facility of the facility | revent/Heal Pressure Ulcer (i)(ii) grity ure ulcers. ehensive assessment of a | F 6 | 86 | | 11/1/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | TE SURVEY MPLETED |
|---|--|---|---------------------|---|---|----------------------------|
| | | 345505 | B. WING _ | | | C 0/15/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO | | 0/10/2013 |
| | | | | 4600 CUMBERLAND ROAD | | |
| CAROLIN | A REHAB CENTER C | OF CUMBERLAND | | FAYETTEVILLE, NC 28306 | | |
| (X4) ID PREFIX TAG | (EACH DEFICI | Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 686 | pressure ulcers a ulcers unless the demonstrates tha (ii) A resident with necessary treatment of the professional promote healing, new ulcers from of This REQUIREMI by: Based on record facility failed to impressive ulcers. (Resident treatment for a state of the professional promote healing, new ulcers from of this REQUIREMI by: Based on record facility failed to impressive ulcers. (Resident treatment for a state of the professional professio | dards of practice, to prevent and does not develop pressure individual's clinical condition at they were unavoidable; and pressure ulcers receives ent and services, consistent standards of practice, to prevent infection and prevent eveloping. ENT is not met as evidenced review and staff interviews, the plement a physician ordered age 3 pressure ulcer of the resident reviewed for pressure #9) End dated to the facility on moses to include; Stage 3 sacrum, Urinary tract infection, yet imbalance, and Muscle e plan dated 9/13/19 eventions in place for pressure de following the prescribed End Set (MDS) dated 9/19/19 dent #9 was cognitively intact. behaviors, and no rejection of | F 6 | F686 How corrective action will be accomplished for those resid have been affected by the correctice; "The facility failed to imperoratice; "The facility failed to imperoratice of the sacrum #9. Resident #9 no longer refacility. How the facility will identify the having the potential to be affected by the correction of the sacrum #9. Resident #9 no longer refacility. How the facility will identify the having the potential to be affected by the correction of the sacrum #9. All residents with pressure at risk for deficient practice. "All residents with pressure at risk for deficient practice. "All current residents see physician were reviewed for treatment orders. | edents found to deficient alefor a stage 3 in for Resident esides at other residents fected by the ure ulcers are en by wound accuracy of | |
| | mobility, and trans | d extensive assistance with bed sfers, and limited assistance aily living (ADL's). She was a Stage 3 pressure ulcer on | | The measures that will be put or systemic changes made to the deficient practice will not " Director of Nursing (DO | to ensure that t recur; | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|---|---|--|-------------------------------|----------------------------|
| | | 345505 | B. WING | | | 10/1 | ; 5/2019 |
| | ROVIDER OR SUPPLIER A REHAB CENTER OF C | UMBERLAND | | STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | | 1071 | 372010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | | (X5) COMPLETION DATE |
| F 686 | A physician order datorder to continue Calonce daily and add DResident #9's stage 3 sacrum for thirty days The Treatment Admir Resident #9 on 10/10 through 10/7/19 revenerable for the sacrum once daily the new order written solution once daily to The October 2019 MRecord (MAR) for Resident #9's record and revealed no record Dakin's solution to the The most recent skin of Resident #9's sacrum easurements of 3 cm width x 0.9 cm de A nursing note dated documented Resident Emergency Medical Shospital due to respir symptoms of elevated oxygen saturation. In an interview on 10, #6 she acknowledged the order that she recophysician regarding a resident's wound treated. | ed 10/3/19 revealed an cium Alginate with silver akin's solution once daily to 3 pressure ulcer on the 3. distration Record (TAR) for 1/19 for the period of 10/3/19 aled treatments were sium Alginate with silver to 1/2. There was no record of 1/2. There was reviewed on 1/2. There was reviewed on 1/2. The sacral wound. Dedication Administration sident #9 was reviewed on 1/2. The 1/2 of the 10/03/19 order for 1/2 esacrum once daily. Design assessment dated 10/3/19 all wound revealed 1/2. The sacral wound | F 68 | training to all nurses that roun wound care physician on impl new treatment orders at time of How the facility plans to monit performance to make sure that are sustained; " DON or designee will review ound care physician notes to treatment orders are initiated visit. Audits will occur for every weekly x 4 weeks and then 5 be reviewed monthly x 2 mont. " Results of the audits will at the quarterly QAPI meeting. Date of compliance is Noveml. The Director of Nursing is response implementing the acceptable procorrection. | lementing of rounds for its at solution riew all o ensure after his ry resident ths. be review gs. | nt will ved | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | IPLE CONSTRUCTION NG | | DATE SURVEY COMPLETED |
|--------------------------|--|--|-------------------------|--|-------------|----------------------------|
| | | 345505 | B. WING _ | | | C 10/15/2019 |
| | ROVIDER OR SUPPLIER | CUMBERLAND | | STREET ADDRESS, CITY, STATE, ZIP COD 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | E . | 10/10/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETION DATE |
| F 686 | Continued From page | e 48 | F 6 | 886 | | |
| | after the resident was on 10/07/19. Nurse # stage 3 pressure ulce from 10/03/19 to 10/0 | e didn't remember it until s transferred to the hospital 6 confirmed the resident's er was not treated as ordered 07/19 because the Dakin's inistered to the ulcer as | | | | |
| | 10/10/19 at 1:24 PM, surgical debridement to aid in healing) of F wound on 10/3/19. H wound had declined after surgical debride solution to be applied He commented that rorder of Dakin's solution/7/19 could result i stated no assessment | he wound specialist on he stated that he performed (removal of necrotic tissue desident #9's sacral pressure the commented that the from the previous week and ment he ordered Dakin's I to the wound for thirty days. The following the prescribed from 10/3/19 through a decline of the wound and and of or measurements had 10/3/19 due to the resident ital. | | | | |
| F 842 SS=D | the Regional Nurse 0 5:30 PM, the Director nurse should have tra order for Dakin's so pressure ulcer for Re order was received. | sident #9 on the day the | F 8 | 342 | | 11/1/19 |
| | (i) A facility may not r resident-identifiable t | elease information that is | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|-------------------|-----|--|-----|----------------------------|
| | | 345505 | B. WING | | | · | C 15/2019 |
| | ROVIDER OR SUPPLIER | | | 4 | STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | 10/ | 13/2019 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 842 | agrees not to use or of except to the extent to do so. §483.70(i) Medical re §483.70(i)(1) In according professional standard must maintain medical that are- (i) Complete; (ii) Accurately documing; Readily accessible (iv) Systematically org. §483.70(i)(2) The factual information contains regardless of the form records, except when (i) To the individual, or epresentative where (ii) Required by Law; (iii) For treatment, part operations, as permit with 45 CFR 164.506 (iv) For public health neglect, or domestic vactivities, judicial and law enforcement purpurposes, research permedical examiners, for a serious threat to he by and in compliance | ntract under which the agent disclose the information he facility itself is permitted cords. rdance with accepted ls and practices, the facility al records on each resident ented; e; and ganized dility must keep confidential hed in the resident's records, he or storage method of the release isor their resident permitted by applicable law; yment, or health care ted by and in compliance | F | 842 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|---------------------|---|--|--------------------------------|----------------------------|
| | | 345505 | B. WING _ | | · · · · · · · · · · · · · · · · · · · | | C / 15/2019 |
| | ROVIDER OR SUPPLIER | CUMBERLAND | | 4600 CUM | DDRESS, CITY, STATE, ZIP CODE IBERLAND ROAD EVILLE, NC 28306 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 842 | Continued From page §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requirem (iii) For a minor, 3 years legal age under State §483.70(i)(5) The mage (ii) A record of the record rec | gle 50 al records must be retained be required by State law; or the date of discharge when ent in State law; or ears after a resident reaches the law. Bedical record must containtion to identify the resident; the sident's assessments; the plan of care and services By preadmission screening the evaluations and the ucted by the State; the sident's and other licensed the ses notes; and blogy and other diagnostic the equired under §483.50. The is not met as evidenced The interview the the medical record was the resident's condition and the the a resident was found covered the ated Cardio Pulmonary the for one (Resident # 1) of the reviewed for accuracy of | F 8 | F84: How acco have pract | 2 corrective action will be mplished for those residents four been affected by the deficient | nd to | |
| | Record review reveathe facility from 8/30 The last narrative nu Nurse #3 and dated read, "Resident sent | aled Resident # 1 resided at | | the n facilit at 1: trans distre resid the re | nedical record for resident #1. The ty did complete a note on 9/15/20/15 am that noted resident #1 afterred to the hospital for respirate tess however did not include that the the twas found covered in ants or esident stopped breathing. Resimplify in the test was found covered. | e 019 ory the that | |
| | | ot contain any information | | I | the facility will identify other resid | lents | |

| OL: VILI | O T OIT III DIO/ II LE C | . OLIVIOLO | _ | | | | . 0000 0001 |
|---|-------------------------------|--|--------------|---------------------------------------|--|-------------------|--------------------|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
| | | | A. BOILD | _ | | ، ا | c |
| | | 345505 | B. WING | | | | 15/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S ⁻ | TREET ADDRESS, CITY, STATE, ZIP CODE | 1 10/ | 10/2010 |
| | | | | 40 | 600 CUMBERLAND ROAD | | |
| CAROLIN | A REHAB CENTER OF C | UMBERLAND | | F | AYETTEVILLE, NC 28306 | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PRÉFIX TAG | , | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFI TAG | | (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | COMPLETION DATE |
| F 842 | Continued From page | a 51 | F | 842 | | | |
| | | found the resident covered | ' | 072 | having the potential to be affected by the | ho | |
| | | provided a shower to remove | | | same deficient practice; | ie | |
| | 1 | topped breathing during the | | | " All residents who transfer to the | | |
| | _ | ated CPR on the resident. | | | hospital are at risk for the deficient | | |
| | | | | | practice. | | |
| | On 10/4/19 at 5:45 Pl | M the facility provided written | | | " All hospital transfers within the las | t | |
| staff statements regarding the events prior to | | | | thirty days were reviewed to ensure a | | | |
| Resident # 1 being transferred to the hospital of 09/15/19. Review of Nurse # 3's statement | | ansferred to the hospital on | | | detailed transfer note was documented | 1. | |
| | | Nurse # 3's statement | | | The measures that will be put into plac | e | |
| | revealed the resident | | | | or systemic changes made to ensure the | nat | |
| | 1 | M on 9/15/19 to have a | | | the deficient practice will not recur; | | |
| | | red ants, of various sizes to | | | " Director of Nursing or designee wi | | |
| | | ce, in her nose and mouth, | | | provide training to all nurses to ensure | | |
| | I . | rso and bilateral upper lent was taken to the shower | | | documentation reflects an accurate account of events leading to transfer. | | |
| | | nd during the time of the | | | " Any nurse who did not receive the | | |
| | shower the resident s | • | | | education by the compliance date will the | | |
| | I . | were then begun by staff | | | removed from the schedule until | , | |
| | I . | cal staff were called and | | | completed | | |
| | arrived. | | | | " All new nurses will receive educati | ion | |
| | | | | | during the orientation process. | | |
| | Nurse # 3 was intervi | ewed on 10/3/19 at 4:45 PM | | | How the facility plans to monitor its | | |
| | | at 3:15 PM. During the | | | performance to make sure that solution | าร | |
| | | alidated that when the | | | are sustained; | | |
| | | n 09/15/19 at around 1:00 | | | " DON or designee will review all | | |
| | | ant amount of ants on her | | | residents who transfer to ensure a note | | |
| | | oving her body or verbally | | | written that reflects the account of ever | | |
| | | e confirmed the resident ring a shower given to | | | Audits will occur weekly x 4 weeks and | | |
| | remove the ants and | | | | then 5 residents will be reviewed month x 2 months. | шу | |
| | Terriove the ants and | Ci it was illitiated. | | | " Results of the audits will be review | hav | |
| | The Corporate Nurse | Consultant was interviewed | | | at the quarterly QAPI meetings x 1 | , 54 | |
| | on 10/5/19 at 10:00 A | | | | | ĺ | |
| | | cord was incomplete about | | | Date of compliance is November 1, 20 | 19 | |
| | I . | Resident #1 was found | | | The Director of Nursing is responsible | | |
| | covered in ants on 09 | | | | implementing the acceptable plan of | ſ | |
| | Consultant stated the | information which had been | | | correction. | ſ | |
| | written in Nurse # 3's | statement should have | | | | ſ | |
| | been entered into the | medical record. The Nurse | | | | | |

| STATEMENT OF DEF AND PLAN OF CORR | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPI A. BUILDING | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--|--|--|-----------------------------|---|----------------------------------|
| | | 345505 | B. WING | | C 10/15/2019 |
| NAME OF PROVIDE | ER OR SUPPLIER | CUMBERLAND | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLETION |
| Con assu state finis but t | ure the nurse ent ement into the mo hed their investig this had not yet b | e facility had planned to ered the information from the edical record after they lation regarding the incident, | F 84. | | 11/1/19 |
| SS=K CFF §483 progrode This by: Bas inter pest inter faile prev three pest #1 v inclu expe trans and hosp vend The Imm Nurs with over rem an a Jeop | R(s): 483.90(i)(4) 3.90(i)(4) Maintai gram so that the factor of the ents. REQUIREMENT of the ents of | n an effective pest control acility is free of pests and is not met as evidenced iew, resident interview, staff view, physician interview, an interview, entomologist officer interview the facility est free environment to tering resident rooms for ed residents reviewed for ats #1, #7 and #8). Resident bed covered with fire ants outh and nose. Resident #1 us fire ant bites and was ergency room for treatment dent #1 expired while in the interview revealed fire ant outributed to her death. | F 92 | F925 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; "Resident # 1 was found on 9/15/11:00 AM with ants on her face, in her mouth, in her nose, and on other parts her body. According to interviews with NAs # 3 and # 5 during the survey, the had seen ants in Resident #1 sroom prior to the date of 9/14/19. Interview the facility spest control technician of 10/9/19 at 12:26 PM revealed he had seen 6 or 7 fire ants in Room 408 on 9/23/19 when he was in the building. In had treated them. Also, the technician stated he had been in the facility on the date of the interview (10/9/19) and identified the baseboards were loose in Rooms 407 and 408 around the area of the night stand; approximately ¿ to 1/8 the baseboard was loose and he identified. | 9 at s of ey with n He near 3 of |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---------------------------|---|---|---------------------|-------|---|-------------------------------|----------------------------|
| | | 345505 | B. WING _ | | | | C / 15/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | 1 | | STI | REET ADDRESS, CITY, STATE, ZIP CODE | 1 10/ | 13/2013 |
| | | | | | 00 CUMBERLAND ROAD | | |
| CAROLINA | A REHAB CENTER OF C | CUMBERLAND | | | YETTEVILLE, NC 28306 | | |
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| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 925 Continued From page | | e 53 | F 9 | 25 | | | |
| | minimal harm that is the facility to complete | potential for more than not immediate jeopardy) for te staff training and to ensure out in place are effective. | | | this by getting down on his knees with flashlight. He could see the hole at the bottom of the sheet rock behind the loc baseboard. According to the techniciar this could contribute to any type of ant | ose I | |
| | | | | | getting into the building. The facility fail | | |
| | | y from the hospital on | | | to show it has a system to identify the to ants getting into the building, that the | | |
| | 8/30/19. Resident #1 resided on the facility's 400 hallway during her stay at the facility. | | | | have assessed all rooms and filled holes/cracks which might allow entry | 7 y | |
| | Nursing notes, dated | 9/14/19 at 11:48 AM, | | | | | |
| | included documentat | ion Resident # 1 had been | | | How the facility will identify other reside | ents | |
| | bleeding from her bild | ateral nostrils intermittently | | | having the potential to be affected by the | ıe | |
| | throughout the shift b | out refused to let the nurse | | | same deficient practice; | | |
| | | r nose or clean her face and | | | | | |
| | | hich had blood on them. The | | | " All residents have the potential to | эe | |
| | | n via a nasal cannula, and | | | affected by this practice | | |
| | | clotted with blood due to the | | | | | |
| | bleeding. | | | | The measures that will be put into place | | |
| | | | | | or systemic changes made to ensure the | nat | |
| | | ident # 1 on 9/14/19 from | | | the deficient practice will not recur; | | |
| | | I. NA # 3 was interviewed on | | | " All staff education began on | | |
| | | nd reported the following. | | | 10/2/2019. Administrator educated | | |
| | _ | was very independent. On | | | department managers who provided | nto | |
| | _ | 9 she was drowsy. Her | | | education to their respective department | its | |
| | family came that eve | ng the staff and the family | | | on the following components: Understanding fire ants as per informations. | tion | |
| | | of Resident # 1's bed to the | | | sheet provided on Red imported fire ar | | |
| | • | ere her roommate was so | | | a threat to nursing homes, identifying fi | | |
| | | o the air conditioning unit. | | | ants, removing patients from affected | 10 | |
| | | was put in the position | | | room if suspect fire ants, immediately | | |
| | | 11:00 shift change time, she | | | contact maintenance director if any | | |
| | | nt # 1 and she was in bed | | | activity is suspected, when in resident | | |
| | - | ed okay. She had not seen | | | rooms inspect floor, linen and windows | sill | |
| | | that day, but she had in | | | for ant activity this education was | · • | |
| | • | e times total and no more." | | | completed on 10/3/2019. | | |
| | - | five or six ants at one time, | | | " On 10/11/2019 a letter was deliver | ed | |
| | | the roommate would call | | | to all residents and mailed to families | | |
| | | kill the ants, and tell the | | | using the information sheet Red import | ed | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | IPLE CONSTRUCTION | | ATE SURVEY DMPLETED |
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| | | 345505 | B. WING _ | | | C 10/15/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, | • | 10/13/2013 |
| | | | | 4600 CUMBERLAND ROAD | | |
| CAROLIN | A REHAB CENTER O | F CUMBERLAND | | FAYETTEVILLE, NC 28306 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PREFIX (EACH CORRECTIVE ACTION SHOUL | | (X5) COMPLETION DATE |
| F 925 | kind of ants they we color. NA # 5 cared for R 7:00 AM shift which 9/14/19. NA # 5 hat to the facility regar # 5's statement read 12:35 AM, went in looked at her and changing colors, the see this lady in (Regot ants on her fact NA # 5 was intervious and realized the bid she got Nurse # 3 her. The resident's ants." They were "mouth was open, a was not moving or the room one time reported the ants. been messy with for the sident was been messy with for the sident was open, a was not moving or the room one time reported the ants. | duty. She did not know what were. They appeared black in desident # 1 on the 11:00 PM to h began at 11:00 PM on ad provided a written statement ding the incident of 9/15/19. NA ad, "Started passing ice around (Resident # 1's room) and thought she was black and men I looked at her again. When a and thought it was freckles, and moving and decided to call alled her I said can you come esident #1's room)? I think she | FS | fire ants: a threat to nu letter highlights imports ants, how they come in how they can assist wi and what to do if they education provided als resident and family sprevention of fire ants uneaten food or placin sealed container that we the center. All new ac receive this letter during process. "Any employee that education will be remoschedule until education." All new employee on Understanding fire information sheet provimported fire ants: a the homes and day care of fire ants, removing pat room if suspect fire and contact maintenance of activity is suspected, we rooms inspect floor, ling for ant activity by direct designee during new here. | arsing homes. The ant facts about fire n, why they come in, th preventing them see ants. The so included the responsibility in by disposing of g such food in a will be provided by dmissions will not receive the even from the even from the even is completed. In the even is completed, so will be educated ants as per ided on Red even areat to nursing enters, identifying enters, identifying enters from affected tes, immediately the even in resident even and window sill even and window. The event is even to the exterior event of the exterior received for no if found. The event inspected | |
| | her, they appeared the room where th located. | d to be coming from the area of e air conditioning unit was | | completed 10/10/2019 How the facility plans to performance to make second | o monitor its | |

PRINTED: 11/15/2019 FORM APPROVED OMB NO. 0938-0391

| OLIVILIV | OT OIL WEDTON THE G | · · · · · · · · · · · · · · · · · · · | | | | | 7. 0000 000 I |
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| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | CONSTRUCTION | (X3) DATE COMP | SURVEY |
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| | | 345505 | B. WING | | | | 15/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | 10/2010 |
| | | | | 46 | 600 CUMBERLAND ROAD | | |
| CAROLINA | A REHAB CENTER OF C | CUMBERLAND | | F. | AYETTEVILLE, NC 28306 | | |
| (X4) ID | SUMMARY ST | TATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREF TAG | | (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | COMPLETION DATE |
| F 005 | 0 11 15 | | | | | | |
| F 925 | Continued From page | | F | 925 | | | |
| | | at 3:15 PM. She reported | | | are sustained; | | |
| | _ | NA # 5 called her to the | | | " All resident rooms and exterior | | |
| | | A, she went into the room, | | | grounds inspected daily by maintenand | e | |
| | flipped on the light, and found the resident had ants on her face, neck, trunk, bilateral arms, and | | | | department or designee that has been initially provided by pest control technic | sian | |
| | | They were red ants of | | | for fire ant activity beginning on 9/16 a | | |
| | | nd other staff members | | | will continue daily x 4 weeks bi weekly | | |
| | | and took her to the shower. | | | weeks and monthly x 1. Any pest | Λ Ι | |
| | | shower, she stripped the bed | | | sightings will be reported to the | | |
| | linens and clothes an | | | | Maintenance Director for treatment and | t | |
| | bathroom. While in th | ne shower, they were "just | | | EcoLab pest control services will be ca | lled | |
| | wiping and wiping an | ts away" from Resident # 1's | | | for follow up as needed. | | |
| | body. There were to | o many to estimate the | | | " EcoLab pest control services will | | |
| | | t stopped breathing while in | | | perform bi-weekly ant treatments until | | |
| | the shower and CPR | · · · · · · · · · · · · · · · · · · · | | | November 1 and will resume April 1 | | |
| | | egun. Paramedics arrived | | | through the late spring and summer pe | | |
| | | to the resident leaving, Nurse | | | pest control recommendation. This beg | an | |
| | | ultiple bites on the resident's | | | on 9/17/2019 | | |
| | | d arms. When she returned m, she bagged the linen | | | | | |
| | | room. The rest of the ants in | | | Date of compliance is November 1, 20 | 10 | |
| | | vere "just gone." She could | | | The Administrator is responsible for | 13 | |
| | | pecause there had been a | | | implementing the acceptable plan of | | |
| | | towards the bed earlier when | | | correction. | | |
| | | t had looked like they had | | | | | |
| | , | chind the resident's oxygen | | | | | |
| | _ | lled the Director of Nursing | | | | | |
| | (DON) that night and | told her what had occurred. | | | | | |
| | | nate had not seemed to | | | | | |
| | | happened and had not been | | | | | |
| | | . Resident # 1's roommate | | | | | |
| | was moved that night | t to another room. | | | | | |
| | Nurse # 4 was intervi | iewed by phone on 10/4/19 | | | | | |
| | at 6:45 AM. Nurse # | 4 reported the following in | | | | | |
| | | nt to Resident # 1's unit when | | | | | |
| | | there was an emergency on | | | | | |
| | 9/15/19. When he er | ntered the resident's room, | | | | | |

Nurse # 3 was in the room trying to get the

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 345505 | B. WING _ | | | C 0/15/2019 | |
| | ROVIDER OR SUPPLIER | 1 1111 | | STREET ADDRESS, CITY, STATE, ZIP COL 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | | 0/13/2019 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| F 925 | Continued From pag | | F 9 | 25 | | | |
| | were open and she were open and she were open and she were of ants around the were open and she were o | | | | | | |
| | 7:00 AM. NA # 4 rep interview. When she help on 9/15/19 she room to find the nurs | ved by phone on 10/4/19 at orted the following in her heard the page for STAT went also and entered the lest trying to get the resident lent was "covered with ants" | | | | | |
| | from her "hair to feet ears, nose, mouth, a | ." They were also in her nd private areas. Her eyes vas not talking nor trying to | | | | | |
| | Nurse # 5 reported to the interview. On 09, a call for "stat" help. unit and observed N to the shower. The re She recalled seeing | iewed on 10/3/19 at 6:05 PM. The following information in 1/15/19 at 1:00 AM she heard she went to Resident # 1s are # 3 taking Resident # 1 are ident was not responding. The following from her mouth and nose. | | | | | |
| | revealed the residen arrest and expired in noted, "Multiple sma on face and trunk. N | ER) records for 9/15/19 t entered the ER with cardiac the ER. The ER physician Il flat erythematous lesions ote occasional ants crawling uding head and face." | | | | | |
| | 10/7/19 at 3:15 PM. the following. When conveyed to him in the on her by the paramwas a rash on her true. | as interviewed by phone on The ER physician reported Resident # 1 arrived it was ne report that she had ants edics. At first, he thought it unk, but then he realized her vered with bites. One ant | | | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | PLE CONSTRUCTION IG | | TE SURVEY MPLETED |
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| NAME OF F | PROVIDER OR SUPPLIER | 040000 | | STREET ADDRESS, CITY, STATE, ZIP COL | | 0/15/2019 |
| | | | | 4600 CUMBERLAND ROAD | | |
| CAROLIN | IA REHAB CENTER OF (| CUMBERLAND | | FAYETTEVILLE, NC 28306 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 925 | Continued From pag | e 57 | F 9 | 25 | | |
| F 920 | crawled out of her noworking with her. Accan individual is cover someone would mist a black resident, their the overwhelming first her death but stated. According to the ER received hundreds of overwhelming immur which can contribute. On 10/5/19 at 11:00 interviewed and repositivestigating the incit there needed to be in Nurse # 3 referred to other staff members ants. They placed a 9/16/19. They sprayed themselves because could not come out to the candy bar on 9/1 the Pest Control Tech the treated for fire and been made aware of the facility although to a professor of Entexpertise in the area learned about the natability to conglomerat prevent problems with travel one to two inclusions wondered if the residual have attracted them. Staff on monitoring for | ose while the ER staff were cording to the ER physician if red in ants to the point that ake a Caucasian resident for a there was a "good chance" a ant venom did contribute to he could not say for sure. physician when an individual f bites the body can have an an eresponse to the venom to death. | F 9 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1 | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | , , | (X3) DATE SURVEY COMPLETED | |
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| | | 345505 | B. WING | | | C | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COL | | 0/15/2019 | |
| CAROLIN | A KLIIAD CLITICK OF | COMBERCAND | | FAYETTEVILLE, NC 28306 | | | |
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| F 925 | Continued From pag | | F 92 | 25 | | | |
| | checked the rooms t | for ants. | | | | | |
| | Administrator into Re revealed no mention prior to the incident that exterior and dai on 9/15/19 to ensure The summary also reinspection of all residual affected by this issue continues to receive for pest control and specifically designed incident there were ants." The summary second contractor w | d for ants. Prior to this no other sightings of fire also noted the facility had a ho came to the facility after t control company and treated | | | | | |
| | 10/4/19 at 9:00 AM at PM and reported the started work in July some "pop ups of suthere, and the staff were more than one and get rid of the an reoccurring problem of 9/15/19, and he hto 9/17/19 in the buil records left for him f maintenance director started in July, 2019 system where they of themselves and make them. He did not recopointed out to him si | r about a problem when he . They have a maintenance | | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | TIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED |
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| | | 345505 | B. WING _ | | | 10/15/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | I | STREET ADDRESS, CITY, STATE, ZIF | CODE | |
| | | | | 4600 CUMBERLAND ROAD | | |
| CAROLIN | A REHAB CENTER OF | CUMBERLAND | | FAYETTEVILLE, NC 28306 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN (X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE | CTION SHOULD BE O THE APPROPRIA | |
| F 925 | empty room. They we date of 9/17/19 they had come to the ca black with a little she. Control Technician as fire ants, and he Resident # 1's room and they had not obe courtyard. They talk Technician and got They thought the arthe slab foundation through cracks when building. Because or residents' rooms, you the sheetrock when had ordered new be the baseboard in recracks at the botton the replacement bastaff member had sin a room, then he was about it prior to 9/17. The facility's Pest Conterviewed on 10/5 PM. He routinely diffacility which involves olution around the ants. Additionally, the sprayed a liquid permonths around the had been called our maintenance treatments in the wind fire ants in the wind. | they placed a candy bar in the waited for 24 hours and on the y found about 50 or 60 ants andy bar. Some of them were een of red on them. The Pest came and identified the ants treated the entire facility. In backed up to a courtyard, oserved mounds in the sed to their Pest Control as second opinion as well. In the could be burrowing under of the building and coming in the the foundation met the off the glued baseboard in the could not see all the way to be the wall met the floor. They aseboard but had not taken off sidents' rooms to look for an of the sheetrock because seboard had not come in. If a een more than five or six ants would have wanted to know | FS | 925 | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| | | | A. BOILD | _ | | (| |
| | | 345505 | B. WING | | | 10/ | 15/2019 |
| | ROVIDER OR SUPPLIER A REHAB CENTER OF (| CUMBERLAND | • | 46 | REET ADDRESS, CITY, STATE, ZIP CODE 600 CUMBERLAND ROAD AYETTEVILLE, NC 28306 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | х | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 925 | Maintenance Director write down the room had directed them the need to be fixed. He baseboards himself Directors took note of did recall he had ide baseboards but did recall he had ide baseboards but did recall he had ide baseboards but did recall to the candy bar test Fire ants secrete pheromones help dramatter of minutes to follow the trail. Also, identify two fire ant noutside of Resident activity when he look On 10/7/19 at 2:40 F conducted with the Fhad checked his recotreatment of fire ants the facility extra for the was sure he had in the window sill of facility would have known identified in. Review of pest contributes of pest con | nce Director or current or would accompany him and as of any that were loose. He at loose baseboards would did not keep a list of the because the Maintenance of them as he checked. He notified some loose not recall which rooms and on dated that the ants that came on 9/17/19 were fire ants. Peromones and the aw other fire ants. Within a hours, other fire ants can on the date of 9/17/19 he did nounds in the courtyard of 1's room, but they had no seed at them on 9/17/19. PM a follow up interview was pest Control Technician. He pords for the May, 2019 of the in between treatment, but identified them in May, 2019 are resident. He stated the ept a record of the room they | F | 925 | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | TIPLE CONSTRUCTION NG | | DATE SURVEY COMPLETED | |
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| | | 345505 | B. WING _ | | | C 10/15/2019 | |
| | ROVIDER OR SUPPLIER | CUMBERLAND | | STREET ADDRESS, CITY, STATE, ZIP COL 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | /, STATE, ZIP CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| F 925 | and reviewed on 10 | ated 8/11/19, was obtained 8/19. It noted police officer # | F | 925 | | | |
| | hall to which Reside The report noted the different stories whe asking for Resident removed because the disruptive. When the 8's family member s was upset because 8's room. Police Off that she (the officer) near Resident # 8's officer noted in her r staff there were ants | 8/11/19 to a call for the same nt # 1 was later admitted to. e police officer received two n she arrived. The nurse was # 8's family member to be the family member was to officer spoke to Resident # the found the family member there were ants in Resident # ficer # 1 noted in her report observed ants along the wall proommate (Resident #7). The eport that she was told by the in other resident rooms, ware, and they would be in | | | | | |
| | 10/9/19 at 7:38 PM. following. She saw a floor along the wall was Resident # 7's side of the window side of the sugar ants at first to sure. She saw them she moved the shoe ants on that wing and take care of it. | as interviewed by phone on The officer reported the about 40 to 50 ants on the which was near the corner of of the room (which was near ne room). They looked like her, but she did not know for in Resident # 7's shoes and s. Staff told her there were d maintenance was going to | | | | | |
| | was admitted on 7/3 longer resided at the Resident # 8's admit the resident was cog total staff assistance | t #8's record revealed she 1/19 to the 400 hall and no e facility. According to ession MDS, dated 8/13/19, gnitively impaired and needed e. member was interviewed by | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | | | |
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| | | 345505 | B. WING | | | C 10/15/2019 | |
| | ROVIDER OR SUPPLIER | CUMBERLAND | | STREET ADDRESS, CITY, STATE, ZIP COL 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | | 0/10/2013 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| F 925 | following. She had we two occasions in Recocasions in Recocasions, they were staff could do because needed was locked corner of the room in later someone spray seemed to scatter the They were later informatter they left that excalled for assistance ants had climbed into family member saw. The baseboard was and they seemed to She was concerned not call for help. She got stung by them alkind of ants they we left, they moved Resident and admitted on 8/2 Resident's MDS assindicated Resident. Resident # 7 was into 10/8/19 at 7:34 PM and While she resided in hall she had seen browere "all over the roabout them. The antibite her feet. She did but knew they bit he covers off the floor, 1 #8) did not know to confused. One night | 4:30 PM and reported the vitnessed thin black ants on sident #8's room. On the first told there was nothing the se the key to what they up. The ants were in the ear Resident # 7's side. Then red with ant spray and it tem to Resident #8's side. The med by Resident #7 that rening, Resident #7 had for Resident #8 because the o Resident #8's bed. The the ants again on 8/11/19. The total and the coming from that area. The because Resident #8 could the was not aware Resident #8 and she did not know what re. That night after the officer sident #8. Then shortly | F 92 | | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION G | | TE SURVEY MPLETED |
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| | | 345505 | B. WING | | | C 1 0/15/2019 |
| | ROVIDER OR SUPPLIER | CUMBERLAND | | STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | <u>'</u> | 10/10/2013 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY) | IOULD BE | (X5) COMPLETION DATE |
| F 925 | since Resident #8 co and changed the res sprayed and it "slow stop them." Then on into her room and sharea. After she was problem, and she we Resident #7's family phone on 10/8/19 at following. He visited week. After Resident 8/2/19 he did not not few visits he noticed nowhere all of the suthan 20 at a time. The floors and appeared They finally gave the then she went home. The facility's ant more started following the reviewed. This reviewed. This reviewed. This reviewed. The audit 10/3/19 in Room 408 which Resident #7, F1 resided. The audit 9/18/19 that the room the window side of the maintenance director made aware. On 10/9 was sprayed and clean audit for Room 40 to an audit for Room 40 to a | puld not do so. Staff came in ident's bed linens. Staff ed them down but it did not e night a police officer came ie was moved to another moved, she did not have a ent home shortly after that. Immember was interviewed by 7:25 PM and reported the about three to four times a t # 7 was initially admitted on ice the ants, but then after a "they just came out of idden." He would see more ley were on the walls and the to him to be little black ants. | F 9: | 25 | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | | | | |
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| | | | A. BOILD | NG | | ، ا | С |
| | | 345505 | B. WING | | | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STF | REET ADDRESS, CITY, STATE, ZIP CODE | • | |
| CAROLIN | A REHAB CENTER O | F CUMBERI AND | | 460 | 00 CUMBERLAND ROAD | | |
| OAROLIN | A REHAD CENTER C | OUNDERCEARD | | FA | YETTEVILLE, NC 28306 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 925 | sheets. The Admir aware the police re thought it was beet there was a need to very upset. She was had complained of understanding their residents were more and the room was not aware of any resident # 8's Resident # 7 had to problems and it was # 7 had moved als her roommate so we pest control comparissue. They would been a repetitious number of ants, ar understanding this audits, the Administ understanding this audits were tiny sustated she would of director and follow. On 10/9/19 at 10:5 information by email, the first was on 9/18/19; a company had been told there might be hours after the sprithey did not reach company. They sp control company had been told company in the sprithey did not reach company. They sp control company had been told company in the sprithey did not reach company. They sp control company had been told there might be control company in the sprithey did not reach company. They sp control company had been told there might be control company in the sprithey did not reach company. They sp control company in the sprithey did not reach company. | dent #8, and the ant monitoring histrator reported she was esponded on 8/11/19 but she ause of a domestic issue and to remove the family who was as aware Resident #8's family ants, but it was her y were sugar ants, the ved on the night of 8/11/19, sprayed and cleaned. She was eports the ants had crawled bed. She was not aware been experiencing any as her understanding Resident to because she got along with well. They had not called their any to deal with the 8/11/19 have only done so if it had thing or there were a large and it had not been her was the case. Regarding the strator stated it was her ants noted on the facility igar ants. The Administrator sheck with her maintenance | F | 925 | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | IPLE CONSTRUCTION | (X3 | B) DATE SURVEY COMPLETED |
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| | | 345505 | B. WING _ | | | C 10/15/2019 |
| | ROVIDER OR SUPPLIER A REHAB CENTER O | F CUMBERLAND | | STREET ADDRESS, CITY, STATE, ZIP OF 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | ' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE |
| F 925 | the room. On 10/3 couple black ants. again, and the Pes scheduled for 10/9 During a follow up Technician on 10/9 validated that prior Resident # 8 and I he had last been in was not called for 8/11/19 incident. T people were fire abuilding on 9/23/19 Room 408 to be fir seven of them. He facility that day (10 baseboards were 1 rooms were 407 arof the baseboard of the corner behind able to detect that of the sheetrock with them, he had facility they could a had talked to the minformed him if the ants then he would monthly services, adozen they could a laways willing to loant they might find to help them identifular. | on 9/23/19, and he sprayed in /19 in Room 408 there were a They sprayed and cleaned at Control Technician was /19. interview with the Pest Control /2/19 at 12:26 PM the technician of to the incident of ants in Resident #7's room on 8/11/19, in the facility on 7/24/19 and he an extra service to address the right only local ants that bit ints. When he was in the 9 he had identified the ants in reants. There were six or sprayed. While he was in the 10/9/19) he had identified the roose in two rooms. These and 408. Approximately 1/4 to 1/8 on the window wall was loose at the nightstands. He had been there were cracks at the base here the baseboard was loose in the hands and knees and "All along" as he contracted left a particular spray with the realso spray with if needed. He maintenance director and here were a dozen or two dozen of come out between his and for sightings of less than a ruse the spray. He also was rook at a picture of any type of 1 in between his monthly visits | FS | 025 | | |

| | | | ATE SURVEY OMPLETED | | | |
|--------------------------|--|--|------------------------|---|------------------------------|----------------------------|
| | | 345505 | B. WING _ | | | C 0/15/2019 |
| | ROVIDER OR SUPPLIER | CUMBERLAND | | STREET ADDRESS, CITY, STATE, ZIP COI 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | | 0/13/2013 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 925 | Food for fire ants in a linens, serum and bo cues is discovered by trail will be laid betwee closest foraging tunn a scout ant encounted the ant nest, numero follow the new scent repeat the process. It is stronger the scent be additional ants recruif fast at approximately Within 1-2 hours (con ants could be recruited. The Professor of Ent 10/8/19 at 10:30 AM facilities needed to be ants. They also need that are getting into the and inject a toxin at the sensation. The respondividualized. For so have a reaction with other people might be bites. The toxin is into the ward animals from nursing homes do not the threat fire ants me to be better protocols. On 10/9/19 at 7:29 Prinformed of the Imme provided a credible as | and a facility consist of stained and fluids. When one of these by even a single scout ant, a seen the food source and the leel of the colony. As soon as are a recruit on the borders of the state of the more ants on a trail, the ecomes, and the more sted. Fire ants are relatively and to a patients' bed. The more ants on a trail, the ecomes, and the more sted. Fire ants are relatively and to a patients' bed. The stated he counseled that the every proactive with fire and to identify any type of ants the building. Fire ants sting the site that creates a fiery onse to their sting is highly one individuals, they can one or two bites, whereas the able to withstand a lot of the ended to be painful in order at them. He stated many of understand the gravity of tight pose, and there needs as to deal with them. What he Administrator was ediate Jeopardy. The facility allegation of Immediate and 10/11/19. The allegation of | F9 | 25 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | | | |
|--|---|--|---|--|------------------------------|----------------------------|--|
| | | 345505 | B. WING | | | C 0/15/2019 | |
| | ROVIDER OR SUPPLIER A REHAB CENTER OF | | STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| F 925 | are likely to suffer, a a result of the noncount the facility's pest conhe stated he treated a resident's room in seen ants every day date of 8/11/19. On came into the room, moved later that nig ants would "bite" he shoes. She observe roommate's bed (Refined the date of 8/11/19, bed linens. Residen 10/8/19 at 4:30 PM ants in the resident's occasions and obsesealed where the arresident # 1 was fo with ants on her fact and on other parts of interviews with NAs survey, they had seprior to the date of 9 facility's pest control 12:26 PM revealed Room 408 on 9/23/10 building. He had treated | ents who have suffered, or a serious adverse outcome as ampliance; ce - During an interview with antrol technician on 10/5/2019 fire ants in the window sill of May 2019. Resident # 7 had in her room (401) up until the that date a police officer saw the ants, and she was the ants, and she was the theorem of the feet and get in her did them crawl into her esident # 8) one night before and staff had to change the theorem on two different revealed they saw multiple is room on two different reved the baseboard was not atts were coming from. In the mouth, in her nose, of her body. According to # 3 and # 5 during the technician on 10/9/19 at the had seen 6 or 7 fire ants in 19 when he was in the lated them. Also, the | F 93 | | | | |
| | the date of the intenthe baseboards wer 408 around the area approximately 1/4 to loose and he identifications with a flashlight | had been in the facility on view (10/9/19) and identified e loose in Rooms 407 and a near the night stand; 1/8 of the baseboard was ed this by getting down on his iht. He could see the hole at eet rock behind the loose | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|-----------------------------|--|----------------------------|--|
| | | 345505 | B. WING | | C 10/15/2019 | |
| | ROVIDER OR SUPPLIER | CUMBERLAND | | STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | 10/10/2013 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY) | JLD BE COMPLETION | |
| F 925 | contribute to any typ building. "Facility Action on Resident # 1 ex on Resident # 7 and room on 8/11/2019 and empty room the next on All staff education Administrator education who provided education departments on the Understanding fire and provided on Red impurising homes so idepartments from affected immediately contact activity is suspected inspect floor, linen and proper food storage, containers, and remore promptly. This education of 10/3/2019. The one of 10/3/2019 to company provided c | pired on 9/15/2019 d 8 were removed from their and Maintenace sprayed the t day on began on 10/2/2019. ted department managers tion to their respective following components: nts as per information sheet corted fire ants: a threat to entifying fire ants, removing and room if suspect fire ants, maintenance director if any, when in resident rooms and window sill for ant activity availability of storage oving trash in resident rooms action was completed on the facility's pest control complete exterior treatment rayed internally in room 405. Services from monthly to ents to reduce ant activity. Ilaster exterminators came out | F 925 | · · | | |
| | erase pheromones in per the direction of a o All resident roor inspected daily by m | n room after ant activity noted a university entomologist. ms and exterior grounds a unitenance department or seen initially provided by pest | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|--|-----------------------------|--|-------------------------------|
| | | 345505 | B. WING | | C 10/15/2019 |
| | ROVIDER OR SUPPLIER | CUMBERLAND | | STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 | , |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | JLD BE COMPLETION |
| F 925 | 9/16 and will continu 4 weeks and monthly be reported to the M treatment and the far will be called for follo | fire ant activity beginning on e daily x 4 weeks bi weekly x x 1. Any pest sightings will aintenance Director for cility's pest control services w up as needed. | F 92 | 5 | |
| | process or system faradverse outcome from when the action will in the action who provided educated educated educated education activity is suspected, inspect floor, linen and this education was composed in the action was co | on began on 10/2/2019. ed department managers ion to their respective following components: Ints as per information sheet orted fire ants: a threat to tifying fire ants, removing d room if suspect fire ants, maintenance director if any when in resident rooms and window sill for ant activity completed on 10/3/2019. I letter was delivered to all to families using the d imported fire ants: a threat the letter highlights important how they come in, why they an assist with preventing | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | CONSTRUCTION | (X3) DATE COMP | SURVEY |
|--------------------------|--|---|--------------------|-----|--|-------------------|----------------------------|
| | | 345505 | B. WING | | | 1 | C 15/2019 |
| | ROVIDER OR SUPPLIER A REHAB CENTER O | F CUMBERLAND | | 46 | REET ADDRESS, CITY, STATE, ZIP CODE 00 CUMBERLAND ROAD NYETTEVILLE, NC 28306 | 1 10 | 10/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIE | ' STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION) | ID PREFI TAG | х | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 925 | education will be reducation is comp " All new employ Understanding fire provided on Red in nursing homes and fire ants, removing suspect fire ants, i maintenance direct when in resident rowindow sill for ant designee during not a spect the reduction of the wall the lead cracks/holes and sin all rooms were in exist. This will be " All resident rowinspected daily by designee that has control technician 9/16 and will continued and will continued to the treatment and the will be called for form the second of the secon | e that did not receive the emoved from the schedule until leted. lyees will be educated on ants as per information sheet inported fire ants: a threat to day care centers, identifying a patients from affected room if immediately contact it for if any activity is suspected, soms inspect floor, linen and activity by director of nursing or ew hire orientation. commendation of pest control in ance department began on ing all resident room cove base did to the exterior inspecting for it is sealing if found. The cove base inspected and ensured no gaps completed 10/10/2019 oms and exterior grounds in maintenance department or been initially provided by pest for fire ant activity beginning on the daily x 4 weeks bi weekly x hly x 1. Any pest sightings will Maintenance Director for facility's pest control services allow up as needed. Dest control company will ant treatments until November April 1 through the late spring eest control recommendation. | F | 925 | | | |
| | | is responsible for implementing immediate jeopardy removal | | | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|--|--|-------------------|-----|---|-------------------|----------------------------|
| | | | | _ | | (| |
| | | 345505 | B. WING | | | 10/ | 15/2019 |
| | ROVIDER OR SUPPLIER A REHAB CENTER OF C | UMBERLAND | | 4 | TREET ADDRESS, CITY, STATE, ZIP CODE 600 CUMBERLAND ROAD AYETTEVILLE, NC 28306 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 925 | Continued From page On 10/15/19 the facility jeopardy removal was Multiple residents were they had seen no ante had received letters fr fire ant education. Ra throughout the facility clean and without any were observed to be bottom of the sheet re during their interviews within the past week, and caulked before re the window side of the revealed there had be in the past week withi documented evidence exterior grounds per t Immediate Jeopardy also had documentati their credible allegatic Interviews were cond nurses, and nurse aic interviews included st different shifts. During validated they had re facility's credible alleg They were knowledge ants, monitoring for fire | ty's plan for immediate so validated by the following. The interviewed and stated so. Residents validated they from the facility in regards to findom room observations of revealed the rooms were of type of ants. Baseboards tight against the floor at the fock. Residents reported so that staff had been in fremoved the baseboard at the room. Staff interviews the facility. The facility had the facility. The facility had their credible allegation of fremoval plan. The facility from of inservice training per form of Jeopardy removal plan. The facility form of inservice training per form of Jeopardy removal plan. The facility form of inservice training per form of Jeopardy removal plan. The facility form of inservice training per form of Jeopardy removal plan. The facility form of inservice training per form of Jeopardy removal plan. The facility form of inservice training per form of Jeopardy removal plan. The facility form of inservice training per the gration of compliance plan. The facility form of compliance plan. The facility form of Jeopardy removal plan. The facility form of Jeopardy form o | | 925 | | | |
| | Administrator on 10/1 been no further sighti | aintenance Director and 5/19 revealed there had ngs of fire ants, and the ction would be ongoing. | | | | | |