STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345505	A. BUILDING _____ B. WING _____	C 09/03/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted on 9/1/20 - 9/3/20. Two of the 36 allegations were substantiated resulting in a deficiency (F689). Event ID# 6RPK11.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide assistance of 2 staff during Activity of Daily Living (ADL) care with bed mobility according to the care plan which resulted in a fall for 1 of 3 residents reviewed for accidents (Resident #5). Findings included: Resident #5 was originally admitted on 9/4/2012 and re-admitted on 11/2/2019. Her diagnoses included Huntington's disease, convulsions, dementia and functional quadriplegia. An annual Minimum Data Set (MDS) assessment dated 5/11/2020 indicated Resident #5 had memory problems. She required total assistance of two staff with bed mobility and toileting and total assistance of one staff with hygiene and bathing.	F 689	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F689 How corrective action will be accomplished for those residents found to	9/18/20

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

Electronically Signed | 09/18/2020

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F 689	Continued From page 1 Resident # 5's current care plan directed that the resident needed 2 staff members for bed mobility secondary to her weakness. The two-person assistance for bed mobility was initially added to the care plan on 8/28/15 and remained as an active intervention on the care plan revision date of 4/7/20. The care plan also directed the resident needed 2 staff members for toilet use. This was initially added to the care plan on 9/10/2018 and remained as an active intervention on the care plan revision date of 4/7/20. The [patient care guide] was reviewed and indicated Resident #5 required total dependence of 2 staff members for bathing/showering, bed mobility and toilet use. The care guide was noted as revised on 7/06/2020 to include under the Safety section "be sure 2 aides present when performing ADL care." Nursing documentation, a post-fall note dated 7/2/2020 at 3:26 PM indicated Resident #5 had sustained a fall, had generalized weakness and unable to control movements. She was awake, unable to make her needs known, her behaviors were noted as normal and she had no signs or symptoms of distress. The note explained while the nurse aide (NA) was providing incontinent care, Resident #5 jerked her leg up and rolled over from bed and hit the floor. Nursing documentation, a post-fall note dated 7/2/2020 at 3:35 PM indicated Resident #5 had sustained a witnessed fall while the NA was changing Resident #5. Noted her skin was intact with no discoloration or skin tears. Recommendations: bed in a lower position and for two NAs assist [with incontinent care].	F 689	have been affected by the deficient practice. Resident #5□s Kardex was updated on 7/6/2020 to ensure under safety section that two people are used at all times. Nurse Aide (NA) received education regarding following the patient□s Kardex when providing care on 9/17/2020. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. The measures put into place or systemic changes made to ensure that the deficient practice will not recur. The Director of Nursing (DON) and the Assistant Director of Nursing (ADON) provided education to all nursing staff on September 17th, 2020 on the following: Kardex□s for resident care, -NA should review QD to ensure there has not been a change. If there is doubt contact Charge Nurse. Any staff who have not completed the in-service will be removed from the schedule until completed. Nursing administration will conduct observation audits for a random sample of 5 certified nursing assistants weekly x 4 weeks, twice monthly x 1 month, and monthly x 1 month to ensure the nursing assistant is providing care according to the Kardex. How the facility plans to monitor its performance to make sure that solutions are sustained. The DON will report results of the audits to the QAPI	

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F 689	Continued From page 2 The facility's investigation into the fall was dated 7/2/2020 at 11:38 AM. The report indicated "while NA (Nurse Aide) was changing resident; resident jerked her leg up and rolled over from bed and hit the floor. NA attempted to prevent fall by catching resident. Resident did not hit her head during fall. Patient unable to give description. Resident was assessed for injuries and bruises, place back in bed. Bed in low position and fall mats in place. Ensure 2 aides present when completing resident ADLs. No injuries noted at time of incident." The responsible party and physician had been notified of the incident. A significant change in status Minimum Data Set (MDS) assessment dated 8/6/2020 indicated Resident # 5 had memory problems. She required total assistance of two staff with bed mobility and required total assistance with toileting, hygiene and bathing of one staff. On 9/1/2020 at 2:40 PM Resident #5 was observed being provided incontinent care. Resident #5 appeared to be stiff with slight upper and lower tremors while being turned and positioned by two nurse aides. On 9/2/2020 at 2:30 PM Resident #5 was observed in bed positioned on her right side with the head of the bed up. Resident was observed with trembling movements in her upper extremities. On 9/3/2020 at 12:20 PM Resident #5 was observed lying on her right side in bed with the head of the bed elevated. No jerking or tremors were observed. On 9/3/2020 at 12:30 PM an interview was conducted with NA #1 who regularly cared for Resident # 5. The NA explained that she had	F 689	committee quarterly x 1 for analysis of patterns, trends, or need for further systemic changes. Any staff found to be non-compliant will receive progressive discipline up to and including termination Date of compliance for all plan of corrections is September 18th, 2020	

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F 689	Continued From page 3	F 689		

been caring for Resident #5 without the assistance of another staff member when Resident # 5 fell. She stated she thought resident #5 had only required one staff assistance at the time of her 7/02/2020 fall. She explained she had turned Resident #5 on her side to clean her back and bottom when suddenly Resident #5 jerked her leg which gave her the momentum to roll off the bed. She stated it had not been a hard fall or high fall from the bed and she did not hit her head. The NA stated she immediately got to her knees to check Resident #5 and then called the nurse. She stated Resident #5 had no injuries from the fall.

A phone interview was attempted on 9/03/2020 at 2:15 PM with the nurse who had cared for Resident #5 on the day of her fall. The nurse no longer worked at this facility and could not be reached for an interview.

An interview with the interim Director of Nursing (DON) was conducted on 9/03/2020 at 3:39 PM. She understood there were interventions noted on Resident # 5's care plan for bed mobility and toileting requiring 2 staff assist prior to the care plan revision on 7/06/2020. She explained she would expect nursing or nurse aide staff to check the care plans or [patient care guide] if there were any questions regarding resident care.