| 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 10/11/2024 |

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

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| F 000 | INITIAL COMMENTS<br><br>The surveyor entered the facility on 10/9/24 to conduct an unannounced complaint survey and exited on 10/10/24 Additional information was obtained on 10/11/24. Therefore, the exit date was changed to 10/11/24. Event ID# DQ3U11.<br><br>The following intakes were investigated NC00221151, NC00221851, NC00222198, NC00222630, NC00222722, NC00222909.<br><br>One (1) of the fourteen complaint allegations resulted in deficiency. | F 000 | | |
| F 696 SS=E | Prostheses<br>CFR(s): 483.25(j)<br><br>§483.25(j) Prostheses<br>The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, and interviews with staff and a prosthetic company employee, the facility failed to facilitate replacement of a lost prosthetic liner so the resident could use his prosthesis and walk. This was for one (Resident # 4) of one sampled resident who had a prosthesis. The findings included:<br><br>Resident # 4 was admitted to the facility on 12/19/22 with diagnoses which in part included diabetes, chronic kidney disease, and left below knee amputation. | F 696 | 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 deficiencies cited have been or will be corrected by the date or dates indicated.<br><br>F696<br>How corrective action will be accomplished for each resident found to | 10/19/24 |

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

Electronically Signed | 10/17/2024

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| F 696 | Continued From page 1<br>The resident's quarterly Minimum Data Set assessment, dated 7/27/24, coded the resident as cognitively intact and as not using a prosthesis during the assessment period. The resident was also coded to have moderate impairment of his vision.<br><br>Review of physical therapy documentation from 7/21/24 through 8/5/24 revealed the following information. Resident # 4 was certified to receive therapy services during the dates of 7/21/24 to 7/31/24. One of his precautions was that he was "blind." On 7/29/24 Physical Therapist # 1 documented "unable to perform static stand or ambulate for the last 3 days due to inability to locate gel sleeve for prosthesis. DOR (Director of Rehab) notified. On 7/30/24 Physical Therapist # 1 documented "treatment time spent on continued search for gel sleeve for prosthesis; therapist searched room again as well as laundry. Unable to locate. Notified DOR again and requested to order another gel sleeve." On 8/5/24 Physical Therapist # 1 completed a discharge summary noting the resident was being discharged from therapy. His ambulation goal had been noted to be 250 feet with forward wheel walker (FWW) and contact guard assistance. At time of discharge, he had not met that goal. The resident was walking 60 to 100 feet with FWW and periods of minimal assistance at time of discharge.<br><br>Physical Therapist # 1 was interviewed on 10/10/24 at 3:00 PM and reported the following information. The resident needed the gel sleeve (liner) in order to use his prosthesis. It allowed suction between the resident's stump and the prosthetic device so that it would fit correctly. It also prevented the resident from having shearing | F 696 | have been affected by the deficient practice:<br>Resident #4 received prosthesis sleeve on 10/10/2024.<br><br>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:<br>All residents who have a prosthesis will be audited to ensure they have a sleeve by 10/18/2024 by a therapist.<br>Measures to be put in place or systemic changes made to ensure practice will not re-occur:<br>All therapy staff will receive education on ensuring all residents with prosthesis have a sleeve available for mobility by Director of Rehab or designee by 10/18/2024<br>Therapy or designee will audit all residents who have a prosthesis weekly x 12 weeks to ensure they have a sleeve available for mobility.<br>Any new therapy staff will be educated by Staff Development Nurse or designee during orientation process.<br>Any staff who have not received this education by 10/18/2024 will be removed from the schedule until completed.<br>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed.<br><br>Completion October 19th 2024 | |

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| F 696 | Continued From page 2 | F 696 | | |

on his stump. She had looked for the gel sleeve/liner and could not find it. Without it, he could not continue to wear the prosthesis and continue with gait training. She had told the DOR. Not having the liner in order to utilize the prosthesis had hindered his progress with gait training. He also had not made a lot of progress with transfers, and that had not been related to not having the prosthesis liner. He also could not see objects well, and that had also hindered his progress.

On 9/3/24 at 12:50 PM Nurse # 2 documented the following information. Resident # 4 called 911 to report his missing prosthetic sleeve/liner. The 911 responders informed the resident that no crime had been committed and to allow the facility to have one delivered for him.

On 9/3/24 a facility "service concern report" for Resident # 4 was completed that noted, "Pt. (patient) reports liner to left prosthetic leg has been missing for 30 days. Pt called police to inform them it was missing. 2 officers, DOR, UM (Unit Manager) met with patient officers assured patient that facility directors were on top of the issue and were working to replace the liner as it has not been located." On the service form there was an area noted as "action taken." On this part of the form, there was documentation that the DOR contacted a prosthetic company employee who stated they would check to see if the sleeve was in stock. The form further included documentation, "awaiting delivery."

Resident # 4 was interviewed on 10/9/24 at 12:40 PM and again on 10/10/24 at 5:35 PM and reported the following information. He thought he had two liners for his prosthesis at one time and

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| F 696 | Continued From page 3 | F 696 | | |

now he had none. It had been several months since he had a prosthesis liner, and no one had helped him get another one. They had stopped therapy, and he wanted to use the prosthesis and walk. They would tell him his vision was poor, but he could see some things. During one of the interviews the resident pointed out to the surveyor the fire alarm on the wall. He also pointed out the clock, but stated he could not make out the time. He could also see whether the surveyor was wearing white or dark clothing but could not see details of clothing.

On 10/10/24 at 11:50 PM the DOR was interviewed and reported the following information. She recalled the resident reporting his liner had been stolen on 9/3/24. She knew the liner had to be ordered. When the resident had the prosthetic liner, he had walked with therapy but was unsteady. He also had visual deficits that contributed to not making progress. During the interview, the DOR reported she would check on the status of the replacement prosthetic liner which had been ordered.

On 10/10/24 at 2:40 PM a follow- up interview was conducted with the DOR who reported the following information. The liner had not yet been delivered. It would be delivered later that day (10/10/24). Regarding the lost prosthetic liner, the resident was not able to take off the liner himself and would have needed help. The facility did his laundry, and she did not know what had happened to his last prosthetic liner.

The DON (Director of Nursing) was interviewed and reported she first became aware of the issue during a clinical meeting after the resident had called 911 on 9/3/24. She had not been made

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| F 696 | Continued From page 4<br>aware of the problem in July 2024 when the prosthetic liner was lost.<br><br>An employee at the orthotic's and prosthetics company was interviewed on 10/10/24 at 3:10 PM and reported the following information. The first call they received from the facility requesting the prosthetic liner was on 9/4/24. The company told the facility staff a prescription was needed for the liner. The prescription was sent to the prosthetic company on that afternoon (9/4/24). The liner was not in stock, and it was ordered by the prosthetic company. The facility was notified on 9/19/24 that the prosthetic liner had arrived. A voice mail was left with the DOR on that date. On 10/3/24 the prosthetic company received a call from the facility saying they would call with payment for the liner the next week. They heard nothing further until the current day of 10/10/24 at 1:33 PM when the staff called and submitted payment. According to the prosthetic company employee, delivery was slated for that evening (10/10/24). | F 696 | | |
| F 842 SS=D | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(h)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.<br><br>§483.70(h) Medical records.<br>§483.70(h)(1) In accordance with accepted | F 842 | | 10/25/24 |

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| F 842 | Continued From page 5 | F 842 | | |

professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

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| F 842 | Continued From page 6<br><br>§483.70(h)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews the facility failed to maintain an accurate record regarding medical diagnoses. This was for one (Resident # 1) of one sampled resident reviewed for accurate diagnoses. The findings included:<br><br>Resident # 1 resided at the facility from 7/15/24 until her discharge on 9/29/24. The resident's diagnoses in part included respiratory failure with tracheostomy placement.<br><br>The resident's hospital discharge summary, dated 7/15/24, noted the resident had MRSA (methicillin resistant staphylococcus aureus) pneumonia while hospitalized and had received treatment.<br><br>A review of the facility's record revealed a list of cumulative diagnoses. MRSA pneumonia was listed as one of the resident's diagnoses while she had been hospitalized. There was an accompanying ICD code (International Statistical Classification of Disease) by the diagnosis of MRSA. (This medical classification system assigns a code for different diagnoses.) | F 842 | F842<br>How corrective action will be accomplished for each resident found to have been affected by the deficient practice:<br>Resident #1 did not have an accurate diagnosis for antibiotic use on the care plan.<br><br>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:<br>All residents who receive antibiotics will be audited for accurate diagnosis on the care plan and on their antibiotic orders by 10/25/2024 by infection preventionist.<br>Measures to be put in place or systemic changes made to ensure practice will not re-occur:<br>All MDS coordinators and the Infection Preventionist will receive education on ensuring the accurate diagnosis is on the care plan by DON or designee by | |

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| F 842 | Continued From page 7<br><br>A review of the resident's record revealed the resident had three chest x-rays performed while she resided at the facility. These were on 7/21/24, 8/15/24, and 8/29/24. All of the x-rays were negative for pneumonia.<br><br>On 9/7/24 at 12:11 AM Nurse # 1 documented in a nursing note that Resident # 1 had yellow/green tinged tracheal secretions, and the physician was notified.<br><br>On 9/7/24 at 12:19 AM Nurse # 1 documented in a nursing note that the physician had ordered the resident to be given Ciprofloxacin 500 milligrams twice per day for 10 days for an upper respiratory infection. (Ciprofloxacin is an antibiotic.)<br><br>On 9/7/24 Nurse # 1 entered into the resident's medical record, the verbal order for the Ciprofloxacin. The order included the information that Ciprofloxacin was for yellow/green tracheal secretions. It also included an accompanying diagnosis. The diagnosis was listed as MRSA pneumonia.<br><br>On 9/9/24 the resident' s care plan was updated to reflect the resident had developed pneumonia and was receiving antibiotics for pneumonia.<br><br>A review of physician notes revealed the resident was seen by the physician on 9/19/24. The physician noted the resident had recently completed the antibiotics secondary to a "possible" upper respiratory infection and her lungs were clear.<br><br>The facility's care plan nurse was interviewed on 10/11/24 at 12:43 PM and reported the following | F 842 | 10/18/2024<br>All licensed nurses will receive education on ensuring an accurate diagnosis code is entered in PCC with an antibiotic order by the DON or designee by 10/25/2024<br>Infection Preventionist or designee will audit all antibiotic care plans for accurate diagnosis 5x weekly x 4 weeks, then weekly x 8 weeks, then monthly x 3<br>Infection Preventionist or designee will audit all antibiotic orders for accurate diagnosis daily Monday-Friday x4 weeks, 3x weekly x 4 weeks ad weekly x 4 weeks.<br>Any MDS staff, licensed nurse or infection preventionist who is not educated will not be allowed to work until education received.<br>Any new MDS, licensed nurse or infection preventionists will be educated by Staff Development Nurse or Director of Nursing or designee during orientation process<br><br>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed.<br><br>Completion October 25th 2024 | |

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information. When verbal orders are entered by a nurse, there is a drop-down box in the electronic system that allows the nurse to tie an order to an ICD diagnostic code in the resident's record. When Nurse # 1 entered the antibiotic order, she had checked the ICD code for MRSA pneumonia which had been entered upon admission to reflect the resident's history of pneumonia while hospitalized. Instead, she should have just entered the order to read that the antibiotic had been ordered for the discolored sputum and concluded the order with that alone. When the care plan nurse looked at the record, it appeared as if the resident was being treated for pneumonia, but she had not been. She (the care plan) nurse had then inaccurately placed on the care plan that the resident had pneumonia. There had been no diagnosis of pneumonia, and it was an error in the record.

Resident # 1's Responsible Party (RP) was interviewed on 10/9/24 at 11:34 AM and expressed concern that Resident # 1's facility medical record had inaccurately reflected whether the resident had pneumonia again while she resided at the facility. The RP reported she had talked to facility staff members about Resident # 1 and her status. During conversations staff referenced the resident's medical record to provide her (the RP) information. At one point she had been told Resident # 1 had pneumonia and at another point she had been told the resident did not have pneumonia while she was at the facility.

Resident # 1's physician was interviewed on 10/10/24 at 2:00 PM and reported the following information. The resident's RP had been concerned about the color of the resident's

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| F 842 | Continued From page 9<br>mucous and the resident had been placed on antibiotics because of the concern of the color. The resident had not been identified to have pneumonia while she resided at the facility. | F 842 | | |