| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345376 | A. BUILDING _____ B. WING _____ | C 02/08/2013 |

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| CUMBERLAND NURSING AND REHABILITATION CENTER | 2461 LEGION ROAD FAYETTEVILLE, NC 28306 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 272 SS=D | 483.20(b)(1) COMPREHENSIVE ASSESSMENTS<br><br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and<br>Documentation of participation in assessment. | F 272 | Cumberland Nursing & Rehabilitation Center acknowledges receipt of The statement of deficiencies and Proposes this plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care of residents. The plan of correction is submitted as a written allegation of compliance.Cumberland Nursing andRehabilitation Center's response to the Statement of deficiencies does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further Cumberland Nursing and Rehabilitation Center reserves the Right to refute any of the deficiencies on this statement through informal dispute resolution, formal appeal procedure and or any other administrative legal proceedings.<br>**F 272**<br>On 1/25/13 Resident #39 was assessed for proper oral care by the Director of Nursing with the NA staff. Resident #39 was provided with proper oral care immediately upon assessment by the Nursing Assistant. | 02/15/13 |

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 2/20/13

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that r safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days wing 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 s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ram participation.

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

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| F 272 | Continued From page 1<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews and record review, the facility failed to assess the need for frequent oral care for 1 of 1 resident (resident # 39) not allowed anything by mouth with a gastrostomy tube and required total assistance of her oral care. Findings include:<br><br>Resident # 39 was admitted 1/22/09 diagnosis of cerebral vascular accident, dementia, dysphagia, and seizures. This required resident #39 to need a gastorstomy tube for her nutrition.<br><br>Her quarterly minimum data set dated 12/20/12 indicated that she had severe cognitive impairment and required extensive to total assist with activities of daily living (ADL's). She was coded total assistance for her personal hygiene which included oral care.<br><br>A review of her ADL care plan indicated that resident # 39 required assistance with bathing. There was no mention of oral care or the specialized need for oral care for a resident with a gastrostomy tube who was not allowed and food or fluids by mouth. Resident # 39 was also care planned for combativeness during medical exam, but there was no mention of combativeness or resistance with her ADL care.<br><br>A review of medical record dental history report dated 9/15/12 stated that oral hygiene was poor with heavy plague and calculus with evidence of periodontitis. The report also indicated that she did not have the ability to clean them herself. | F 272 | The Care Plan and Care Guide of Resident #39 was updated 1/25/13 by the MDS nurse with specific interventions for oral care.<br>On 1/28/13 a 100% audit was conducted by the Director of Nursing, Assistant Director of Nursing, QI Nurse, MDS Nurses, and Staff Facilitator for all dependant residents in regards to oral care to include residents with nothing by mouth with a gastrostomy tube .Oral care was provided to all dependant residents upon identification of any potential concern by the nursing assistants.<br>A 100% audit was conducted on 02/07/13 for accuracy of appropriate interventions relating to oral care for all dependent residents by the Director of Nursing, Assistant Director of Nursing, Staff Facilitator, MDS Nurses, and Quality Improvement Nurse.<br>All identified areas of concerns related to care plans and care guides were corrected by MDS Nurse on 1/25/13.<br>The MDS Nurses were educated on updating all care plans by the RAI process on admission,quarterly, annually, significant changes,and as needed toinclude new implementationof new interventions on 2/15/13 by the MDS Nurses | |

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| F 272 | Continued From page 2<br>There was evidence found that resident # 39 was being assessed by dental services every 6 months.<br><br>On 1/23/13 at 3:17pm, resident # 39 was noted to be resting in bed. When asked to smile, she was cooperative. There was a noted pale yellowish substance bordering the gums of teeth and a dry whitish substance. The mucus membranes were moist. There was no debris in her mouth but her tongue was coated with a pale yellowish substance extending to the back of her mouth. An observation of the room revealed no oral care products out in view.<br><br>In an interview with MDS coordinator on 1/24/13 at 10:10 am, she stated she generated and updated the care plan as needed. She also stated that she and another person were responsible for completing the comprehensive and quarterly assessments for the residents. The MDS coordinator stated she was responsible to ensure the Resident Care Guide were accurate and reflect the care plan. The MDS coordinator stated the Resident Care Guide should be updated to reflect the care needed for each resident ' s individual needs. The MDS coordinator was unable to offer and explanation as to why the care plan did not include frequent oral care for resident # 39 because of the nothing by mouth status. She also was not able to offer an explanation regarding the lack of directive for the NA ' s on the Resident Care Guide regarding the need for frequent oral care related to resident # 39's nothing by mouth status.<br><br>On 1/24/13 at 11:40 am, the director of nursing (DON) stated the MDS coordinator completes all | F 272 | The MDS Nurses was Re-Educated on 02/15/13 via video training m odule the MDS 3.0 Care Area Assessment Process And Care Planning.<br>An in-service was initiated for all licensed nurses on 02/07/13 by the Staff Facilitator regarding quarterly, annually, significant changes, and as needed to include new implementation of new interventions on 2/15/13 by the MDS Nurses<br>The MDS Nurses was Re-Educated on 02/15/13 via video training module the MDS 3.0 Care Area Assessment Process And Care Planning.<br>An in-service was initiated for all licensed nurses on 02/07/13 by the Staff Facilitator regarding notifying the MDS Nurse of changes in care; to include frequent oral care; by submitting a copy of the updated resident care guide of any changes to the MDS Nurse for review and re-assessment As indicated. | |

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| F 272 | Continued From page 3<br>of the comprehensive and quarterly assessments for all of the residents. The MDS nurse was responsible to update the care plan and the MDS nurse and hall nurses were responsible to update the Resident Care Guides when changes are made.<br><br>On 1/24/13 at 1:35 pm, resident # 39 was sitting up in a reclining chair. Her responsible party was also in the room. Resident # 39 opened mouth upon request. Her lips appeared dry. Her teeth were covered with a pale yellowish colored substance. Her tongue was coated with a pale yellowish substance extending to the back of her mouth.<br><br>On 1/24/13 at 1:50pm, NA #9 stated she was assigned resident #39 and she did provided her oral care but that the stuff in her mouth does not come off when she cleaned her mouth. She stated she used the green colored toothette sponges damped with water and the toothpaste was already in the swab.<br><br>On 1/24/13 at 2:00 pm, the Resident Care Guide located inside the closet door indicated that resident # 39 was not allowed anything my mouth (NPO). There was nothing indicating the she required assisted with her oral care.<br><br>On 1/25/13 at 8:45am, resident # 39 was observed sitting up in her reclining chair. Her teeth appeared to have been cleaned. There was less of the pale yellowish debris noted to the top front teeth and the back bottom right teeth. Her tongue was without debris and appeared moist.<br><br>On 1/25/13 at 9:00am, an observation of oral care | F 272 | All newly hired licensed nurses will be in serviced regarding notifying the MDS nurse of changes in resident assessement to include frequent oral care by submitting a copy of the updated resident care guide of any changes to the MDS Nurse during the Orientation process by the Staff Facilitator.<br><br>All Licensed Nurses were educated on how to notify the MDS Nurse of changes in assessment for the need for frequent oral care by submitting a copy of the updated resident care guide with any changes to the MDS Nurses | |

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| F 272 | Continued From page 4<br>provided by NA # 9 was done. Resident # 39 was cooperative and appeared to understand the process. An inspection of the swab used to clean the bottom teeth revealed no debris. The gums toward the front bottom teeth began to bleed but quickly subsided. There was noted a pale yellowish substance on the swab after cleaning the top teeth and the roof of her mouth. NA # 9 stated she provided oral care earlier and she was cooperative then as well. | F 272 | On 2/1/13 a QI tool was put into place by the Director of Nursing to ensure that oral care is provided frequently throughout the day and to monitor oral care for all dependant residents to include Resident #39. The Director of Nursing along with the QI nurses will review the QI tool on a five times a week x 4 weeks then three times a week x 4 weeks, then weekly X 4 weeks then monthly x 2 months Follow up will occur by the Director Of Nursing upon the identification of any potential concern. The results of the oral care for dependent residents audits will be forwarded to the Exceutive QI Committee monthly for the identification of trends, development of action plans as indicated, and to determine frequency of continued QI monitoring. | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews and | | | |

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| F 279 | Continued From page 5<br>record review, the facility failed to care plan the need for frequent oral care for 1 of 1 resident (resident # 39) not allowed anything by mouth with a gastrostomy tube and required total assistance of her oral care. Findings include:<br><br>Resident # 39 was admitted 1/22/09 diagnosis of cerebral vascular accident, dementia, dysphagia, and seizures. This required resident #39 to need a gastorstomy tube for her nutrition.<br><br>Her quarterly minimum data set dated 12/20/12 indicated that she had severe cognitive impairment and required extensive to total assist with activities of daily living (ADL's). She was coded total assistance for her personal hygiene which included oral care.<br><br>A review of her ADL care plan indicated that resident # 39 required assistance with bathing. There was no mention of oral care or the specialized need for oral care for a resident with a gastrostomy tube who was not allowed and food or fluids by mouth. Resident # 39 was also care planned for combativeness during medical exam, but there was no mention of combativeness or resistance with her ADL care.<br><br>A review of medical record dental history report dated 9/15/12 stated that oral hygiene was poor with heavy plague and calculus with evidence of periodontitis. The report also indicated that she did not have the ability to clean them herself. There was evidence found that resident # 39 was being assessed by dental services every 6 months.<br><br>On 1/23/13 at 3:17pm, resident # 39 was noted to | F 279 | **F279**<br>On 1/25/13 Resident #39<br>Care plan was reviewed and revised as necessary by the MDS nurse to include the provision of frequent oral care related to being nothing by mouth and<br>The MDS Nurse<br>revised the care plans<br>for all resident changes to<br>include frequent oral care for<br>residents with nothing by mouth with<br>gastrostomy feeding tubes on<br>2/7/13.<br><br>The DON or ADON<br>will review the care<br>Plans of all residents<br>with frequent oral care to<br>include those with nothing by mouth with<br>gastrostomy feeding tubes to ensure<br>care plans have been<br>revised by utilization of the<br>Care plan interventions QI tool<br>3 times per week for 4<br>Weeks, 2 times per week for<br>4 weeks, and monthly thereafter.<br>Immediate follow up will be taken<br>by the DON or ADON upon the identification<br>of any potential concerns. | |

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| F 279 | Continued From page 6<br>be resting in bed. When asked to smile, she was cooperative. There was a noted pale yellowish substance bordering the gums of teeth and a dry whitish substance. The mucus membranes were moist. There was no debris in her mouth but her tongue was coated with a pale yellowish substance extending to the back of her mouth. An observation of the room revealed no oral care products out in view.<br><br>In an interview with MDS coordinator on 1/24/13 at 10:10 am, she stated she generated and updated the care plan as needed. The MDS coordinator stated she was responsible to ensure the Resident Care Guide were accurate and reflect the care plan. The MDS coordinator stated the Resident Care Guide should be updated to reflect the care needed for each resident ' s individual needs. The MDS coordinator was unable to offer and explanation as to why the care plan did not include frequent oral care for resident # 39 because of the nothing by mouth status. She also was not able to offer an explanation regarding the lack of directive for the NA ' s on the Resident Care Guide regarding the need for frequent oral care related to resident # 39's nothing by mouth status.<br><br>On 1/24/13 at 11:40 am, the director of nursing (DON) stated the MDS coordinator was responsible to update the care plan and the MDS nurse and hall nurses were responsible to update the Resident Care Guides when changes are made.<br><br>On 1/24/13 at 1:35 pm, resident # 39 was sitting up in a reclining chair. Her responsible party was also in the room. Resident # 39 opened mouth | F 279 | The MDS Nurse was educated on 02/15/13 by the MDS Nurse Consultant on the utilization of assessment data for accurate care plan development for all residents to include residents that were identified as dependent for oral care.<br>The MDS Nurses were educated on updating all care plans by the RAI process on admission, quarterly, annually, significant changes, and as needed to include new implementation of new interventions.<br>The MDS Nurse was Re-Educated on 02/15/13 via video training module the MDS 3.0 Care Area Assessment Process And Care Planning. | |

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| F 279 | Continued From page 7<br>upon request. Her lips appeared dry. Her teeth were covered with a pale yellowish colored substance. Her tongue was coated with a pale yellowish substance extending to the back of her mouth.<br><br>On 1/24/13 at 1:50pm, NA #9 stated she was assigned resident #39 and she did provided her oral care but that the stuff in her mouth does not come off when she cleaned her mouth. She stated she used the green colored toothette sponges damped with water and the toothpaste was already in the swab.<br><br>On 1/24/13 at 2:00 pm, the Resident Care Guide located inside the closet door indicated that resident # 39 was not allowed anything my mouth (NPO). There was nothing indicating the she required assisted with her oral care.<br><br>On 1/25/13 at 8:45am, resident # 39 was observed sitting up in her reclining chair. Her teeth appeared to have been cleaned. There was less of the pale yellowish debris noted to the top front teeth and the back bottom right teeth. Her tongue was without debris and appeared moist.<br><br>On 1/25/13 at 9:00am, an observation of oral care provided by NA # 9 was done. Resident # 39 was cooperative and appeared to understand the process. An inspection of the swab used to clean the bottom teeth revealed no debris. The gums toward the front bottom teeth began to bleed but quickly subsided. There was noted a pale yellowish substance on the swab after cleaning the top teeth and the roof of her mouth. NA # 9 stated she provided oral care earlier and she was cooperative then as well. | F 279 | An in-service was initiated by the Staff Facilitator for all licensed nurses on 02/07/13 by the Staff Facilitator regarding notifying the MDS Nurse of changes in care; to include frequent oral care; by submitting a copy of the updated resident care guide of any changes to the MDS Nurse.<br>All newly hired licensed nurses will be in serviced regarding notifying the MDS nurse of changes in resident assessment to include frequent oral care by submitting a copy of the updated resident care guide of any changes to the MDS Nurse during the Orientation process by the Staff Facilitator.<br>The findings of the QI monitoring audits will be forwarded to the QI committee by the DON or QI Nurse for review quarterly for the identification of trends, development of action plans as indicated, and to determine frequency of continued QI monitoring. | |

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| F 281 SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to follow the physician's orders for daily blood glucose monitoring for 1 of 5 sampled residents with diabetes (Resident #48). Findings included:<br><br>Resident #48 was admitted to the facility on 7/24/12 with multiple diagnoses including diabetes.<br><br>Review of the resident's clinical record revealed physician orders dated 1/16/13 to discontinue Novolog (insulin), discontinue accuchecks four times daily, start fasting accuchecks every morning, and notify the physician if results were greater than 200 mg/dL (milligram/deciliter). Record review revealed no other orders for insulin or oral anti-diabetic medications.<br><br>Accucheck or fingerstick blood sugar (FSBS) monitoring is conducted by sticking the resident's finger for a blood sample, which is then placed on a strip. The strip goes into a glucometer that reads the blood sugar level.<br><br>Review of the resident's January 2013 medication administration record (MAR) revealed an undated entry for fasting accucheck every morning and notify MD if accucheck is greater than 200 mg/dL. Review revealed the MAR was blocked off for | F 281 | The Medication Administration Record was updated for resident #48 immediately Upon notification by charge nurse on 1/25/13.<br><br>A 100% audit was conducted on 1/25/13 by the Staff Facilitator of all diabetic residents. All diabetic residents charts were reviewed and compared to the MAR for accuracy with no issues identified<br><br>100% in servicing of all Licensed Nursing Personnel regarding proper transcription and correct procedure to intiate orders was completed on 2-7-13 by the Staff Facilitator.<br><br>All newly hired Licensed Nurses will receive education during orientation by the Staff Facilitator on proper transcription of orders and correct procedure to initiate orders | |

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| F 281 | Continued From page 9<br>weekly accucheck monitoring instead of daily monitoring. Review of the MAR revealed accucheck results of 81 mg/dl at 6AM on 1/17/13 and 96 mg/dl at 6AM on 1/24/13.<br><br>Review of the resident's Blood Glucose (FSBS) Monitoring Sheet revealed no documentation of daily accuchecks. Review revealed results of 81 mg/dl on 1/17/13 and 96 mg/dl on 1/24/13.<br><br>Record review of the resident's nursing notes revealed no documentation of daily accuchecks.<br><br>In an interview on 1/25/13 at 12:42AM, Nurse #3 examined the MAR and acknowledged the accuchecks for Resident #48 should have been completed daily as ordered by the physician. Nurse #3 stated she transcribed the order to the MAR but the third shift nurse blocked off the MAR to indicate weekly accucheck monitoring. The third shift nurse was responsible for completing FSBS monitoring at 6AM. Nurse #3 stated one copy of the order remained in the resident's chart, one copy was sent to the physician to sign, and one copy, the pink copy, was filed at the nursing station. The administrative nurses collected the pink copies daily to be sure the staff followed through on new orders or order changes.<br><br>In an interview on 1/25/13 at 1:06PM, the Director of Nursing (DON) stated when the nurses received new orders, they updated the MAR immediately. One copy of the order remained on the chart, one copy went to the pharmacy, and the pink copy went to the Quality Assurance (QA) nurse. After the morning staff meetings, the QA nurse checked all new orders against the MARS for accuracy. The DON examined Resident #48's | F 281 | 24 Hour Chart Checks were initiated on 2/1/13 by the Director of Nursing to verify that orders were transcribed to MARs correctly by 11-7 nursing staff.<br><br>Nurse Supervisors/Quality Improvement Nurses will audit orders daily to ensure they are correctly placed on MAR.<br>Monitoring will be done on 12 selected residents to include Resident # 48, 3 x week for 4 weeks 2x week for 4 weeks and weekly thereafter by QI nurses. Follow up action will be taken upon identification of any potential concern by the Nurse Supervisors and/or QI Nurse<br><br>The results of the Audits will be forwarded to the Executive QI Committee by the QI Nurse monthly for review for follow up action<br>As deemed appropriate, evaluation of the effectiveness of the Plan, and to determine the frequency of and/or need for continued monitoring. | |

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| F 281 | Continued From page 10<br>MAR and stated the third shift nurse should not have blocked the accucheck order as weekly. Her expectation was for all orders to be transcribed correctly to the MARS. The DON stated the error should have been caught by the QA nurse and every nurse that read the order.<br><br>The QA nurse and third shift nurse were unavailable for interview. | F 281 | | |
| F 312 SS=D | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>This REQUIREMENT is not met as evidenced by: .<br>Based on observation, interview and record review, the facility failed to provide needed oral care for 1 of 1 resident (resident # 39) who was not allowed any by mouth. Findings include:<br><br>Resident # 39 was admitted 1/22/09 with a of cerebral vascular accident, dementia, dysphagia, and seizures. Resident #39 used gastrostomy tube for her nutrition.<br><br>Her quarterly Minimum Data Set dated 12/20/12 indicated that she had severe cognitive impairment and required extensive to total assist with activities of daily living (ADL's). She was coded total assistance for her personal hygiene which included oral care. | F 312 | On 1/25/13 Resident #39 was assessed for proper oral care by the Director of Nursing with the NA staff member. Resident #39 was provided with proper oral care immediately upon assessment by the NA staff member.<br><br>On 1/25/13 a 100% audit was Conducted by the Assistant Director of Nursing for all dependant residents in regards to oral care to include residents with nothing by mouth with a gastrostomy tube. Oral care was provided to all dependant residents upon identification of any potential concern by the nursing assistants.<br><br>All nursing staff members were reeducated in regards to proper oral care on 1/25/13 by the Staff Facilitator | |

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| F 312 | Continued From page 11<br>A review of her ADL care plan indicated that resident # 39 required assistance with bathing. There was no mention of oral care or the specialized need for oral care for a resident with a gastrostomy tube who was not allowed food or fluids by mouth. Resident # 39 was also care planned for combativeness during medical exam, but there was no mention of combativeness or resistance during her ADL care.<br><br>A review of medical record dental history report dated 9/15/12 stated that oral hygiene was poor with heavy plaque and calculus with evidence of periodontitis. The report also indicated that she doesn't have the ability to clean her mouth herself.<br><br>On 1/22/13 at 11:20 am, in an interview with the responsible party, she stated that the facility was not cleaning her mouth. A visual assessment of resident #39's mouth revealed a dried white substance in the corners of her mouth. There was a pale yellowish substance bordering the gums of the teeth.<br><br>On 1/23/13 at 3:17pm, resident # 39 was noted to be resting in bed. When asked to smile, she was cooperative. There was a noted a dry whitish substance in the corners of her mouth. The mucus membranes were moist. Her tongue was coated with a pale yellowish substance extending to the back of her mouth. An observation of the room revealed no oral care products in view.<br><br>On 1/24/13 at 1:35 pm, resident # 39 was sitting up in a reclining chair. Her responsible party was also in the room. Resident # 39 opened mouth upon request. Her lips appeared dry. Her teeth | F 312 | On 2/1/13 a QI tool was put into place by the Director of Nursing to ensure that oral care is provided frequently throughout the day and to monitor oral care for all dependant residents to include Resident #39. The QI tool will be monitored daily by the Staff Nurse. Follow up will occur by the Director of Nursing upon identification of any potential concern.<br><br>The findings of the QI monitoring tool will be forwarded to the QI committee for review quarterly for the identification of trends, development of action plans as indicated, and to determine frequency of continued QI monitoring. | |

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were covered with a pale yellowish colored substance. Her tongue was coated with a pale yellowish substance extending to the back of her mouth.

On 1/24/13 at 1:45 pm, nursing assistant # 8 (NA) stated that resident # 39 was not allowed anything by mouth and she had a gastrostomy tube. NA # 8 stated she was not assigned resident # 39 but she knew that any resident with a gastrostomy tube required frequent oral care.

On 1/24/13 at 1:50pm, NA #9 stated she was assigned resident #39 and she did her oral care but that the stuff in her mouth does not come off when she tries to clean her mouth.

On 1/24/13 at 2:10pm, the assistant director of nursing stated her expectation would be frequent oral care for all residents ' especially tube feeding residents.

On 1/24/13 at 3:00 pm, the director of nursing (DON) stated she expected oral care be done for all the residents, but more frequently for a tube feeding resident. She stated that the responsible party for resident #39 had mentioned her concerns with resident # 39's oral care but the resident was known to resist care.

On 1/25/13 at 8:45am, resident # 39 was observed sitting up in her reclining chair. Her teeth appeared to have been cleaned. The corners of her mouth were clean and the tongue was clean and appeared moist.

On 1/25/13 at 9:00am, an observation of oral care provided by NA # 9 was done. Resident # 39 was

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| F 312 | Continued From page 13<br>cooperative and appeared to understand the process. An inspection of the swab used to clean the bottom teeth revealed no debris. The gums toward the front bottom teeth began to bleed but quickly subsided. There was noted a pale yellowish substance on the swab after cleaning the top teeth and the roof of her mouth. NA # 9 stated she provided oral care earlier and she was cooperative then as well. | F 312 | | |
| F 323 SS=G | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews and staff interviews, the facility failed to use a mechanical lift to transfer 1 of 3 sampled residents who needed extensive assistance with transfer, resulting in a left distal femur fracture. (Resident # 27). Findings included:<br><br>Resident # 27 was admitted to the facility on 2/13/2012 with diagnoses of Muscle weakness; Cognitive communication Deficit; Lack of coordination and Osteoporosis. The most current Minimum Data Set (MDS) dated 10/1/2012 revealed the resident's cognition as moderately impaired; she needed extensive assistance with bed mobility and transfer. | F 323 | Past noncompliance: no plan of correction required. | |

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| F 323 | Continued From page 14<br><br>Resident # 27's Care Area Assessment ( CAA) worksheet dated 4 /11/2012 documented "Flagged for falls CAA due to balance problems during transitions, i.e.(example) moving from a seated to standing position and surface to surface transfers. (Resident #27) currently requires the use of (mechanical lift # 1), but at times will need a (mechanical lift # 2) due to weakness. Staff currently anticipates all of (Resident # 27)'s needs and provide care as needed."<br><br>Resident # 27's care plan dated 10/23/2012 documented the resident required assistance for transferring from one position to another related to physical limitation. The care plan documented the following interventions: "Provide two persons for constant supervision/ physical assist with mechanical aid at all times, Resident cannot weight bear, Use mechanical lift."<br><br>Review of Resident # 27's "Care Guide" dated 10/10/2012 indicated the resident needed a large mechanical lift to be used for transfers.<br><br>On 10/29/2012 a nurse's note at 1:41 AM on 10/29/2012 documented "Observed resident left leg seem to be more swollen and shorten. Call placed to PA (Physician Assistant). An order was given to transfer resident to (hospital) for evaluation. EMT (Emergency Medical Technician) arrived and resident was sent out to (hospital)."<br><br>On 10/29/2012 a nurse's note at 7:25 AM documented "Resident returned from hospital. Transported back to facility by EMS (Emergency Medical Services) on stretcher. Alert with | F 323 | | |

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confusion. Left thigh/knee remains edematous, tests negative, to follow up the doctor."

On 10/29/2012 a nurse's note at 10:41 AM documented "Swelling to left thigh. No redness or warmth. Without tenderness when leg moved. Able to move leg and toes at will."

On 10/31/2012 a nurse's note at 10:45 AM documented "called in to room by NA (Nurse Assistant) # 8. Upon assessment hematoma noted to thigh that was noted previously on 10/29/2012. Resident had gone to ED (Emergency Department) for Doppler (Radar that uses Doppler effect to measure velocity) which came back negative. PA (Physician Assistant) notified and an order received for X- ray of left hip and femur."

On 10/31/2012 a nurse's note at 2:44 PM documented " Results of X- ray to left thigh received. Oblique fracture noted. PA notified and order received for consult with orthopedic. Also Percocet 5/325 mg (milligram) to be given every 4 hours as needed for pain. "

On 10/31/2012 a nurse's note at 11:33 PM documented "Resident remain in room this shift, medicated for pain one times, knee immobilizer applied to left knee per physician order until appointment on 11/1/2012, staff uses draw sheet for positioning and resident not ambulatory at this time."

Review of the facility's investigation report dated 10/31/2012 documented "Resident noted with swelling and pain on 10/28/2012 on 3-11 shift. Resident sent to (Hospital) per MD (Medical

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Doctor) order. Receiving nurse given report from (hospital) that all test results were negative. Resident obtained an x- ray on 10/31/2012 that showed left distal fracture. "Further review of the facility's investigation report revealed the staff at the facility was re-trained on safe movement and handling of residents.

Nurse's note dated 11/1/2012 documented "Resident alert and able to verbalize, no swelling to left thigh noted, remains in soft splint, PRN( as needed Percocet given for pain to leg, remains in bed this shift, will continue to monitor."

Nurse's note dated 11/2/2012 documented "Resident had an appt with the (Orthopedic doctor) this am (morning) order to keep knee immobilizer on full extension."

Review of the facility's investigation report revealed the facility submitted to Health Care Personnel Registry (HCPR) a 24 hour report on 11/1/2012 and a 5 day report on 11/5/2012.

Review of a second facility's 24 hour report dated 11/6/2012 revealed the Assistant Director of Nursing(ADON) conducted an investigation due to the family alleging neglect related to left femoral fracture. It further revealed NA # 11 assigned to the resident on 10/28/2012 second shift (3-11) and 10/29/2012 second shift (3-11) was terminated from employment on 11/8/2012 related to violation of facility policy.

Review of the "Disciplinary warning notice" dated 11/8/2012 revealed NA# 11 ( Nurse

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Assistant) who was assigned to Resident # 27 on 10/28/2012 second shift (3-11) and 10/29/2012 second shift (3-11) was terminated from work at the facility due to " failure to follow safe movement and handling policy."

Nurse's note dated 11/7/2012 documented "Resident sent to (Hospital) per family member request for femur fracture."

Review of the hospital's History and Physical dated 11/7/2012 documented " The patient initially evaluated on 10/29/2012 for the femur fracture and was recommended closed treatment. Mobilization was performed and patient was transferred to a local nursing facility. The patient was brought back to the emergency department tonight because of increased deformity and discomfort by the patient and the family wishes that she be seen again. The patient was noted to have increased swelling with an increased deformity noted. On presentation to the ER (Emergency Room), the patient was noted to have approximately 3 inches of shortening with obvious deformity of the left femur with a prominent time bone fragments along the lateral side of the distal femur with skin that is intact."

Review of Resident # 27's hospital's discharge summary dated 11/14/2012 documented the reason for hospitalization as "Pain and deformity in the left thigh. Left distal femur fracture." Further review of the discharge summary documented "after family decision was made patient had ORIF (Open Reduction and Internal Fixation). Overall the patient has had significant improvement in her pain and she will be going to a skilled nursing facility today. The family has

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| F 323 | Continued From page 18<br>elected a different skilled nursing facility and she will be transferred there."<br><br>During the interview with DON (Director of Nursing) on 1/24/2013 at 10:00 AM, she reported she initiated an investigation for injury of unknown origin on Resident # 27 after her family member alleged abuse. The DON further stated NA #11 was terminated on 10/8/2012 because of her possibly not using the mechanical lift properly. The DON also stated the resident had diagnoses of osteoporosis and the result of x- ray completed on 10/31/2012 indicated she had a fracture on her left distal femur. DON also stated NA # 11 had been in -serviced before in reference to the use of mechanical lifts on the residents at the facility and was in-serviced again after it was found out that she had not applied the facility's policy in the use of the mechanical lift on Resident # 27.<br><br>During the interview on 1/24/2013 at 3:00 PM, The SDC (Staff Development Coordinator) reported she in-serviced the staff at the facility after the incident of failure to use the facility's policy in the use of the mechanical lift by NA #11 on Resident # 27. SDC reported that the NA # 11 transferred Resident # 27 without using a mechanical lift. She added the nurse's aides at the facility were required to use a correct type of a mechanical lift when transferring the residents. The types of the lifts to be used were recorded on the residents' care guide. SDC further stated that the care guide also indicated number of staff required when using a mechanical lift to transfer the residents. How many staff is required to assist | F 323 | | |

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| F 323 | Continued From page 19<br>on the named mechanical lift. SDC also stated NA # 11 had been trained before on the use of the mechanical lift on residents who needed extensive assistance with transfer but chose to lift Resident # 27 without the use of the lift. SDC further stated the entire staff at the facility had been in-serviced in reference to the use of the mechanical lift on the residents.<br><br>During the interview on 1/25/2012 at 10:35 AM, the administrator reported that he had just started working at facility 3 days before the interview. He reported that his expectation of his staff was that they should follow the policy regarding lifting of residents who require extensive assistance with transfer using a mechanical lift. The administrator added that he was aware of the interventions that had been put in place after Resident # 27 was found with a fracture. He further stated that the staff at the facility had been in-serviced in the use of the mechanical lifts, audits had been completed for residents who could had potential been injured and monitoring tools had been, put in place to make sure the incident does not happen again. He added the QA (Quality Assurance) Committee had discussed the concerns of preventing the problem from happening again, and the committee will continue to discuss the concerns monthly.<br><br>NA#11 who was accused of lifting Resident # 27 without the use of the mechanical lift was unavailable for interview. She (NA #11) was terminated from employment on 10/8/2012. | F 323 | | |

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| F 323 | Continued From page 20<br>The corrective action for past non-compliance dated 10/31/2012 included:<br>1. A 100 % body audit on all residents to ensure that there were no acute changes in regards to edema and pain was completed by 10/31/2012- ADON, DON, SDC and facility ' s consultant completed the audits. No concerns were found.<br><br>2.100% in-service with return demonstration of lift was completed by 11/2/2012- SDC completed the training with the nurses aides<br><br>3. A lift transfer audit was to be completed weekly X 4 weeks and completed by 11/29/2012<br><br>4.100 % in-service will be completed related to safe handling resident movement policy and completed by 11/13/2012 - SDC completed the in service with the nurse's aides.<br><br>5.100% in-service signs/symptoms of fracture completed by 11/6/2012- SDC completed the service with the licensed staff (Licensed practical nurses and Registered nurses)<br><br>6. QI (Quality Improvement) of acute changes related to pain/edema to be implemented on 11/8/2012 daily 5x/ week x 4 weeks then 3 times/ week x 4 weeks then 2 times per week x 4 weeks then weekly x4 weeks then monthly x 2 months will be completed 4/18/2013<br><br>7.Monitoring of the system will occur on January 16, 2013 then monthly for 90 days and then quarterly through QA (Quality Assurance) process. Review of system will be monitored and updated as needed. | F 323 | | |

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| (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 |
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| F 323 | Continued From page 21<br>As part of the validation process on 1/25/2013, the entire plan of correction was reviewed including re-education of staff and observations of the use of a lift transfer on residents (Resident # 70 and Resident # 57) at the facility. Interviews of the nurse aides and nurses revealed they were aware of proper usage of the mechanical lift for the transfer of the residents at the facility. Interviews with nurse aides also revealed they were aware of the residents who require the mechanical lifts by looking at the care guides and identifying the type of the mechanical lift required. A review of the monitoring tools revealed that the facility had completed the 100 % in-service of the use of mechanical lift and return demonstration on 11/2/2012. | F 323 | | |
| F 431 SS=D | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature | F 431 | Nurse # 2 was immediately re-educated on 1/25/13 by the Director of Nursing in regards to the proper storage of medications on the medication cart and the locking of the care when not in attendance of the nurse<br><br>Audits were immediately completed 1-25-13 in the building regarding medication carts by the QI Nurses with no further issues identified. | |

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|---|---|---|---|
| | 345376 | A. BUILDING _____ B. WING _____ | C 02/08/2013 |

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| F 431 | Continued From page 22<br>controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, policy review, and staff interviews, the facility failed to securely store insulin in 1 of 5 medication carts during medication pass. Findings included:<br><br>The facility's policy titled Medication Storage, undated, read in part: "all medications and prescription biologicals shall be stored in locked carts or medication rooms."<br><br>Observation on 1/24/13 at 9:24AM on the 500 hall revealed Nurse #2 entered Resident #49's room to administer medications. Observation revealed multiple vials of insulin were stored in a plastic tray on top of the medication cart. The insulin vials were not in view of Nurse #2 while she was in resident #49's room.<br><br>Observation on 1/24/13 at 9:27AM revealed Nurse #2 prepared five medications at the medication cart for Resident #117. The nurse | F 431 | 100% Inservice of Licensed Nursing Staff on 2/7/13 by the Staff Facilitator was conducted on medication storage to include locking themedication cart when nurses not in attendance .<br><br>Monitoring for proper storage of medications to include locking of the med cart when nurse not in attendance utilizing a QI tool will be completed 3 x week for 4 weeks, 2 x week for 4 weeks, weekly x 4 weeks, then monthly thereafter by the QI Nurse. Follow up will be taken immediately upon the identification of any medication storage issue with the involved staff by the QI Nurse.<br><br>The results of the medication storage audits will be forwarded to the Executive QI Committee by the QI Nurse monthly for review for follow up action as deemed appropriate, evaluation of the effectiveness of the plan, and to determine the frequency of and/or need for continued monitoring. | |

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| F 431 | Continued From page 23<br>entered the resident's room and administered the medications. The insulin vials remained unattended on top of the medication cart during the medication administration.<br><br>Observation on 1/24/13 at 9:30AM revealed Nurse #2 prepared ten medications for Resident #69. On 1/24/13 at 9:36AM, Nurse #2 locked the prepared medications in the medication cart and stated she had to go to the medication room on another hall. The insulin vials remained unattended on top of the medication cart. Nurse #2 returned to the medication cart on 1/24/13 at 9:41AM and prepared Lantus (insulin) 80 units for injection. The nurse entered the resident's room and administered the medications and insulin. The insulin vials remained on top of the medication cart unattended during the medication administration.<br><br>Observation on 1/24/13 at 9:50AM revealed Nurse #2 prepared three medications for Resident #29. The nurse entered the resident's room and administered the medications. The insulin vials remained unattended on top of the medication cart during the medication administration.<br><br>Observation on 1/24/13 at 10:05AM revealed four vials of Lantus insulin, three vials of Novolin R (regular) insulin, three vials of Novolog insulin, two vials of Levemir insulin, and one vial of Novolog insulin were in the plastic tray on top of the medication cart.<br><br>In an interview on 1/24/13 at 10:12AM, Nurse #2 stated she kept the insulin on the medication cart during medication pass and returned it to the | F 431 | | |

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| F 431 | Continued From page 24<br>medication room when the pass was completed. The facility policy was to keep all medications locked in the medication cart. Nurse #2 acknowledged she left the insulin vials on top of the cart unattended. She stated "I should have locked them in the cart."<br><br>In an interview on 1/25/13 at 1:01PM, the Director of Nursing (DON) stated the staff was trained on facility protocol by the staff facilitator upon employment. The staff facilitator and pharmacist conducted medication pass observations of the staff. The DON stated the facility policy was to keep all medications locked in the cart unless they were in view of the nurse passing medications. She stated "that's fundamental nursing." Her expectation was for the staff to store medications properly by locking them up any time they left the medication cart unattended. | F 431 | | |

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

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| | 345376 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 02/19/2013 |

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| K 000 | INITIAL COMMENTS<br><br>This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This facility is Type III protected construction utilizing North Carolina Special locking arrangements, and is equipped with an automatic sprinkler system.<br><br>CFR#: 42 CFR 483.70 (a) | K 000 | Cumberland Nursing and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.<br><br>Cumberland Nursing and Rehabilitation's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Cumberland Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. | 3/5/13 |
| K 012 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1<br><br>This STANDARD is not met as evidenced by:<br>Based on the observations and staff interviews on 2/19/2013 the following Life Safety item was observed as noncompliant, specific findings include:<br><br>1. There were unsealed penetrations in the rated ceiling in the mechanical room on the 300 hallway/ Special Care hallway.<br><br>2. There were unsealed penetrations in the rated ceiling in the mechanical room in the mail mechanical room around piping in the back corner. | K 012 | The unsealed penetrations in the rated ceiling in the mechanical room on the 300 hallway/Special Care hallway were sealed.<br><br>The unsealed penetrations in the rated ceiling in the mechanical room in the main mechanical room around piping in the back corner were sealed.<br><br>All mechanical rooms were inspected for unsealed penetrations. Any unsealed penetrations were sealed at that time. | |
| K 018 SS=D | CFR#: 42 CFR 483.70 (a)<br>NFPA 101 LIFE SAFETY CODE STANDARD | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 3/5/13

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

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| K 018 | Continued From page 1<br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3<br><br>Roller latches are prohibited by CMS regulations in all health care facilities.<br><br>This STANDARD is not met as evidenced by:<br>Based on the observations and staff interviews on 2/19/2013 the following Life Safety item was observed as noncompliant, specific findings include: The central supply room did not have rated door hardware installed on the rated door.<br><br>CFR#: 42 CFR 483.70 (a) | K 012 | Mechanical rooms will be inspected for unsealed penetrations weekly X 4 weeks and after any work has been done in the mechanical rooms utilizing a QI audit tool.<br><br>The audits will be forwarded to the Executive QI Committee quarterly for review to determine the need for frequency or continued monitoring.<br><br>K 018 Rated door hardware was installed on the rated door in the central supply room.<br><br>All rated doors were inspected to ensure they have rated door hardware. Any discrepancies were corrected at that time.<br><br>Rated doors will be inspected randomly for rated door hardware weekly X 4 weeks utilizing a QI audit tool.<br><br>The audits will be forwarded to the Executive QI Committee quarterly for review to determine the need for frequency or continued monitoring. | |
| K 029<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system | | | |

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| K 029 | Continued From page 2<br>option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1<br><br>This STANDARD is not met as evidenced by:<br>Based on the observations and staff interviews on 2/19/2013 the following Life Safety item was observed as noncompliant, specific findings include: The soiled linen room on the 200 hallway had a hole in the rated wall just behind the door which left an unsealed penetration in that rated wall.<br><br>CFR#: 42 CFR 483.70 (a) | K 029 | The hole in the rated wall behind the door in the soiled linen room on the 200 hallway was sealed.<br><br>All soiled linen rooms were inspected for unsealed penetrations. Any unsealed penetrations were sealed at that time.<br><br>Soiled linen rooms will be inspected for unsealed penetrations weekly X 4 weeks utilizing a QI audit tool.<br><br>The audits will be forwarded to the Executive QI Committee quarterly for review to determine the need for frequency or continued monitoring. | |
| K 062 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5<br><br>This STANDARD is not met as evidenced by:<br>Based on the observations and staff interviews on 2/19/2013 the following Life Safety item was observed as noncompliant, specific findings include: The sprinkler head in the 200 shower room was blocked by the light fixture.<br><br>CFR#: 42 CFR 483.70 (a) | | | |

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| | | K 062 | The light fixture in the 200 shower room was moved away from the sprinkler head.<br><br>All shower rooms were inspected to ensure the light fixture was not blocking the sprinkler head.<br><br>Shower rooms will be inspected to make sure the light fixture is not blocking the sprinkler head weekly X 4 weeks utilizing a QI audit tool.<br><br>The audits will be forwarded to the Executive QI Committee quarterly for review to determine the need for frequency or continued monitoring. | |