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CAROLINA REHAB CENTER OF CUMBERLAND	4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306

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E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was conducted on April 21-24, 2020. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. The census was 119.	E 000		
F 000	INITIAL COMMENTS A complaint investigation survey was conducted from April 21, 2020 through April 24, 2020. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity J The tags F689 constituted Substandard Quality of Care. An extended survey was conducted remotely on 04/24/20. One of one complaint allegations was substantiated resulting in a deficiency. A COVID-19 Focused Survey was conducted from April 21- 24, 2020. Event ID# R0UP11	F 000		
F 689 SS=J	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.	F 689		5/5/20

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

Electronically Signed | 05/07/2020

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F 689	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, Emergency Room Physician, Physician interview, and staff interviews, the facility failed to provide 2 person assistance when using a mechanical lift for 1 of 3 sampled residents reviewed for accidents (Resident #1). As a result of not using 2 persons when using the mechanical lift, the resident fell from the lift and hit her head on the floor. The resident sustained lacerations on the back of her head and was sent to the emergency room for treatment. The resident had seizures while emergency medical services attended to her, was diagnosed with a subarachnoid hemorrhage (bleeding in space between brain and surrounding membrane) and died in the emergency room. The findings included: Resident #1 was admitted on 4/30/2019 with diagnoses of hypertension, hyperlipidemia, old myocardial infarction and osteoarthritis. The annual Minimum Data Set (MDS), dated 2/13/2020, indicated Resident 1#'s cognition was intact, and she required extensive assistance with help of 2 persons for bed mobility, transfer, dressing, personal hygiene and toileting. The MDS also indicated Resident #1 had upper extremity impairment on one side. The MDS and the Care Area Assessment (CAA) did not indicate Resident #1 exhibited any behaviors of resisting care. Resident #1's care plan, updated on 2/20/2020 indicated Resident #1 had problems which included, activity of daily living (ADL) self- care	F 689	Past noncompliance: no plan of correction required.	

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performance deficit due to impaired mobility, resistive to care as the resident will refuse care/showers/medication due to adjustment to environment and verbally aggressive to staff due to ineffective coping skills, mental /emotional illness and poor impulse. The interventions included. "Resident # 1 required maximum staff assistance with transfers (a mechanical lift with 2-person transfer), and if resident resisted assistance with ADLs, then reassure resident, document observed behavior and attempted interventions."

The incident report dated 4/6/2020 completed by Nurse #1 documented Resident #1 fell out of a mechanical lift while being transferred from a shower bed to bed. Resident #1 was being transferred by NA #1 using a mechanical lift without a second person to assist with the transfer. The report indicated Resident #1 fell out of a mechanical lift and hit the back of her head. The assessment of the resident revealed she sustained 2 lacerations on the back of her head in the shape of a horse shoe and the resident was bleeding from back of head. The report further indicated Nurse #1 and Nurse #2 placed gauze on resident's head and wrapped around head to stop the bleeding. Resident #1 was alert to person. Pupils equal round and reactive to light with accommodation. The report also indicated Resident #1 was able to follow simple commands. Did not remember what happened. Repeatedly asked what happened to her and was awake the whole time. The report further revealed 3 other personnel helped lift resident from floor to bed. The resident's vital signs were then taken. Blood Pressure (BP) 94/64, Heart Rate (HR) 93, temperature 97.3, Respiration (R) 20, Oxygen (O2) saturation 96%. 911 was called for resident

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to be transported to the hospital. The recommendation was documented as following: In-service done with all staff on transferring residents with mechanical lift and to always have 2 people when transferring residents."

During the interview on 4/21/2020 at 10:30 AM, NA #1 reported she had been assigned to Resident #1 before 4/6/2020 and normally the resident would be verbally abusive when she is given ADL care. NA #1 reported on 4/6/2020 after she had given Resident #1 a shower, on the way back to the room she started yelling at her about her shower. She reported there was no staff members in the hallway to assist her with the mechanical lift transfer. She added since no one was available she did not ask for help so she proceeded to transfer Resident #1 from the shower bed to her bed. While transferring the resident, she started yelling saying the lift pad which was the right size for the resident was too tight and she started to shift on one side and the lift pad twisted under her. NA #1 lowered the lift trying to prevent the fall, but the Resident fell anyway. She added Nurse #1 was immediately notified about the fall. NA #1 further reported she did not try to get help because they were short of staff on that day because she looked in the hallway and no staff could be seen to ask for assistance. NA #1 reported she was aware that she needed a second person for transfer. She further reported she was trained on the proper use of a mechanical lift when she was first hired at the facility.

During the interview on 4/21/2020 at 10:48 AM, NA #2 reported she assisted NA #1 to transfer Resident #1 from her bed to the shower bed before getting her shower. NA #2 reported she

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did not recall NA #1 requesting assistance to transfer Resident #1 back to bed from the shower bed after getting her shower. NA #1 reported Resident #1's pad was correct size and they had no problems transferred the resident from her bed to the shower bed. NA#2 also reported they had enough staff at the facility on 4/6/2020.

During the interview on 4/21/2020 at 12:15 PM, Nurse #2 reported NA #1 reported to her on 4/6/2020 that Resident #1 fell on the floor during a transfer. She asked NA #1 why she did not ask her to assist her, but NA #1 did not have a reason. Nurse #2 reported after assessing the resident, she took precautions to keep head and neck in-line to maintain C (cervical spine)-spine (vertebral column). Once she realized Resident #1 was bleeding from her head, three additional personnel assisted with lifting resident from floor to bed. Nurse #2 added the Resident was awake the whole time. She reported Resident #1 was alert to herself and could not tell her what happened moments before, and Resident #1 repeatedly asked Nurse #2 what happened to her. Once resident was in the bed, she was able to get the vitals. Nurse #2 also reported prior to Resident #1's fall, she was alert and oriented to herself and her surroundings. She added after the fall, the resident was very confused and asked repeated questions. Nurse #1 reported on 4/6/2020, the facility had enough staffing. She added she did not understand the reason NA #1 did not ask her for assistance to transfer Resident #1. She also reported the resident's lift pad size was correct size during the transfer by NA #1.

During the interview on 4/21/2020 at 11:40 AM, Nurse #1 reported unit Nurse #2 came at about 10:00 AM and asked her to come help her in

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Resident #1's room. When she walked into the room, the resident was lying on the floor and her head was resting on the base leg of a mechanical lift. She reported it appeared to her that the resident may have hit the back of her head on the corner of the lift. She indicated she immediately moved what to keep the resident's head still as possible and put her gloved hand over the bleeding to apply pressure. Nurse #1 reported the resident had the correct size lift pad underneath her. She added, she stayed with the resident the whole time with Nurse #1 until Emergency Medical Services (EMS) arrived to take her out .They relayed any information they could to EMS and told them she was not at her baseline in personality at that time. Nurse #1 reported Resident #1 was upset and could not remember anything they were telling her. Nurse #1 further reported they had no problems with staffing on 4/6/2020.

Emergency Medical Services (EMS) report dated 4/6/2020 documented the EMS personnel arrived at the facility and located the resident lying flat in her bed with a bandage wrap noted to her head. The document indicated Nurse #1 advised the EMS personnel that Resident #1 had fallen out of the mechanical lift into the floor. Nurse #1 advised the EMS personnel that the resident hit her head on the metal leg of mechanical lift. The document further indicated upon the EMS personnel leaving Resident #1's room, they stopped at the nurse's desk to grab the paperwork. The resident was then noted to have seizure that lasted around 30 seconds the personnel administered the medication and the resident stopped seizing. The document also indicated that after the seizure the resident was noted to be confused and asked over and over

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where she was and what was happening. The resident was not noted to have any other seizures while in route to the hospital.

During the interview on 4/21/2020 at 12:30 PM, the Director of Nursing (DON) stated it was reported to her by Nurse #1 that Resident #1 fell on the floor during when NA #1 used a mechanical lift to transfer Resident #1 without the assistance of another staff member. She reported after Resident #1 was sent out to the hospital she did an investigation about the fall incident and NA #1 was terminated due to failure to follow the guidelines, on the use of a mechanical lift with the assistance of another staff member. DON stated her investigation revealed no mechanical problems with the lift and NA #1 used the correct lift pad. DON indicated the facility had enough staff on duty on 4/6/2020 and she concluded NA #1 was negligent because she should have requested for assistance before transferring Resident #1 from shower bed to her bed.

During the interview on 4/21/2020 at 12:45 PM, Administrator reported she investigated Resident #1's fall after the resident was sent out to the Emergency room. She reported NA #1 was aware Resident #1 required 2 person assistance but chose to use the lift by herself. She reported NA #1 was terminated and an action plan was put in place following the incident. The staff had been educated that a mechanical transfer was to occur with at least two clinical staff members. She further added the staff were educated to use a call light and wait for assistance if they could not find another staff member in the hallway. Did the admin know about staffing and lift pad size?

During the interview on 4/22/2020 at 1:13PM,

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Physician reported he was notified immediately of Resident #1's fall on 4/6/20. He reported the resident died at the hospital, but he could not state that the fall caused the resident's death. He added the resident had a lot of comorbidities that included old myocardial infarction and hypertension. Physician stated all residents that fall do not die from a fall.

Emergency room documentation dated 4/8/2020 indicated: "The emergency room department neurosurgeon was consulted. Secondary to a noted head bleed on Computed tomography (CT) scan on Resident #1. A small intraparenchymal (blood pools in the brain) versus subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain) was noted on CT scan in the right frontal region. The patient had 7 seizures. She was apneic (a temporary cessation of breathing) during these periods with significant decreased mental status and no active motion. Patient was coded for 4 minutes and Return of Spontaneous Circulation (ROSC). Life saving measures were attempted with no successful ROSC." Patient died on 4/8/20 at 8:28 AM."

During the interview on 4/22/2020 at 3:00 PM, The Emergency room Physician reported Resident #1's fall contributed to her death due to her diagnoses of intracranial hemorrhage. He reported all the life saving measures were attempted with no success after the resident was admitted to the Emergency room.

Death certificate dated 4/21/2020 indicated Resident #1's cause of death was Subarachnoid Hemorrhage.

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F 689	Continued From page 8 Corrective action for past noncompliance dated 4/7/2020. How the corrective action will be accomplished for the resident(s) affected. On 4/6/2020 Resident #1 fell from a mechanical lift operated by Nurse Assistant #1. Resident #1 sustained 2 lacerations on the back of her head in the shape of a horse shoe. Resident #1 was bleeding from back of head. Nurse #1and Nurse #2 placed gauze on resident's head and wrapped around head to stop the bleeding after initial assessment was transferred from floor to bed. Resident #1 was alert to person. Pupils equal round and reactive to light with accommodation. Resident #1 was able to follow simple commands. Did not remember what happened. Repeatedly asked what happened to her. Resident awake the whole time. Resident vital signs were then taken BP 94/64, HR 93, temp 97.3, R 20, O2 saturation 96% RA. Responsible party was notified and Physician was notified. 911 was called for resident to be transported to the hospital and later expired. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. The center reviewed staffing levels on 4/6/2020 for the day of the incident. The staffing levels were more than adequate to have had two people operate the lift. On 4/6/2020 the lift that was used during the transfer was inspected for safety and functionality. The maintenance director found the	F 689		

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lift to be functional.

A review of all falls with injury within the last year was conducted on 4/6/2020 related to transfer and found no falls occurred due to inappropriate transfer. The center immediately initiated lift transfer training on 4/6/2020.

Measures in place to ensure practices will not occur.

All nursing assistants were in-serviced on proper use of a mechanical lift, referencing manufacturer's guidelines which included:
" Proper pad position on resident for safety, prior to beginning of transfer.
" Proper pad position on resident to maximize comfort in the pad, prior to beginning of transfer.
" Assessing patient behavior prior to transfer and not initiating the transfer should the patient exhibit behaviors.
" Using two people to operate a mechanical lift.
" to obtain assistance of second person before initiating the mechanical transfer ways to obtain assistance of a second nursing assistant prior to transfer if not already present, such as verbal request and using the call bell for assistance.
" Do not adjust lift pad mid transfer.

This was completed on 4/6/2020. Any staff member who did not receive the education on 4/6/2020 did not work until completed.
A sample of 5 certified nursing assistants were used for return demonstration post education on 4/7/2020 and successfully completed the transfer.
All new nursing assistants will continue to have training on:
" Proper pad position on resident for safety, prior to beginning of transfer.

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" Proper pad position on resident to maximize comfort in the pad, prior to beginning of transfer.
" Assessing patient behavior prior to transfer and not initiating the transfer should the patient exhibit behaviors.
" Using two people to operate a mechanical lift.
" to obtain assistance of second person before initiating the mechanical transfer ways to obtain assistance of a second nursing assistant prior to transfer if not already present, such as verbal request and using the call bell for assistance.
" Do not adjust lift pad mid transfer.
All certified nursing assistants will continue to complete return demonstration during orientation.

How the facility plans to monitor and ensure correction is achieved and sustained.

Audit 5 mechanical lift transfers or proper return demonstration weekly x 4, bi weekly x 2 and monthly x 1. These audits will be reviewed in our quarterly quality assurance x 2 for further review.
Date of Compliance: 4/7/2020.

As part of the validation process on 4/24/2020, the entire plan of correction was reviewed including re-education of staff and observations of the use of a lift transfer on another resident (Resident # 5) 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 by asking a second person to assist. 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 4/6/2020.

The facility's completion date of 4/7/2020 was

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F 689	Continued From page 11 validated.	F 689		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		5/8/20

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F 880	Continued From page 12 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review and observations, the facility failed to ensure all accessible entrances had a screening station to assess anyone who entered the facility for signs or symptoms of the COVID-19 virus. This failure occurred during a COVID-19 Pandemic and had the potential to affect all residents.	F 880	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will	

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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
F 880	Continued From page 13 The findings included: Review of the facility's policy entitled Infection Prevention & Control Policies & Procedures dated on 03/24/20 was not updated to include the following information. Center for Medicare and Medicaid (CMS) dated on 04/02/20. entitled "COVID-19 Long Term Care Facility Guidance" revealed "3. Long-term care facilities should immediately implement symptom screening for all. b. Facilities should limit access points and ensure that all accessible entrances have a screening station." Observations on 04/21/20 at 9:05 AM, revealed a screening station was in the front lobby at the Service Ambassador's desk. Observations revealed hand sanitizer was near the desk, but no masks were available at the desk. On 04/21/20 at 9:10 AM, the Service Ambassador was interviewed. She stated that she enters the front door for work at 8:00 AM and she takes her temperature and completes the screening questions to assess herself for signs and symptoms of the COVID-19 virus. She stated that it is her responsibility to screen people as they enter the building. The Service Ambassador further stated she works from 8:00 AM to 4:30 PM and another person relieves her from 4:30 PM to 8:00 PM at the front lobby. On 04/21/20 at 10:22 AM, during an interview with Nursing Assistant #3 (NA) she indicated that she enters the building at the back door off the service hall which leads to the 300 and 400 halls. She further stated that when she arrives for work she clocks in, puts on her mask, washes her hands, gets report from the NA that is getting off,	F 880	take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F880 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility designated one entrance for all staff on 4/28/2020 all other entrances were locked down. 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 facility designated one entrance for all staff on 4/28/2020 all other entrances were locked down. The facility designated staff members to man the entrance during all shift changes for various departments. The designated staff members were educated on ensuring of donning mask, taking temperature and signing log prior to entering patient care areas. This was completed on 5/8/2020. An audit verifying the log sign in compared to the schedule will be completed on 5 staff members daily Monday- Friday x 4 weeks, weekly x 4 weeks.	

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 04/24/2020

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F 880	Continued From page 14 checks on her residents and then goes to the screening station in the lobby area to have her temperature checked by the Service Ambassador and answers the COVID-19 screening questions. Record review revealed that NA #3 was trained on 04/21/20, immediately after the interview with the State Agency Surveyor, about being screened for COVID-19 when she entered the facility. Observations on 04/21/20 at 10:45 AM of the facility's back entrance door off the service hall leading to 300 and 400 halls revealed there was not a screening station at this entrance. On 04/22/20 at 4:10 AM, during a telephone interview with the NA #4 he indicated that he entered the facility at the back-door entrance. NA #4 explained after he enters the facility he puts on a mask, washes his hands and goes to the front lobby screening station to take his temperature and complete the COVID-19 screening questions. On 04/22/20 at 4:40 AM, during a telephone interview with the 3rd shift Nurse Supervisor (Nurse #3) she indicated that she entered the facility using the front door. After she entered the facility, she goes to the screening station in the front lobby to sanitize her hands, take her temperature and answer the COVID-19 screening questions. She stated that the Service Ambassador does not work on the 3rd shift, so each person was responsible for taking their own temperature and completing the screening questions. She further stated that she goes around the building with the sign in sheets to ensure all staff are screened for the COVID virus. On 04/22/20 at 2:02 PM, during a telephone	F 880	How the facility plans to monitor its performance to make sure that solutions are sustained. The results of the audits will be reported to the QAPI committee quarterly x 1 for analysis of patterns, trends, or need for further systemic changes. Any staff found to be non-compliant with the procedure will receive progressive discipline. Date of compliance for all plan of corrections is May 8th, 2020	

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F 880	Continued From page 15	F 880		

interview with the Maintenance Director he indicated that he entered the facility at the back door. He explained he previously had to walk to the front lobby to be screened by the Service Ambassador, but when he came in this morning there was a screening station at the back-door entrance that was not staffed. He stated he got someone to witness his temperature and he completed the COVID -19 screening questions.

On 04/22/20 at 2:20 PM, during a telephone interview with the Housekeeping Supervisor she indicated that she entered the facility at the back door. She explained she previously had to walk to the front lobby to be screened by the Service Ambassador. But, this morning there was a screening station at the back entrance that was not staffed. She stated this morning she took her own temperature and recorded it on the screening form and answered the COVID-19 screening questions.

On 04/22/20 at 3:30 PM, during a telephone interview with the Activity Director she indicated that she entered the facility at the back door. She explained that after she entered the facility she went to the breakroom and washed her hands. She further stated that she then walked through the 300-hall resident area to be screened in the front lobby area. She stated that the Service Ambassador would take her temperature and she completed the COVID-19 screening questions.

On 04/22/20 at 3:40 PM, a telephone interview with the Administrator she indicated starting on 4/22/20 the facility placed a COVID-19 screening station at the facility's back entrance which included a thermometer and screening forms. She further stated this screening station would

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F 880	Continued From page 16 not be staffed, so staff who used the back entrance to enter the facility would do a self-screening.	F 880		