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 06/11/2021

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

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E 000	Initial Comments An unannounced recertification survey was conducted on 06/06/2021 through 06/11/2021. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #R41511.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 06/06/2021 through 06/11/2021. Event ID #R41511. 11 of the 38 complaint allegations were substantiated but did not result in a deficiency. 8 of the 38 complaint allegations were substantiated resulting in deficiencies. 19 of the 38 complaint allegations were not substantiated. Immediate Jeopardy was identified at: CFR 483.25 at tag F 689 at a scope and severity (J) Immediate Jeopardy began on 10/01/2020 and was removed on 06/09/2021. An extended survey was conducted. Substandard Quality of Care was identified at: CFR 483.25 at tag F689 at a scope and severity (J) Tag F 000 was amended on 6/28/21. The immediate jeopardy removal date was changed from 6/8/2021 to 6/9/2021. Tag F689 was amended on 6/28/21. The immediate jeopardy removal date was changed from 6/8/2021 to 6/9/2021 and a typo corrected a	F 000		

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

Electronically Signed | 06/25/2021

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F 000	Continued From page 1 date of 10/1/2021 to 10/1/2020.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to honor a resident's choice and provide showers as scheduled for 1 of 27 residents (Resident #67) reviewed for	F 561	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported	7/6/21

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F 561	Continued From page 2 showers. Findings included: Resident #67 was admitted to the facility on 06/29/12 with diagnoses which included, in part, paraplegia, muscle weakness and unspecified injury of muscles and tendons of the rotator cuff of right shoulder. Record review of Resident #67's quarterly Minimum Data Set (MDS), dated 04/27/21, revealed Resident #67 to be cognitively intact with the ability to understand and make herself understood. The MDS indicated the resident had impairment on both of her lower extremities and required total dependence with one staff assist for bathing. Record review of Resident #67's Care Plan, last revised 05/25/21, revealed the following: "The resident has an Activities of Daily Living (ADL) self-care performance deficit related to paraplegia. Interventions included, in part, "the resident requires dependent assistance times 1 assist for bathing and showering." "The resident ...will refuse skin assessments and showers at times ...and requests the nursing assistants to dry and curl her hair. Interventions included, in part, "allow the resident to make decisions about treatment regiment to provide a sense of control and to provide resident with opportunities for choice during care provisions." A review of Resident #67's May 2021 ADL Documentation Survey Report revealed she was scheduled for showers on second shift every Monday, Wednesday and Friday.	F 561	conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. How corrective action will be accomplished for those residents found to have been affected: Residents #67 received a shower on 6/11/2021. F679 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 this practice. " All residents will be offered a shower by 6/30/2021 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur " The director of nursing or designee will educate all nursing staff on resident□s rights related to resident choice to be provided showers by 7/6/2021. " Any nursing staff who has not completed the education by 7/6/2021 will be removed from the schedule.	

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F 561	Continued From page 3 During an interview with Resident #67 on 06/09/21 at 9:20 a.m., Resident #67 stated she had not had a shower, nor had her hair washed, in over a month despite being scheduled to have a shower every Monday, Wednesday, and Friday. Resident #67 explained she preferred having showers over bed baths and would only refuse a shower when the nursing assistant (NA) refused to wash her hair during the shower. She further explained she had very long hair and must have her hair blown dry after having it washed or else her wet hair would make her bed linens wet and uncomfortable. Resident #67 indicated this had been an on-going issue during her residence at the facility. During a telephone interview with Resident #67 on 06/11/21 at 1:01 p.m., Resident #67 explained she felt like she was not getting the same treatment as other residents at the facility in regard to getting showers because her hair is long and staff did not want to take the time to wash it during her showers. Resident #67 explained when she did not get her hair washed it caused her scalp to become very itchy and she would scratch sores into it which caused her to have anxiety. During a telephone interview NA #7 on 06/11/21 at 11:46 a.m., NA #7 stated had been assigned to care for Resident #67 on 05/12/21, 05/14/21, 05/17/21 and 05/21/21. NA #7 stated she did not provide a shower to Resident #67 on these dates and explained that once, when she had gone into the resident's room, the resident had complained staff had not given her a shower as scheduled. NA #7 stated she went to the nurse who informed her the resident's showers were scheduled on day shift. When NA #7 was asked how she knew	F 561	" All new hire nursing staff will receive this education during the orientation process " Unit Coordinator/Manager or designee will audit showers daily 5 x weekly x 4 weeks, 3x weekly x 4 weeks and weekly x 4 weeks. F584 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Findings from audits will be reviewed at the Quarterly Quality Assurance meeting x1 for any further problem resolution if needed. Completion date 7/6/2021	

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F 561	Continued From page 4	F 561		

which resident had a shower scheduled on a particular day or shift, NA #7 explained there was a shower schedule in a notebook at the nurses' station. When NA #7 was asked if she had checked the shower schedule on the days she had been assigned to care for Resident #67, she stated she could not remember if she had.

An email correspondence with the Administrator on 06/11/21 at 12:51 revealed Resident #67's shower schedule had been back and forth between days and nights due to the accommodations of length and time it took to complete Resident #67's showers.

During a telephone interview with Nurse #3 on 06/11/21 at 1:53 p.m., Nurse #3 indicated he had been the unit manager of Resident #67's unit in the recent past. Nurse #3 explained Resident #67s shower schedule had often been flipped from day shift to evening shift in attempts to fit in her long showers to accommodate her and the nursing assistants.

During a telephone interview NA #8 on 06/11/21 at 2:49 p.m., NA #8 stated she had been assigned to care for Resident #67 on 05/24/21, 05/28/21 and 06/07/21. NA #8 explained she always checked the shower schedule at the beginning of her 7 p.m. to 7 a.m. shift to determine which residents are to have showers. She stated she often did not document whether she provided a resident a shower or a bed bath and stated she had never provided Resident #67 with a shower. NA #8 indicated many residents refused to take a shower during the shift she works because it is late, and the facility is usually colder in the evenings. NA #8 acknowledged she provided a complete bed bath to residents if she

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F 561	Continued From page 5 did not give them their scheduled showers however failed to acknowledge if Resident #67 had ever refused a shower on her scheduled shower days. The administrator provided the following statement in an email correspondence on 06/11/21 at 1:37 p.m., "my expectation would be that residents receive their showers according to their preference. A communication breakdown led to the reason why these showers were not completed ..."	F 561		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) 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; This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interviews the facility failed to shave 2 of 2 dependent male residents (Resident #7 and Resident #82) with facial stubble who were reviewed for Activities of Daily Living (ADL) care. Findings included: 1. Resident #7 was readmitted to the facility on 01/01/15 and had diagnoses of spastic hemiplegia and vascular dementia. The quarterly Minimum Data Set (MDS) dated 02/26/21 revealed that Resident #7 was cognitively intact and did not refuse care. Resident #7 required the supervision of one person for personal hygiene.	F 677	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #7 and #82 were shaved on 6/8/2021 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. " 100% audit of all residents was completed to ensure they were shaved on 6/30/2021 as needed. The measures put into place or systemic changes made to ensure that the deficient	7/6/21

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F 677	Continued From page 6 The Care Plan revised on 02/26/21 revealed that Resident #7 had an ADL self-care deficit related to left hemiplegia and a Cerebral Vascular Accident (CVA). Interventions revealed that Resident #7 was totally dependent on one staff member for bathing and showering. The undated shower schedule revealed that Resident #7 was scheduled for showers on Monday and Wednesday on the afternoon shift. In an observation and interview on 06/06/21 at 11:05 AM Resident #7 was unshaven and said that he would like to be shaved but that he could not shave himself. He indicated that he had asked a staff member to shave him but could not remember who it was. In an observation on 06/06/21 at 4:51 PM Resident #7 was still unshaven. In an observation and interview on 06/07/21 at 8:18 AM Resident #7 was still unshaven. He stated that he would like to be shaved but was unable to shave himself. In an observation on 06/07/21 at 10:12 AM Resident #7 was still unshaven. In an interview on 06/08/21 at 8:51 AM Nursing Assistant (NA) #5 stated that residents were shaved either during morning care or on shower days. She indicated she had not been assigned to Resident #7 the previous day when he would have received a shower, but she planned to shave him this morning after the breakfast trays were collected. In an observation on 06/08/21 at 10:18 AM	F 677	practice will not recur. " The Director of Nursing or designee will educate all nursing staff on ensuring shaving is completed at least 3x weekly with showers or baths and as needed per patient preference by 7/6/2021. " Any nursing staff member who has not received this education by 7/6/2021 will be removed from the schedule until completed. " Any new hire nursing staff will be educated on ensuring shaving is completed 3x weekly with showers or baths and as needed during orientation. " The Director of nursing or designee will audit 10 residents 5x a week x 4 weeks, then 3x weekly x 4 weeks and weekly x 4 weeks to ensure shaving has been offered during ADL care. 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. Date of compliance for all plan of corrections is July 6th 2021.	

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F 677	Continued From page 7	F 677		

Resident #7 had been shaved.

In an interview on 06/09/21 at 8:47 AM NA #6 stated that residents were shaved on shower days or if they looked "scruffy."

In an interview on 06/09/21 at 3:17 PM NA #7 confirmed she worked with Resident #7 in the afternoon on 06/07/21. She indicated she provided the resident with a bed bath and did not shave Resident #7 because he did not ask to be shaved. She stated that she did not offer to shave him or ask him if he wanted to be shaved.

In a telephone interview on 06/11/21 at 2:06 PM the Director of Nursing (DON) #1 stated that residents should be shaved when they needed it. She indicated that different generations expected different things with shaving and the elderly population expected to be shaved every day. The DON indicated she had spoken to Resident #7 and he was happy that he had been shaved.

2. Resident #82 was readmitted to the facility on 05/10/19 and had diagnoses of diabetes, chronic pain, and peripheral venous insufficiency.

The quarterly MDS dated 05/04/21 revealed that Resident #82 was cognitively intact and did not reject care. Resident #82 required the extensive assistance of two persons for personal hygiene.

The Care Plan revised 05/04/21 revealed that Resident #82 had an ADL self-care performance deficit related to muscle weakness. Interventions revealed that Resident #82 was totally dependent on one staff member for personal hygiene.

The undated shower schedule revealed that

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F 677	Continued From page 8	F 677		

Resident #82 was scheduled for showers on Monday and Wednesday on the afternoon shift.

In an observation and interview on 06/06/21 at 10:43 AM Resident #82 was unshaven and said that he would like to be shaved.

Resident #82 stated he was unable to shave himself and that he had requested to be shaved. He indicated he could not recall who he had asked to shave him.

In an observation on 06/06/21 at 4:51 PM Resident #82 was unshaven.

In an observation and interview on 06/07/21 at 8:18 AM Resident #82 was unshaven and stated that he would like to be shaved.

In an observation on 06/07/21 at 10:12 AM Resident #82 was still unshaven.

In an observation on 06/08/21 at 8:49 AM Resident #82 was sitting up in bed and had been shaved.

In an interview on 06/08/21 NA #5 stated that residents were shaved either during morning care or on shower days. She indicated she had not been assigned to Resident #82 the previous day when he would have received a shower, but that she had shaved him this morning.

In an interview on 06/09/21 at 8:47 AM NA #6 stated that residents were shaved on shower days or if they looked "scruffy."

In an interview on 06/09/21 at 3:17 PM NA #7 confirmed she worked with Resident #82 in the

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F 677	Continued From page 9 afternoon on 06/07/21. She indicated she did not shave Resident #82 because he did not ask to be shaved. She stated that she did not offer to shave him or ask him if he wanted to be shaved. In a telephone interview on 06/11/21 at 2:06 PM the DON #1 stated that residents should be shaved when they needed it. She indicated that different generations expected different things with shaving and the elderly population expected to be shaved every day.	F 677		
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. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to supervise and monitor a resident who was not compliant with the smoking policy and was found smoking in room with oxygen via nasal cannula on three occasions for one of five sampled residents (Resident #87) reviewed for smoking compliance. There was also no system or interventions in place to prevent recurrent noncompliance with the smoking policy by residents. The immediate jeopardy (IJ) began on 10/1/20 when Resident # 87 was found to be smoking in his room with oxygen present and no effective	F 689	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #87□s smoking materials were removed from his person and belongings. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have who smoke are at risk to be affected by the alleged deficient practice. The measures put into place or systemic	7/6/21

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F 689	Continued From page 10 interventions were implemented to prevent reoccurrence. Immediate Jeopardy was removed 6/9/21 when the facility submitted an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance with a scope and severity D (isolated, not actual harm with potential for more than minimal harm) to complete educations and ensure monitoring systems put into place are effective related to supervision to prevent accidents. The findings included: The facility's smoking policy dated 01/23/2020 read in part: use of tobacco products and other electronic smoking paraphernalia was not permitted within the health and rehabilitation center by patients, staff, or visitors. If the administrator chose to designate on ground area approved for tobacco use by patients, family's visitors and employees, the administrator was to establish an administrative review of the campus-free smoking plan with the regional vice president of operations prior to implementation. The policy also included that patients who desired to smoke in the administratively designated grounds area must be assessed by the interdisciplinary team for their ability to safely smoke in the designated areas. Patients smoking in the designated grounds areas were to be supervised as deemed appropriate through their individual safe smoking evaluations. During an interview 6/7/21 at 4:40 PM, the Admissions Director stated the facility's Patient Smoking Acknowledgement Policy was used to inform new residents that it was a non-smoking facility and smoking in the facility was not allowed. If they smoke, admissions educated	F 689	changes made to ensure that the deficient practice will not recur. " The department managers completed education to all staff on 6/8/2021 regarding immediately notifying administrator and/or DON at the time of occurrence for any resident caught smoking out of the designated times and area. Consequences of smoking with oxygen on can result in serious injury. " Nurse management (director of nursing, assistant director of nursing, unit managers and/or staff development coordinator) removed any employee that did not receive the education on 6/8/2021 from the schedule until education is completed. " All future employees will be educated by staff development coordinator on the above in-services during new hire orientation. " Receptionists were educated by administrator on asking resident # 87□s if he has any smoking materials on his person and belongings at the time of returning from any outings including dialysis days which are Monday Wednesday and Friday. If resident has smoking materials they will be surrendered to the receptionist who will give to a nurse to lock up. This was completed 6/8/2021. " Resident #87 will be checked hourly from the hours of 11pm □ 7am by a designated staff member to ensure resident is not smoking in his room daily x 4 weeks, 3x weekly x 4 weeks and weekly x 4 weeks	

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

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F 689	Continued From page 11 them on the process of telling the nurse they were leaving the floor and then sign out at receptions. Residents had to leave the property to smoke. All residents signed the policy at admission. Resident #87 was admitted 9/9/20 with diagnoses that included kidney failure receiving dialysis, heart failure, and seizure disorder. His admission Minimum Data Set (MDS) dated 9/15/20 indicated he was cognitively intact and was dependent on staff to push wheelchair. The MDS indicated he used oxygen. He was not indicated to be a tobacco user. Record review of Resident #87's doctor's orders found an order dated 9/10/20 for continuous oxygen therapy 3 liters per minute via nasal cannula every shift, every day. Resident #87's Care Plan dated 9/23/20 indicated he had oxygen therapy as needed with interventions that included monitor for signs of respiratory distress and oxygen via nasal cannula as ordered. During an interview on 6/8/21 At 5:30 PM, Resident #87 reported he was aware the facility is non-smoking. He stated he usually had the nurse take his oxygen off in the room, went outside to smoke, and staff would come check up on him. He stated on the occasions he was smoking in his room, he was "completely out of it" and had just woken from sleep and lit his cigarette not realizing he was not outside nor in his own home. When he became more alert, he put the cigarette out and staff entered. He stated his cigarettes and lighter were at bedside. He stated his Responsible Party (RP) provided the cigarettes to the front desk and he picked them up from there.	F 689	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 2 for analysis of patterns, trends, or need for further systemic changes. Any staff found to be non-compliant will receive progressive discipline. Date of compliance for all plan of corrections is July 6th 2021	

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 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 12	F 689		

Resident #87 further stated he always used oxygen at night via nasal cannula and a concentrator but on these occasions the oxygen was off. He knew the oxygen was off because he could not feel it in coming out. He stated he was aware it was dangerous to smoke while on oxygen.

During an interview 6/10/21 at 3:30 PM, Resident #87's RP stated she was unaware of the smoking policy and Resident #87 would go out whenever he wanted to smoke. She provided cigarettes to reception or gave it directly to Resident #87 because their "were no restrictions." She stated he usually would not bring oxygen tank outside with him to smoke. She further stated she was not aware of him smoking in his room.

A social work progress note dated 9/25/20 documented the resident was upset about not being able to go outside to smoke. The note explained due to COVID-19 restrictions, the residents were encouraged to stay in their rooms. The resident stated he will smoke in the bathroom if he must. The social worker notified Resident #87 and his Responsible Party (RP) he would be immediately discharged if caught smoking in the room.

During an interview 6/7/21 at 3:50 PM, the social worker stated she was not aware of Resident #87 smoking in his room while on oxygen. She stated if she had been aware, she would have discussed with the administrator and started discharge proceeding.

Record review of a Safe Smoking Evaluation dated 9/29/20 completed by Director of Nursing (DON) #2 indicated Resident #87 was safe to

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 06/11/2021

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F 689	Continued From page 13	F 689		

smoke without supervision. The question "Does resident need facility to store lighter and cigarettes?" was answered "no." The Safe Smoking Evaluation did not include a question about oxygen use.

A Care Plan dated 9/29/20 indicated he was a smoker and non-compliant with COVID-19 precautions to stay in room. The inventions included instruct resident about facility smoking policy, notify charge nurse immediately if it is suspected resident has violated facility smoking policy, and resident can smoke unsupervised.

A behavior progress note written by Nurse #7 and dated 10/1/20 indicated resident was smoking in his room while on oxygen on night shift. When confronted by staff, he was noted to be angry and cursing at the nurse. It was documented "he forgot."

During an interview 6/7/21 at 5:00 PM, Nurse #7 recalled charting at the nurse's station when she smelled smoke. Resident #87 was in the bathroom on oxygen and denied smoking. She stated she reported this to her unit manager and the director of nursing. She stated they removed Resident #87's cigarettes and lighter and put them in a drawer at the nurse's station. She further stated the policy is if someone is caught smoking in their room, they were supposed to be discharged from the facility.

A behavior progress note written by Nurse #8 and dated 4/14/21 indicated Resident #87 was smoking in his room while on oxygen on night shift. Intervention noted by the nurse was educated resident on effects of smoking indoors with oxygen on and encourage resident to refrain

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	345505	A. BUILDING _____ B. WING _____	C 06/11/2021

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F 689	Continued From page 14	F 689		

from smoking indoors.

A behavior progress note dated 5/21/21 indicated Resident #87 was smoking in the bathroom on night shift. He stated to Nurse #8 he forgot where he was and that he was not supposed to smoke inside. Intervention was to educate resident on effects of smoking indoors with oxygen on and encourage resident to refrain from smoking indoors.

During an interview 6/7/21 at 6:00 PM, Nurse #8 stated in April she smelled smoke coming from Resident #87's room and confiscated his lighter and cigarettes. She stated she wrote a progress note and notified the oncoming nurse. Nurse #8 stated the event in May was similar and that she believed Resident #87 was aware of what he was doing. She stated she did not notify management because she wrote it on the 24-hour report, entered a behavior progress note, and told the oncoming nurse.

Written 24-hour reports were not available for review.

During an interview on 6/7/21 at 6:25 PM, the DON #2 did not recall staff notifying her about a resident smoking in his room while on oxygen and she was unaware that this occurred. She stated she completed the Safe Smoking Evaluation 9/25/20 and updated the care plan because she was aware Resident #87 was smoking outside in the designated area.

During an interview 6/11/21 at 1:30 PM, the DON #1 stated staff should have notified the DON or the administrator when the resident was found smoking in his room while on oxygen. Residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 15	F 689		

should have to ask for smoking materials and not have them in their room. Residents should understand the smoking policy at admission.

During interviews on 6/7/21 at 2:40 PM and 5:20 PM, the Administrator stated she was not aware of any residents smoking in their room. She further stated if she had been aware, the resident would have been immediately discharged. She further stated there was no designated smoking area on the property, they went to an area off campus to smoke, and the residents signed out at reception. She further stated staff would confiscate smoking materials if residents were unsafe to smoke. She stated she was unaware of the policy that stated materials must be locked up.

During an interview on 6/11/21 at 2:30 PM, the Administrator stated staff should notify management of any residents smoking in their room or while using oxygen.

The Administrator was notified of the immediate jeopardy on 6/8/21 at 9:06 AM.

On 6/9/21 the facility provided the following credible allegation of IJ removal:

Plan for removing the immediate jeopardy:

The department managers completed education to all staff on 6/8/2021 regarding immediately notifying administrator and/or DON at the time of occurrence for any resident caught smoking out of the designated area. Consequences of smoking with oxygen on can result in serious injury. Nurse management (director of nursing, assistant director of nursing, unit managers

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F 689	Continued From page 16	F 689		

and/or staff development coordinator) will remove any employee that did not receive the education from the schedule until education is completed. All future employees will be educated by staff development coordinator on the above in-services during new hire orientation. This was completed on 6/8/2021

All nurses were educated to screen new admissions. Smoking assessments must be completed on all smokers and all smoking materials confiscated at time of admission and locked behind closed doors. This was completed 6/8/2021.

Resident #87's smoking assessment was completed by Assistant Director of Nursing and was deemed to be unsafe to smoke unsupervised. This was completed on 6/7/2021

Resident #87 was immediately notified he would be moved to a private room due to safety risks by discharge planning director on 6/7/2021.

Resident # 87 was reeducated by Administrator, Director of Nursing and Assistant Director of Nurse on facility smoking procedures and seriousness of consequences of smoking with oxygen. Resident was agitated initially however did understand the risk and reeducation on 6/7/2021.

Family was notified of facility smoking procedures and seriousness of consequences of smoking with oxygen on 6/8/2021

Resident # 87 was placed on one-on-one observation on 6/7/2021 due to increased agitation/risk from room move and reeducation

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	345505	A. BUILDING _____ B. WING _____	C 06/11/2021

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F 689	Continued From page 17	F 689		

conversation this was reassessed on 6/8/2021 and resident was no longer agitated. He was pleasant and understanding of changes made to ensure resident safety.

All smoking residents' rooms and persons were searched by unit manager and all smoking materials were confiscated and placed behind locked doors. Unit manager provided education to smokers on risks of having smoking materials in room and on person. This was completed 6/7/2021

Administrator will ensure all residents will receive updated smoking plan letter in person and all families will have the letter mailed postmarked on 6/8/2021

Resident # 87's social worker at dialysis center was notified by discharge planning director of concerns related to smoking indoors on 6/8/2021.

Receptionist was educated by administrator on searching resident # 87's person and belongings at the time of returning from any outings including dialysis days which are Monday Wednesday and Friday to ensure any smoking materials are removed and locked away starting 6/7/2021

Resident #87 will be checked hourly from the hours of 11pm - 7am daily by a designated staff member assigned by the administrator to ensure resident is not smoking in his room this will begin 6/8/2021

The administrator will ensure implementation of ongoing surveillance of resident #87 's compliance of not having smoking materials on the person or in his belongings beginning

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	345505	A. BUILDING _____ B. WING _____	C 06/11/2021

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F 689	Continued From page 18 6/8/2021 Alleged date of IJ removal is June 8th Person responsible for implementation is the Administrator Validation: The validation of the immediate jeopardy removal was on 6/9/21. Validation of the credible allegation for IJ removal was completed as evidenced by interviews with nursing staff related to in-service on completing Safe Smoking Evaluations, interviews with various staff regarding new smoking policy, interview with resident and responsible parties about smoking procedures and interview with dialysis social worker about smoking concerns. Observations were made of Resident #87 in private room with and without supervision, smoking in designated area with supervision, and of smoking material location in locked medication room. Record review was completed for all listed smokers' Safe Smoking Evaluation. The immediate jeopardy was removed on 6/9/21.	F 689		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 697		7/6/21

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 06/11/2021

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F 697	Continued From page 19 Based on observation, record review and resident, staff, Consultant Registered Pharmacist (RPh), Physician Assistant (PA), and Physician interviews the facility failed to have an as needed pain medication available as ordered for a resident who verbalized a pain level of 9 on a 0-10 pain scale for 1 of 1 residents (Resident #261) who was reviewed for pain. Findings included: Resident #261 was admitted to the facility on 05/11/21 and had diagnoses of diabetes, a non-displaced fracture of the left foot, and a wedge compression fracture of the thoracic vertebra. The Care Plan created on 05/12/21 revealed that Resident #261 had acute and chronic pain with an intervention to administer analgesia per order. Another intervention listed was that Resident #261 preferred to have pain controlled by Tramadol (an opioid pain medication) 50mg (milligrams) every 8 hours as needed. The Physician Order dated 05/12/21 revealed an order for Tramadol 50mg by mouth every 8 hours as needed for moderate to severe pain. The order continued with instructions to hold the medication if an altered mental status or increased sedation was noted. The Controlled Medication Utilization Record revealed that 10 doses of Tramadol 50mg were received in the facility on 05/13/21. The 10th dose of Tramadol was dispensed on 05/21/21 at 5:19 AM. The admission Minimum Data Set (MDS) dated 05/17/21 revealed that Resident #261 was	F 697	1. How corrective action will be accomplished for those residents found to have been affected: Resident # 261 received Tylenol at 10:57am, Ibuprofen at 2:30pm and tramadol at 4:32pm on 6/8/2021. How the facility will identify other residents having the potential to be affected by the same deficient practice: " All residents with opioid analgesic orders are at risk for the deficient practice. " An order summary report for all residents receiving opioid analgesics was run on 6/30/2021 and all resident□s opioid analgesics were assessed on the cart to ensure the residents had adequate supply of pain medication and that medication was ordered from pharmacy if necessary. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur " Director of Nursing or designee will provide education to all licensed nurses to ensure all residents with opioid analgesic orders have an adequate supply of pain medication by 7/6/2021. " All licensed nursing staff who has not received this education by 7/6/2021 will be removed from the schedule until complete " All new hire licensed nurses will receive education during the orientation process.	

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F 697	Continued From page 20 cognitively intact and did not receive scheduled pain medications but did receive as needed pain medications. Resident #261 had been in almost constant pain during the 5 day look back period. Resident #261's pain level was listed as 10 on a 1-10 scale. In an interview on 06/08/21 at 10:00 AM Nurse #1 stated that Resident #261 had complained of pain and when she went to get pain medication for her she discovered there was none on the medication cart. She indicated she went to the Emergency Medication Supply and discovered they did not carry Tramadol in the supply. She indicated that she approached the Unit Manager (UM) who instructed her to print out a prescription and to locate the PA who was in the building and have him sign it. She indicated she was waiting for the Tramadol to be delivered and had not provided any other pharmacologic intervention for pain to Resident #261. In an observation and interview on 06/08/21 at 10:10 AM Resident #261 stated that the pain in her left leg was a 9 on a 0-10 pain scale. She indicated that she also felt uncomfortable because she felt constipated. Resident #261 was making small adjustments in her position in the bed and stated that she was unsure if she could participate in therapy due to the pain. She indicated that she had not received any type of pain medication although she had requested them. She stated that she usually received Tramadol for her pain. The Order Note dated 06/08/21 at 10:51 AM and written by Nurse #1 revealed that Resident #261 had requested pain medication for leg pain of 6 out of 10. The provider was notified and an order	F 697	" On 6/14/2021 pharmacy added tramadol to Omnicell emergency back up at the facility. " Director of nursing or designee will audit 10 residents with opioid analgesics to ensure adequate supply is available 3x weekly x 4 weeks, then weekly x4 weeks and monthly x 1. F584 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Findings from audits will be reviewed at the Quarterly Quality Assurance meeting x2 for any further problem resolution if needed. Completion date 07/06/2021	

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 06/11/2021

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F 697	Continued From page 21	F 697		

for Tylenol was received.

The Physician Order dated 06/08/21 at 10:56 AM revealed an order for Tylenol 650mg by mouth every 6 hours as needed for pain.

The June 2021 Medication Administration Record (MAR) dated 06/08/21 revealed that Tylenol 650mg by mouth was administered to Resident #261 at 10:57 AM.

In an interview on 06/08/21 at 11:02 AM Nurse #1 stated she had spoken to Resident #261's provider and he did not want to order any other narcotic for the resident's pain. She indicated he had ordered Tylenol instead. Nurse #1 stated that the prescription for Tramadol had been sent to the pharmacy and she had requested it be filled "stat."

The Physician Order dated 06/08/21 revealed an order for Ibuprofen 800mg by mouth every 6 hours as needed for pain was administered at 2:15 PM.

In an interview on 06/08/21 at 11:08 AM the Occupational Therapist (OT) and the Physical Therapy Assistant (PTA) stated they had worked with Resident #261 that morning. They indicated that it took about 15 minutes of encouragement and motivation to get Resident #261 to agree to participate in therapy. The OT and PTA indicated that Resident #261 complained of constipation and left leg pain and told her that getting up and moving would help both. They indicated that when Resident #261 took pain medication it made her drowsy and that she still complained of pain.

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	345505	A. BUILDING _____ B. WING _____	C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 697	Continued From page 22	F 697		

In an observation and interview on 06/08/21 at 11:47 AM Resident #261 presented with facial grimacing. She indicated that she had received a stool softener to help with her constipation and Tylenol for her leg pain but that her pain was still at a level of 9. She indicated that the leg pain and the uncomfortable feeling of constipation were different, and she could distinguish between the two. She indicated that her left leg hurt all the way down to her foot. Resident #261 stated she had agreed to go to therapy but could hardly participate due to the pain. Resident #261 stated that coffee or prune juice could help with her constipation and her request was passed on to Nurse #1.

In an observation and interview on 06/08/21 at 1:05 PM Nurse #2 looked through the controlled medications on the 600 Hall medication cart where Resident #261 resided until 06/03/21. She confirmed there was no Tramadol on the cart for Resident #261 and there was no controlled medication sign off sheet in the 600 Hall narcotic book.

In an observation and interview on 06/08/21 at 1:09 PM Nurse #1 looked through the controlled medications on the 700 Hall medication cart where Resident #261 now resided. She confirmed there was no Tramadol on the cart for Resident #261 and there was no controlled medication sign off sheet in the 600 Hall narcotic book.

In an interview on 06/08/21 at 2:15 PM the Director of Nursing (DON) #1 stated that she had not known about the missing Tramadol. She indicated that the nurse should have informed her, and they could have ordered the pain

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 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 697	Continued From page 23	F 697		

medication from the local back-up pharmacy. She indicated that the Tramadol should be here from the pharmacy any minute.

The June 2021 MAR revealed that ibuprofen 800mg by mouth was administered to Resident #261 at 2:30 PM.

In an observation and interview on 06/08/21 at 3:22 PM Resident #261 was lying on her back in bed. Her left leg was shaking up and down. She indicated she had received some brown pills but had not received the Tramadol yet. She indicated that the pain in her leg had not changed and was just as bad.

In an observation and interview on 06/08/21 at 3:25 PM Nurse #3 accompanied the surveyor to the Emergency Medication Supply dispenser. He confirmed that there was no Tramadol stocked in the machine. He indicated that the facility had requested that Tramadol be placed in the machine but that the medication had not been stocked yet.

In an interview on 06/08/21 at 3:28 PM the DON stated that Resident #261's Tramadol was enroute from the pharmacy.

The Health Status Note dated 06/08/21 at 3:53 PM and written by Unit Manager (UM) #1 revealed that Resident #261 had complaints of leg pain. When she went to assess the resident, she was on the phone talking and laughing. Resident #261 told UM #1 that she felt much better now that she had some pain medication. Resident #261's pain level was at an 8. The note revealed that per the DON the resident was offered non-pharmacological pain interventions

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 06/11/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 24	F 697		

that were refused.

In an interview on 06/08/21 at 4:08 PM Resident #261 stated she wanted a hot cup of coffee to help with her constipation. She indicated that she did not receive any prune juice earlier, but she did receive Milk of Magnesia (MOM). She stated she had been told her Tramadol was on its way to the facility.

In an interview on 06/08/21 at 4:09 PM Nurse #1 stated that she had tried non-pharmacological interventions to help with Resident #261's pain throughout the day. She indicated that she elevated Resident #261's head for approximately 10 minutes. She offered to place a pillow under Resident #261's leg, offered to reposition her, and offered her an ice pack. Nurse #1 indicated that these interventions were refused by Resident #261.

In an interview on 06/08/21 at 4:13 PM DON #1 stated she had offered to reposition Resident #261 and had offered a pillow for her leg. She indicated that the nurse was calling the provider to get an order for something else to help with Resident #261's constipation. DON #1 stated that the nurse was getting a cold pack for Resident #261's leg and that she had received prune juice and coffee.

The June 2021 MAR dated 06/08/21 revealed that Tramadol 50mg by mouth was administered to Resident #261 at 4:32 PM.

The Skilled Note dated 06/08/21 at 8:52 PM and written by Nurse #1, revealed that Resident #261 had complained of pain that morning and was out of her prescription Tramadol. Nurse #1 printed

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F 697	Continued From page 25	F 697		

out a hard copy of the prescription and the provider signed it, and it was faxed to the pharmacy. A stat order was placed on the prescription. The resident said her pain was an 8 on the 0-10 pain scale and Nurse #1 checked the Emergency Medication Supply but there was no Tramadol available. The provider was notified but did not want to give anything stronger than Tramadol and ordered Tylenol. The resident's pain was assessed after an hour and was an 8 on the 0-10 scale. Non-pharmacological interventions were offered. An order for ibuprofen 800mg was ordered by the provider. Resident #261 received MOM and the provider also ordered Colace and Miralax for her constipation. The resident was reassessed after the ibuprofen and her pain was still at an 8 on the 0-10 scale. The Tramadol arrived at the facility and it was administered at approximately 4:30 PM. Resident #261's pain level was assessed after an hour and her pain level was 5. Resident #261 had a small bowel movement but still felt constipated.

In a telephone interview on 06/09/21 at 6:30 AM Nurse #4 stated that if there were 10 doses left of a medication, she would re-order them. She indicated that the facility should never run out of a resident's pain medication. Nurse #4 stated that if the medication was not on the medication cart the nurse should check the Emergency Medication Supply machine, and if not there, should notify the provider that something else was needed. Nurse #4 indicated that a "stat" order should take between 1-2 hours to arrive at the facility.

The Health Status Note dated 06/09/21 at 7:06 AM and written by Nurse #4, revealed Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 697	Continued From page 26	F 697		

#261 had two large bowel movements overnight and that she felt much better.

In an observation and interview on 06/09/21 at 8:40 AM Resident #261 indicated that her pain level was an 8 on the 0-10 pain scale. She stated that she felt better, and her pain was easing down. Resident #261 stated that her constipation was also better.

The Skilled Note dated 06/09/21 at 8:43 AM and written by UM #1 revealed that Resident #261's pain was at a 7 on the 1-10 pain scale and that the pain medication was gradually working. Non-pharmacological interventions were offered and refused. Resident #261 showed no outward signs of pain.

The Health Status Note dated 06/09/21 at 10:15 AM and written by Nurse #6, revealed that Resident #261's pain level was now a 5 on the 0-10 pain scale.

In a telephone interview on 06/09/21 at 8:55 AM the RPh stated that the Tramadol prescription had been filled on 06/08/21. He stated that controlled medications were not automatically refilled and needed to be ordered by the facility prior to running out of the medication. He indicated that there was a prescription on file in the pharmacy prior to 06/08/21 and that all the facility needed to do was call to order it. The RPh indicated there were multiple ways that the facility could reorder medications including electronically ordering, faxing the order, or calling the order to the pharmacy. He stated that the stat order for the Tramadol was received at 12:19 PM and that the pharmacist needed to check it and fill it and the order was ready to go out at 1:30 PM. The

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F 697	Continued From page 27	F 697		

RPh stated that the pharmacy had up to 3 hours from the time filled to dispense the medication. He indicated that another faster option would have been to have the local pharmacy fill the prescription. The RPh stated that another option would be to stock Tramadol in the Emergency Medication Supply machine. He stated that it was not acceptable that the resident had to wait that long for pain medication and that the facility should have utilized the local back-up pharmacy.

In an interview on 06/09/21 at 9:14 AM Nurse #5 who provided Tramadol to Resident #261 when there were two doses left, stated that when a resident got down to two doses of medications the nurse needed to reorder them. She stated that she should have reordered Resident #261's Tramadol and that she did not. Nurse #5 stated that the pharmacy did not automatically refill controlled medications and that the nurse needed to request them. She stated that it was not acceptable that Resident #261 did not have pain medications because the facility ran out of the medication and that she should have called the pharmacy to reorder them.

In an interview on 06/09/21 at 11:09 AM UM #1 stated she was told by Nurse #1 that Resident #261 was in pain and that they were out of her Tramadol. She indicated that she did not know why the Tramadol was not available, but it should have been. UM #1 indicated that Resident #261 received Tylenol and ibuprofen and that non-pharmacological interventions were also offered but they were refused. She stated that Resident #261's complaints of constipation were also addressed and that the medications had worked overnight. She stated that the nurses needed to call the pharmacy to reorder controlled

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F 697	Continued From page 28	F 697		

medications because they were not refilled automatically by the pharmacy. UM #1 stated that Resident #261 was resting and had no signs or symptoms of pain and that her pain level had decreased to a 7. She indicated that the medication should have been requested from the local backup pharmacy so the pain medication could have been given sooner.

In a telephone interview on 06/10/21 at 3:36 PM Physician Assistant (PA) #1 stated that he had been notified that no Tramadol was available for Resident #261's pain. He indicated that he did not want to order anything stronger than Tramadol because he wanted to wean the resident off the medication. He indicated he ordered Tylenol to be given while the facility waited for the Tramadol to be delivered. He stated the facility was to call him back if the Tylenol was not effective and when they called back, he ordered ibuprofen. He stated that he wanted to try and get the pain under control without using addicting pain medications. PA #1 stated that he did not remember if he had been told of Resident #261's constipation but on review of the record he indicated that she had been treated for it. He stated that the facility should not run out of pain medications that are ordered for the residents. He indicated that medications should be reordered when there were 7-10 doses left to make sure they got to the facility in time to be administered. PA #1 stated that it was not acceptable for the facility to not have ordered medication on hand and that wasn't the way it was supposed to work.

In a telephone interview on 06/11/21 at 1:05 PM Physician #1 confirmed that she was Resident #261's physician. She stated that it was not

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F 697	Continued From page 29 acceptable for the facility to run out of any medications. She indicated that the PA was there every weekday and they should be checking to see if any medications were needed on Thursdays so they could be ordered. She stated again that medications should be in the facility and available for resident use as ordered. Physician #1 stated that the facility should have requested the Tramadol from the local pharmacy so that Resident #261 could have received the pain medication more quickly and that it was unacceptable that they had not. She stated that Resident #261 should not have had to be in pain as long as she was because the facility had not reordered the Tramadol. Physician #1 stated the facility should not run out of any medications at all and not just pain medications. She stated there was no excuse for the facility not to have medications ordered by the providers in the facility for administration to the residents. In a telephone interview on 06/11/21 at 2:06 PM DON #1 stated that a resident's pain should be addressed immediately. She indicated that a resident should never have to wait as long as Resident #261 had to wait to receive her pain medication. The DON stated that if she had known the medication would take so long to arrive, she would have gone to the local pharmacy to get it herself. She indicated that it was her expectation that pain control be provided to the residents and that what happened to Resident #261 was unacceptable.	F 697		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with	F 725		7/6/21

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F 725	Continued From page 30 the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, the facility failed to provide nursing staff of sufficient quantity resulting in 2 of 2 residents (Resident #7 and Resident #82) not getting assistance with shaving and 1 of 27 residents (Resident #67) not getting preferred showers. This tag is cross referred to: F677-D: Quality of care: Based on observation, record review and staff interviews, the facility failed to shave two of two dependent male	F 725	1. How corrective action will be accomplished for those residents found to have been affected: Resident # 7 and #82 were shaved on 6/8/2021. Resident #67 received a shower on 6/11/2021. 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	

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F 725	Continued From page 31 residents (Resident #7 and Resident #82) with facial stubble reviewed for Activities of Daily Living Care. F561-D: Based on record review and resident and staff interviews, the facility failed to honor a resident's choice and provide showers as scheduled for 1 of 27 residents (Resident #67) reviewed for showers. During an interview on 6/10/21 at 1:00 PM, Nurse Aid (NA) #1 stated she was unable to give showers and provide nail care due to not having enough nurse aids on each shift. She stated each nurse aid would care for 25 total care residents per night shift and 18-20 residents on weekend day shift. She reported speaking with the scheduler about her concerns and nothing was done. During an interview 6/10/21 at 4:00 PM, NA #3 reported she struggled to complete all assigned tasks on day shift due to not enough nurse aids working per floor and too many residents to care for. She stated it was difficult to provide showers as assigned due to many other needs to residents. During an interview 6/11/21 at 11:30 AM, the scheduler reported the facility lost a lot of staff due to COVID-19 and again in January/February 2021. She stated if someone called out, they used part-time staff or agency nurses and nurse aids. She did not recall staff speaking with her about issues providing care. During an interview 6/11/21 at 1:30 PM, the Director of Nursing (DON) reported that if someone called out, the nurse manager would find someone to cover the shift. She stated staff	F 725	affected by this practice. " All residents will be offered a shower by 6/30/2021 " 100% audit of all residents was completed to ensure they were shaved on 6/30/2021 as needed. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur " Director of nursing or designee will educate all nursing staff that if they are unable to complete all tasks assigned, they will immediately notify Administrator or Director of Nursing. " The director of nursing or designee will audit 10 residents daily 5x weekly x 4 weeks, then 3x weekly x 4 weeks and weekly x 4 weeks to ensure shaving has been offered during ADL care. " Unit coordinator/manager or designee will audit showers daily 5 x weekly x 4 weeks, 3x weekly x 4 weeks and weekly x 4 weeks. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Findings from audits will be reviewed at the Quarterly Quality Assurance meeting x1 for any further problem resolution if needed. Completion date 7/6/2021	

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F 725	Continued From page 32 has not come to her with any concerns about not getting work done on assigned shift. She further stated the expectation was that staff communicates to get assignments completed.	F 725		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 732		7/6/21

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F 732	Continued From page 33 §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to post the resident census on the daily nursing staffing sheets for 1 of 4 days of the recertification survey. The findings included: During entry on Sunday, 6/6/21 at 10:00 AM, the daily nursing staffing sheet dated 6/6/21 was observed in the entry foyer of the facility did not include the daily census. During an interview on 6/11/21 at 11:30 AM, the scheduler stated on weekends the receptionist or the manager on duty updated the census number on the daily staff posting. She further stated they find the census in the electronic medical record. During an interview 6/11/21 at 1:30 PM, the Director of Nursing (DON) stated the daily staff posting should have the census posted at the beginning of each day. She stated she believed all reception staff were aware they needed to update census number on weekends and this was something she monitored on weekends when she worked.	F 732	How corrective action will be accomplished for those residents found to have been affected: On 6/7/2021 census was reflected on daily staffing sheet. How the facility will identify other residents having the potential to be affected by the same deficient practice: No residents are affected by this deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur The scheduler and service ambassadors were educated on ensuring the census information is filled out on the daily staffing sheet each day on 6/25/2021. The scheduler or designee will audit the daily staffing sheet for census completion 2 x weekly x 4 weeks, weekly x 4 weeks and monthly x 1. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained	

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F 732	Continued From page 34	F 732	Findings from audits will be reviewed at the Quarterly Quality Assurance meeting x1 for any further problem resolution if needed. Completion date 7/6/2021	
F 755 SS=G	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs	F 755		7/6/21

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F 755	Continued From page 35 is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff, Consultant Registered Pharmacist (RPh), Physician Assistant (PA), and Physician interviews the facility failed to reorder medications which caused a delay in medication administration for 1 of 1 residents (Resident #261) who was reviewed for pain. Findings included: Resident #261 was admitted to the facility on 05/11/21 and had diagnoses of diabetes, a non-displaced fracture of the left foot, and a wedge compression fracture of the thoracic vertebra. The admission Minimum Data Set (MDS) dated 05/17/21 revealed that Resident #261 was cognitively intact and received as needed pain medications. In an interview on 06/08/21 at 10:00 AM Nurse #1 stated that Resident #261 had complained of pain and when she went to get pain medication for her she discovered there was none on the medication cart. She indicated she went to the Emergency Medication Supply and discovered they did not carry the medication in the dispenser. She indicated that she approached Unit Manager (UM) #1 who instructed her to print out a prescription and to locate the PA who was in the building and have him sign it. She indicated she was waiting for the medication to be delivered. In an interview on 06/08/21 at 11:02 AM Nurse #1 stated that the prescription for the medication had been sent to the pharmacy and she had	F 755	How corrective action will be accomplished for those residents found to have been affected by the deficient practice; " Resident #261□s opioid analgesic arrived from the pharmacy and was given to the resident at 4:32pm on 6/8/2021. How the facility will identify other residents having the potential to be affected by the same deficient practice; " All residents with opioid analgesic orders are at risk for the deficient practice. " An order summary report for all residents receiving opioid analgesics was run on 6/30/2021 and all resident□s opioid analgesics were assessed on the cart to ensure the residents had adequate supply of pain medication and that medication was ordered from pharmacy if necessary. The measures that will be put into place or systemic changes made to ensure that the deficient practice will not recur. " Director of Nursing or designee will provide education to all licensed nurses to ensure all residents with opioid analgesic orders have an adequate supply of pain medication by 7/6/2021. " All licensed nursing staff who has not received this education by 7/6/2021 will be removed from the schedule until complete " All new hire licensed nurses will receive education during the orientation process. " Director of nursing or designee will	

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	345505	A. BUILDING _____ B. WING _____	C 06/11/2021

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

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F 755	Continued From page 36 requested it be filled "stat." In an observation and interview on 06/08/21 at 1:05 PM Nurse #2 looked through the controlled medications on the 600 Hall medication cart where Resident #261 resided until 06/03/21. She confirmed there was no pain medication on the cart for Resident #261 and there was no controlled medication sign off sheet in the 600 Hall narcotic book. In an observation and interview on 06/08/21 at 1:09 PM Nurse #1 looked through the controlled medications on the 700 Hall medication cart where Resident #261 now resided. She confirmed there was no pain medication on the cart for Resident #261 and there was no controlled medication sign off sheet in the 600 Hall narcotic book. In a telephone interview on 06/09/21 at 6:30 AM Nurse #4 stated that if there were 10 doses left of a medication, she would re-order them. She indicated that the facility should never run out of a resident's medication. Nurse #4 stated that if the medication was not on the medication cart the nurse should check the Emergency Medication Supply machine, and if not there, should notify the provider that something else was needed. Nurse #4 indicated that a "stat" order should take between 1-2 hours to arrive at the facility. In a telephone interview on 06/09/21 at 8:55 AM the RPh stated controlled medications were not automatically refilled and needed to be ordered by the facility prior to running out of the medication. The RPh indicated there were multiple ways that the facility could reorder medications including electronically ordering,	F 755	audit 10 residents with opioid analgesics to ensure adequate supply is available 3x weekly x 4 weeks, then weekly x4 weeks and monthly x 1. 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 year 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 is July 6th 2021	

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F 755	Continued From page 37	F 755		

faxing the order, or calling the order to the pharmacy. The RPh stated that the pharmacy had up to 3 hours from the time filled to dispense the medication. He indicated that another faster option would have been to have the local pharmacy fill the prescription. The RPh stated that another option would be to stock the medication in the Emergency Medication Supply dispenser. He stated that it was not acceptable that the resident had to wait for medication and that the facility should have utilized the local back-up pharmacy.

In an interview on 06/09/21 at 9:14 AM Nurse #5 who provided the missing medication to Resident #261 when there were two doses left, stated that when a resident got down to two doses of medication the nurse needed to reorder them. She stated that she should have reordered Resident #261's medication and that she did not. Nurse #5 stated that the pharmacy did not automatically refill controlled medications and that the nurse needed to request them. She stated that it was not acceptable that Resident #261 did not have medication because the facility ran out of the medication and that she should have called the pharmacy to reorder them.

In a telephone interview on 06/10/21 at 3:36 PM Physician Assistant (PA) #1 stated that he had been notified that the medication was not available in the facility for Resident #261. He stated that the facility should not run out of medications that were ordered for the residents. He indicated that medications should be reordered when there were 7-10 doses left to make sure they got to the facility in time to be administered. PA #1 stated that it was not acceptable for the facility to run out of resident's

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F 755	Continued From page 38 medications. In a telephone interview on 06/11/21 at 1:05 PM Physician #1 confirmed that she was Resident #261's physician. She stated that it was not acceptable for the facility to run out of any medications. She indicated that the PA was there every weekday and they should be checking to see if any medications were needed on Thursdays so they could be ordered. She stated again that medications should be in the facility and available for resident use as ordered. She stated there was no excuse for the facility not to have medications ordered by the providers in the facility for administration to the residents. In a telephone interview on 06/11/21 at 2:06 PM Director of Nursing (DON) #1 stated that she expected the nurses to reorder medications when they got down to the seven-day level. She indicated that even if it was too early, the pharmacy would send it out at the correct time. DON #1 stated that a nurse should never use the last dose of a medication without reordering the medication. She stated it was important that medications be in the facility so they could be administered as ordered by the physician.	F 755		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493	F 770		7/6/21

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F 770	Continued From page 39 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Consulting Laboratory Technician (Lab Tech), and Physician Assistant (PA) interviews the facility failed to provide laboratory services as ordered by the provider for 1 of 1 residents (Resident #361) whose laboratory values were reviewed. Findings included: Resident #361 was admitted to the facility on 03/26/21 with diagnoses of pneumonia, urinary tract infection (UTI) and chronic lymphocytic leukemia. The admission Minimum Data Set (MDS) dated 04/01/21 revealed Resident #361 was moderately cognitively impaired and did not reject care. The Physician Orders dated 04/13/21 at 10:05 AM revealed an order to check a stat urinalysis with culture and sensitivity (UA C&S) for Resident #361. The specimen could be collected using an in and out catheter or using the clean catch method. The Medication Administration Record (MAR) dated 04/13/21 revealed the urine had been initialed as collected at 3:27 PM by Nurse #12. The Physician Orders dated 04/13/21 at 3:00 PM revealed an order to check a complete blood count (CBC) and basic metabolic panel (BMP) in the morning on 04/14/21. The Medication Administration Record (MAR) dated 04/13/21 for the 11:00 PM-7:00 AM shift revealed the CBC and BMP had been initialed by	F 770	How corrective action will be accomplished for those residents found to have been affected by the deficient practice; " Resident #361 discharged to the hospital on 4/17/2021. How the facility will identify other residents having the potential to be affected by the same deficient practice; " All residents with lab orders are at risk for the deficient practice. The measures that will be put into place or systemic changes made to ensure that the deficient practice will not recur. " Director of Nursing or designee will provide education to all licensed nurses on how to process lab orders by 7/6/2021. " Any nurse who did not receive the education by the compliance date will be removed from the schedule until completed " All new nurses will receive education during the orientation process. " Unit Coordinator/managers or designee will review all lab orders from the previous day 5x weekly x 4 weeks, 2x weekly x4 weeks and monthly x 1. 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	

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F 770	Continued From page 40 Nurse #8. In an interview on 06/09/21 at 3:26 PM the Assistant Director of Nursing (ADON) stated she was unable to produce the 04/13/21 UA C&S results from the laboratory. She also stated that she was unable to produce the 04/14/21 CBC and BMP results. She indicated she was unsure if either lab test was collected. In an interview on 06/09/21 at 3:54 PM Nurse #12 stated she had attempted to collect the urine sample using an in and out catheter for Resident #361 two times and did not enter the urethral tract either time. She indicated that another nurse had also attempted to collect the sample using an in and out catheter and did not enter the urethral tract either time. Nurse #12 stated the previous Unit Manager (UM) also tried two times to collect the urine sample using an in and out catheter and was able to enter the urethral tract on the second try and collected the sample. She indicated she called the Consultant Laboratory to pick up the stat urine and was told they were no longer accepting specimens. Nurse #12 stated she was told by the previous UM to place the specimen in the specimen refrigerator and she would notify the provider. She indicated she put the urine specimen in the refrigerator and left for the day. Nurse #12 stated she did not know what happened with the urine specimen after she left. In a telephone interview on 06/09/21 at 8:16 PM the previous UM stated that if she had done any of the things that Nurse #12 attributed to her it would be in her documentation because it was her practice to document those types of things. She stated emphatically that if it was not in her documentation, she did not do it.	F 770	non-compliant with the procedure will receive progressive discipline. Date of compliance is July 6th 2021	

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F 770	Continued From page 41	F 770		

In a telephone interview on 06/10/21 at 8:52 AM UM #1 stated that blood lab tests were drawn at 5:00 AM. She stated if the lab test was ordered stat the lab would come out and collect the specimen either drawing it themselves or picking up from the facility.
In a telephone interview on 06/10/21 at 9:57 AM the Consultant Lab Tech stated the lab had a cut-off time of 4:00 PM for specimen pick-up. She stated that after 4:00 PM the pick-up was dispatched to a courier for them to pick-up and bring to the lab. She indicated there was no record that Resident #361's urine had been tested on 04/13/21. She indicated she would check into the matter and would call back with further information.

In a follow-up telephone interview on 06/10/21 at 11:15 AM the Consultant Lab Tech stated she had researched the urine and that a phlebotomist had been sent to collect the urine sample on 04/13/21. She indicated when the phlebotomist arrived to pick-up the urine specimen, they had been told the sample had already been sent to the hospital for testing.

In a follow-up telephone interview on 06/10/21 at 3:10 PM the ADON stated that she had contacted the hospital and they had no record of testing Resident #361's urine on 04/13/21. She indicated that the CBC and CMP that had been ordered to be done in the morning on 04/14/21 had not been done until 04/16/21.

In a telephone interview on 06/10/21 at 3:45 PM PA #1 stated that he would have expected the facility to call him and let him know that the labs he ordered had not been done.

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F 770	Continued From page 42 In a telephone interview on 06/10/21 at 2:06 PM DON #1 stated that she expected labs to be done when ordered. She stated that for stat labs during business hours the Consultant Lab should be called and if they could not arrive in a short amount of time the facility should take them to the hospital to be tested. She indicated that if after business hours the facility should take the specimen to the hospital lab directly. DON #1 indicated that if labs were not collected as ordered the provider should be notified.	F 770		
F 809 SS=B	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, and	F 809	How corrective action will be	7/6/21

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F 809	Continued From page 43 resident and staff interviews, the facility failed to provide the residents with meals served at regularly scheduled times for 2 of 16 sampled residents reviewed for dining observations. (Resident #161 and Resident #313). Findings included: 1.The admission Minimum Data Set (MDS) dated 06/08/2021 had Resident #161 coded as cognitively intact and was independent with eating. The meal tray times read: "400 hall at 12:45 PM." The form which documents when meal carts come to the hall dated 06/06/2021 read in part: "400 Hall -----". During the 400-hall lunch observation on 06/06/2021 at 12:30 PM, staff were waiting for the lunch trays to come out. The meal cart reached the 400 hall at 2:00 PM. During an interview with the Dietary Manager (DM) on 06/06/2021 at 12:46 PM, the DM stated they recently switched their dietary software and "hit a snag from complaints concerning the new menus." The staff were running late from breakfast because they had to make new breakfast trays and there was also new staff being trained. The DM also stated the residents' meals are expected to be out according to the scheduled times and 400 hall's lunch is scheduled to come out at 12:45 PM. During an interview with Resident #161 on 06/06/21 at 01:17 PM, Resident #161 stated her meals are late often and she has only been at the	F 809	accomplished for those residents found to have been affected by the deficient practice. Residents received lunch on the 400 hall at 2:00pm on 6/6/2021. 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. " Dietary manager or designee will educate all dietary staff on the importance of being on time for meal services and adhering to meal times by 7/6/2021. " Dietary manager or designee will audit the time meal carts leave the kitchen daily x 4 weeks, 3 x weekly x 4 weeks to ensure they are on time. 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. Date of compliance for all plan of	

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F 809	Continued From page 44 facility for 4 days. During an interview with the Regional Culinary Director (RD) on 06/07/2021 at 2:22 PM, the RD stated dietary is contracted to her company and it is a new contract, but meals should be on time and according to their hall meal times. During an interview and observation with Resident #161 on 06/06/21 at 02:23 PM, Resident #161 was found in her wheelchair eating her lunch. Resident #161 stated her lunch was late again. During an interview with Nurse #9 on 06/06/2021 2:37 PM, Nurse #9 stated lunch is usually between 11:30 AM and 12:30 PM and sometimes it is late but today it was unusually late. Nurse #9 also stated there were no residents on her hall that needed insulin before meals. During an interview with the DM on 06/09/2021 at 4:12 PM, the DM stated her staff member that keeps track of the times had missed the time on 06/06/2021 for 400 hall lunch of 2:00 PM because they were behind and was helping get the trays out. During an interview with the Administrator on 06/09/2021 at 4:16 PM, the Administrator stated for meals. 2. Resident #313 was admitted 5/19/2021. The admission Minimum Data Set (MDS) dated 5/25/21 coded Resident #313 as cognitively intact and independent with eating. The meat tray times read: "600 hall at 12:15 PM." The form which documents when meal carts	F 809	corrections is July 6th 2021	

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F 809	Continued From page 45	F 809		

come to the hall dated 06/06/2021 read: 600 Hall --.

During an interview with Resident #313 on 06/06/21 at 12:10 PM, Resident #313 stated meals come late most of the time especially lunch. Resident #313 stated family members brings fast food meals often.

During the 600-hall lunch observation on 06/06/2021 at 12:15 PM, staff were waiting for the lunch trays. The meal cart reached the 600 hall at 1:48 PM.

During an interview with the Dietary Manager (DM) on 06/06/2021 at 12:46 PM, the DM stated they recently switched their dietary software and "hit a snag from complaints concerning the new menus." The staff were running late from breakfast because they had to make new breakfast trays and there was also new staff being trained. The DM also stated the residents ' meals are expected to be out according to the scheduled times and 600 hall ' s lunch is scheduled to come out at 12:15 PM.

An interview with Nurse Assistant #4 on 06/06/2021 at 12:55 PM, Nurse Assistant #4 stated "trays can run a little late sometimes, but today it is late-late."

During an interview with Resident #313 on 06/06/21 at 1:43 PM, Resident #313 stated, "I told you they come late." Her meal tray did not get serviced until 1:50 PM.

During an interview with the Regional Culinary Director (RD) on 06/07/2021 at 2:22 PM, the RD stated dietary is contracted to her company and it

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F 809	Continued From page 46 is a new contract, but meals should be on time and according to their hall meal times. During an interview with the DM on 06/09/2021 at 4:12 PM, the DM stated her staff member that keeps track of the times had missed the time on 06/06/2021 for 600 hall lunch because they were behind and was helping get the trays out. During an interview with the Administrator on 06/09/2021 at 4:16 PM, the Administrator stated dietary staff are expected to follow the times designated for meals.	F 809		
F 880 SS=D	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;	F 880		7/6/21

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F 880	Continued From page 47 §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 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.	F 880		

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F 880	Continued From page 48 §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 observation, staff interviews, and review of the Center for Disease Control and Prevention (CDC) guidelines and the facility Infection Prevention and Control Policies (IPCP) for Personal Protection Equipment (PPE), the facility failed to implement their PPE policy when 1 of 1 staff member (Service Ambassador) failed to wear a mask that covered the mouth and nose while screening visitors. These failures occurred during a COVID-19 pandemic. Findings included: The CDC guidelines updated November 4, 2020 read: Implement Universal Source Control Measures. Source Control refers to use of well-fitting cloth masks or face masks to cover a person's mouth and nose to prevent spread of a respiratory secretions when they are talking, sneezing, or coughing. Healthcare Personnel (HCP) should always wear a facemask while they are in the healthcare facility. Record review of the facility's Infection Prevention and Control Policy #2203 last revised date of 5/04/21 read: "c. Face covering or mask (covering mouth and nose), when indicated." During entry to the facility on 6/06/21 at 10:05 AM, the Service Ambassador was observed wearing a surgical mask under her nose while screening six surveyors while entering the facility. She explained her masks slips but she pulls it back up. When asked about training she	F 880	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility removed the service ambassador from the center after being discovered not wearing her mask over her nose on 6/6/2021. Her employment was terminated on 6/23/2021. 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 infection preventionist or DON will educate all staff on the video Using personal protective equipment correctly during COVID-19" published by the CDC. " Any staff member who did not receive the training was removed from the schedule until it was completed. " All new staff reviewed the video during the orientation process. This will be completed by 7/6/2021. " The DON or infection preventionist will audit 5 staff members 5 x weekly x 2 weeks, twice weekly x 2 weeks, weekly x 4 weeks and monthly x 1. How the facility plans to monitor its	

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 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 49 explained she was trained to wear her mask at all times in the facility. She stated she had been employed over ten years and had training from Infection Control Nurses, Directors of Nursing, and Administrators in the use of PPE. The Administrator in an interview on 06/06/21 at 2:21 PM, stated the staff takes the infection control protocols seriously and she knew all staff were trained and knew the importance of wearing their PPE properly. During an interview with the Infection Control Nurse (ICN) on 06/06/21 at 4:01 PM she stated all staff were trained on how to don and doff Personal Protective Equipment (PPE), including placing the facemask over their mouth and nose. She stated all staff in the facility should have on the surgical mask at the minimum, other masks are use on the quarantine halls and if there is an outbreak in the facility. She added staff were monitored daily regarding PPE usage. She also expressed the Service Ambassador should have the mask correctly placed over her nose and her mouth. The ICN expressed the facility were following the guidelines and recommendations of the Center for Disease Control for Nursing Homes and the county public health guidance. An interview with the Administrator on 6/11/21 at 1:50 PM, she stated all staff should be wearing their mask according to according to guidelines of infection control.	F 880	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 July 6th 2021	