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 02/02/2023

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 and complaint investigation survey was conducted on 01/29/23 through 02/02/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # LWDV11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 01/29/23 through 02/02/23. Event ID# LWDV11. The following intakes were investigated: NC00190139, NC00190626, NC00190666, NC00191133, NC00191695, NC0019284, NC00192420, NC00192637, NC00192675, NC0093101, NC00194240, NC00194398, NC00194910, NC00196469, NC00196472, NC00196547, and NC00196595. 45 of the 45 complaint allegations did not result in deficiency.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the	F 585		2/25/23

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

Electronically Signed | 02/22/2023

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facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for

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example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.

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F 585	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review, family and staff interviews the facility failed to record and investigate a grievance for 1 of 7 residents (Resident #428) reviewed for grievances. Findings included: Review of the facility grievance policy dated 1/23/20 indicated a policy statement which stated nursing staff or any other management team member receiving questions or issues of concern regarding care and/or services are to immediately respond at the point of service in an effort to satisfactorily resolve issues of concern. If an issue of concern cannot be immediately or satisfactorily resolved at the point of service, the management staff member will notify the patient/family member that the concern is being submitted to the appropriate department manager and that follow up for resolution will be provided as quickly as possible. The grievance form is to be promptly initiated by the management staff member. Resident #428 was admitted on 8/12/22 and discharged home on 9/10/22 with diagnoses including heart failure and pulmonary edema. Review of the admission Minimum Data Set (MDS) assessment dated 8/16/22 for Resident #428 revealed she was moderately cognitively impaired and was able to understand/be understood. Review of the facility grievances log from May 2022 through January 2023 revealed no recorded grievances for Resident #428.	F 585	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. Correction F585 1. How corrective action will be accomplished for those residents found to have been affected: Resident #428 has been discharged from the facility. 2. 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 to ensure any grievances have been identified and placed in writing by 2/25/2023 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur " The administrator or designee will educate all staff on resident□s rights related to the right to voice grievances and have written response provided by	

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F 585	Continued From page 4 Resident #428 passed away on 9/13/22. Review of a handwritten statement by the Administrator dated 9/7/22 at 12:42 PM revealed Resident #428's family member came to the Social Worker (SW) on this date with concerns related to oxygen therapy, request for vital signs, room temperature too cold, and meal tray out of reach. The family member was reminded Resident #428 was weaning from oxygen therapy and vital signs were provided by the SW. Resident #428 was ambulatory and could change the air temperature as well as retrieve her own meal tray. The family member was informed they would ensure Resident #428 was at a comfortable temperature and food was within reach; however, she was eating all her meals. The SW stated the family member was calmed and relieved and was just nervous because of Resident #428's COVID diagnosis and upcoming discharge. A telephone interview was conducted with Resident #428's family member on 1/30/23 at 12:56PM. She revealed she spoke to the SW and Director of Nursing (DON) on a day in between 9/3/22 and 9/1022 about all her concerns related to meal service, incontinence care, and respiratory therapy. The DON told her that she would address the issues. During a follow-up interview with the family member on 2/2/23 at 11:22 AM, she revealed no one from the facility contacted her after she communicated her concerns, and they did not resolve the issues on the day she complained. The family member indicated she did not feel comfortable leaving Resident #428 by herself at the facility.	F 585	02/25/2023. " Any staff who has not completed education by 02/25/2023 will be removed from the schedule. " All new hire staff will receive this education during the orientation process " administrator or designee will audit all grievances collected daily Monday-Friday x12 weeks to ensure all voiced grievances are in written format. 4. 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. 5. Completion date 2/25/2023	

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During an interview with the SW on 1/31/23 at 11:08 AM, she revealed she could not recall the concerns brought up by Resident #428's family member on 9/7/23. The SW stated Unit Manager #1 was present during one of the concerned conversations. She further stated she did not file a grievance regarding the family member's concerns, and she needed to improve on her process with concerns and grievances.

An interview was conducted with Unit Manager #1 on 2/1/23 at 9:02 AM, and she revealed she could not recall any specifics regarding Resident #428's family member's concerns from 9/7/22. She indicated there was not any documentation written by her in Resident #428's medical record related to complaint details.

The DON was interviewed on 2/2/23 at 8:34 AM, and she revealed any complaints brought up by Resident #428 or her family would have been directed to Unit Manager #1 to address directly. She stated she did respond to the family member's concern regarding Resident #428's wet briefs, and she followed up with the nurse aide on duty after she changed Resident #428's briefs. The DON indicated Resident #428, nor her family member seemed upset after she was clean.

During an interview with the Administrator on 2/1/23 at 3:06 PM, she revealed her expectation was that if the grievance could be immediately resolved then it would not have followed the service concern process. The service concern process involved initiation of a service concern report, which would be sent to the appropriate department manager for follow-up action within 48 hours. She indicated the issues brought up by

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F 585	Continued From page 6 Resident #428's family member were resolved at that time because her staff were aware of the process to resolve any issues at the point of concern. During a follow-up interview with the Administrator on 2/1/23 at 3:29 PM, she revealed she could not provide documentation that Resident #428's issues were resolved.	F 585		
F 742 SS=D	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with resident and staff, the facility failed to ensure residents diagnosed with Post-Traumatic Stress Disorder (PTSD) had person-centered care plans developed with individualized approaches that direct staff on how to care for their assessed needs for 1 of 1 resident (Resident #24) reviewed for PTSD. The findings included: Resident #24 was admitted to the facility on 02/27/2015 with multiple diagnoses that included	F 742	F742 1. How corrective action will be accomplished for those residents found to have been affected: Resident #24□s care plan was updated to reflect diagnosis of Post-Traumatic Stress Disorder and individualized approaches that direct staff. 2. How the facility will identify other residents having the potential to be	2/25/23

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F 742	Continued From page 7 depression and Post Traumatic Stress Disorder (PTSD). The quarterly Minimum Data Set (MDS) assessment dated 11/11/22 indicated Resident #24's cognition was intact. He had no behaviors and no rejection of care. A review of Resident #24's care plan revised on 11/30/22. Revealed Resident #24 was not care planned for individualized approaches related to her history of trauma. An observation and interview were conducted for Resident #24 on 02/01/2023 at 10:30 AM. The resident was lying in bed and no behavioral symptoms were noted. The resident indicated she was doing fine, and she did not have concerns related to staff caring for her. During an interview with the Social Worker (SW) on 02/01/2023 at 1:00 PM, She verified that Resident #24's care plan included no person centered and individualized approaches to care for Resident #24 in relation to her diagnosis of PTSD. The SW acknowledged that a care plan should be completed for the residents at the facility who have been identified as having PTSD. During an interview with Minimum Data Set (MDS) nurse on 02/01/2023 at 1:15 PM, she verified that Resident #24 had a diagnosis of PTSD. She stated that it was essential for the facility staff to have a care plan in place that provided them with person-centered approaches to care for Resident #24 in relation to her history of PTSD. An interview was conducted with Nursing	F 742	affected by the same deficient practice: " All residents with Post Traumatic Stress Disorder have the potential to be affected by this practice. " All resident□s care plans who have a diagnosis of Post Traumatic Stress Disorder were reviewed to ensure the individualized plan of care is developed. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur " The administrator or designee will educate all discharge planning staff on ensuring all residents with a diagnosis of Post Traumatic Stress Disorder have an individualized care plan by 02/25/2023. " Any staff who has not completed education by 02/25/2023 will be removed from the schedule. " All new hire staff will receive this education during the orientation process " MDS or designee will audit diagnosis report daily Monday-Friday x 4 weeks, 3x weekly x 4 weeks and weekly x 1 month to ensure Post Traumatic Stress diagnosis residents have an individualized care plan. 4. 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. 5. Completion date 2/25/2023	

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Assistant (NA) #1 on 02/02/2023 at 10:55 AM. She indicated that she was unaware Resident #24 had a history of PTSD. She further indicated there were no specific interventions or approaches to care for Resident #24.

An interview was conducted with Nurse #1 on 02/02/2023 at 11:30 AM. She indicated that she was unaware Resident #24 had a diagnosis of PTSD. She further indicated there were no specific interventions or approaches to care for Resident #24

An interview was conducted with the Director of Nursing (DON) and Administrator on 02/02/2023 at 11:14 AM. They both indicated their expectation was for a care plan to be developed that included person-centered and individualized approaches to care for residents who had a diagnosis of PTSD.