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	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carolina Rehab Center of Cumberland	4600 Cumberland Road Fayetteville, NC 28306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0696 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care/assistance for a resident with a prosthesis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13289 Based on record review, and interviews with staff and a prosthetic company employee, the facility failed to facilitate replacement of a lost prosthetic liner so the resident could use his prosthesis and walk. This was for one (Resident # 4) of one sampled resident who had a prosthesis. The findings included: Resident # 4 was admitted to the facility on [DATE] with diagnoses which in part included diabetes, chronic kidney disease, and left below knee amputation. The resident's quarterly Minimum Data Set assessment, dated 7/27/24, coded the resident as cognitively intact and as not using a prosthesis during the assessment period. The resident was also coded to have moderate impairment of his vision. Review of physical therapy documentation from 7/21/24 through 8/5/24 revealed the following information. Resident # 4 was certified to receive therapy services during the dates of 7/21/24 to 7/31/24. One of his precautions was that he was blind. On 7/29/24 Physical Therapist # 1 documented unable to perform static stand or ambulate for the last 3 days due to inability to locate gel sleeve for prosthesis. DOR (Director of Rehab) notified. On 7/30/24 Physical Therapist # 1 documented treatment time spent on continued search for gel sleeve for prosthesis; therapist searched room again as well as laundry. Unable to locate. Notified DOR again and requested to order another gel sleeve. On 8/5/24 Physical Therapist # 1 completed a discharge summary noting the resident was being discharged from therapy. His ambulation goal had been noted to be 250 feet with forward wheel walker (FWW) and contact guard assistance. At time of discharge, he had not met that goal. The resident was walking 60 to 100 feet with FWW and periods of minimal assistance at time of discharge. Physical Therapist # 1 was interviewed on 10/10/24 at 3:00 PM and reported the following information. The resident needed the gel sleeve (liner) in order to use his prosthesis. It allowed suction between the resident's stump and the prosthetic device so that it would fit correctly. It also prevented the resident from having shearing on his stump. She had looked for the gel sleeve/liner and could not find it. Without it, he could not continue to wear the prosthesis and continue with gait training. She had told the DOR. Not having the liner in order to utilize the prosthesis had hindered his progress with gait training. He also had not made a lot of progress with transfers, and that had not been related to not having the prosthesis liner. He also could not see objects well, and that had also hindered his progress. (continued on next page)

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

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

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F 0696 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/3/24 at 12:50 PM Nurse # 2 documented the following information. Resident # 4 called 911 to report his missing prosthetic sleeve/liner. The 911 responders informed the resident that no crime had been committed and to allow the facility to have one delivered for him. On 9/3/24 a facility service concern report for Resident # 4 was completed that noted, Pt. (patient) reports liner to left prosthetic leg has been missing for 30 days. Pt called police to inform them it was missing. 2 officers, DOR, UM (Unit Manager) met with patient officers assured patient that facility directors were on top of the issue and were working to replace the liner as it has not been located. On the service form there was an area noted as action taken. On this part of the form, there was documentation that the DOR contacted a prosthetic company employee who stated they would check to see if the sleeve was in stock. The form further included documentation, awaiting delivery. Resident # 4 was interviewed on 10/9/24 at 12:40 PM and again on 10/10/24 at 5:35 PM and reported the following information. He thought he had two liners for his prosthesis at one time and now he had none. It had been several months since he had a prosthesis liner, and no one had helped him get another one. They had stopped therapy, and he wanted to use the prosthesis and walk. They would tell him his vision was poor, but he could see some things. During one of the interviews the resident pointed out to the surveyor the fire alarm on the wall. He also pointed out the clock, but stated he could not make out the time. He could also see whether the surveyor was wearing white or dark clothing but could not see details of clothing. On 10/10/24 at 11:50 PM the DOR was interviewed and reported the following information. She recalled the resident reporting his liner had been stolen on 9/3/24. She knew the liner had to be ordered. When the resident had the prosthetic liner, he had walked with therapy but was unsteady. He also had visual deficits that contributed to not making progress. During the interview, the DOR reported she would check on the status of the replacement prosthetic liner which had been ordered. On 10/10/24 at 2:40 PM a follow- up interview was conducted with the DOR who reported the following information. The liner had not yet been delivered. It would be delivered later that day (10/10/24). Regarding the lost prosthetic liner, the resident was not able to take off the liner himself and would have needed help. The facility did his laundry, and she did not know what had happened to his last prosthetic liner. The DON (Director of Nursing) was interviewed and reported she first became aware of the issue during a clinical meeting after the resident had called 911 on 9/3/24. She had not been made aware of the problem in July 2024 when the prosthetic liner was lost. An employee at the orthotic's and prosthetics company was interviewed on 10/10/24 at 3:10 PM and reported the following information. The first call they received from the facility requesting the prosthetic liner was on 9/4/24. The company told the facility staff a prescription was needed for the liner. The prescription was sent to the prosthetic company on that afternoon (9/4/24). The liner was not in stock, and it was ordered by the prosthetic company. The facility was notified on 9/19/24 that the prosthetic liner had arrived. A voice mail was left with the DOR on that date. On 10/3/24 the prosthetic company received a call from the facility saying they would call with payment for the liner the next week. They heard nothing further until the current day of 10/10/24 at 1:33 PM when the staff called and submitted payment. According to the prosthetic company employee, delivery was slated for that evening (10/10/24).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 13289 Based on record review and staff interviews the facility failed to maintain an accurate record regarding medical diagnoses. This was for one (Resident # 1) of one sampled resident reviewed for accurate diagnoses. The findings included: Resident # 1 resided at the facility from 7/15/24 until her discharge on 9/29/24. The resident's diagnoses in part included respiratory failure with tracheostomy placement. The resident's hospital discharge summary, dated 7/15/24, noted the resident had MRSA (methicillin resistant staphylococcus aureus) pneumonia while hospitalized and had received treatment. A review of the facility's record revealed a list of cumulative diagnoses. MRSA pneumonia was listed as one of the resident's diagnoses while she had been hospitalized . There was an accompanying ICD code (International Statistical Classification of Disease) by the diagnosis of MRSA. (This medical classification system assigns a code for different diagnoses.) A review of the resident's record revealed the resident had three chest x-rays performed while she resided at the facility. These were on 7/21/24, 8/15/24, and 8/29/24. All of the x-rays were negative for pneumonia. On 9/7/24 at 12:11 AM Nurse # 1 documented in a nursing note that Resident # 1 had yellow/green tinged tracheal secretions, and the physician was notified. On 9/7/24 at 12:19 AM Nurse # 1 documented in a nursing note that the physician had ordered the resident to be given Ciprofloxacin 500 milligrams twice per day for 10 days for an upper respiratory infection. (Ciprofloxacin is an antibiotic.) On 9/7/24 Nurse # 1 entered into the resident's medical record, the verbal order for the Ciprofloxacin. The order included the information that Ciprofloxacin was for yellow/green tracheal secretions. It also included an accompanying diagnosis. The diagnosis was listed as MRSA pneumonia. On 9/9/24 the resident' s care plan was updated to reflect the resident had developed pneumonia and was receiving antibiotics for pneumonia. A review of physician notes revealed the resident was seen by the physician on 9/19/24. The physician noted the resident had recently completed the antibiotics secondary to a possible upper respiratory infection and her lungs were clear. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's care plan nurse was interviewed on 10/11/24 at 12:43 PM and reported the following information. When verbal orders are entered by a nurse, there is a drop-down box in the electronic system that allows the nurse to tie an order to an ICD diagnostic code in the resident's record. When Nurse # 1 entered the antibiotic order, she had checked the ICD code for MRSA pneumonia which had been entered upon admission to reflect the resident's history of pneumonia while hospitalized . Instead, she should have just entered the order to read that the antibiotic had been ordered for the discolored sputum and concluded the order with that alone. When the care plan nurse looked at the record, it appeared as if the resident was being treated for pneumonia, but she had not been. She (the care plan) nurse had then inaccurately placed on the care plan that the resident had pneumonia. There had been no diagnosis of pneumonia, and it was an error in the record. Resident # 1's Responsible Party (RP) was interviewed on 10/9/24 at 11:34 AM and expressed concern that Resident # 1's facility medical record had inaccurately reflected whether the resident had pneumonia again while she resided at the facility. The RP reported she had talked to facility staff members about Resident # 1 and her status. During conversations staff referenced the resident's medical record to provide her (the RP) information. At one point she had been told Resident # 1 had pneumonia and at another point she had been told the resident did not have pneumonia while she was at the facility. Resident # 1's physician was interviewed on 10/10/24 at 2:00 PM and reported the following information. The resident's RP had been concerned about the color of the resident's mucous and the resident had been placed on antibiotics because of the concern of the color. The resident had not been identified to have pneumonia while she resided at the facility.