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	03/05/2025

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48007 Based on record review, and staff, Wound Care Nurse Practitioner and Podiatrist interviews, the facility failed to obtain orders to coordinate care with the resident's Podiatrist to ensure care needs were met when a resident was admitted with no orders regarding care to a surgical incision site of the right heel. The surgical dressing was not removed, and no treatment was provided. At the Podiatrist visit on 1/13/25 the wound was significantly macerated (skin had become soft and broken down due to prolonged moisture) that had extended laterally out of the incision. Podiatrist #1 saw Resident #4 on 1/13/25 and started oral antibiotics and treatment orders to the incision site. Podiatrist #2 saw Resident #4 on 1/15/25 and changed the treatment orders to the incision site. Podiatrist #1 saw Resident #4 again on 1/24/25 and started him on another antibiotic along with continuing the first antibiotic. On 1/27/25 Resident #4 was seen by Podiatrist #1 and sent him to the emergency room for admittance into the hospital for a bone biopsy and possible surgery due to infection at the surgical site. Resident #4 required two surgeries to remove all of the hardware from the right ankle and intravenous antibiotics for the infection. This was for 1 of 2 residents reviewed for wound care (Resident #4). Findings included: A review of Resident #4's hospital discharge orders 12/27/24 noted an order for non-weight bearing to his right lower extremity, a follow-up appointment with podiatry scheduled for 1/2/25, and no orders noted regarding care of the surgical incision or soft cast. A review of Resident #4's facility admission orders revealed an order dated 12/27/24 for a wound consultation as needed. Resident #4 was admitted into the facility on [DATE] with diagnoses of a right calcaneus comminuted fracture (a severe break of the heel bone that shatters into multiple pieces) status post open reduction internal fixation surgery with primary subtalar arthrodesis (permanently joining the joint that connects the ankle bone to the heel bone), diabetes and peripheral vascular disease. (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 0684 Level of Harm - Actual harm Residents Affected - Few	A review of Resident #4's comprehensive care plan dated 12/28/24 included a focus problem of skin impairment with interventions of notify physician as indicated, observe area for signs of improvement or decline, and treatment as ordered. A focus problem of a risk for pressure ulcers related to chronic health conditions and incontinence with interventions of assessing resident for risk of skin breakdown, keep skin clean and dry as possible, and skin assessments as indicated. On 12/30/24 A focus problem of a surgical wound to his right lower extremity and is at risk for infection and complications was added with interventions of notify physician as indicated, observe surgical site for signs and symptoms of redness/infection, surgeon follow-up as indicated, and treatment as ordered. On 1/2/25 a focus problem of noncompliance related to weight bearing status and getting up unassisted was added with interventions of listen to resident and try to calm, provide repeat education of risk and benefits of following weight bearing status. A review of Resident #4's electronic medical record included progress notes by the Wound Care Nurse Practitioner dated 12/30/24 noted Resident #4 had a full thickness surgical area on right lower leg and documented per Surgeon's request, monitor for signs/symptoms of increased drainage or infection and notify Surgeon of any changes right away and to keep post op wrap in place and there was no evidence of infection noted today upon assessment. A review of Resident #4's admission Minimum Data Set, dated dated dated [DATE] indicated he had clear speech, was understood and able to understand and was cognitively intact. He had no behaviors, no rejection of care, had impairment on one side of a lower extremity, and used a wheelchair for mobility. He had one fall since admission with injury, had recent surgical repair of a fracture, a surgical wound, and had received physical therapy for 6 days and occupational therapy for 5 days. A review of Resident #4's electronic medical record included progress notes by the Wound Care Nurse Practitioner dated 1/6/25, noted Resident #4 had a full thickness surgical area on right lower leg and documented per Surgeon's request, monitor for signs/symptoms of increased drainage or infection and notify Surgeon of any changes right away and to keep post operative wrap in place and there was no evidence of infection noted today upon assessment. A review of Resident #4's electronic medical record included progress notes by the Wound Care Nurse Practitioner dated 1/15/25, 1/24/25, and 1/27/25 indicated she did not see Resident #4 due to him being out of the building. A telephone interview with the Wound Care Nurse Practitioner on 3/4/25 at 3:31 PM revealed that she had not removed the soft cast to inspect the incision because she does not carry supplies to replace an orthopedic cast and she had no direction to remove the cast, so she defaulted, due to previous experience, to not removing the soft cast until Resident #4 was seen by the podiatrist. She stated she was aware there were no orders to remove the soft cast, and she further revealed that she had not spoken to the podiatrist in regard to the care of the surgical incision or the removal of the soft cast. The Wound Care Nurse Practitioner further indicated that in her experience a soft cast was kept in place until the resident was seen by the surgeon, so she did not find the lack of treatment orders concerning. She further stated that while she did not speak to the podiatrist, she always used the general terminology of surgeon request in all of her notes. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on 3/4/25 at 2:00 PM with Nurse #1, who admitted Resident #4, stated that he received the order to not change the hospital dressing to the right ankle from the Wound Care Nurse Practitioner on 12/29/24. He explained that after the Wound Care Nurse Practitioner sees a Resident he receives via email the Wound Nurse Practitioner orders which he then transcribes onto the physician order sheet after making the resident's physician aware and gets approval to implement the orders. He further revealed he was notified of the 1/2/25 Podiatrist appointment at the time of the resident's admission. Nurse #1 indicated he was notified by the family member on 1/2/25 of the appointment being rescheduled for 1/13/25 due to insurance issues as the fracture was from a motor vehicle accident and she was still working with the person who caused the accident insurance to ensure payment. A review of the spreadsheet received by Nurse #1 from the Wound Care Nurse Practitioner on 12/30/24 noted an order from the Wound Care Nurse Practitioner to keep the post operative wrap in place. A review of Resident #4's physician orders indicated an order dated 1/1/25 to keep the post operative. wrap in place. A review of Resident #4's Podiatrist #1 progress note dated 1/13/25 revealed Resident #4 stated the facility had completed no dressing changes since the surgical intervention. Podiatrist #1 noted there was significant maceration (skin had become soft and broken down due to prolonged moisture) noted to the lateral extends out of incision and a pressure area on the heel. The incision was cleaned with saline and a topical antiseptic solution-soaked gauze was applied as well as a compressive dressing. Resident #4 was to be strictly non-weightbearing. The note included an order for an antibiotic one tablet twice a day for 10 days and wound care orders were placed for the facility to change the dressing daily. Podiatrist #1 wrote that out of an abundance of caution Resident #4 was to follow up with his colleague on Wednesday for a wound check and dressing change. A review of Resident #4's facility electronic medical record revealed a treatment order dated 1/13/25 for the right heel incision to be cleansed with saline and a topical antiseptic solution-soaked gauze apply abdominal pad and wrap with gauze and compressive dressing three times weekly. A review of Resident #4's treatment administration record noted a treatment dated 1/13/25 for the right heel incision to be cleansed with saline and a topical antiseptic solution-soaked gauze apply abdominal pad and wrap with gauze and compressive dressing daily was completed as ordered. A review of Resident #4's facility electronic medical record revealed a medication order dated 1/13/25 for an antibiotic tablet twice a day for 10 days. A review of Resident #4's medication administration record revealed he received the ordered antibiotic medication twice a day as ordered. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of Resident #4's Podiatrist #2's progress note dated 1/15/25 indicated Resident #4 complained of pain to the right foot which was sharp with Resident #4 rating the pain as severe. Podiatrist #2 noted there was mild maceration along the central portion of the incision with no incision dehiscence (splitting or bursting open). The sutures were intact and a bullae (fluid filled sac) extended plantarly (sole of the foot). Podiatrist #2 noted edema and erythema (swelling and redness) to the right foot. Podiatrist #2 cleansed the surgical site with saline and a topical antiseptic solution-soaked gauze. Podiatrist #2 wrote Resident #4 has maceration to the incision and recommended a topical antiseptic solution dressing change every 2 days to prevent dehiscence and Resident #4 was to remain absolutely non-weightbearing to the right foot. Podiatrist also wrote Resident #4 was to see Podiatrist #1 next week. A review of Resident #4's facility electronic medical record revealed a treatment order dated 1/15/25 for the right heel incision to be cleansed with saline and a topical antiseptic solution-soaked gauze apply abdominal pad and wrap with gauze and compressive dressing every 2 days. A review of Resident #4's treatment administration record noted a dated 1/15/25 treatment for the right heel incision to be cleansed with saline and a topical antiseptic solution-soaked gauze apply abdominal pad and wrap with gauze and compressive dressing every two days was completed as ordered. A review of Resident #4's Podiatrist #1's progress note dated 1/24/25 revealed Resident #4 complained of severe pain to the right foot and confirmed he was taking the prescribed antibiotic. On examination of the incision to the right foot Podiatrist #1 noted the sutures were intact with maceration along the central portion of the incision. Podiatrist #1 noted the wound did probe (a tool used to determine the extent and depth) but not to bone or hardware, and no dehiscence. Podiatrist #1 also noted edema and erythema to the right foot. Podiatrist #1 cleansed the surgical site with saline and a topical antiseptic solution bandage was applied. Podiatrist #1 sent recommendations for the site to be cleansed with saline and a topical antiseptic solution dressing to be changed daily to prevent dehiscence. Podiatrist #1 also ordered two different antibiotics to be administered orally. A review of Resident #4's facility electronic medical record revealed a treatment order dated 1/24/25 for the right heel incision to be cleansed with saline and a topical antiseptic solution-soaked gauze apply abdominal pad and wrap with gauze and compressive dressing daily. A review of Resident #4's treatment administration record noted a treatment dated 1/24/25 for the right heel incision to be cleansed with saline and a topical antiseptic solution-soaked gauze apply abdominal pad and wrap with gauze and compressive dressing daily was completed as ordered. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A telephone interview with Podiatrist #1 on 3/4/25 at 2:15 PM indicated that Resident #4 should have been discharged from the hospital with orders for daily dressing changes to the surgical site. He stated that he was not on duty when Resident #4 was discharged and was unaware that the facility had not received any orders regarding dressing changes. He further indicated that the facility should have called and clarified what wound care was required. Podiatrist #1 further stated that when he saw Resident #4 on 1/13/25 there was serosanguinous drainage and significant maceration on the side of the incision line, and he prescribed an antibiotic for 10 days and orders to clean the incision site daily with saline and a topical antiseptic solution to be done daily. On 1/15/25 Resident #4 was seen by his colleague who changed the wound care orders to clean incision site with saline and a topical antiseptic solution every two days to prevent incision dehiscence. The Podiatrist further indicated he saw Resident #4 again on 1/24/25 and noted there was maceration along the central portion of the incision and noted edema erythema and sent new orders to the facility for two different antibiotics and changed the treatment to the surgical site to cleanse the incision site with saline and a topical antiseptic solution back to daily. When he saw Resident #4 on 1/27/25 he sent him to the emergency room , he was admitted and had two surgeries to remove all of the hardware from the right ankle and intravenous antibiotics for the infection. The Podiatrist further stated that in his opinion if the facility had called for treatment orders when Resident #4 was admitted the infection would have been caught earlier. The Podiatrist said that he could not definitively say that the lack of dressing changes caused the infection but that the changes in the incision would have been caught earlier and treated sooner if the facility had called for orders. A review of the emergency room Physician's provider's note dated 1/27/25 included Resident #4 was being followed by the podiatry clinic after surgery had been performed to the area of the right heel. Resident #4 was sent from Podiatrist office for admission for a bone biopsy and possible surgery due to infection at the surgical site. The focus exam noted swelling, tenderness along the heel and the wound was present with some drainage noted. The emergency room Physician also noted that the podiatry team was in the triage area evaluating and placing orders. An interview with the Director of Nursing on 3/5/25 at 10:26 AM revealed the facility followed the wound care provider's orders which were to keep the soft cast on. The order was noted on the spreadsheet sent by email on 12/30/24 from the Wound Care Nurse Practitioner to the Director of Nursing and Nurse #1. She further stated that she had not received any orders from the Medical Director after he saw Resident #4 on 12/27/24 regarding removing the soft cast. She further revealed that maybe the facility should have questioned the wound care provider after the second time she saw Resident #4 and did not reach out to the Podiatrist and unfortunately with the Wound Care Nurse Practitioner writing per surgeon the facility did not question it. She stated that she was aware of the family member contacting the facility regarding the cancellation of the podiatry appointment on 1/2/25 and rescheduling it for 1/13/25. An interview with the Administrator on 3/5/25 at 8:15 AM indicated that all appointments were discussed at the morning meeting Monday through Friday. This discussion included if the resident made it to the appointment and if the resident had not, was it rescheduled, was paperwork received by the facility from the visit and if not the facility attempted to contact the physician for the information. The units and administration were informed by admissions of any scheduled appointments on the discharge paperwork from the hospital which are then placed on the unit calendar. She further indicated the facility was aware the family member had changed the podiatrist appointment from 1/2/25 to 1/13/25 which was discussed in the morning meeting on 1/3/25 and had called the family member to ensure she would be taking him to the appointment. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	An interview with the Administrator on 3/5/25 at 10:02 AM indicated that when the Wound Care Nurse Practitioner sees a resident with any type of surgical wound and there were no orders, the wound care provider was responsible for clarifying what orders the surgeon wanted. She further indicated that the facility had a telephone discussion with the wound care company about Resident #4 and the provider stated that orders for wound care needed to be clearly stated on the hospital discharge orders or the Wound Care Nurse Practitioner would be responsible for obtaining and clarifying orders from the surgeon. A telephone interview with the Medical Director on 3/5/25 at 9:05 AM indicated that he made a judgement call to not remove the soft cast and that he did not see an issue with the decision to leave the soft cast in place when he saw Resident #4 on 12/27/24. He further indicated that in hindsight the facility probably should have called and received clarification from the Podiatrist regarding the care of the incision but again he did not see an issue with the soft cast remaining in place. He stated that there was a lack of communication from the hospital and while the Podiatrist may have wanted the soft cast removed and daily dressing changes, this did not mean the discharging physician did. He further stated that it was unusual for the facility to remove a soft cast and start daily treatments. Also, the delay in seeing the Podiatrist due to Resident #4's family member cancelling the 1/2/25 appointment could have played a role in the state of the incision when Resident #4 went to his podiatry appointment.