STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345049	A. BUILDING _____ B. WING _____	C 12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RALEIGH REHABILITATION CENTER	616 WADE AVENUE RALEIGH, NC 27605

(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
E 000	Initial Comments An unannounced Recertification survey was conducted from 12/2/19 through 12/5/19. The facility was found to be in compliance with the requirement CFR 483.73 Emergency Prepardness. Event ID# 32VI11.	E 000		
F 000	INITIAL COMMENTS An unannoounced Complaint investigation survey was conducted on 12/2/19 through 12/5/19. 0 of 8 allegations were unsubstantiated.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to accurately code the Minimum Data Set (MDS) assessment for 2 of 22 residents (Resident #54 and #97) reviewed. The findings included: 1. Resident #54 was admitted to the facility on 6/27/2019 with diagnoses to include schizophrenia and depression. Resident #54's admission Minimum Data Set (MDS) assessment, dated 7/4/2019 revealed the resident's cognition was moderately impaired, and she was not evaluated to be a level 2 for PASRR. The assessment included the diagnoses of schizophrenia and depression. A review of Resident # 54's Pre-Admission	F 641	F641 1) 1-Resident #54's assessment was modified to reflect the correct PASRR. 2- On 12/6/2019 the Regional Process Analyst conducted formal education for the MDS department sighting the RAI manual in reference to coding Level 2 PASRRs 3-An audit was conducted of all residents with a Level II PASRR on 12/9/2019. Incorrect assessments were modified. MDS Nurse #2 MDS will audit 100% of completed assessments weekly for PASRR level accuracy for 4 weeks and then monthly times 3 months. 4- The results of the audits will be reviewed in the monthly QAPI meeting to	12/31/19

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

Electronically Signed | 12/19/2019

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F 641	Continued From page 1 Screening and Resident Review (PASRR) dated 1/23/2019 revealed a Level 2 category. On 12/4/2019 at 11:35 AM, an interview was conducted with the Social Worker (SW) who stated Resident #54 had been admitted from another facility with a lifetime level 2 PASRR already in place. On 12/4/2019 at 3:22 PM, an interview was conducted with the MDS nurse #2 who stated she did not understand the resident was a PASRR level 2. On 12/4/2019 at 4:21 PM, an interview was conducted with the regional Director of Nursing (DON) who stated the MDS coding with a level 1 was an error because she had her Level 2 category on admission. On 12/5/2019 at 9:08 AM, an interview was conducted with the Administrator who stated she expected the MDS assessment to be coded accurately. 2. Resident #97 was admitted to the facility on 3/26/17 and had a diagnosis of end stage renal disease and dependence on renal dialysis. Review of the physician's orders revealed an order dated 9/21/19 for Plavix 75 milligrams (mg) every day. The Quarterly Minimum Data Set (MDS) Assessment dated 11/15/19 revealed Resident #97 received an anticoagulant for 7 days during the assessment period. Plavix is a medication that prevents platelets from	F 641	assure compliance maintained ongoing. The QAPI committee will determine the need for further auditing beyond 3 months. 2) 1-Resident #97's MDS was modified on 12/5/2019 to reflect the Plavix as an antiplatelet. 2-On 12/6/2019 the Regional Process Analyst conducted formal education for the MDS department sighting the RAI manual in reference to coding medications based on their classification. Residents on Plavix were reviewed by the lead MDS Nurse on 12/11/2019 to ensure classification accuracy. Incorrect assessments were modified. 3- On 12/6/2019 the Regional Process Analyst conducted formal education for the MDS department sighting the RAI manual in reference to coding medications based on their classification. MDS Nurse #1 will audit 100% of completed assessments weekly for anticoagulant/antiplatelet coding accuracy for 4 weeks and then monthly times 3 months. 4- The results of the audits will be reviewed in the monthly QAPI meeting to assure compliance maintained ongoing. The QAPI committee will determine the need for further auditing beyond 3 months.	

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F 641	Continued From page 2 clumping together to form blood clots and is classified as an anti-platelet medication and not an anticoagulant. An interview was conducted with MDS Nurse #1 and MDS Nurse #2 on 2/5/19 at 11:04 AM. MDS Nurse #1 stated Plavix was not an anticoagulant and they would need to modify the assessment. MDS Nurse #2 stated she did the assessment and she looked up the medication as an anticoagulant instead of looking up the classification of the medication. On 12/5/19 at 2:47 PM the Administrator stated in an interview that Plavix was not an anticoagulant and should not be coded on the MDS as an anticoagulant.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon	F 644		12/31/19

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F 644	Continued From page 3 a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to make a referral for a re-evaluation for Pre-Admission Screening and Resident Review (PASRR), after new mental health diagnoses were added for 1 of 2 residents (Resident #25) reviewed for PASRR. The findings included: A review of Resident #25's Pre-Admission Screening and Resident Review (PASRR) dated 3/12/2019 revealed a level 1 category. Resident #25's transfer paperwork from the discharging facility included diagnoses of osteomyelitis, diabetes, chronic obstructive pulmonary disease, hypertension and congestive heart failure. Resident #25 was admitted to the facility on 7/22/2019 with diagnoses of osteomyelitis, diabetes, chronic obstructive pulmonary disease, hypertension and congestive heart failure. Review of the facility's Physician admission history and physical for Resident #25, dated 7/22/2019, included under the Plan: ". . . (the resident) seems to exhibit antisocial/borderline personality traits, and she herself mentioned "bipolar"." Resident #25's admission Minimum Data Set (MDS) assessment dated 7/29/2019, revealed her cognition to be intact, and she had not been evaluated to be a level 2 PASRR.	F 644	F644 1-Resident #25's clinical information was submitted to PASARR on 12/4/2019 by the facility Social Worker for review. 2-An audit of diagnosis records of residents residing in the facility will be conducted by the DON/Designee by 12/19/19 to ensure any resident with PASARR Level II criteria are screened appropriately. 3-The Interdisciplinary Team was in serviced by the Regional Clinical Director on 12/11/2019 regarding appropriate diagnosis/criteria for Level II PASARR. The education included ensuring admissions/readmissions are reviewed in the daily clinical meeting to ensure PASARR levels are appropriate. 4-Audits will be conducted weekly on new admissions/readmissions for PASARR level appropriateness by the DON/Designee weekly X 8 weeks and then monthly X 3 months. The audits will be reviewed in the monthly QAPI meeting to assure compliance maintained ongoing. The QAPI committee will determine the need for further auditing beyond 3 months.	

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F 644	Continued From page 4	F 644		

On 12/4/2019 at 11:24 AM, an interview was conducted with the Social Worker (SW) who stated Resident #25 was admitted on 7/22/2019 and came with a PASRR of level 1 from another facility. The SW stated she would not have questioned the PASRR on admission because the Admission Social Service/Coordinator made sure the PASRR was in place when the resident was admitted.

On 12/4/2019 at 4:26 PM, an interview was conducted with the Regional Director of Nursing (DON) and the SW. The DON stated Resident #25 was admitted with no mental health diagnoses. The SW stated when conducting her assessments of Resident #25 for the admission MDS, the resident indicated she was depressed and down, and so the SW put in a request for the Physician to get a psychology consult, and that was completed on 8/16/2019. The DON and SW were uncertain where the diagnoses came from. The DON and SW were unable to look up Resident #25's current PASRR to see if the mental health diagnoses were included on submission.

On 12/4/2019 at 4:48 PM, the MDS nurse #1 joined the interview with the DON and SW. The MDS nurse stated after reviewing Resident #25's records, she thought she took the diagnoses from the Physician's admission history and physical report dated 7/22/2019, and since that was conducted on the resident's day of admission, they were included in her medical record with that date. The MDS nurse did not know if the SW had seen the diagnoses that would have triggered a re-screening of the PASRR.

On 12/5/2019 at 11:26 AM, an interview was

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F 644	Continued From page 5 conducted with the Administrator who stated the facility should have submitted resident #25 for a re-screening for PASRR when the mental health diagnoses were included in her medical record.	F 644		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to update a resident's Care Plan	F 657	F657 1-The Care Plan for Resident #9 was	12/31/19

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F 657	Continued From page 6 upon return from the hospital for 1 of 25 residents whose care plans were reviewed (Resident #9). The findings included: Resident #9 was admitted to the facility on 9/19/16 and had a diagnosis of chronic respiratory failure. Review of the Care Plan for Resident #9 revealed the care plan was last revised on 4/18/19 and did not include information regarding a problem of respiratory failure or the need for oxygen therapy. Review of the clinical record revealed Resident #9 was admitted to the hospital on 8/20-27/19 and had a discharge diagnosis of acute respiratory failure. There was no information added to the resident's Care Plan regarding the problem of respiratory failure or that the resident required oxygen therapy. The Quarterly Minimum Data Set (MDS) Assessment dated 9/3/19 revealed the resident was cognitively intact and required extensive to total assistance with activities of daily living with the exception she was independent with eating. The MDS noted the resident received oxygen therapy. There was no information added to the Care Plan regarding the resident's respiratory problems or the need for oxygen. On 12/2/19 at 3:52 PM Resident #9 was observed lying in bed with oxygen by nasal cannula at 2 liters per minute. On 12/5/19 at 11:11 AM an interview was conducted with MDS Nurse #1 and MDS Nurse #2. MDS Nurse #1 stated she had never known the resident to have a respiratory event since she had worked at the facility and when the resident	F 657	updated on 12/5/2019 to include oxygen therapy and respiratory diagnoses. Education was provided on 12/5/19 to the MDS nurses by the DON regarding admission and readmission updates to the Care Plans. 2. Residents' medical diagnoses were reviewed and care plans were audited for respiratory failure and oxygen therapy. Revisions were made as needed. The 100% audit was completed on 12/16/2019. 3-The MDS nurses will update/revise the care plans for admissions and readmissions. Audits will be completed by the DON/designee weekly times 4 weeks, then monthly times 3 months. The audits will cover admissions and readmissions from the prior week. 4- The results of the audits will be reviewed in the monthly QAPI meeting to assure compliance maintained ongoing. The QAPI committee will determine the need for further auditing beyond 3 months.	

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F 657	Continued From page 7 returned from the hospital she was not on oxygen. MDS Nurse #1 further stated she would normally put issues of respiratory failure under activities of daily living (ADLs) as this could affect the resident's ability to perform her ADLs. MDS Nurse #1 was observed to review the resident's Care Plan and stated the information was not on the resident's Care Plan. MDS Nurse #1 stated when a resident was re-admitted from the hospital they would reconcile the care plan and look at the diagnoses from the hospital and when the MDS assessment was conducted on 9/3/19 the risk for respiratory failure should have been added to the resident's Care Plan. MDS Nurse #1 continued and stated there was a new order for oxygen dated 12/2/19 and they would normally pick up new orders that needed to be added to the care plan in their morning meeting but their morning meeting had been cancelled for the last few days. On 12/5/19 at 2:45 PM the Administrator stated in an interview that Resident #9 had PRN (as needed) orders for oxygen for a long time and should have been included in the resident's Care Plan. The Administrator further stated the resident's Care Plan should have included information regarding her breathing problems and recent acute respiratory failure.	F 657		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761		12/31/19

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F 761	Continued From page 8 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to store unopened insulin in the refrigerator per manufacturer's specifications for 1 of 4 medication carts observed (200 Hall). The findings included: Levemir, Novolog and Basalgor insulin are used to control blood sugar in people with diabetes mellitus. Levemir is a long acting insulin and the manufacturer's specifications says that Levemir insulin should be kept in the refrigerator between 36 and 46 degrees Fahrenheit and once opened is good for 6 weeks. Novolog insulin is a short acting insulin. The manufacturer's specifications stated to keep unopened Novolog Flexpen in the refrigerator between 36 and 46 degrees Fahrenheit and once opened could store at room	F 761	F761 1-No specific resident was affected by the alleged deficient practice. 2-Residents with orders for Insulin Flexpen have the potential to be affected by the alleged deficient practice. All medication carts in the facility were audited on 12/5/2019 to ensure there were no unopened Insulin Flexpens. 3-Education was initiated by the DON/Designee on 12/5/2019 regarding the required refrigeration of unopened Insulin Flexpens. The education will be completed by 12/27/2019. The DON/designee will audit the medication carts daily for 4 weeks, then monthly for 3 months. Any needed re-education will be completed during the audits.	

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F 761	Continued From page 9 temperature for up to 28 days. Basalgor is a long acting insulin. The manufacturer's specifications included to store unopened insulin in the refrigerator between 36 and 46 degrees Fahrenheit and once opened is good for 28 days. On 12/05/19 at 1:48 PM an observation of the medication cart on the 200 Hall was made with Nurse #2. There was one unopened Novolog flexpen, one unopened Lantus Flexpen, and one Basalgar flexpen that was dispensed by the pharmacy on 12/3/19. There was no date on the medications as to how long the medication had been stored on the medication cart and out of the refrigerator. During the observation, Nurse #2 stated the insulin should be stored in the refrigerator until ready to be used and then should be dated when opened. An interview was conducted with the Administrator on 12/05/19 at 1:55 PM. The Administrator stated the unopened insulin should be stored in the refrigerator until opened.	F 761	4- The results of the audits will be reviewed in the monthly QAPI meeting to assure compliance maintained ongoing. The QAPI committee will determine the need for further auditing beyond 3 months.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		12/31/19

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F 880	Continued From page 10 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions 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.	F 880		

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F 880	Continued From page 11 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview the facility failed to have laundry personnel wear an apron when sorting soiled laundry for 1 of 1 observation of the laundry area (laundry employee #1). The findings included: The contract company's laundry process, dated as revised on 1/30/2013, indicated under Sorting: As linens are sorted into the proper wash classifications, employees must wear the proper personal protective equipment (PPE). On 12/3/2019 at 8:55 AM, observations were conducted of laundry employee #1 as he delivered clean linens to the linen closets on 4th floor, 3rd floor and 2nd floor. On 12/3/2019 at 9:54 AM, a continuous observation was conducted in the washing machine area of the laundry room with laundry employee #1 sorting soiled linen in the washers. The laundry employee #1 had gloves on and a	F 880	F880 1-No specific resident was affected by the alleged deficient practice. 2-Facility residents have the potential to be affected by the alleged deficient practice. Laundry employee #1 was immediately in serviced by the Contract Housekeeping Supervisor on 12/3/2019 at 10:30 AM on the policy for wearing PPE when sorting dirty laundry. 3-All housekeeping/laundry staff were re-educated on 12/3/2019 on the policy/procedure for handling soiled linen, which included the use of PPE. 4-Housekeeping Supervisor will conduct random weekly audits of housekeeping/laundry staff sorting soiled linen to ensure compliance with PPE for 4 weeks, then monthly for 3 months. The results of the audits will be reviewed in the monthly QAPI meeting to assure compliance maintained ongoing. The QAPI committee will determine the need for further auditing beyond 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345049	A. BUILDING _____ B. WING _____	C 12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RALEIGH REHABILITATION CENTER	616 WADE AVENUE RALEIGH, NC 27605

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F 880	Continued From page 12	F 880		

black shirt and blue pants uniform which he was wearing on the floor prior to sorting the dirty laundry and did not have a PPE gown or apron covering his clothing. The laundry employee sorted visibly soiled linen and clothes into 2 washer machines, and 2 barrels. Some linens were enclosed in plastic bags, some linens were loose. The laundry employee's clothing was touched by plastic bags, and the laundry barrel as he reached in to retrieve the laundry.

On 12/3/2019 at 10:10 AM, an interview was conducted with the Housekeeping Manager (HM), who stated after the loads of laundry were finished, laundry employee #1 would put them in the dryer and then bring the linens to the clean side of the laundry area, fold linens, and then redistribute to the floors. The HM displayed the PPE aprons that were in the laundry sorting area hanging on hooks and stated laundry employee #1 had been educated to wear the PPE apron and should have had it on when sorting the laundry.

On 12/3/2019 at 10:12 AM, an interview was conducted with the Administrator who stated laundry employee #1 should have been wearing an apron when sorting dirty laundry and they would do staff education.