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 12/19/2024

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

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 12/16/24 through 12/19/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #4YQL11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 12/16/24 through 12/19/24. Event ID# 4YQL11. The following intakes were investigated NC00223670, NC00223437, NC00222702, NC00220134, NC00218511, NC00212440, NC00211008, NC00210914 and NC00210899. 20 of the 20 complaint allegations did not result in deficiency.	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, resident and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of vision (Resident #69), and for the use of a wander elopement alarm and hypoglycemic (medications that help lower blood sugar levels in people with diabetes) medication (Resident #74) for 2 of 26 residents whose MDS assessments were reviewed. The findings included: 1. Resident #69 was admitted to the facility on	F 641	Accuracy of Assessment Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. On 12/18/24 Resident #69 Minimum Data Set (MDS) significant change assessment dated 11/29/24 was modified	1/10/25

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

Electronically Signed | 01/10/2025

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F 641	Continued From page 1 11/29/23 with diagnoses which included diabetes and diabetic retinopathy (eye condition that can cause vision loss and blindness in people with diabetes). The vision provider visit note dated 5/15/24 revealed Resident #69 was legally blind. The Minimum Data Set (MDS) significant change assessment dated 11/29/24 revealed Resident #69 was cognitively intact and was coded for adequate vision. An interview was conducted on 12/16/24 at 1:51 pm with Resident #69 who reported he was blind. An interview was conducted with Nurse Aid #2 on 12/18/24 at 12:27 pm who revealed Resident #69 had very poor vision and he needed staff to tell him where items were located. NA #2 stated she made sure Resident #69 had his personal items in reach and he knew where they were prior to leaving the room. An interview was conducted on 12/19/24 at 2:19 pm with MDS Nurse #1 who revealed she was aware of Resident #69's blindness. MDS Nurse #1 stated she must have coded Resident #69's assessment in error. During an interview on 12/19/24 at 2:36 pm with the Administrator she stated the MDS Nurse was responsible to ensure the resident MDS assessments were accurately coded. 2. Resident #74 was admitted to the facility on 12/03/22 with diagnoses which included anxiety, post-traumatic stress disorder, and diabetes.	F 641	to reflect the resident blindness in section B1000: Vision by the MDS Nurse. On 12/18/24 Resident # 74 Minimum Data Set (MDS) quarterly assessment dated 11/05/24 was modified to reflect the resident wander/elopement alarm in section P0200. On 12/18/24 Resident #74 Minimum Data Set (MDS) quarterly assessment dated 11/05/2024 was modified to reflect the use of hypoglycemic medication in section N0415. 2. On 1/10/24 MDS nurse completed an audit of current residents identified with MDS completed in last thirty days to ensure section B1000, N0415, and P0200 were accurately coded. Completed on 1/10/24. 3. On 1/7/24 the facility Director of Nursing provided education to the MDS department regarding accurately coding section B1000: Vision, N0415: High-Risk Drug Classes: Use and Indication , and PO200: Alarms on the MDS. 4. The facility Director of Nursing/designee will complete audit of 5 sampled residents to ensure that section B1000: Vision, N0415:High-Risk Drug Classes: Use and Indication, and PO200: Alarms on the MDS are accurately coded. The audit will be completed weekly times 12 weeks. Data obtained during the audit process	

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F 641	Continued From page 2 a. Review of the Elopement Risk Screening assessment dated 9/11/24 revealed Resident #74 was at risk for elopement. Resident #74 had a physician order dated 9/24/24 for alerting bracelet to be placed on left ankle. Resident #74 had a physician order dated 9/24/24 to check alerting bracelet everyday twice a shift for placement and function. A care plan last reviewed on 10/23/24 revealed Resident #74 was at risk for elopement as evidence by cognitive impairment and ability to self-propel with an intervention of alerting bracelet to left ankle. The nursing progress note date 11/03/24 at 5:02 pm revealed Resident #74 had a wander elopement alarm on the left ankle. Review of Resident #74's Medication Administration Record (MAR) for November 2024 revealed the alerting bracelet was in place and functioning as ordered. Review of the Minimum Data Set (MDS) quarterly assessment dated 11/05/24 revealed Resident #74 had moderate cognitive impairment and was independent for mobility. Resident #74 was not coded for a wander elopement alarm (alerting bracelet) during the 7-day lookback period. An interview was conducted with MDS Nurse #2 on 12/18/24 at 2:15 pm who revealed he completed Resident #74's quarterly assessment. He stated he utilized order review and observations to complete resident assessments, but he stated he probably just missed Resident	F 641	will be analyzed for patterns and trends and reported to the Quality Assessment and Assurance (QA & A/QAPI) Committee by the Director of Nursing monthly x 3 months. At that time, the QA & A/QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 641	Continued From page 3 #74's wander elopement alarm when he completed the assessment. b. Resident #74 had a physician order dated 11/03/24 for insulin glargine (long-acting insulin) 100 units per milliliter (ml). Inject 10 units at bedtime for diabetes management. Resident #74 had a physician order dated 11/03/24 for insulin lispro (fast-acting insulin) 100 units/ml. Inject 3 units before meals for diabetes. Review of Resident #74's Medication Administration Record (MAR) for November 2024 revealed the insulin glargine and insulin lispro were administered as ordered. Review of the Minimum Data Set (MDS) quarterly assessment dated 11/05/24 revealed Resident # 74 had moderate cognitive impairment. Resident #74 was not coded for use of hypoglycemic medication during the 7-day lookback period. An interview was conducted with MDS Nurse #2 on 12/18/24 at 2:15 pm who revealed he completed Resident #74's quarterly assessment. He stated he utilized record review to code for medication use. MDS Nurse #2 confirmed Resident #74's insulin was administered during the 7-day look back period. MDS Nurse #2 stated he was not sure how he missed Resident #74's insulin. An interview was conducted on 12/19/24 at 2:36 pm with the Administrator who stated the MDS Nurse was responsible to ensure the resident assessments were accurately coded.	F 641		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning	F 695		1/10/25

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F 695	Continued From page 4 CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to change the disposable inner cannula for 1 of 1 resident observed for tracheostomy care (Resident #111). The findings included: Resident #111 was admitted to the facility on 1/30/23 with diagnoses which included chronic respiratory failure and tracheostomy (a surgical opening through the front of the neck into the windpipe for an air passage to help breathe). Resident #111 had an active physician order dated 11/14/23 to perform tracheostomy care every shift and as needed. The Minimum Data Set (MDS) quarterly assessment dated 11/08/24 revealed Resident #111 was coded for tracheostomy care. The care plan last reviewed on 11/22/24 revealed Resident #111 had a tracheostomy related to impaired breathing mechanics. During a continuous observation of tracheostomy	F 695	F695 Respiratory /Tracheotomy Care and Suctioning Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. On 12/1824 Nurse #1 was provided education regarding providing Tracheotomy Care and Suction for a resident, to include changing the inner cannula every shift. On 12/18/24 the facility Director of Nursing completed competency observation of Care for a respiratory /Tracheotomy Care and Suctioning of Resident 2. The facility Director of Nursing will complete an audit of residents identified	

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F 695	Continued From page 5 care on 12/18/24 at 11:01 am through 11:13 am Nurse #1 was observed to perform hand hygiene, put on clean gloves and remove the soiled tracheostomy gauze and discard in trash. She then removed the soiled gloves and performed hand hygiene. Nurse #1 was then observed to open the sterile tracheostomy kit and put on sterile gloves and clean around Resident #111's tracheostomy site with sterile water and hydrogen peroxide solution. She was then observed to remove the sterile gloves and perform hand hygiene. Nurse #1 was observed to put on clean gloves and replace the gauze sponge around the tracheostomy site and placed a new tracheostomy tie holder. Nurse #2 removed the soiled gloves and performed hand hygiene. Nurse #1 reported Resident #111's tracheostomy care was complete because the disposable inner cannula did not have to be changed every day. An immediate interview was conducted on 12/18/24 at 11:14 am with Nurse #1 who revealed she changed Resident #111's inner cannula the day before when she completed tracheostomy care. Nurse #1 stated the inner cannula did not have to be changed every day and was only changed as needed. Nurse #1 was unable to state how often Resident #111's inner cannula was changed. During an interview on 12/18/24 at 2:26 pm with the Staff Development Coordinator she revealed tracheostomy care was provided per the physician order and was normally every shift and as needed. The Staff Development Coordinator stated the disposable inner cannula was to be replaced when tracheostomy care was completed.	F 695	with the need for care of a Tracheotomy to ensure the physician orders are accurate to include changing of the inner cannula every shift. The audit will be completed by 1-10-25. 3. The Director of Nursing/designee will provide education to licensed nurses regarding Respiratory /Tracheotomy Care and Suction of a resident. The education will be completed by 1-10-25. Any licensed nurse that is identified as not receiving the education will receive prior to working next scheduled shift. Newly hired licensed nurses will be provided the educated during Department Orientation by the Staff Development Coordinator/designee. 4. The Director of Nursing/designee will complete audit of residents identified with Tracheotomy Care to ensure that physician orders include changing the inner cannula every shift and documented. The audit will be completed weekly times 12 weeks. Data obtained during the audit process will be analyzed for patterns and trends and reported to the Quality Assessment and Assurance (QA & A/QAPI) Committee by the Director of Nursing monthly x 3 months. At that time, the QA & A/QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 695	Continued From page 6 During an interview on 12/18/24 at 4:40 pm with the Director of Nursing (DON) she revealed Resident #111's disposable inner cannula did not have to be changed every shift but could be changed daily. She confirmed Resident #111's physician order was for tracheostomy care to be completed every shift and that the order did not exclude the inner cannula change. A follow-up interview was conducted with the DON on 12/19/24 at 2:28 pm who revealed Resident #111's disposable inner cannula should have been changed when the tracheostomy care was completed.	F 695		
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 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	F 761		1/10/25

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F 761	Continued From page 7 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 observations, record review and staff interviews, the facility failed to: discard expired zinc supplement tablets for 1 of 2 medication rooms (Unit 3 Medication Storage Room), discard an opened bottle of aspirin that had no expiration date for 1 of 3 medication carts (4 B Medication Cart), and dispose of loose and unidentified pills for 2 of 3 medication carts (Medication Cart 3A and Medication Cart 4B) reviewed for medication storage. The findings included: a. An observation of the Unit 3 medication storage room on 12/18/24 at 3:50 PM revealed an unopened bottle of Zinc 50mg (milligrams) 100 tablets with an expiration date of August 2022. b. An observation of the 3A medication cart with Nurse #3 on 12/18/24 at 3:27 PM revealed 3 pills (one round white pill, one oblong shaped white pill, and one white capsule) were loose in the medication cart. Nurse #3 revealed she was not aware the loose pills were in the cart. Nurse #3 stated she could not identify the loose pills. Nurse #3 stated the loose medications were to be discarded. c. An observation of the 4B medication cart with Nurse #2 on 12/18/24 at 4:00 PM revealed an opened bottle of Aspirin 81 mg (milligrams) with no expiration date. The observation also revealed 3 pills (one oblong white pill, one peach oval pill,	F 761	F761 Label/ Store Drugs and Biologicals Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. On 12/18/24 The Director of Nursing removed and discarded the unopened Zinc 50 mg (milligrams) 100 tablets from medication room (Unit 3 Medication Storage Room). On 12/18/24 the Director of Nursing removed and discarded one oblong shaped pill, one round white pill and one white capsule from 3 A medication cart. On 12/18/24 the Director of Nursing removed and discarded an opened bottle of Aspirin 81 mg(milligrams). On 12/18/24 the Director of Nursing removed and discarded one oblong white pill, one peach oval pill, and one white round pill from 4 B medication cart. 2. On 12/18/24 the Director of Nursing /designee completed an audit of all	

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F 761	Continued From page 8 and one white round pill) were loose in the medication cart. Nurse #2 revealed she was not aware the loose pills were in the cart. Nurse #2 stated she could not identify the loose pills. Nurse #2 stated the loose medications, and Aspirin were to be discarded. An observation verifying there was no expiration date on the bottle of Aspirin was conducted with the Director of Nursing on 12/18/24 at 4:18 PM. An interview was conducted with the Director of Nursing (DON) on 12/19/24 at 3:16 PM. The Director of Nursing stated the unit managers and management team were responsible for completing a medication cart and medication room check each morning. The DON stated she would need to change the process and have the Staff Development Coordinator check each cart first thing in the morning. She additionally stated that she now sees that the unit managers need to check the carts each shift.	F 761	medication carts and medication rooms to validate that there were no loose pills or expired medication in the facility. No further medications were identified during the audit. 3. The Director of Nursing/designee will provide education to all licensed nurses regarding labeling, storing medication and Biologicals. The education will be completed by 1/10/25. Any licensed nurse that is identified as not receiving the education will receive prior to working next scheduled shift. Newly hired licensed nurses will be provided the educated during Department Orientation by the Staff Development Coordinator/designee. 4. The Director of Nursing/designee will complete audit of medication storage rooms and medication carts three times week for 12 weeks. Data obtained during the audit process will be analyzed for patterns and trends and reported to the Quality Assessment and Assurance (QA & A/QAPI) Committee by the Director of Nursing monthly x 3 months. At that time, the QA & A/QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	