STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345526	A. BUILDING _____ B. WING _____	R-C 05/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA REHAB CENTER OF BURKE	3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612

(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
{F 309} SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to follow a physician's order for treating chronic leg wounds for 1 of 4 residents sampled (Resident #267). The findings included: Resident #267 was admitted to the facility on 03/13/15 and discharged from the facility on 05/12/15, diagnoses included Diabetes Mellitus Type II, congestive heart failure, cellulitis, chronic leg wounds and others. The Minimum Data Set (MDS) dated 03/20/15 specified the resident's cognition was intact. Resident #267's Pressure Ulcer Care Area Summary (CAA) dated 03/25/15 read in part, "Resident has lymphedema with weeping to bilateral lower extremities and is ordered wraps to legs." Review of Resident #267's care plan dated 03/25/15 specified the resident had bilateral lower extremity lymphedema with weeping of skin. Interventions were to provide treatment/wraps/dressings to bilateral lower extremities as ordered by the physician.	{F 309}	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center¿s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F309 How corrective action will be accomplished for each resident found to have been affected by the deficient practice ¿ Resident #267 no longer resides at the facility. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice ¿ F309 Nursing	5/23/15

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

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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.

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{F 309}	Continued From page 1 Further review of Resident #267's medical record revealed a Physician's Assistant (PA) progress note dated 05/04/15. The progress note specified the resident complained that his dressings were not being changed often enough. The PA documented that he would write an order for Resident #267's dressings be changed at least every shift because the resident, "had a lot of problems with a lot of draining fluid." A physician's order was written 05/04/15 to change leg dressing three times daily. The order was noted by nurse #1. A document titled "Nursing Fax Communication Form" dated 05/08/15 completed by Nurse #2 and faxed to the on-call physician read in part, "patient needs to have dressing of lower extremities changed every shift. There are some (nurses) that won't change it." The on-call physician responded to the fax on 05/11/15 and ordered to "continue appropriate care." Further review of the medical record revealed that there was no clarification what, "appropriate care" was for Resident #267. The Treatment Administration Record (TAR) for the month of 05/15 was reviewed and revealed that Resident #267's dressing to his legs were to be changed daily. Further review of the TAR revealed that the dressings were not changed every shift as ordered by the PA. The PA was unable to be reached for an interview. On 05/13/15 at 12:58 PM the Director of Nursing (DON) was interviewed and explained that process for transcribing a physician's order. She	{F 309}	Administration and MDS completed a 100% audit on 5/13/2015. The audit covered time period of 5/1/2015 to 5/13/2015. The DON and Unit Manager in-serviced and educated all nurses on 1) 24 hour chart check/Monthly chart check and 2) (The following steps) a) Take paper order that was written by physician, b) Read the order carefully and call the doctor back if you have any questions., c) Put the order into Point Click Care, d) Double check the order in the computer against the paper order to ensure that it is the way the physician wrote it, e) ONLY after you are sure the order in the computer is accurate and complete do you sign off on the Paper Order. Sign your legal signature, the date and time that you transcribed the order into Point Click Care. Measures to be put in place or systemic changes made to ensure practice will not Re-occur - F.309 (a) DON, Unit Manager, or designee will audit all paper orders daily and compare to Point Click Care electronic TAR, Monday through Friday until substantial compliance is achieved. Then Mondays, Wednesday and Fridays for a period of 2 months, then every Wednesday x1 month. The DON will review during Interdepartmental Risk Meeting weekly to discuss findings and changes in process if needed to ensure paper orders have been transcribed and placed in Point Click Care electronic TAR. New Nurses hired will be educated on Order Transcription to include Step-by-Step instructions on transcribing	

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{F 309}	Continued From page 2 reported that the nurse who received the order was responsible for entering the order into the facility electronic medical system that would allow the new order to be reflected on the TAR for nurses to follow. The DON also stated that the facility had a secondary system check on night shift the nurses were responsible for conducting a complete chart audit. The DON reviewed Resident #267's medical record, confirmed there was an order written to change the dressing every shift and the order was noted by Nurse #1 but that Nurse #1 failed to enter the order into the computer system. The DON added that 3 of the 4 facility night nurses were new and she wasn't sure if they were aware they should audit the charts for accuracy. On 05/13/15 at 4:15 PM Nurse #1 was interviewed and reported that she overlooked the telephone order to change Resident #267's dressing every shift. She added that the resident had heavy drainage from his legs that saturated the dressings. She was unable to recall if she changed the dressing during her shift. On 05/14/15 at 9:30 AM nurse aide (NA) #1 was interviewed and reported she routinely cared for Resident #267. She stated that the resident had problems with excessive drainage from his legs. She explained that the drainage was so heavy that she would put a towel under his feet to absorb the drainage.	{F 309}	paper orders into Point Click Care electronic TAR and 24 hour Chart Check and Monthly Chart Check. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur - F.309 The DON or Administrator will present audits to QA&A monthly times 6 months for review and revision. This time frame can be extended at the discretion of the Administrator/DON based on findings of audits.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and	F 520		5/23/15

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F 520	Continued From page 3 assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff and resident interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in March of 2015. This was for one recited deficiency that was originally cited in February 2015 on a complaint investigation, recited in March on the recertification survey and recited in May 2015 on the current complaint investigation. The deficiency was in the area of wellbeing. The continued failure of the facility during three federal surveys of record show a pattern of the facility's inability to sustain an effective Quality	F 520	How the corrective action will be accomplished for the resident(s) affected. Resident # 267 no longer a resident and was discharged on 5/12/2015, prior to notification of oversight, Medication error completed on 5/13/2015. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. Nursing Administration and MDS completed a 100% audit on 5/13/2015. The audit covered time period of 5/1/2015 to 5/13/2015. The DON and	

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F 520	Continued From page 4 Assurance Program. The findings included: This tag is cross referred to: F 309: Care and Services to maintain wellbeing: Based on staff interviews and record review the facility failed to follow a physician's order for treating chronic leg wounds for 1 of 4 residents sampled (Resident #267). The facility was recited for F309 for failing to follow physician order's to change leg dressings three times daily for a resident who had copious amount of fluid draining from his legs. F309 was originally cited during the February 2015 complaint investigation for failing to monitor daily weights for a resident with congestive heart failure and failed to obtain weekly laboratory testing for 1 of 3 sampled residents. F309 was recited again in March, 2015 during the recertification survey for failing to administer an as needed antianxiety medication for 1 of 3 sampled residents who requested as needed medications. During an interview on 05/14/15 at 4:52 PM the Administrator stated the Quality Assessment and Assurance Committee met monthly and their action plans had been driven by the plan of correction they developed as a result of the previous complaint and recertification surveys. She stated the facility had weekly risk meetings where they discussed citations and monitoring tools to see what was working and what was not working. She stated it was a work in progress and acknowledged they still had areas to work on.	F 520	Unit Manager in-serviced and educated all nurses on 1) 24 hour chart check/Monthly chart check and 2) (The following steps) a) Take paper order that was written by physician, b) Read the order carefully and call the doctor back if you have any questions., c) Put the order into Point Click Care, d) Double check the order in the computer against the paper order to ensure that it is the way the physician wrote it, e) ONLY after you are sure the order in the computer is accurate and complete do you sign off on the Paper Order. Sign your legal signature, the date and time that you transcribed the order into Point Click Care. Measures in place to ensure practices will not re-occur. Corporate Education provided to Facility Administration on QA process and it¿s relation to Plan of Correction by Corporate Quality Assurance Nurse. DON, Unit Manager, or designee will audit all paper orders daily and compare to Point Click Care electronic TAR, Monday through Friday until substantial compliance is achieved. Then Mondays, Wednesday and Fridays for a period of 2 months, then every Wednesday x1 month. The DON will review during Interdepartmental Risk Meeting weekly to discuss findings and changes in process if needed to ensure paper orders have been transcribed and placed in Point Click Care electronic TAR. New Nurses hired will be educated on Order Transcription to include Step-by-Step instructions on transcribing paper orders into Point Click Care	

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F 520	Continued From page 5	F 520	electronic TAR and 24 hour Chart Check and Monthly Chart Check. How the facility plans to monitor and ensure correction is achieved and sustained. The DON or Administrator will present audits to QA&A monthly times 6 months for review and revision. This time frame can be extended at the discretion of the Administrator/DON based on findings of audits.	

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L 043	.2209(D) INFECTION CONTROL 10A-13D.2209 (d) The facility shall ensure communicable disease testing as required by 10A NCAC 41A, "Communicable Disease Control" which is incorporated by reference, including subsequent amendments. Copies of these Rules may be obtained at no charge by contacting the N.C. Department of Health and Human Services, Division of Public Health, Tuberculosis Control Branch, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. Screening shall be done upon admission of all patients being admitted from settings other than hospitals, nursing facilities or combination facilities. Staff shall be screened within seven days of the hire date. The facility shall ensure tuberculosis screening annually thereafter for patients and staff. This Rule is not met as evidenced by: Based on a review of facility policy and staff interviews the facility failed to screen new employees for tuberculosis for 4 of 4 new employees hired after 04/08/15. The findings included: The facility's policy and procedure dated 02/01/15 for the prevention and control of tuberculosis stated in part: "g. Employee Counseling and Screening. 1. At the time of hire, annually and as needed all employees will receive education specific to tuberculosis (TB), TB infection and their risk of developing active TB disease. 3. At the time of hire, all employees will have an initial two-step PPD (skin test used to screen for tuberculosis). 6. Employees will receive an annual one-step PPD and TB screen following their initial 2- step PPD at the time of hire."	L 043	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F441 How the corrective action will be accomplished for the resident(s) affected. File audits were completed for all staff to	5/23/15

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

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L 043	Continued From page 1 1. a. Review of a list of employees hired after 04/08/15 revealed Housekeeping Assistant #1 was hired on 04/22/15. An interview was conducted with Housekeeping Assistant #1 on 05/14/15 at 4:03 PM in the staff development office. Educational information regarding tuberculin skin testing was observed in front of him on the table. Housekeeping Assistant #1 confirmed he had worked at the facility since his hire date on 04/22/15 and had not been screened for risk of tuberculosis exposure, previous PPD skin test, or administered an initial PPD skin test. An interview with the Director of Nursing (DON) on 05/14/15 at 4:03 PM revealed she assumed the Unit Manager (UM) was screening new employees for tuberculosis exposure, previous PPD skin test, and administering an initial PPD skin if needed on the first day of their orientation. The interview further revealed the DON could not provide documentation of screening for tuberculosis exposure, previous PPD skin test, or administration of an initial PPD skin test for Housekeeping Assistant #1. An interview was conducted with the UM on 05/14/15 at 4:20 PM. The UM stated she did not recall being assigned the task of screening new employees or administering new employee's initial PPD skin test the first day of orientation and had never administered an initial PPD to a new employee. A follow up interview with the DON on 05/14/15 at 4:39 PM revealed she had informed the UM in February of 2015 that she would be responsible for screening new employees and administering	L 043	determine what staff members had not received TB screening and first step PPD testing between the time of exit and 5/18/15. Missing TB screening and PPD first step testing occurred between 5/18 and 5/20 to ensure that all staff members currently employed had been screened and tested per policy. The first step PPD¿s were completed by 5/20/15. Second step of the 2-step process for PPD¿s are still being completed per policy. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. Any staff member identified that had not received the required TB screening or first step PPD testing by 5/20/15 was not allowed to work until they received their TB screening and PPD testing. Measures in place to ensure practices will not occur. The DON, Unit Manager and Human Resources Manager were in-serviced by the Regional nurse consultant on Infection Control Policies, including 1) Policy 106 ¿ Employee Health, 2) Policy 108 - Student/Internship Health, 3) Policy 1401 ¿ Prevention and Control, 4) Policy 1402 ¿ Two-Step Mantoux on May 19, 2015 regarding the practices for TB screening and PPD testing for new hires and yearly thereafter. After a job offer has been made and accepted, but before the employee begins any activities, the HR manager will ensure	

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L 043	Continued From page 2 the initial PPD as needed the first day of orientation. b. Review of a list of employees hired after 04/08/15 revealed Nurse Aide (NA) #2 was hired on 05/05/15. During an interview on 05/14/15 at 4:12 PM NA #2 stated she had not been screened for risk of tuberculosis exposure and previous PPD skin test during her orientation. NA #2 further stated no mentioned or administered an initial PPD skin test since she was hired. The interview further revealed the facility had contacted her today (05/14/15) and asked her to come in for a skin test and screening. An interview with the Director of Nursing (DON) on 05/14/15 at 4:03 PM revealed she assumed the Unit Manager (UM) was screening new employees for tuberculosis exposure, previous PPD skin test, and administering an initial PPD skin if needed on the first day of their orientation. The interview further revealed the DON could not provide documentation of screening for tuberculosis exposure, previous PPD skin test, or administration of an initial PPD skin test for NA #2. An interview was conducted with the UM on 05/14/15 at 4:20 PM. The UM stated she did not recall being assigned the task of screening new employees or administering new employee's initial PPD skin test the first day of orientation and had never administered an initial PPD to a new employee. A follow up interview with the DON on 05/14/15 at 4:39 PM revealed she had informed the UM in February of 2015 that she would be responsible	L 043	the employee will complete the portion of the MFNC Employee PPD or Chest X-Ray Form. This may be done on any day prior to orientation or on the day of orientation prior to the beginning of orientation. How the facility plans to monitor ensure correction is achieved and sustained. SDC/Infection Control Nurse, DON or Designee will do a weekly audit to ensure that all new hires have received the required TB Screening or PPD testing if not contraindicated. This documented information will be shared with the QA/QI committee monthly for 6 months and revisions to practice made if needed to ensure compliance.	

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L 043	Continued From page 3	L 043		

for screening new employees and administering the initial PPD as needed the first day of orientation.

c. Review of a list of employees hired after 04/08/15 revealed Housekeeping Assistant #2 was hired on 04/22/15.

An interview with Housekeeping Assistant #2 on 05/14/15 at 4:15 PM revealed she was not screened for risk of tuberculosis exposure, previous PPD skin test, or administered a PPD skin test during orientation. Housekeeping Assistant #2 stated she was administered the PPD skin test today (05/14/15).

An interview with the Director of Nursing (DON) on 05/14/15 at 4:03 PM revealed she assumed the Unit Manager (UM) was screening new employees for tuberculosis exposure, previous PPD skin test, and administering an initial PPD skin if needed on the first day of their orientation. The interview further revealed the DON could not provide documentation of screening for tuberculosis exposure, previous PPD skin test, or administration of an initial PPD skin test for Housekeeping Assistant #2.

An interview was conducted with the UM on 05/14/15 at 4:20 PM. The UM stated she did not recall being assigned the task of screening new employees or administering new employee's initial PPD skin test the first day of orientation and had never administered an initial PPD to a new employee.

A follow up interview with the DON on 05/14/15 at 4:39 PM revealed she had informed the UM in February of 2015 that she would be responsible for screening new employees and administering

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L 043	Continued From page 4 the initial PPD as needed the first day of orientation. d. Review of a list of employees hired after 04/08/15 revealed NA #3 was hired on 05/05/15. An interview with NA #3 on 05/14/15 at 4:27 PM revealed she was not screened for risk of tuberculosis exposure, previous PPD skin test, or administered a PPD skin test during orientation. NA #3 stated she was administered the PPD skin test today (05/14/15). An interview with the Director of Nursing (DON) on 05/14/15 at 4:03 PM revealed she assumed the Unit Manager (UM) was screening new employees for tuberculosis exposure, previous PPD skin test, and administering an initial PPD skin if needed on the first day of their orientation. The interview further revealed the DON could not provide documentation of screening for tuberculosis exposure, previous PPD skin test, or administration of an initial PPD skin test for NA #3. An interview was conducted with the UM on 05/14/15 at 4:20 PM. The UM stated she did not recall being assigned the task of screening new employees or administering new employee's initial PPD skin test the first day of orientation and had never administered an initial PPD to a new employee. A follow up interview with the DON on 05/14/15 at 4:39 PM revealed she had informed the UM in February of 2015 that she would be responsible for screening new employees and administering the initial PPD as needed the first day of orientation.	L 043		