| 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 04/12/2016 |

| 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 |
|---|---|---|---|---|
| F 241 SS=D | 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff and resident interview, the facility failed to respond to resident ' s request for assistance for 1 (Resident #142) of 3 sampled residents reviewed for dignity which made the resident cry and miserable. Findings included:<br>Resident #142 was admitted to the facility on 7/9/15 with multiple diagnoses including stage 4 pressure ulcer. The quarterly Minimum Data (Set MDS) assessment dated 2/25/16 indicated that Resident #142 ' s cognition was intact with a BIMS (Brief Interview for Mental Status) score of 15. The assessment also indicated that the resident needed extensive assistance with toileting. The assessment also indicated that the resident had adequate vision.<br>The care plan dated 3/8/16 indicated that Resident #142 had an indwelling urinary catheter.<br>The nurse ' s notes for Resident #142 were reviewed. The notes dated 3/2/16 at 2:25 PM indicated that the nurse was called by the nurse aide to the room of Resident #142 and found the resident ' s pad to be wet and the catheter was leaking. The notes further indicated that the resident complained of irritation upon urination. The catheter was removed and was replaced.<br>The notes dated 4/6/16 at 3:03 PM indicated that the catheter was found to be leaking and reported to the nurse by the nurse aide. The nurse | F 241 | F241 Dignity and respect of individuality<br><br>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.<br><br>1. Interventions for affected resident:<br>Resident #142 had her catheter removed on 4/6/16. Since 4/6/2016, she has been incontinent and is being provided incontinent care as needed. The Director of Nursing discussed with her how to call for assistance as often as needed and that she may discuss issues/concerns with any staff member. This occurred on 4/13/2016.<br>A care planning with Inner-Disciplinary Team will occurred on 4/25/2016 with the | 4/28/16 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 04/23/2016 |

| 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 04/12/2016 |

| 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 |
|---|---|---|---|---|
| F 241 | Continued From page 1<br>assessed the catheter and the balloon was found to have 20 centimeter (cc) of water. The notes further indicated that the balloon should have 30 cc of water and so the nurse re-inflated the balloon to have 30 cc of water. The notes also indicated that the doctor was made aware and a urology consult was made to address issue of continuous leaking of the catheter. On 4/6/16 at 7:20 PM, the notes indicated that the doctor had ordered to discontinue the catheter and to cancel the urology appointment and the catheter was removed.<br>The wound doctor progress notes dated 4/6/16 was reviewed. The hand written notes were hard to read but it addressed the resident ' s leaking catheter.<br>On 4/11/16 at 9:05 AM, Resident #142 was interviewed. She indicated that last week (April 6), she was lying on a soaking wet brief from 10:30 AM to 3:30 PM. She was miserable, could not stand lying on a soaking wet brief and cried the whole time. Resident #142 stated that NA #1 (assigned to her) had changed her disposable brief that morning of 4/6/16. NA #1 was aware that her catheter was leaking and heard her informing Nurse #1 about it. The resident revealed that Nurse #1 did not come to check her catheter after the NA had informed her. Around 1 PM that day (4/6/16), Nurse #2 (Wound Nurse) and the wound doctor came to assess her wounds and to change the dressing. Nurse #2 did not change the dressing to her wounds because she was soaking wet and her catheter was leaking. Resident #142 indicated that she heard Nurse #2 informing Nurse #1 to check her catheter as it was leaking and she was wet. Nurse #2 informed her that she would be back to change her dressing later. Resident #142 stated that Nurse #1 did not come to check her catheter | F 241 | resident and her responsible party to review care. Resident verbalized no concerns at that time regarding incontinence needs or care needs during that meeting.<br>2. Interventions for residents identified as having the potential to be affected:<br>Beginning on 4/15/2016 the Director of Nursing(DON), Regional Clinical Director(RCD), Assistant Director of Nursing(ADON), Staff Development Coordinator(SDC), Minimum Data Set(MDS) Nurse, and Unit Managers(UM) were each assigned one hall in the facility. Each staff began conducting rounds on the residents to observe dignity and to inspect the physical layout for any potential concerns regarding care. Examples include call bell location, resident understanding and convenience for each individual to use the call bell, check water pitchers, bedside table placement. Concerns that were found during audits and immediately corrected at that time. The completed audit was presented to the DON at morning clinical meeting on 4/16/2016 and findings were discussed and acted upon as necessary.<br>3. Systematic Change:<br>All facility staff were required to be in-serviced in the area of dignity and respect. Facility staff attended all staff in-services from 4/14/2016 □ 4/16/2016 regarding dignity and respect. They included facility staff who are full time(FT), part time(PT) or as needed(PRN) across all shifts. They included all departments. These in-services were conducted by the Administrator, DON and a representative | |

| 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 04/12/2016 |

| 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 |
|---|---|---|---|---|
| F 241 | Continued From page 2<br>after Nurse #2 informed her about the leaking catheter. It was around 3:30 PM, when NA #2 (3-11 shift NA) came to her room and saw her crying and she told her that she was lying on a soaking wet brief from 10:30 AM and her catheter was leaking. Two NAs (NA #3 & NA #4) came around 3:30 PM to provide incontinence care for her. Resident #142 indicated that Nurse #2 came around 5 PM and changed the dressing to her wounds and Nurse # 1 came after 6 PM to remove her catheter.<br><br>On 4/11/16 at 9:30 AM, Nurse #2 was interviewed. Nurse #2 stated that last week (4/6) around 12:30 PM - 1 PM, she went to the room of Resident #142 with the wound doctor to assess the resident ' s wounds and to change her dressing. When she removed the resident ' s cover and looked at the wounds on the resident ' s thigh, she noticed a big pool of urine under her. The wound doctor had also observed that the resident was wet and that her catheter was leaking. She decided not to change the dressing and to come back later. She then informed Nurse #1 to check the resident ' s catheter as it was leaking and she was wet. She and the wound doctor proceeded to see other residents. Around 5 PM, she came back to the resident ' s room to change the wound dressing and found the resident crying. She was informed by the resident that she was lying on a soaking wet brief since 10:30 AM and was changed at 3:30 PM. The resident also informed her that Nurse #1 never come to check her catheter. Nurse #2 stated that around 6 PM, the resident ' s doctor was in the building and had asked her if the resident ' s catheter could be removed and she | F 241 | from Alliant Quality, Quality Initiative Organization(QIO), and SDC. The in-services included education, small group participation regarding dignity and respect and root cause analysis. All staff unable to attend the in-service preformed on 4/14/2016-4/16/2016 will be in-serviced as they are scheduled to work prior to starting their assigned shift by DON, ADON, or SDC. Newly hired employees will receive similar training by the SDC prior to working with residents.<br>4. Monitoring of the change to sustain system compliance ongoing:<br>Room audits for dignity and respect will be performed seven days a week on all shifts for two weeks, then five days a week on all shifts for four weeks, then three times a week on all shifts for six weeks to be completed by the DON, ADON, SDC, MDS, RCD, or UM. Concerns that are identified will be correct at that time.<br>Monthly for a minimum of three (3) months, the Director of Nursing or Assistant Director of Nursing will report audit findings from the audit of residents rooms regarding dignity issues to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three (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 04/12/2016 |

| 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 |
|---|---|---|---|---|
| F 241 | Continued From page 3 | F 241 | | |

responded that it could be removed as long as she was kept dry due to her wounds.

On 4/11/16 at 10:50 AM, NA #1 was interviewed. NA #1 stated that she was assigned to Resident #142 on 4/6/16 on 7-3 shift. She indicated that right after 7 AM that day, she checked the resident and she was wet. Around 9:30 -10:00 AM, the resident was wet again and had changed her brief. She noticed that the resident ' s catheter was leaking and she informed Nurse #1 about it. NA #1 indicated that she didn ' t know if Nurse #1 had checked the resident ' s catheter or not. NA #1 stated that there were student aides that day and they helped with incontinence care. NA #1 could not remember if she had checked the resident for incontinence after lunch but she indicated that according to the resident she did not check her or provided her with incontinence care.

On 4/11/16 at 11:00 AM, Nurse #1 was interviewed. Nurse #1 was assigned to Resident #142 on 4/6/16 on 7A - 7P shift. Nurse #1 stated that she was informed that the catheter of Resident #142 was leaking but she could not remember the exact time she was informed and who informed her. She indicated that she checked the resident ' s catheter around 10:30-10:45 AM and informed the doctor who was in the building that the catheter was leaking. The doctor had ordered to discontinue the catheter and she removed the catheter around 11:45 AM.

On 4/11/16 at 2:15 PM, Nurse #1 was again interviewed to clarify information after reading the nurse ' s notes of Resident #142. Nurse #1 indicated that the time documented in the nurse '

| 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 04/12/2016 |

| 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 |
|---|---|---|---|---|
| F 241 | Continued From page 4 | F 241 | | |

s notes was not the same time she checked the catheter or removed the catheter. She further indicated that she did not remember the exact time she had checked the catheter or removed the catheter. She also indicated that she did not inform NA #1 after she had checked the resident ' s catheter.

On 4/11/16 at 3:30 PM, Resident #142 was again interviewed. The resident indicated that NA #1 was aware that she was wet due to her leaking catheter but the NA was waiting for Nurse #1 to check her catheter. After lunch, the student aides came to her room to empty her catheter bag.
On 4/11/16 at 4:20 PM, NA #2 was interviewed. NA #2 had worked 3-11 shift on 4/6/16 on the hall where Resident #142 resided. NA #2 stated that around 3:30 PM on 4/6/16, she went to the room of Resident #142. She observed the resident was crying and when asked what happened, the resident informed her that she had been lying on a soaking wet brief since before lunch. NA #2 indicated that she had observed 2 NAs (NA# 3 & NA #4) provided incontinent care to the resident and had to change the brief, the draw sheet and the pad on the resident ' s bed.

On 4/11/16 at 4:45 PM, NA #3 was interviewed. She stated that she was assigned to Resident #142 on 4/6/16 on 3-11 shift. She stated that around 3:30 PM, she was called to the resident ' s room and found the resident wet. She added that with the help of NA #4, they provided incontinence care to the resident. NA #3 did not remember if they had changed the resident ' s draw sheet or pad that day but her brief was wet.

NA #4 was not available for interview.

| 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 04/12/2016 |

| 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 |
|---|---|---|---|---|
| F 241 | Continued From page 5<br>On 4/12/16 at 2:45 PM, the Director of Nursing was interviewed. He stated that he was informed of the incident regarding Resident #142 on 4/11/16 and he had talked to Nurse #1 about it. He stated that the information conveyed to us by the resident was the same information he gathered from the resident during the interview. | F 241 | | |