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 12/20/2017

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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey. Event ID BEEW11.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information	F 636		1/8/18

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

Electronically Signed | 01/07/2018

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F 636	Continued From page 1 regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete Care Area Assessment summaries which included underlying causes, risk factors and factors to be considered in developing individualized care plan interventions for 3 of 7 sampled residents (Resident #5, #3 and #1). The findings included: 1. Resident #5 was admitted to the facility on	F 636	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged	

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F 636	Continued From page 2 10/30/17 and had a diagnosis of multiple sclerosis, dysphagia (difficulty swallowing), protein/calorie malnutrition and dehydration. The Admission Minimum Data Set (MDS) Assessment dated 11/6/17 noted the resident was cognitively intact, required extensive assistance for activities of daily living (ADLs), was incontinent of bowel and bladder, was at risk for pressure ulcers and received nutrition/hydration to manage skin problems. The Admission MDS triggered the following care areas for further assessment and factors to be considered in developing the resident ' s Care Plan: Visual Function, ADL Functional/Rehabilitation Potential, Urinary Incontinence, Falls, Nutritional Status, Dehydration/Fluid Maintenance, Pressure Ulcers, Pain and Return to Community Referral. Review of the Care Area Assessment (CAA) worksheets signed and dated as complete on 11/13/17 by MDS Nurse #1 revealed no assessments or summaries regarding the above care areas in order to develop an individualized care plan for the resident. MDS Nurse #1 stated in an interview on 12/19/17 at 1:15 PM that she started working at the facility in October 2017 and she did not know to do CAA summaries as they did not do this where she came from. On 12/20/17 at 12:52 PM the Administrator stated in an interview it was her expectation that any care area that triggered on the MDS would have a CAA summary done.	F 636	deficiencies cited have been or will be corrected by the dates indicated. F636 Plan for correcting specific deficiency. The process that led to deficiency cited. The facility failed to complete Care Area Assessment summaries which included underlying causes, risk factors and factors to be considered in developing individualized care plan interventions for 3 of 7 sampled residents (Resident #5, #3, and #1). The assessments for resident #5, #3 and #1 have been modified as of 1/3/2018 to include CAA summary for triggered areas and care plans were developed in accordance to those triggers. Residents that reside in the facility have the potential to be affected by this deficient practice. The MDS coordinator will complete a quality review of MDS assessments submitted within the past 30 days to ensure CAA summaries were completed for triggered areas as well as care plan development by 1/8/2017. Procedure for implementing the acceptable plan of correction. The MDS nursing staff was educated on 12/20/2017 by the Regional MDS, information included completion of CAA summaries for triggered areas as well as the development of care plans based on	

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F 636	Continued From page 3 2. Resident #3 was admitted to the facility on 10/19/17 and had a diagnosis of hip fracture, diabetes, chronic obstructive pulmonary disease (COPD), peripheral vascular disease and generalized muscle weakness. The Admission Minimum Data Set (MDS) Assessment dated 10/26/17 revealed the resident was cognitively intact, had verbal behaviors directed towards others 1-3 days and had behavioral symptoms not directed towards others 4-6 days of the 7 day assessment period. The MDS revealed the resident had a fall prior to admission and required limited to total assistance with activities of daily living (ADLs) and was frequently incontinent of bowel. The Admission MDS triggered the following care areas for further assessment and factors to be considered in developing the resident ' s Care Plan: Cognitive Loss/Dementia, ADL Functional/Rehabilitation Potential, Urinary Incontinence, Psychosocial Well-Being, Behavioral Symptoms, Falls, Nutritional Status, Pressure Ulcers, Pain and Return to Community Referral. Review of the Care Area Assessment (CAA) worksheets signed and dated as complete on 11/7/17 by MDS Nurse #1 revealed no assessments or summaries regarding the above care areas in order to develop an individualized care plan for the resident. MDS Nurse #1 stated in an interview on 12/19/17 at 1:15 PM that she started working at the facility in October 2017 and she did not know to do CAA summaries as they did not do this where she	F 636	triggered areas. Any in-house staff member who completes the MDS assessment and CAA summaries who did not receive in-service training by 1/7/2017 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Regional MDS Consultant or designee will monitor and audit comprehensive assessments each week to ensure completion of CAA summaries and cross referenced to care plan. These audits will include 5 random comprehensive assessments for 4 weeks and then monthly for 3 months until resolved by QAPI committee. The RN MDS nurse will present reports to the monthly QA committee to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the monthly QA meeting. The monthly QA meeting is attended by the ADministrator, DON, MDS Coordinator, Therapy, HIM, Dietary Manager, and other facility representatives as appropriate to	

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F 636	Continued From page 4 came from. On 12/20/17 at 12:52 PM the Administrator stated in an interview it was her expectation that any care area that triggered on the MDS would have a CAA summary done. 3. Resident #1 was admitted to the facility on 10/10/16 and had a diagnosis of generalized muscle weakness, diabetes mellitus and below the knee amputation. The Annual Minimum Data Set (MDS) Assessment dated 10/18/17 revealed the resident was cognitively intact, had verbal behavioral symptoms directed towards others 1 to 3 days of the 7 day assessment period and required minimal to extensive assistance with activities of daily living (ADLs). The Annual MDS triggered the following care areas for further assessment and factors to be considered in developing the resident ' s Care Plan: Cognitive Loss/Dementia, ADL Functional/Rehabilitation Potential, Urinary Incontinence, Psychosocial Well-Being, Behavioral Symptoms, Falls, Nutritional Status, Dental Care, Pressure Ulcers and Psychotropic Drug Use. Review of the Care Area Assessment (CAA) worksheets signed and dated as complete on 10/27/17 by MDS Nurse #1 revealed no assessments or summaries regarding the above care areas in order to develop an individualized care plan for the resident. MDS Nurse #1 stated in an interview on 12/19/17	F 636	conversation. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	

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F 636	Continued From page 5 at 1:15 PM that she started working at the facility in October 2017 and she did not know to do CAA summaries as they did not do this where she came from. On 12/20/17 at 12:52 PM the Administrator stated in an interview it was her expectation that any care area that triggered on the MDS would have a CAA summary done.	F 636		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656		1/8/18

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F 656	Continued From page 6 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a Care plan for pressure ulcers for 1 of 3 residents reviewed for pressure ulcers (Resident #5). The findings included: Resident #5 was admitted to the facility on 10/30/17 and had a diagnosis of multiple sclerosis, protein/calorie malnutrition, dysphagia (difficulty swallowing) and dehydration. The Admission Minimum Data Set (MDS) Assessment dated 11/6/17 revealed the resident was cognitively intact, required extensive to total assist with activities of daily living (ADLs) was incontinent of bowel and bladder and at risk for pressure ulcers. The MDS revealed the resident was admitted to the facility with one Stage 2 pressure ulcer and one unstageable pressure ulcer. The MDS noted the resident had a pressure relieving device to the bed and chair, received nutrition/hydration to manage skin	F 656	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F656 Plan for correcting specific deficiency. The process that led to deficiency cited. The facility failed to develop a care plan for pressure ulcers for 1 of 3 residents reviewed for pressure ulcers (resident #5).	

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F 656	Continued From page 7 problems, and received pressure ulcer care. The Care Area Assessment (CAA) summary sheet revealed pressure ulcers triggered but there was not a summary written regarding the resident ' s pressure ulcers and further risk for pressure ulcers. The CAA worksheet for pressure ulcers signed by MDS Nurse #1 as complete on 11/13/17 contained a checkmark to show that pressure ulcers would be addressed in the resident ' s Care Plan. Review of the resident ' s Comprehensive Care Plan dated 11/1/17 and revised on 11/13/17 contained no information or interventions regarding the treatment or prevention of pressure ulcers. An interview was conducted with MDS Nurse #1 on 12/19/17 at 1:15 PM. The MDS Nurse was observed to review the Care Plan for Resident #5. The MDS Nurse stated she did not do a Care Plan for pressure ulcers for the resident and stated "I missed it." The Administrator stated in an interview on 12/20/17 at 12:52 PM she expected pressure ulcers to be care planned per results of the Care Area Assessment.	F 656	Resident #5 has a pressure ulcer care plan and interventions in place as of 12/20/2017 All residents that reside in the facility have the potential to be affected by this deficient practice. A quality review of residents with wounds was completed by Assistant Director of Nursing on 1/5/2018 and care plans updated with interventions in place for residents being treated for wounds. Procedure for implementing the acceptable plan of correction. The MDS nursing staff was educated on 12/20/2017 by the Regional MDS Nurse, on the completion of CAA summaries for triggered areas as well as the development of care plans based on triggered areas. Any in-house staff member who completes the MDS Assessments and CAA Summaries who did not receive in-service training by 1/7/2017 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Monitoring Procedure to ensure that the	

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F 656	Continued From page 8	F 656	plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The DON or designee will complete quality review of 5 random care plans weekly based on the MDS completion schedule to ensure implementation of care plans. This quality review will be completed for 5 care plans weekly for 4 weeks then monthly for 3 months until resolved by QAPI committee. The DON or designee will present reports to the monthly QA committee to ensure corrective action initiated as appropriate and plan modified based on findings. The monthly QA meeting is attended by the Administrator, DON, ADON, MDS Coordinator, Therapy, HIM, Dietary Manager, and other facility representatives as appropriate to conversation. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	