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 02/01/2018

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RALEIGH REHABILITATION CENTER	**616 WADE AVENUE RALEIGH, NC 27605**

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F 000	INITIAL COMMENTS Event ID# HMU211 for recertification and complaint survey was conducted on 2/1/18 along with the follow-up for event BEEW12. The facility remains out of compliance. The Statement of Deficiencies was amended on 2/15/18 at tag F686, F689 and F698.	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of	F 623		2/28/18

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

Electronically Signed | 02/20/2018

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F 623	Continued From page 1	F 623		

this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402,

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F 623	Continued From page 2 codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to notify the ombudsman of a resident ' s transfer to the hospital and provide a written reason for transfer to the responsible party (RP) within 30 days for 1 of 1 residents reviewed for transfer/discharge. (Resident #127). The findings included: Resident #127 was admitted to the facility on 12/21/17 and had a diagnosis of respiratory	F 623	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. 1. Resident #127 no longer resides in the facility as of 12/29/2017. The ombudsman was notified of the residents	

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F 623	Continued From page 3 failure, hypertension and diabetes. There was a physician ' s order dated 12/29/17 to send the resident to the hospital due to abnormal laboratory results. On 1/31/18 at 10:20 AM, the Social Worker stated in an interview she did not send a letter to the resident/ RP or the ombudsman when Resident #127 was transferred to the hospital. On 1/31/18 at 10:25 AM, the Administrator stated in an interview she had left a message on the ombudsman ' s voice mail and had sent the ombudsman e-mails asking how often she would like to receive the list of residents transferred to the hospital but she had not heard back from the ombudsman. The Administrator further stated she had planned to send to the ombudsman a list of hospital admissions back to the end of November to catch up since she had not heard back from the ombudsman but had not done this yet. The Administrator stated they had not instituted the letter to the resident/RP and was still in the planning stage for this.	F 623	discharged on 1/31/2018 by the administrator. 2. A review of residents transferred from the facility within the past 30 days was conducted by the social worker and notifications were sent to resident responsible parties on 2/16/2018. 3. The administrator or designee will educate the social worker, business office staff, and licensed nurses on notification of transfer and discharges to the responsible party and ombudsman by 2/23/2018. When the patient is sent to the ER the discharge notice is sent in the patient discharge envelope packet by the discharging nurse. The following business day the social worker or designee will complete the notice of transfer/discharge and mail to the representative or patient, keep a copy in the medical file and log on the transitional care log. The administrator will review all transfers and discharges weekly to ensure notification has been made to the ombudsman and responsible party and this will continue for 3 months. 4. Findings to be reported to QAPI committee monthly and quality monitoring schedule will be modified based on findings. QAPI committee will review the results of the audits monthly for three months and as needed thereafter.	
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a	F 625		2/28/18

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F 625	Continued From page 4 nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review and staff interviews, the facility failed to provide a written notice of the bed hold policy at the time of transfer for 1 of 1 residents reviewed for transfers (Resident #127). The findings included: The facility ' s policy titled Bed Hold dated 5/24/16 read: "The facility provides written notification to all residents, family members and/or legal representative of the bed-hold policy upon	F 625	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. 1. Resident #127 no longer resides in the facility as of 12/29/2017. 2. Review of transfers within the past 30 days will be conducted by the business	

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F 625	Continued From page 5 admission, and at the time of transfer, in accordance with federal and state guidelines." Resident #127 was admitted to the facility on 12/21/17 and had diagnoses of respiratory failure, dysphagia, anemia and diabetes. The resident was transferred to the hospital on 12/29/17. On 1/30/18 at 10:25 AM an interview was conducted the Business Office Manager who stated they did not send the bed hold policy with a resident when transferred to the hospital but they called the family to see if they wanted to hold the resident ' s bed and let them know the cost of holding the bed. On 1/31/18 at 11:08 AM the second floor Unit Supervisor stated in an interview they did not send a copy of the bed hold policy with a resident when sent to the hospital. The Unit Supervisor stated if the family wanted to hold the bed, she got the information from the business office. On 2/1/18 at 1:53 PM The Director of Nursing (DON) stated in an interview she was aware a bed hold policy should be sent with the resident to the hospital but was not aware the staff were not providing the bed hold policy at the time of transfer.	F 625	office coordinator by 2/17/2018 to review the bed hold policy. 3. The administrator or designee will educate the social worker, business office staff, and licensed nurses on the policy of providing a bed hold notice at time of transfer. Transfers will be reviewed during morning clinical meeting to ensure written notice was provide to the resident at time of discharge. When the patient is sent to the ER the bed hold policy is sent in the patient discharge envelope packet by the discharging nurse. The following business day the business office coordinator or designee contacts the patient or representative to ensure they received the information, ask if they plan to pay room hold, document in the medical record, mail out if necessary and place a copy in the financial file. The administrator or designee will conduct a quality review 5 times weekly to ensure notices were provided. This will continue for 3 months. 4. Findings to be reported to QAPI committee monthly and quality monitoring schedule modified based on findings. QAPI committee will review the results of the audits monthly for three months and as needed thereafter.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 658		2/28/18

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F 658	Continued From page 6 (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to document an assessment after returning from dialysis for 1 of 2 residents reviewed for dialysis (Resident #107). The facility also failed to follow professional standards of practice by leaving medications unattended in a resident ' s room for 1 of 1 residents observed to have medications in his room (Resident #103) and failed to order a CAT (Computed Axial Tomography) Scan per physician's orders for 1 of 1 residents who had a CAT scan ordered (Resident #328). The findings included: 1. Resident #107 was admitted to the facility on 6/7/17 and had a diagnosis of end stage renal disease with dialysis, anemia, diabetes with dependence on insulin and congestive heart failure. The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 1/4/18 revealed the resident had severe cognitive impairment and required limited to total assistance with all activities of daily living. The MDS noted the resident received dialysis. The resident ' s Care Plan dated 11/28/17 noted the resident received hemodialysis related to renal failure. The interventions included the following: Dialysis on Tuesday, Thursday and Saturday. Monitor/document/report to physician any signs or symptoms of infection to access site, changes in level of consciousness, changes in skin turgor, Monitor/document/report to physician	F 658	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. 1. No adverse reactions were noted to resident #107. An assessment was completed on resident #107 to include dialysis access site on 2/1/2018.1. Root Cause: the facility failed to document an assessment after returning from dialysis for resident #107. The facility further identified a lack of education of the post dialysis assessment process as the root cause of the deficient practice. Resident #103 no longer resides in the facility as of 1/29/2018. Nurse #4 is no longer employed with this facility as of 1/31/2018. Root Cause: nurse#4 singularly acted and violated the standard of care of medication administration by leaving medication at the bedside. Resident #328 had his CT scan completed on 2/7/2018 and it has been reviewed by the MD. Root Cause: the facility identified a lack of system process for tracking the completion of ordered outside diagnostic test. 2. The dialysis residents will have assessments of their access sites and overall status to be completed by the unit	

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F 658	Continued From page 7 signs and symptoms of bleeding, bacteremia or septic shock. Review of the nursing progress notes for January 2018 revealed one nursing note documented when the resident returned to the facility from dialysis and was dated 1/20/18 at 7:03 PM. The note revealed the dialysis center called to notify the facility that due to excessive bleeding from the access port they were going to send the resident back to the facility with a pressure bandage. The progress note revealed the resident ' s vital signs were stable, the dressing was dry and intact, the resident ' s breathing was even and non-labored and the resident had no pain. The nurse ' s notes for January 2018 revealed no other documentation of a nursing assessment when the resident returned from dialysis. There was no documentation that the resident did not go to dialysis 3 times per week and no documentation the resident had a change of condition after dialysis in January 2018. On 1/31/18 at 11:30 AM Nurse #3 stated in an interview Resident #107 returned from dialysis after her shift but the nurses were supposed to check the shunt site for bruit and thrill and the resident ' s vital signs. On 2/1/18 at 11:49 AM the facility ' s Nurse Consultant stated in an interview that upon returning from dialysis the nurse should take the resident ' s vital signs, assess the site for signs of infection and bleeding and check the fistula for bruit and thrill. On 2/1/18 at 2:00 PM the Director of Nursing stated when a resident returned from dialysis, the nurse should conduct an assessment of the	F 658	managers by 2/22/2018. No residents were identified to have medications at bedside therefore, affected by this deficient practice. A quality review of any diagnostic test for the past 30 days will be conducted by the unit manager or designee by 2/23/2018. 3. The director of nursing or designee will educate the licensed nurses on the process of assessing dialysis residents after treatment to include assessment of access site, vitals and function of device. The director of nursing or designee will review dialysis progress notes weekly to ensure compliance with the process for 4 weeks and then for 2 months. The director of nursing or designee will educate the licensed nurses on safe medication administration by 2/23/2018 and will be added to the orientation agenda. The director of nursing or designee will conduct random medication administration reviews 5 times weekly to ensure proper procedures are followed and no medication if left at this bedside this will continue for 4 weeks and then monthly for 2 months. This will continue for 3 months. The director of nursing or designee will educate the licensed nurses on the process for scheduling appointments and documentation to be completed after returning. The education with licenses nurses for will be completed by 2/23/2018 and will be added to the orientation agenda. The clinical team will review outside diagnostic tests during the daily clinical meeting to ensure transportation has been schedule and the appointment completed. The director of	

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F 658	Continued From page 8 resident ' s fistula, response to dialysis and vital signs and document in the nurse ' s notes. 2. Resident #103 was admitted to the facility on 12/15/17 and had a diagnosis of adult failure to thrive and cellulitis of an extremity. The Admission Minimum Data Set (MDS) Assessment dated 12/22/17 revealed the resident was cognitively intact and required limited assistance with activities of daily living. The resident had not been assessed to administer his own medications. Review of the resident ' s Medication Administration Record revealed the resident received the following medications in the morning: Bactrim DS (antibiotic), Tenofovir (antiviral), Fluconozole (antifungal), A Multivitamin, Prezcobix (antiviral) and Voltaren gel (antiantiflammatory). On 1/29/18 at 11:20 AM, Resident #103 was observed lying in bed with eyes closed and appeared to be asleep. The resident ' s over-bed table was beside the bed and a medicine cup that contained 5 pills and a medicine cup 3/4 full of a gel substance was on the table. On 1/29/18 at 11:24 AM, the second floor Unit Manager was observed to enter the room and stated the medications should not have been left in the resident ' s room. On 1/29/18 at 11:25 AM, Nurse #4 stated in an interview the resident usually took the medications with fruit at breakfast and apparently	F 658	nursing or designee will conduct a quality review of appointments weekly to ensure compliance. This will continue for 3 months. 4. Findings to be reported to QAPI committee monthly and quality monitoring schedule will be modified based on findings. QAPI committee will review the results of the audits monthly for three months and as needed thereafter.	

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the resident did not get fruit for breakfast this morning. The Nurse further stated the pills were his morning medications and she had more residents than usual this morning and the resident could be very difficult and yell so she left the pills for the resident to take. The Nurse stated the gel was Voltaren (anti-inflammatory medication) that the resident rubbed on the knees.

On 2/1/18 at 1:53 PM the Director of Nursing stated in an interview it was her expectation for the nursing staff to follow the policy of medication administration to a resident and stated the nurse should not have left medications unattended at the bedside.

Ex 3

Resident #328 was admitted to the facility on 3/30/17 and re-admitted on 8/4/17 with diagnoses including Dementia and a history of a lung nodule.

Review of the Physician visit dated 10/4/17 read: "RUL Lung nodule: will order follow up CAT scan of this, since a diagnosis of cancer would likely explain, weight loss and offer prognostic information to his family."

Review of the Physician visit dated 10/20/17 read: "RUL lung nodule: follow up CAT scan?"

Review of the Physician visit dated 12/4/17 MD read: "follow up CAT scan of lung not sure if done and will request from hospital."

Review of the Physician visit dated 1/30/18 read: "RUL (right upper lobe) Lung nodule: Follow up

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F 658	Continued From page 10 CAT scan." During an interview with the 3rd floor nursing unit manager on 1/30/18 at 3:17 PM she stated that the results may be downstairs in "the bin" for filing. She checked the computer and it was not under the results tab as uploaded to the computer. During an interview with Medical Records on 1/30/18 at 3:30 PM she stated she would first find out if the CAT scan was actually done. During an interview with the 3rd floor Nursing Unit Manger on 1/31/18 at 8:59 AM she stated if there was a CAT scan to be booked she was now the scheduler. She stated she would call the appropriate office/hospital and book. She stated she would need to check to see if the scan were done. During an interview with Medical Records on 1/31/18 at 9:30 AM she stated she telephoned the area hospitals and the CT scan was never done. During an interview with the Director of Nursing (DON) on 1/31/18 at 10:56 AM she stated currently the unit managers are scheduling all scans. She stated she would expect that all orders be taken off and be completed as ordered.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F 677		2/28/18

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F 677	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on medical record review, observations and staff interviews the facility failed to provide incontinence care for 1 of 3 residents (Resident # 428) requiring extensive to total assistance with care. The findings included: Resident # 428 was admitted to the facility on 11/6/17 with diagnoses of hypertension, Alzheimer's dementia, diabetes mellitus, and chronic kidney disease. A review of the most recent admission Minimum Data Set (MDS) dated 11/13/17 revealed that he was cognitively impaired. He required total care for transfers, personal hygiene, eating and toileting. He was always incontinent of bowel and bladder and was at risk for developing a pressure ulcer but had no pressure ulcer on admission. A review of the resident's care plan dated 1/4/18 revealed that staff were to apply protective or barrier lotion after incontinence paying attention to bony prominences. On 01/31/18 at 11:15 AM the Treatment Nurse was observed providing care. The resident's under pad was observed with dark, yellow dried stains with a strong urine odor. The Treatment Nurse removed the resident's adult brief and it was observed saturated in urine and stool with a strong urine odor. During the observation Nursing Assistant (NA#2) came into the Resident ' s room and stated that she had come in to do the resident's morning care and was waiting for the Treatment Nurse to complete her treatment	F 677	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. 1. Resident #428 received incontinence care on 1/31/18 and is continuing to receive timely incontinence care. Root Cause: NA#2 singularly acted and violated the standard of timely incontinent care. 2. Random audits were conducted by the unit managers or designee to ensure care is being rendered on 2/12/2018 to ensure no other residents were affected. 3.The director of nursing or designee will educate the licensed nurses and certified aides on the importance of timely incontinence care by 2/23/2018 and will be added to the orientation agenda. The director of nursing or designee will audit 5 residents per day for 4 weeks and then monthly for 2 months. 4. Findings to be reported to QAPI committee monthly and quality monitoring schedule will be modified based on findings. QAPI committee will review the results of the audits monthly for three months and as needed thereafter.	

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F 677	Continued From page 12 before she cleaned him. On 01/31/18 at 11:34 AM an interview with the Assistant Director of Nursing, Nurse Supervisor #1 with the Nursing Assistant (NA#2) revealed that the NA#2 had checked on the resident when she came to work in the morning but had not looked at the resident's under pad or his adult brief. NA #2 further stated that if she had she would have known that the pad was soiled. On 01/31/18 at 11:43 AM the ADON and the Nurse Supervisor revealed that their expectations would have been that NA#2 would have checked to make sure the resident was clean and dry and changed him.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews the facility failed to provide activities for 1 of 1 resident reviewed for activities (Resident #64). The findings included:	F 679	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely	2/28/18

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F 679	Continued From page 13 Resident #64 was admitted to the facility on 2/3/17 and re-admitted on 5/8/17 with diagnoses including Cerebrovascular Accident and Dementia without behavioral disturbance. Review of the October 2017 recreation participation record documented Resident #64 had two 1:1 visits and one musical interaction in the evening. Review of the November 2017 recreation participation record documented Resident #64 attended three socials and had one 1:1 visit for the month. Review of the activity progress note dated 11/14/17 documented Resident #64 had cognitive impairment and limited mobility. He was currently receiving 1 on 1 room visits 2-3 times weekly, due to his short attention span he received smaller intervention with small achievable activities. Review of the activity progress note dated 12/7/17 documented Resident #64 refused most invites to out of room group activities and was currently receiving 1 on 1 room visits with small achievable activities 2-3 times weekly. He was alert and able to make needs known. Review of the most recent quarterly Minimum Data Set (MDS) assessment dated 12/8/17 identified Resident #64 as having short and long term memory problems and moderately impaired cognitively in making daily decisions. Review of the December 2017 recreation participation record documented Resident #64 attended three socials, had five 1:1 visits, one musical interaction in the evening and was	F 679	because it is required by both Federal and State laws. 1. Resident #64 is receiving activities as outlined by his plan of care. Root Cause: the Activities Director didn't have a effective monitoring system in place to ensure completion and documentation of resident #64 activities as outlined in the plan of care. 2. A review of residents dependent on staff for activities will be conducted by the activity director to ensure activities are provided as written by 2/21/2018. 3. The administrator or designee will educate the activity staff on following the plan of care for outlined activities for residents who are dependent on staff. The director of activities will meet with her staff, on a as needed basis, based on resident assessment to ensure resident activities needs are being met per the plan of care. A quality review will be conducted for residents outlined with one on one activities 3 times weekly for 4 weeks and then monthly for 2 months. to ensure compliance and appropriate documentation by the administrator or designee. 4. Findings to be reported to QAPI committee monthly and quality monitoring schedule will be modified based on findings. QAPI committee will review the results of the audits monthly for three months and as needed thereafter.	

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F 679	Continued From page 14	F 679		

provided an activity calendar.

Review of the January 2018 recreation participation record documented Resident #64 attended two socials.

Review of the Quarterly Therapeutic Recreation/Activity assessment dated 1/26/18 documented the resident was interested in participating in activities including group activities, large activities, one-to-one, day/activities room, inside facility/off unit and indoor activities. Resident #64 participation is passive, past interest included cards, checkers, football, country music and reading the sports section. Current interest included spiritual/religious activities, talking and conversing, watching TV, watching movies and parties/social events.

Review of the activity progress note dated 2/9/17 documented Resident #64 was assessed by the activity staff and provided a calendar. The assessment read that Resident #64 was interested in participating in activities that's provided of his choice, liked to play cards, checkers, football country music and reading sports information. The note documented he would be assisted to in room activities and activity room two to three times weekly.

Review of the most recent Care Area Assessment dated 2/10/17 did not trigger for Activities.

Review of the Care Plan dated 2/15/17 documented a focus area of "dependent on staff for activities, cognitive stimulations, and social interaction related to cognitive deficits, immobility and physical limitations." The goal read the resident would attend/participate in activities of

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F 679	Continued From page 15	F 679		

choice 2-3 times weekly. Interventions included in meeting the goal were, in part, needs 1 to 1 bedside/in room visits and activities if unable to attend out of room events, needs assistance during the activity, preferred activities are: music, religious, pets, TV, trivia, outside, socials and special events, when he chooses not to participate in organized activities then turn on TV and music in room to provide sensory stimulation.

During an observation on 1/29/18 at 10:30 AM Resident #64 was observed to be in his wheelchair self-propelling near the nursing station. He was crying and asking when his family would visit or if there were snacks.

Observations were made on 1/29/18 at 3:15 PM with the resident in his wheelchair near the nursing station. He was asking about family and would hold his head crying after asking.

Observations were made on 1/30/18 at 10:30 AM, on 1/30/18 at 11:28 AM and between 2:15 PM - 2:30 PM. Resident #64 was self-propelling near the nursing station. He was asking for someone to please change him because he had had a bowel movement. He would then ask if his family was coming. The Nursing Assistant was observed to take Resident #64 to his room and check for incontinence. The State Agency was present and Resident #64 had not had an incontinent episode.

Observations on 1/30/18 at 3:20 PM showed Resident #64 self-propelling in his wheelchair around the nursing station. He had no books, no music and no activity to engage him.

Observations on 1/31/18 at 9:43 AM showed

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Resident #64 sitting at nursing station in his wheelchair.

Observations on 1/31/18 at 11:30 AM Resident #64 was sitting in his wheelchair near the nursing station. He would cry and ask about lunch, snacks and family.

Observations on 2/1/18 in the AM showed Resident #64 in the hall self-propelling near the nursing station. He would continually ask when his family was coming or could someone change him.

Observations on 2/1/18 at 1:56 PM showed Resident #64 sitting in his wheelchair near the nursing station.

Observations on 2/1/18 at 2:14 PM showed Resident #64 sitting in his doorway watching other residents and staff.

During an observation on 2/1/18 at 2:20 PM Resident #64 was sitting in his wheelchair at the nursing station asking about a snack.

During an observation of Resident #64 ' s room on 2/1/18 at 2:27 PM the television was off, there was no equipment to play music in the room and the walls were empty.

During an interview with Nursing Assistant #1 she stated that Resident #64 did to go activities in the past but he'd be very distracting because he'd start saying "wipe me off" and "where's my family". She stated Speech use to do something with him with cards like with his wife's name on it and get him to read the card and say things but he couldn't focus on this.

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F 679	Continued From page 17 During an interview with the Activity assistant on 2/1/18 at 2:44 PM she stated they do 1:1 and sometimes would bring him downstairs for music. She stated this morning the nurse told her he wasn't able to come. She stated it would be nice to have music in his room but the facility does not have radios or tape players available. During an interview with the Assistant Director of Nursing on 2/1/18 at 3:17 PM she stated it would be expected to at least offer him some type of activity at the nursing station or his room.	F 679		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder	F 690		2/28/18

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F 690	Continued From page 18 receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, facility policy review and staff interviews, the facility failed to secure an indwelling urinary catheter to prevent tension to the catheter for 1 of 1 residents reviewed for a urinary catheter (Resident #385). The findings included: Resident #385 was admitted to the facility on 12/29/17 and had a diagnosis of intracranial hemorrhage and palliative care. The Admission Minimum Data Set (MDS) Assessment dated 1/8/18 revealed the resident had short and long term memory loss and severe cognitive impairment. The MDS noted the resident was totally dependent on staff for all activities of daily living and had an indwelling urinary catheter. The resident ' s Care Plan dated 12/19/17 did not address the securing of the urinary catheter. On 1/30/18 at 9:36 AM, Resident #385 was observed lying in bed. The rubber urinary catheter was observed to be taunt and was not secured to	F 690	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. 1. Resident #385 had no adverse reactions related to foley catheter not being secured to her leg. The resident has her leg strap in place as ordered on 2/1/2018. Root Cause: facility nursing staff failed to secure the indwelling urinary catheter for resident #385. The facility determined there was a lack of a system to monitor the securing of indwelling urinary catheters. 2. Residents with foley catheters were audited and devices were secured with appropriate leg strap, completed on 2/21/2018. 3. The director of nursing or designee will educate the licensed nurses on the application of leg straps for residents with	

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F 690	Continued From page 19 prevent tension on the catheter. On 2/1/18 at 1:38 PM the resident ' s urinary catheter was observed with the Assistant Director of Nursing (ADON). The catheter tubing was not secured to prevent tension on the catheter. The ADON stated they did have catheter straps and the resident was at risk for pulling the catheter when staff was turning and repositioning the resident. The ADON further stated she would get a catheter strap to secure the resident ' s catheter. On 2/1/18 at 1:48 PM the ADON stated in an interview that some residents have an entry on the Medication Administration Record for the nurse to check every shift to make sure the catheter was secured but this was not on the MAR for Resident #385. The Director of Nursing stated in an interview on 2/1/18 at 1:53 PM that it was her expectation there would be enough slack to the catheter to prevent tension and she expected the catheter to be secured to prevent pulling of the catheter.	F 690	indwelling catheters to prevent tension at the point of entry. The certified aides will be educated on notification to the nurse if a resident is found without a leg strap. Documentation of the presence of a catheter anchor will be provided added to the medicaiton administration record and added to all care plans for patients with foley catheters. The director of nursing or designee will complete quality audits of 4 residents with catheters per week to include resident #385 to ensure devices are in place and properly secured. This audit will take place weekly for 4 weeks and then then monthly for 2 months. 4. Findings to be reported to QAPI committee monthly and quality monitoring schedule will be modified based on findings. QAPI committee will review the results of the audits monthly for three months and as needed thereafter.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning 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	F 695		2/28/18

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F 695	Continued From page 20 by: Based on record review, observations and resident and staff interviews the facility failed to store respiratory equipment properly for 1 of 1 resident reviewed for nebulizer use (resident #65). The findings included: Resident #65 was admitted to the facility on 6/12/16 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD). Review of the physician ' s orders for January 2018 included Pulmicort 0.5mg (milligrrams)/2ml (milliliters) inhale contents of (1) ampule via nebulizer twice daily at 8am and 8pm and Perforomist UD 20mcg (micrograms)/2ml nebulizer every 12 hours at 8am and 9pm for COPD. During an observation on 1/29/18 at 10:34 AM the nebulizer mask was observed to be lying uncovered on the bedside table. There was a plastic bag hanging on the bedside, which was empty. During an observation on 1/29/18 at 3:03 PM the resident was observed to be completing a nebulizer treatment. During an observation on 1/29/18 at 3:13 PM nebulizer mask was observed to be lying uncovered on the bedside table. There was a plastic bag hanging on the bedside, which was empty. During an observation on 1/30/18 10:34 AM Resident #65 was observed to be receiving a	F 695	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. 1. Resident #65 had no adverse reactions due to the failure to properly store her respiratory equipment. Resident #65 has respiratory equipment stored in plastic bag at the bedside on 1/31/2018. Root Cause: the facility identified a lack of monitoring and education for properly storing respiratory equipment. 2. A review of residents with respiratory equipment will be conducted by the unit manager to ensure proper storage of equipment by 2/21/2018. 3. The director of nursing or designee will educate the licensed nurses on the proper storage of respiratory equipment at the bedside in plastic bags. Education with licenses nurses will be completed by 2/23/2017 and added to the orientation agenda. The director of nursing or designee will conduct quality reviews weekly of 4 residents identified with respiratory equipment per week to include resident #65 to ensure devices are stored properly. This audit will take place weekly for 4 weeks and then then monthly for 2 months to ensure respiratory equipment is stored properly. 4. Findings to be reported to QAPI committee monthly and quality monitoring schedule will be modified based on	

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F 695	Continued From page 21 nebulizer treatment. During an observation on 1/30/18 at 11:28 AM the resident was sleeping. The nebulizer mask was observed to be lying uncovered on the bedside table. There was a plastic bag hanging on the bedside, which was empty. During an observation on 1/30/18 at 11:56 AM the nebulizer mask lying, uncovered, on bedside table. During an observation on 1/30/18 at 3:20 PM the nebulizer mask was lying uncovered on the bedside table. During an observation on 1/31/18 at 9:43 AM the nebulizer mas was observed lying uncovered on the bedside table. During an interview with the 3rd floor Unit Manager on 1/31/18 at 10:00 AM she stated the mask should be in the plastic bag when not in use. During an interview with resident #65 on 1/31/18 at 10:10 AM she stated when she completes the nebulizer treatments the nurses just lay the mask on the bedside table. She stated the nurses don ' t put the mask back in the plastic bag and she doesn ' t take the mask out of the plastic bag. She stated the mask always stays on the bedside table. During an interview with the Director of Nursing on 1/31/18 at 10:51 AM she stated she would expect to be done what our policies and procedures read, which is to keep the mask in the bag when it is not in use.	F 695	findings. QAPI committee will review the results of the audits monthly for three months and as needed thereafter.	

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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 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 and staff interviews the facility failed to lock an unattended medication cart for 1 of 7 medication carts observed. The findings included: During an observation on 1/30/18 at 10:40 AM the 300 hall medication cart was observed to be unlocked with the push in lock observed to be in the out position and the nurse was not in view of	F 761	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. 1. No residents were affected by the nurse failing to lock the medication cart. All	2/28/18

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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 761	Continued From page 23 the cart. The nurse was observed to return to the cart within two minutes coming from a resident ' s room two doors down the hall from the location of the cart. There were no residents observed in the hallway near the cart at the time. During an interview on 1/30/18 at 10:43 AM with Nurse #1 she stated she thought the cart was locked and was observed to push the lock inward locking the cart. She did not state how she was trained on securing a medication cart. During an interview with the Regional Nurse Consultant on 1/30/17 at 3:27 PM she stated the medication carts should be locked when the nurse was not at the cart. During an interview with the Director of Nursing on 1/31/18 at 10:56 AM she stated all medication carts should be locked when the nurse was away from the cart.	F 761	medication carts were secured upon notification from surveyor. Nurse #1 is no longer employed with the facility as of 1/31/2018. Root Cause: nurse#1 singularly acted and violated the standard of care for storage of drugs and biological by leaving her medication cart unsecured. 2. Reviews were completed by the director of nursing or designee from 2/14/2018 through 2/16/2018 to ensure medication carts were locked while unattended. 3. The director of nursing or designee will educate the licensed nurses on med pass with the medication cart to include being locked at all times while unattended by 2/23/2018 and will be added to the orientation agenda. The director of nursing or designee will complete audits of 10 medication carts weekly to include carts on each nursing unit, include each nursing shift and weekends for 4 weeks and then monthly until resolved through QA committee. 4. 4. Findings to be reported to QAPI committee monthly and quality monitoring schedule will be modified based on findings. QAPI committee will review the results of the audits monthly for three months and as needed thereafter.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of	F 867		2/28/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 867	Continued From page 24 action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility ' s Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions that the committee put into place in October, 2017. This was for a cited deficiency area which required facilities to provide care according to professional standards of practice. The facility was originally cited on a complaint investigation completed on 10/23/17. The most recent repeat deficiency area was in the area of assuring professional standards of nursing practice were met. The continued failure of the facility during the two federal surveys of record show a pattern of the facility ' s inability to sustain an effective Quality Assurance Program. The facility was also cited for an ineffective Quality Assurance Program during a recertification survey of 3/10/2016. On the current recertification survey the facility failed to maintain an effective Quality Assurance Program. The findings included: This tag is cross referred to: F658- Based on record review and staff interviews the facility failed to document assessments on a resident upon returning from dialysis and failed to follow professional standards of practice by leaving medications in a resident ' s room and failed to follow physician ' s orders to schedule a CAT Scan for 1 of 1 residents with orders for a CAT scan. During a complaint investigation on 10/23/17 the	F 867	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. 1. Facility held an ad hoc QAPI meeting on 2/21/2018 date to review previous citations regarding assuring professional standards of practice are followed and having an ineffective QA program. Root Cause: in the time period 10/23/2017 to 2/1/2018 there were transitions in multiple facility department managers which led to the facility inability to perform quality monitoring and comprehensive review of previously cited deficiencies. 2. The QA meeting has been revised and changes are being made so that previous citations will be reviewed as needed and followed up on with documentation being recorded in the QA minutes. 3. QAPI team members were in-serviced by the Regional Clinical Director on 2/23/2018. The education included the QA program review of previous survey citations and the inclusion of on-going monitoring to maintain compliance. The QA meeting has been revised and changes are being made so that previous citations will be reviewed as needed and followed up on with documentation being recorded in the QA minutes.	

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F 867	Continued From page 25 facility failed to administer and document medications per professional standards of practice. On 2/1/18 at 6:14 PM the Regional Director stated in an interview the facility had a lot of new staff since the citation in October 2017. The Regional Director stated: "I do not have a specific answer as to why this happened."	F 867	4. The Administrator will document in the QA minutes the monthly review of on-going QAPI plans with the QA team for three months and as needed. The Administrator will be responsible for implementing the POC. QAPI committee will review the results of the audits monthly for three months and as needed thereafter.	