| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345049 | A. BUILDING _____ B. WING _____ | C 07/12/2018 |

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

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|---|---|---|---|---|
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the | F 550 | | 8/7/18 |

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

Electronically Signed | 07/24/2018

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 550 | Continued From page 1<br>exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, resident and staff interviews, the facility failed to promote the dignity of 2 of 2 sampled residents, (Residents #19 and #21), by not assisting them to their needs to use the bedpan or toilet when they requested during a meal.<br><br>The findings included:<br><br>1. Resident #21 was admitted to the facility on 6/12/18 with a diagnoses of a liver impairment. Review of Resident #21's admission orders revealed medication orders for Lactulose (a medication used to reduce the amount of ammonia in the blood of persons with liver disease. It is also used to treat constipation) and Miralax 17grams daily for constipation.<br><br>Review of the resident's Admission Minimum Data Set Assessment (MDS) of 6/19/18 indicated the resident required limited assistance of one staff member for bed mobility and transfer. The MDS indicated the resident required extensive assistance of one staff member for toileting. The MDS indicated the resident was alert and oriented and frequently incontinent of bowel.<br><br>Review of the Resident's care plan revealed problems identified in part as: A) "has a self care performance deficit" (revision date of 7/6/18) with an interventions documented as: Toilet use-assist with toilet as needed; and B) "is a risk for impaired skin integrity r/t (related to) potential for pressure, friction, sheer as well as incontinence of bowel and bladder" with a revision | F 550 | F550<br><br>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.<br>The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws.<br><br>1. Nurse #6 that told Resident #21 he had to wait to have a bowel movement (BM) on 6/21/18 received a verbal in-service from the Director of Nursing (DON) at that time and toileting assistance was provided for the resident per his request. Nurse #5 that told Resident #19 she would have to wait until the trays were off the hall to get toileting assistance was corrected by the other nurse on the hall and assistance was provided for the resident.<br><br>Root cause: Failure of the facility to provide education regarding the expectation of meeting the residents' needs regardless of the trays being on the hallway/meals being served as part of the orientation process.<br><br>2. Any resident that requires assistance with toileting has the potential to be | |

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|---|---|---|---|---|
| F 550 | Continued From page 2<br>date of 7/10/18. The intervention was documented as: "assist with toileting needs routinely to prevent alteration in skin integrity and improve level of continence.<br><br>During an interview with Resident #21 on 7/10/18 at 9:45am, the Resident reported that on approximately 6/21/18 at approximately 9:30am, he rang his call bell for assistance to use the bedpan for bowel movement. The Resident stated that he was told by Nurse #6 that he was not allowed to have a BM (bowel movement) during lunch and that he would have to hold it. The resident stated he has no control of it (his bowels) after a while and would have had had to soil himself waiting on staff to assist him to the toilet. The resident reported it made him mad and he felt the nurse was being vindictive.<br><br>During a telephone interview with Nurse #6 on 7/11/18 at 2:30pm, the nurse stated she told the resident he would have to wait to have a BM since they weren't supposed to take residents to the bathroom while trays are on the hall because of cross contamination. The nurse stated she did talk with the Unit Manager after talking with the resident. Nurse #6 stated the Unit Manager called the Director of Nursing (DON) for clarification. The nurse reported she then told the Nursing Assistant (NA) to assist the resident with the bed pan.<br><br>During an interview with the Director of Nursing (DON) on 7/12/18 at 11:00 am, the DON reported she did not expect staff to tell a resident they would have to wait to toilet or use the bed pan; that staff needed to accommodate the residents' needs. | F 550 | affected. The nursing staff was in-serviced by the Nursing Administration Team 7/12-7/7-27/18 regarding providing toileting assistance to residents during meal time if requested or if it is noted that the resident is soiled. Education regarding the expectation of providing toileting assistance during meal time has been added to the orientation process for nursing staff<br><br>3. The Administrative Nursing Team will interview ten interviewable residents per week for 4 weeks then 5 interviewable residents per week until 100% compliance is met for 2 consecutive months to determine if toileting assistance was requested during meal time and determine if assistance was provided as requested.<br>Five dependent nonverbal residents will be checked per week during meals until 100% compliance is met for 2 consecutive months to ensure residents are not eating while soiled. Results of those audits will be reported to QAPI committee monthly for three months and the quality monitoring schedule will be modified based on findings.<br><br>4. The Director of Nursing will be responsible for implementing the plan of correction. | |

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|---|---|---|---|---|
| F 550 | Continued From page 3 | F 550 | | |

During an interview with the Administrator on 7/12/18 at 11:05am, the Administrator stated staff are expected to take care of resident needs as they come up. The Administrator specified this Included taking residents to the toilet when requested at meal times.

2. Review of Resident # 19's medical record revealed the resident was re-admitted to the facility on 6/10/18 with diagnosis to include: Cerebral Infarct (stroke) and hemiplegia.

Resident #19's Annual Minimum Data Assessment (MDS) of 6/16/18 indicated the resident required extensive assist of 2 or more staff for transfer and extensive assist of one staff member for toileting. The MDS indicated the resident was frequently incontinent of bowel and bladder. The MDS indicated the resident was alert and oriented.

Resident #19's Care Plan identified a problem documented in part as: "has an ADL (Activities of Daily Living) Self Care Performance deficit d/t (due to) decreased strength, decreased functional mobility, decreased ROM (range of motion), impaired balance, impaired cognition". An intervention was documented as "toileting assistance as needed".

During an observation on 7/11/18 at 12:45pm, the lunch meal trays were on the hall. Resident #19 was observed in the hall outside of her room looking for a staff member. She met Nurse #5 and began to talk with her. Nurse #5 was heard to tell Resident #19 that she had to wait to go to the toilet until after the meal trays were picked up.

During an interview with Nurse #5 on 7/11/18 at

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|---|---|---|---|---|
| F 550 | Continued From page 4<br>12:47pm, Nurse #5 confirmed that Resident #19 requested to go the toilet during the lunch meal and she informed the resident that staff could not assist her because meal trays were being served. Nurse #5 reported she heard that was the rule, that toileting could not be done while meal trays were on the unit. The other nurse that worked the other assignment on the 300 hall told Nurse #5 that was not a true rule and residents should be toileted at any time they requested.<br><br>During an interview with the Director of Nursing (DON) on 7/12/18 at 11:00 am, the DON reported she did not expect staff to tell a resident they would have to wait to toilet; that staff needed to accommodate the residents' needs.<br><br>During an interview with the Administrator on 7/12/18 at 11:05am, the Administrator stated staff are expected to take care of resident needs as they come up. The Administrator specified this included taking residents to the toilet when requested at meal times. | F 550 | | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or | F 580 | | 8/7/18 |

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|---|---|---|---|---|
| F 580 | Continued From page 5<br>clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, resident interview, and staff interviews, for one (Resident # 16) of three | F 580 | F580 | |

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|---|---|---|---|---|
| F 580 | Continued From page 6<br>residents reviewed for pain management, the facility failed to consult with the physician when the resident's prescribed extended release pain medication was due and not available to be administered.<br><br>The findings included:<br><br>Record review revealed Resident # 16 was admitted to the facility on 7/9/18 following a residency at another skilled nursing facility.<br><br>The resident had diagnoses of paraplegia, Stage IV sacral and right posterior thigh pressure sores, chronic pain, and chronic osteomyelitis (infection of the bone). According to a hospital discharge summary, dated 6/18/18, the resident had been hospitalized from 5/9/18 until 6/18/18 where he was treated for his osteomyelitis and septic arthritis, and it was determined during the hospitalization that the resident had bony destruction of his proximal femur and acetabulum bones (his hip). The 6/18/18 hospital discharge summary noted the resident routinely took Opana (OxyMorphone) 20 mg (milligrams) twice per day for pain control in addition to Percocet (Oxycodone-Acetaminophen) as needed while he was at home.<br><br>Review of the resident's facility admission note, dated 7/9/18 at 2:30 PM, revealed the resident was alert and oriented times three.<br><br>On 7/10/18 a review of the resident's admission pain medication orders and July MAR (Medication Administration Record) revealed the following:<br><br>OxyMorphone HCL (Hydrochloride) ER (Extended Release) was to be given every 12 | F 580 | 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.<br>The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws.<br><br>1. The Physician Assistant (PA) was notified on 7/10/18 regarding the OxyMorphone for Resident #16 not being available and an alternative (OxyContin 20 mg ER) was prescribed and was administered that afternoon. Nurse #2 was in-serviced on 7/9/18 by the Director of Nursing regarding the requirement for documenting all medication administration, the process for notifying the physician when a medication is not available, and to obtain an order to hold the medication and/or obtain an order for an alternative medication, and to document administration of the alternative medication and efforts to obtain the originally ordered medication. This information will be added as part of the orientation process.<br><br>Root cause: Clinical systems not being followed by Nurse #2 regarding documenting medication administration, notifying the physician when a medication is not available, to obtain an order to hold the medication and/or obtain an order for an alternative medication and document | |

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|---|---|---|---|---|
| F 580 | Continued From page 7<br>hours. The medication was scheduled to start on 7/9/18 at 8 PM. According to the MAR the 8 PM OxyMorphone was not given. There was no explanation found in the nursing notes or on the MAR for this omitted dose. On 7/10/18 at 8 AM, Nurse # 1 documented the OxyMorphone was held and not given.<br><br>According to admission orders the resident also had an order for Oxycodone-Acetaminophen 10-325 mg (milligrams) one tablet every six hours PRN (as needed) for pain. There was no indication on the MAR the resident received any PRN Oxycodone-Acetaminophen on his admission date of 7/9/18.<br><br>Nurse # 3 documented she administered a dose of the Oxycodone-Acetaminophen at 1:15 AM on 7/10/10 and the resident was "grimacing with verbal complaints of pain" at the time of administration. At 2:15 AM on 7/10/18, the nurse documented the resident was resting. At 7:09 AM on 7/10/18 Nurse # 3 documented the resident had complaints of severe abdominal pain. The nurse documented she gave the resident another dose of Oxycodone-Acetaminophen at 7:09 AM.<br><br>Two hours and 51 minutes later, on 7/10/18 at 10 AM, Resident # 16 was observed to be talking to Nurse # 2 in the hallway at the medication cart about his pain medication. Nurse # 2 informed the resident his pain medication was not available.<br><br>On 7/10/18 at 10:20 AM the resident was interviewed in his room. The resident reported the following. He had arrived at the facility the previous day at 12:30 PM. He routinely took | F 580 | holding the prescribed medication and administration of the alternative medication and efforts to obtain the originally ordered medication.<br><br>2. Any resident has the potential to be affected. A Medication Administration Record (MAR) to cart review will be conducted by the pharmacy consultant on 7/30/18 to ensure all ordered medications are available on the medication cart. Any medication that is not available will be ordered by the pharmacy consultant. If the medication will not be available at the time designated for administration, the physician will be notified and orders will be obtained as necessary. The licensed nurses were in-serviced by the Nursing Administration Team 7/12-7/27/18 regarding the process for notifying the physician when a medication is not available, to obtain an order to hold the medication and/or obtain an order for an alternative medication and document holding the prescribed medication and administration of the alternative medication and efforts to obtain the originally ordered medication. The in-service also included checking the medication carts on Wednesday nights for medications that need to be reordered to ensure availability. These processes will be added to the orientation process.<br><br>3. The Administrative Nursing Team will audit ten residents per week for 4 weeks then 5 residents per week until 100% compliance is met for 2 consecutive months to ensure medications are | |

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| F 580 | Continued From page 8<br>OxyMorphone for pain at 8 AM and 8 PM, but the facility did not have his OxyMorphone, and he had not received his dose last night or the current morning. The resident reported he had stayed up until around midnight, while thinking the OxyMorphone would arrive, and the medication never came. The resident reported the nurses gave him Percocet (Oxycodone-Acetaminophen), and it helped ease his pain some but did not totally take it away. The resident stated he currently was in pain, had been miserable without the OxyMorphone, and had a restless night. When asked where he hurt, the resident stated he had sores on his bottom and his thighs. The resident stated Nurse # 4 was looking into why his pain medication was not available.<br><br>Nurse # 4 was interviewed on 7/10/18 at 10:25 AM and reported the following. Nurse # 4 was the unit manager. She had worked the previous day and everything had been sent to the pharmacy timely in order that the resident's OxyMorphone be available on 7/9/18 at 8 PM. The nurse became aware when she arrived to work on the morning of 7/10/18 that the resident's OxyMorphone was on back order, and she had been calling the pharmacy but according to the nurse there had been no resolution to what needed to be done. Following the interview, Nurse # 4 was observed to speak to the administrator about the lack of pain medication, and the administrator informed the nurse she needed to get in touch with the physician.<br><br>Review of the resident's record revealed that the PA (physician's assistant) was first notified the resident's OxyMorphone was not available on 7/10/18 at 10:42 AM. At that time the PA ordered OxyContin 20 mg ER in place of the | F 580 | available as ordered and the physician is notified as necessary. Results of those audits will be reported to QAPI committee monthly for three months and the quality monitoring schedule will be modified based on findings.<br><br>4. The Director of Nursing will be responsible for implementing the plan of correction. | |

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|---|---|---|---|---|
| F 580 | Continued From page 9 | F 580 | | |

OxyMorphone. The resident was documented as receiving the first extended release OxyContin on 7/10/18 at 1:45 PM.

Nurse # 2 had cared for the resident on the 3:00 PM to 11:00 PM shift on 7/9/18. Nurse # 2 was interviewed on 7/11/18 at 10:35 AM. Nurse # 2 reported the following during the interview. She had spoken to the pharmacy four times during her evening shift on 7/9/18. The first time the pharmacy called to validate the resident could take the OxyMorphone because he had an allergy to Morphine. The nurse verified the resident had been taking the OxyMorphone without problems and advised the pharmacy of this. The second time the pharmacy called and stated they were looking for the medication. The third time the pharmacy called and stated they were trying a local back-up pharmacy to obtain the medication. The fourth time the pharmacy called and stated they would send the medication the next day, and were still continuing to look for it. According to the nurse, although she did not document it in the record, she called the physician and obtained an order to give two Oxycodone 5 mg-325 mg tablets to the resident from the facility emergency supply. The nurse recalled she administered this dosage of Oxycodone around 7:15 PM. The nurse stated she did not talk to the physician about the OxyMorphone at any time on her shift because she thought it might come from the pharmacy. The nurse stated she stayed late on her shift and went to complete an assessment on the resident about 11:30 PM. The resident reported he was in pain during the assessment. According to the nurse, it was too soon to administer anymore Oxycodone to the resident and his OxyMorphone had not arrived. Therefore she gave him a dose of Tylenol, which she had

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|---|---|---|---|
| | 345049 | A. BUILDING _____ B. WING _____ | C 07/12/2018 |

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|---|---|---|---|---|
| F 580 | Continued From page 10 | F 580 | | |

not documented in the record.

Nurse # 3 had cared for the resident on the 11 PM to 7 AM shift which began on 7/9/18. Nurse # 3 was interviewed on 7/10/18 at 4:15 PM. Nurse #3 reported the following. It was her understanding from talking to Nurse # 2 that the resident's OxyMorphone would arrive when the pharmacy delivered the medications. Medications were delivered around 1 AM on 7/10/18 and the OxyMorphone did not arrive. There was a written notification stating that the medication was not available. She gave the resident a PRN (as needed) Oxycodone-Acetaminophen around 1 AM, and she recalled the resident seemed to rest well and did not complain further until 7:00 AM. The nurse stated at 7:00 AM on 7/10/18, the resident reported his pain level was a "10" on a scale of 1-10 and she again gave him another Oxycodone-Acetaminophen. The nurse reported she did not consult with the resident's physician about the unavailable OxyMorphone.

Interview with a pharmacy manager on 7/11/18 at 8:45 AM and again on 7/11/18 at 3 PM revealed the following information. OxyMorphone is a medication that was voluntarily recalled by the brand manufacturer due to FDA warnings. The pharmacy had stopped acquiring new stocks of the medication as of July, 2017. The pharmacy had talked to Nurse # 2 on the evening of 7/10/18 several times. The pharmacy validated the resident could take the medication given his allergies and did a search for it at another local pharmacy. They found they could not obtain it from a local pharmacy. According to the pharmacy manager, Nurse # 2 was informed that the pharmacy was not going to be able to deliver the medication on 7/9/18, and the nurse was

| 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 07/12/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 580 | Continued From page 11<br>informed of other medications which could be used in place of it. Also the pharmacy manger stated, although their pharmacy did not continue to obtain new supplies of OxyMorphone, they did have some unused supply on their shelves in a stronger dosage than what was prescribed for Resident # 16. According to the pharmacy manager, Nurse # 2 was informed on 7/9/18 by the pharmacy that the facility would need to call the physician and discuss other alternatives to the OxyMorphone which included a substitute or the higher dosage.<br><br>The pharmacy consultant was interviewed on 7/12/18 at 11 AM. According to the pharmacy consultant, the PRN Oxycodone, which the nurses were using when the OxyMorphone was not available, would not have had the extended effect the OxyMorphone would have had. The pharmacist stated the OxyMorphone would have delivered a longer acting and more even control of the resident's pain. The pharmacist stated there were several extended release alternatives to the OxyMorphone which could be used. According to the consultant pharmacist, it would have been an appropriate measure to have contacted the physician on 7/9/18 regarding a substitute when the nurse was aware the OxyMorphone was not available when due to be administered. The pharmacist stated a substitute medication could have been acquired through their back up pharmacy, which provided 24 hour service to the facility. | F 580 | | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility | F 609 | | 8/7/18 |

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|---|---|---|---|---|
| F 609 | Continued From page 12<br>must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and administrator interviews the facility failed to submit 5 day reports to the state agency following the investigation of abuse for 2 of 2 residents (Resident #18 and Resident #24) reviewed.<br><br>The findings included:<br><br>1. Resident #18 was admitted to the facility on 10/5/17 and had a diagnosis of Alzheimer ' s Disease and anxiety. | F 609 | F609<br><br>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.<br>The plan of correction is prepared and / or executed solely because it is required by both Federal and State | |

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|---|---|---|---|---|
| F 609 | Continued From page 13<br>The most recent Minimum Data Set (MDS) Assessment dated 6/1/18 revealed the resident had severe cognitive impairment and required extensive assistance with activities of daily living.<br><br>A 24 hour report dated 5/1/18 revealed a report that Housekeeper #1 had pinched Resident #18 and was reported to shove and push and yell at other residents. The report revealed these things were unwitnessed but another housekeeper reported Housekeeper #1 told her that she had pinched the nose of Resident #18 to get her to move. It was also reported Housekeeper #1 owed a resident five dollars. The document revealed a police report was filed on 5/1/18. The document revealed the 24 hour report was faxed to the state agency on 5/1/18.<br><br>The 5 day report noted nursing assistants (NAs), alert and oriented residents, Housekeeper #1 and other housekeepers were interviewed and the report could not be validated. However, the contract agency was asked to remove Housekeeper #1 from the facility assignment. The report was faxed to the state agency on 7/10/18.<br><br>On 7/10/18 at 3:36 PM an interview was conducted with the administrator. The Administrator by a housekeeper that Housekeeper #1 had told her she had pinched the nose of Resident #18 to get the resident to move and Housekeeper #1 denied the allegation. The Administrator stated Housekeeper #1 did not have a good working relationship with the other housekeeping staff and did not know who was telling the truth. The Administrator stated they no longer contracted with this housekeeping agency.<br><br>On 7/12/18 at 11:00 AM a separate interview was | F 609 | laws.<br><br>1. The Investigative Report for Residents #18 and #24 that were not sent to the healthcare registry within 5 business days from the 24-hour initial report were submitted to the healthcare registry on 7/10/18.<br><br>Root cause: Lack of a process for the Administrator to track/ensure the 5-Day Investigative Report was successfully faxed into the registry on the date the report was completed.<br><br>2. Any resident with a reportable event has the potential to be affected. The Administrator contacted the healthcare personnel registry requesting al list of all 24-hour initial reports sent in from the facility 4/1/18 to 7/12/18. Any report determined to be missing from the registry were submitted. The Administrator and the Director of Nursing (DON) were in-serviced by the Regional Clinical Director (RCD) on 7/12/18 regarding the mandatory reporting guidelines and timelines. A log/audit tool was implemented to track and record the steps in mandatory reporting to ensure all steps are completed.<br><br>3. The Administrator will utilize the log/audit tool to track the process of all reportable events and ensure all steps are completed. The Administrator will report the results of those audits to the QAPI committee monthly for three months and | |

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|---|---|---|---|
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|---|---|---|---|---|
| F 609 | Continued From page 14<br>conducted with the administrator. The Administrator stated she did the investigation but could not recall what happened and why the 5 day report was not faxed to the state agency until 7/10/18. The Administrator further stated she sometimes delegated this task.<br><br>2. Resident #24 was admitted to the facility on 4/17/12 and had a diagnosis of bipolar disorder, seizures and anxiety.<br>The Annual Minimum Data Set (MDS) Assessment dated 5/3/18 revealed the resident was cognitively intact and required extensive to total assistance with activities of daily living.<br><br>A 24 hour report revealed on 6/25/18 at 2:30 PM a family member reported Resident #24 informed her he was awakened on 6/21/18 between 5:00 and 6:00 AM to a nursing assistant (NA) attempting to pull him out of bed and throw him on the floor. The family member reported the resident was pinned to the left side of the bed with both arms crossed while a second NA was pulling on the resident attempting to throw him on the floor. The document revealed the report was faxed to the state agency on 6/25/18.<br><br>The 5 day report revealed the resident was interviewed with no change in his story. An interview with the NA revealed she interacted with the resident at 12 AM, 3:30 AM and 6:00 AM and the resident refused care each time and the nurse was notified each time. The NA reported there was not a second NA present at any time. The report revealed the allegation was not substantiated but the NA was moved to another assignment. The 5 day report was faxed to the state agency on 7/10/18. | F 609 | the quality monitoring schedule will be modified based on findings.<br><br>4. The Director of Nursing will be responsible for implementing the plan of correction.<br><br>F677<br><br>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.<br>The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws.<br><br>1. Activities of Daily Living (ADL) care was provided for Resident #11 by the Unit Manager during the survey when it was noted that care was needed. The Unit Manager was in-serviced by the Regional Clinical Director on 7/11/18 regarding ensuring residents have a certified assistant (CNA) assigned to provide care as necessary, if a scheduled CNA is not present, the assignment will be redistributed among the other CNAs to ensure care is provided as necessary.<br><br>Root cause: Lack of understanding of the Unit Manager regarding the time the CNA was to arrive, which would have prompted her to redistribute the assignment, and not being aware of her actual arrival time. | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 609 | Continued From page 15<br><br>On 7/12/18 at 11:00 AM a separate interview was conducted with the administrator. The Administrator stated she removed the NA from the resident ' s assignment as the resident did not like the NA. The Administrator stated she did the investigation but could not recall why the 5 day report was not faxed to the state agency until 7/10/18. The Administrator further stated she sometimes delegated this task. | F 609 | 2. Any resident requiring assistance with ADLs has the potential to be affected. The Nursing Staff was in-serviced by the Nursing Administration Team on 7/12-7/27/18 regarding no person being put on the assignment sheet until they are physically visualized in the facility and the assignment sheets needing to be verified by a nursing supervisor to ensure all staff assigned are present. The assignment sheet was modified by the Director of Nursing for signature of the verification by a nursing supervisor. The assignment sheets will be verified by a nursing supervisor daily to ensure all staff assigned are present.<br><br>3. The assignment sheets will be audited every shift daily for the next 4 weeks to ensure all staff noted on the assignment sheets are present, and ADL care is being provided to the residents. The assignment sheets will be audited every shift two times weekly until 100% compliance is maintained for 2 consecutive months. The DON will report the results of those audits to the QAPI committee monthly for three months and the quality monitoring schedule will be modified based on findings.<br><br>4. The Director of Nursing will be responsible for implementing the plan of correction. | |
| F 677 SS=D | ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) | F 677 | | 8/7/18 |

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|---|---|---|---|---|
| F 677 | Continued From page 16<br>§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;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and staff interviews, the facility failed to provide care and services for a resident dependent for Activities of Daily Living for 1 of 3 residents with pressure ulcers.<br><br>Findings include:<br><br>Resident #11 was admitted to the facility 12/28/10. Current diagnoses include: Anemia, Functional Quadriplegia, and pressure ulcer of sacral region, Stage 3.<br><br>The Resident's most recent Minimum Data Set (MDS), a quarterly assessment of 6/7/18 indicated required total assistance of one person assistance for bed mobility, toileting, and personal hygiene. The MDS indicated the resident was always incontinent of bladder (no episodes of continent voiding) and always incontinent of bowel (no episodes of continent bowel movement).<br>Review of the Resident's current care plan revealed a problem identified in part as: "has an ADL (Activities of Daily Living) Self Care Performance Deficit r/t (related to) dementia, impaired mobility, and incontinence and Dx (diagnosis) quadriplegia. Interventions included: "keep resident well groomed and odor free; Provide incontinent care after each incontinent episode".<br>Review of the Resident's Care Guide (no date) indicated instruction to keep the resident well | F 677 | F677<br><br>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.<br>The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws.<br><br>1. Activities of Daily Living (ADL) care was provided for Resident #11 by the Unit Manager during the survey when it was noted that care was needed. The Unit Manager was in-serviced by the Regional Clinical Director on 7/11/18 regarding ensuring residents have a certified assistant (CNA) assigned to provide care as necessary, if a scheduled CNA is not present, the assignment will be redistributed among the other CNAs to ensure care is provided as necessary.<br><br>Root cause: Lack of understanding of the Unit Manager regarding the time the CNA was to arrive, which would have prompted her to redistribute the assignment, and not being aware of her actual arrival time. | |

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|---|---|---|---|---|
| F 677 | Continued From page 17<br>groomed and odor free; and provide incontinent care after each incontinent episode.<br><br>Review of the facility's Daily Nursing Assistant (NA) Assignment for 7/11/18, for the first shift of the resident's hall indicated the assignment was prepared for 3 NAs on the unit. 2 NAs were present on the unit during the first observation of Resident #11 on 7/11/18 at 9:30am. The assignment sheet was unchanged from the 3 NA assignment to indicate the unit would be covered by 2 NAs until the third NA arrived. The assignment sheet did not indicate any staff would be late or that the assignments were changed.<br><br>During an observation on 7/11/18 at 9:30am, Nursing Assistant (NA) #3 finished repositioning the resident on her left side in the bed. The Resident was dressed in a hospital gown. The NA reported she was not assigned to the resident, but had just fed her breakfast and laid her back down in the bed.<br><br>During an observation of Resident #11 on 7/11/18 at 12:00 pm, Unit Manager #1 entered the room and checked the Resident #11's brief to find it soiled and wet. Resident #11 was positioned on her left side. The Unit Manager provided incontinent care and the brief contained a moderate amount of light brown stool and darker yellow urine. The sacral dressing was observed to be lifting from the skin and the Unit Manager removed the dressing. The resident's buttocks were free of redness.<br><br>During an interview with the Unit Manager on 7/11/18 at 12:10pm, the Manager reported that the NA assigned to Resident #11 called in the morning and reported she would be late coming | F 677 | 2. Any resident requiring assistance with ADLs has the potential to be affected. The Nursing Staff was in-serviced by the Nursing Administration Team on 7/12-7/27/18 regarding no person being put on the assignment sheet until they are physically visualized in the facility and the assignment sheets needing to be verified by a nursing supervisor to ensure all staff assigned are present. The assignment sheet was modified by the Director of Nursing for signature of the verification by a nursing supervisor. The assignment sheets will be verified by a nursing supervisor daily to ensure all staff assigned are present.<br><br>3. The assignment sheets will be audited every shift daily for the next 4 weeks to ensure all staff noted on the assignment sheets are present, and ADL care is being provided to the residents. The assignment sheets will be audited every shift two times weekly until 100% compliance is maintained for 2 consecutive months. The DON will report the results of those audits to the QAPI committee monthly for three months and the quality monitoring schedule will be modified based on findings.<br><br>4. The Director of Nursing will be responsible for implementing the plan of correction. | |

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|---|---|---|---|---|
| F 677 | Continued From page 18 | F 677 | | |

to work. The Manager reported she did not change the NA assignments and expected staff to monitor the residents on the NA's assignment.

During an interview with the NA #3 on 7/11/18 at 12:25pm, the NA reported she had only fed the Resident breakfast and lay her down in bed. She did not check or change the Resident at that time.

During an interview with the Treatment Nurse on 7/11/18 at 12:30pm, the nurse reported the Resident's brief was clean and dry when she and the Wound Nurse Practitioner completed the treatment to the Resident's sacrum at 7:30am. The Treatment Nurse stated the 11pm - 7am shift staff would have changed the resident so the resident was ready to be seen by the Wound Nurse Practitioner.
During an interview with NA #4 on 7/11/18 at 12:32pm, the NA reported Resident #11 was on her assignment. The NA reported she didn't arrive to work until 10am and began providing morning care to her residents. The NA stated she had not gotten to Resident #11 to provide any care.

During an interview with NA #5 on 7/11/18 at 12:35pm, the NA stated she was unaware NA #4 was going to be late coming in to work that morning.

A telephone interview was conducted with NA #3 on 7/12/18 at 12:58pm. The NA reported she was told to watch for call lights that morning, but was not told to provide care to any specific resident.

During an interview with the Director of Nursing on 7/12/18 at 12:58pm, the Director stated she

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|---|---|---|---|---|
| F 677 | Continued From page 19<br>expected the Unit Manager and nurse to cover every resident every hour every day. The Director stated the NA assignments need to be re-adjusted even if a NA was going to be a half hour late. | F 677 | | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and staff interviews, the facility failed to provide care and services to promote healing for 1 of 3 sampled residents with pressure ulcers (Resident #11).<br><br>Findings include:<br><br>Resident #11 was admitted to the facility 12/28/10. Current diagnoses include: Anemia, Functional Quadriplegia, and pressure ulcer of sacral region, Stage 3.<br><br>Review of Resident #11's quarterly Minimum Data Set (MDS) dated 6/7/18 indicated the resident | F 686 | F686<br><br>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.<br>The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. | 8/7/18 |

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| F 686 | Continued From page 20<br>severely cognitively impaired and was not able to be interviewed. The MDS indicated the resident had a Stage 3 pressure ulcer; required total assistance of one person assistance for bed mobility, toileting, and personal hygiene. The MDS indicated the resident was always incontinent of bladder (no episodes of continent voiding) and always incontinent of bowel (no episodes of continent bowel movement<br><br>Review of the Resident #11's current care plan dated 6/14/18 revealed a problem identified in part as: "is at risk for further skin breakdown r/t (related to) impaired mobility, B & B (Bowel and Bladder) incontinence, severe cognitive/communication deficit". Interventions included in part: "assist with turning/repositioning, and check for incontinence, provide good incontinence as needed and apply cream as indicated".<br><br>Review of a Wound Assessment of 7/4/18 indicated the resident had a sacral, stage 3 wound. Measurements were documented as 1.0 (centimeters) long by 0.6 (centimeters) wide by 0.3 (centimeters) deep.<br><br>Review of the Resident's Care Guide (no date) indicated to keep the resident well groomed and odor free; and provide incontinent care after each incontinent episode.<br><br>Review of the facility's Daily Nursing Assistant (NA) Assignment for 7/11/18, for the first shift of the resident's hall indicated the assignment was prepared for 3 NAs on the unit. NA #5 was responsible for a split assignment between the resident's hall and resident rooms on the adjoining side of the resident's hall, 2 NAs were | F 686 | 1. Review of the wound documentation for Resident #11 determined there was no deterioration in the wound for this resident. Activities of Daily Living (ADL) care was provided for Resident #11 by the Unit Manager on 7/11/18 during the survey when it was noted that care was needed. The Unit Manager was in-serviced by the Regional Clinical Director on 7/11/18 regarding ensuring residents have a certified nursing assistant (CNA) assigned to provide care as necessary, if a scheduled CNA is not present, the assignment will be redistributed among the other CNAs to ensure care is provided as necessary and the importance of care and repositioning regarding wound healing.<br><br>Root cause: Lack of understanding of the Unit Manager regarding the time the CNA was to arrive, which would have prompted her to redistribute the assignment, and not being aware of her actual arrival time<br><br>2. Any resident requiring assistance with ADLs and that has a wound has the potential to be affected. The Nursing Staff was in-serviced by the Nursing Administration Team 7/12-7/27/18 regarding no person being put on the assignment sheet until they are physically visualized in the facility and the assignment sheets will be verified by a nursing supervisor to ensure all staff assigned are present. The assignment sheet was modified by the Director of Nursing for signature of the verification by a nursing supervisor. The assignment | |

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| | 345049 | A. BUILDING _____ B. WING _____ | C 07/12/2018 |

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

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| F 686 | Continued From page 21<br>present on the unit during the first observation of Resident #11 on 7/11/18 at 9:30am. The assignment sheet was unchanged from the 3 NA assignment to indicate the unit would be covered by 2 NAs until the third NA arrived. The assignment sheet did not indicate any staff would be late or that the assignments were changed.<br><br>During an observation on 7/11/18 at 9:30 am, Nursing Assistant (NA) #3 finished repositioning the resident on her left side in the bed. The NA reported she was not assigned to the resident, but had just fed her breakfast and laid her back down in the bed.<br><br>During an observation of Resident #11 on 7/11/18 at 12:00 pm, Unit Manager #1 entered the room and checked the Resident #11's brief to find it soiled and wet. Resident #11 was positioned on her left side. The Unit Manager provided incontinent care and the brief contained a moderate amount of light brown stool and darker yellow urine. The sacral dressing was observed to be lifting from the skin and the Unit Manager removed the dressing. The resident's buttocks were free of redness.<br><br>During an interview with the Unit Manager on 7/11/18 at 12:10 pm, the Unit Manager reported that the NA assigned to Resident #11 called in the morning and reported she would be late coming to work. The Unit Manager reported she did not change the NA assignments and expected staff to monitor the residents on the NA's assignment.<br><br>During an interview with the NA #3 on 7/11/18 at 12:25 pm, the NA reported she had only fed Resident #11 breakfast and lay her down in bed. She stated she did not check or change the | F 686 | sheets will be verified by a nursing supervisor daily to ensure all staff assigned are present.<br><br>3. The assignment sheets of 5 residents with wounds will be audited every shift daily for the next 4 weeks to ensure all staff noted on the assignment sheets are present and ADL care is being provided to the residents. The assignment sheets of 5 residents with wounds will be audited every shift two times weekly until 100% compliance is maintained for 2 consecutive months. The DON will report the results of those audits to the QAPI committee monthly for three months and the quality monitoring schedule will be modified based on findings.<br><br>4. The Director of Nursing will be responsible for implementing the plan of correction. | |

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| F 686 | Continued From page 22 | F 686 | | |

Resident at any time.

During an interview with the Treatment Nurse on 7/11/18 at 12:30 pm, the nurse reported the Resident's brief was clean and dry when she and the Wound Nurse Practitioner completed the treatment to the Resident's sacrum at 7:30 am. The Treatment Nurse stated the 11:00 pm to 7:00 am shift staff would have changed the resident so the resident was ready to be seen by the Wound Nurse Practitioner.

During an interview with NA #4 on 7/11/18 at 12:32 pm, the NA reported Resident #11 was on her assignment. The NA reported she didn't arrive to work until 10:00 am and began providing morning care to her residents. The NA stated she had not gotten to Resident #11 to provide any care.

During an interview with NA #5 on 7/11/18 at 12:35 pm, the NA stated she was unaware NA #4 was going to be late coming in to work that morning and provided care only to residents on her assignment.

A telephone interview was conducted by NA #3 on 7/12/18 at 12:58pm. The NA reported she was told to watch for call lights that morning, but was not told to provide care to any specific resident.

During an interview with the Director of Nursing (DON) on 7/12/18 8:08am the DON stated she expected the Unit Manager and nurse to cover every resident every hour every day. The Director stated the NA assignments need to be re-adjusted even if a NA was going to be a half hour late. During an interview with the DON on 7/12/18 at 11am, the DON stated staff needed to

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| F 686 | Continued From page 23<br>accommodate resident needs for incontinent care and toileting. | F 686 | | |