STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345526	A. BUILDING _____ B. WING _____	C 11/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Inital exit date was 10/28/16. Returned to the facility to gather additional infomration with exit date of 11/07/16.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to follow the plan of care for a bed alarm that was implemented by the facility to alert staff of unassisted transfers that resulted in a resident falling for 1 of 3 residents reviewed for implementation of the plan of care (Resident #1). Resident #1 was initially admitted to the facility on 10/07/09 and was most recently readmitted to the facility on 08/10/16 and expired at the facility on 09/21/16. Resident #1's diagnoses included weakness, difficulty in walking, insomnia, Alzheimer's disease, dementia, and others. Review of the Minimum Data Set (MDS) dated 06/13/16 revealed that Resident #1 was severely cognitively impaired and required minimal assistance with bed mobility, and transfers and required one person assistance with bed mobility, transfers, and ambulation. No behaviors or rejection of care was identified on the MDS. The MDS also indicated that Resident #1 was not able to stabilize herself without staff assistance during ambulation. Review of a care plan dated 04/18/14 stated,	F 282	How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Alarm was placed on the bed as the care plan indicated for Resident #1. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice – The Director of Nursing/Unit Manager or designee audited all patient rooms and care plans audited for alarms added or care plan updated and revised if needed to reflect what was in the patient rooms and care plan match. The room audit identifying alarms in place in patients' room was completed on 10/31/16. Care plan check and update was completed on 11/16/16. Measures to be put in place or systemic changes made to ensure practice will not Re-occur - Nurses were in-serviced on	11/22/16

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

Electronically Signed | 11/17/2016

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F 282	Continued From page 1 Resident #1 had actual falls with potential for further falls related to gait and balance problems and medications that were in use. The goal of the care plan was Resident #1 would be free of major injury related to falls through the next review date. The interventions of the care plan included personal safety monitor (PSM also known as bed alarm) to bed and indicated it had been added to the care plan on 01/15/16. The facility was unable to retrieve the electronic kardex for Resident #1 as she had expired. Review of a device assessment for Resident #1 dated 07/15/16 indicated that Resident #1 required the use of a bed and chair alarm to alert staff of unassisted transfers. Review of Treatment Administration Record (TAR) dated 08/01/16 through 08/31/16 stated PSM to bed and chair every shift for fall risk and this had been initialed indicating that it had been in use every shift for the month of August when Resident #1 had been in the facility. Review of incident report dated 08/06/16 at 2:45 AM indicated that Nurse #1 entered Resident #1's room to find Resident #1 lying on the her left side on the floor beside the door. After Resident #1 was assessed for injury, staff assisted Resident #1 into the bed and a bed alarm was placed under Resident #1 and a low bed was initiated. Interview with Nurse #1 on 10/26/16 at 4:51 PM revealed that she was working on 08/06/16 when Resident #1 fell. Nurse #1 stated that when they got Resident #1 back into the bed she applied a bed alarm, but stated the alarm was not in place prior to the fall and gave no reason why the alarm was not in place. Interview with Nurse #2 on 10/27/16 at 11:26 AM revealed that she worked first shift on 08/06/16 after Resident #1 had fallen. Nurse #2 stated that during report that morning Nurse #1 stated that	F 282	checking care plans to ensure devices listed on care plans are in the patients' room. CNA's were educated on where to locate the Kardex on Point Click Care to see what devices a patient should have in place. Unit Managers/SDC will check all residents with alarms daily Monday-Friday for a period of 3 weeks then the Unit Managers are to audit new admissions to ensure care plans match what the patient has in their room, weekly x 4 weeks, twice a month x 2 month, and monthly x 1 on 5 residents if applicable. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur - The results of these audits will be reviewed during the Weekly Risk Meeting and results of the audits will be reviewed at the Monthly QA meeting for a period of 4 months for review for compliance and revision as needed.	

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F 282	Continued From page 2	F 282		

Resident #1 had fallen and after Resident #1 was transferred back into the bed she had applied the bed alarm to her bed.
Interview with NA #1 on 10/27/16 at 12:56 PM revealed that he was working on 2nd shift on 08/05/16 and he assisted Resident #1 with getting ready for bed and assisted her to bed. NA#1 stated he did not put on a bed alarm on Resident #1's bed and he had no idea if she had a bed alarm ordered or not. NA#1 also stated he did not know which residents had alarms and which ones did not. NA#1 stated he tried to keep up with that information but was not always aware of what devices each resident had.
Interview with NA #2 on 10/27/16 at 2:58 PM revealed that she was working 3rd shift when Resident #1 fell. NA #2 stated that she did not see Resident #1 fall but did assist in getting her back into bed after she fell. NA #2 stated that NA#3 was actually responsible for taking care of Resident #1 that evening but she assisted as needed. NA#2 stated that she did not know if Resident #1 had a bed alarm and stated that she had never been introduced to any type of documentation that alerted the staff which residents had alarms or other safety devices.
Attempts to reach NA#3 who no longer worked at the facility on 10/27/16 were unsuccessful.
Interview with Corporate Nurse Consultant and the Interim Director of Nursing (DON) on 10/27/16 at 3:26 PM revealed that the Interim DON had only been at the facility for 3 weeks and was not at familiar with Resident #1. The Corporate Nurse Consultant stated that the NAs have access to the electronic kardex system and are required to review it each day, this was where they learned about the resident and any safety devices that the resident may have including bed and chair alarms. The Corporate Nurse

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F 282	Continued From page 3 Consultant stated that it was the understanding that if there was an order for a device and it is on the care plan then it would appear on the kardex and the device should have been in place as stated.	F 282		