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 06/22/2017

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

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F 000	INITIAL COMMENTS The on-site investigation was 6/20/17 and 6/21/17. The investigation was closed on 6/22/17 after a physician's interview was conducted.	F 000		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician assistant interviews the facility failed to ensure a resident ' s safety by not correctly positioning the resident prior to turning that resulted in the	F 323	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is	7/6/17

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

Electronically Signed | 06/29/2017

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F 323	Continued From page 1 resident falling off of the bed sustaining a laceration to the forehead and a small subdural hematoma for 1 of 3 sampled residents that required extensive assistance for turning and positioning in bed. (Resident #1). The findings included: Resident #1 was admitted to the facility on 1/31/15 and had a diagnosis of advanced dementia. The Care Area Assessment (CAA) for Falls dated 1/20/17 revealed the resident had advanced Alzheimer ' s disease, was non-ambulatory and did not attempt to transfer without staff support. The CAA revealed the resident had generalized weakness and cognitive deficits which limited her mobility and falls would not be care planned. The CAA for Urinary Incontinence revealed the resident was non-verbal and unable to communicate by any means. The CAA noted the staff provided total care with toileting due to the resident ' s cognitive and physical limitations. The Care Plan for Resident #1 dated 2/12/15 noted the resident had ADL (Activities of Daily Living) self-care deficit related to overall weakness, severely impaired cognition/communication and poor physical mobility status. Anticipate and provide all ADL care as needed. The Care Plan noted the resident was incontinent. The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 5/23/17 noted the resident was rarely/never understood, had severe cognitive impairment, required extensive assistance of one person for bed mobility and toileting and was incontinent of bowel and	F 323	completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. A. How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #1 care plan was updated on 06/17/17 to use 2 person assistance with all bed mobility. On 6/17/17, the facility Director of Nursing provided one on one training on safe and proper bed positioning of residents with NA #1. A return demonstration was performed by NA #1 to ensure proficiency of training. B. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: On 06/19/17, the facility Director of Nursing and Unit Manager(s) identified all total and extensive dependent residents needing assist of 1 or 2 person for bed mobility. These residents were referred to Therapy for positioning. All therapy	

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F 323	Continued From page 2 bladder. The MDS revealed the resident had no falls since the previous assessment. A nursing progress note dated 6/16/17 at 8:26 AM revealed the nurse was called to the room of Resident #1 around 4:00 AM by a NA (Nursing Assistant) who stated the resident had fallen out of bed. The note revealed upon entering the room the resident was lying face down beside her bed on the floor. The resident was noted to have bleeding from the forehead. The note revealed vital signs were taken, first aid administered to an open wound on the right forehead and 911 was called. It was noted the resident was alert and responsive and was transported to the hospital by ambulance at approximately 4:20 AM. The resident ' s Care Plan was revised on 6/17/17 and noted the resident was at risk for falls related to overall weakness, severely impaired cognition/communication, poor balance, poor postural control, non-ambulatory status and overall decline in physical mobility status. The Care Plan directed staff to anticipate and provide all needs and to use 2 person assistance with all bed mobility. The Care Plan noted staff education with return demonstration was provided. The Hospital Discharge Summary dated 6/19/17 revealed a discharge diagnosis of subarachnoid hemorrhage-traumatic, fall from bed. The summary noted the resident with advanced dementia was chronically bedridden and during care fell out of bed and sustained a large laceration to the right forehead. The summary noted the CAT scan showed a small subdural and subarachnoid bleeding and was at her baseline neurological status. The note revealed the resident had been seen by neurosurgery and no	F 323	screens submitted were completed on 07/6/17. Care plans have been updated based on therapy screen recommendations. An in-service with return demonstration was performed by the Staff Development Coordinator (SDC) on 06/17/17 with all nursing staff on safe and proper bed positioning of residents. C. Measures to be put in place or systemic changes made to ensure practice will not re-occur: Upon admission, Licensed Nurses will complete a bed mobility assessment for all new residents via the Resident Data Set to determine resident level of assistance/support needed. The facility Staff Development Coordinator (SDC) will validate that nursing staff are utilizing proper technique when turning and repositioning by observing (3) employees each week across all shifts including weekends for 3 months. Re-education will be provided immediately for any employee who does not follow the policy / procedure. D. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Monthly for a minimum of three (3) months, the Director of Nursing will report the results of the audits to the Quality Assurance and Performance	

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F 323	Continued From page 3 surgical intervention was indicated and a repeat CAT scan was stable. A nursing progress note revealed Resident #1 was re-admitted to the facility on 6/19/17. The resident ' s Care Plan was revised on 6/20/17 and noted actual skin impairment due to recent fall and was re-admitted with right frontal scalp laceration with intact sutures. The Care Plan directed staff to keep area clean and dry and to monitor for signs of infection daily. On 6/20/17 at 4:35 PM, NA #1 and NA #2 were observed to provide incontinent care for Resident #1. One NA was positioned on each side of the bed to assist with turning and positioning of the resident. On 6/20/17 at 4:58 PM an interview was conducted with NA #1 who was assigned to Resident #1 on 6/16/17 at the time of the fall from the bed. The NA stated she was providing incontinent care and turned the resident away from her and the resident went a little too far and fell off the other side of the bed. The NA further stated the resident was kind of heavy and it happened so fast. The NA stated she had worked with this resident for years and never had anything like this happen. The NA stated she yelled for the nurse and the nurse and another NA came to the room immediately and the nurse assessed the resident and took vital signs and other staff called 911. The NA stated the staff had received additional training and now used 2 persons to turn and position Resident #1. The NA stated they had also been trained when turning residents with one person assistance, to turn the resident toward the care giver.	F 323	improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained and ongoing; and determine the need for further auditing beyond the three (3) months.	

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F 323	Continued From page 4	F 323		

On 6/21/17 at 1:36 PM an interview was conducted with the Administrator and the Director of Nursing (DON). The Administrator stated they had a plan of correction in place and did a root cause of analysis of the fall for Resident #1 that occurred on 6/16/17. The Administrator further stated she re-created the incident with herself lying in the bed and had NA #1 demonstrate how she turned the resident. The Administrator stated the resident ' s legs were stiff and she stiffened her legs during the demonstration and when turned she would have fallen off of the bed if the DON had not been there to catch her. The Administrator stated it was determined the NA did not pull the resident to the center of the bed prior to turning and the resident was too close to the edge of the bed and the resident fell off of the bed. The Administrator stated all the nurses and NAs (except those who were on vacation) were in-serviced by 6/19/17 on turning and positioning dependent residents and were required to perform a return demonstration to show they understood what they were supposed to do. The Administrator further stated the staff who were on vacation had been notified they would not be allowed to work until they had received the in-service on turning and positioning of residents. The Administrator stated they had 105 residents that required assistance with turning and repositioning and therapy was in the process of re-assessing these residents to determine if 1 or 2 person assistance was required and hoped to have this completed by the end of the week. The Administrator stated the staff would then be observed to turn and reposition residents for a determined period of time to ensure this was being done appropriately. The Administrator further stated Resident #1 had been changed to 2

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F 323	Continued From page 5 person assistance for all turning and repositioning and for incontinence care to ensure this would not happen again. On 6/22/17 at 11:30 AM an interview was conducted with Physician ' s Assistant (PA) #1 who cared for the resident in the facility. The PA stated prior to the fall the resident was alert and had some un-intelligible speech but for the most part was non-verbal. The PA further stated she saw the resident this morning and she was eating (fed by staff) and was at her base line.	F 323		