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 10/14/2018

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 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; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to assure incontinent care needs were met for two (Residents # 11 and # 13) of five sampled residents. The findings included: 1. Record review revealed Resident # 11 was admitted to the facility on 3/15/17 with dementia, diabetes, cerebrovascular accident, and epilepsy. Review of the resident's minimum data set (MDS) assessment, dated 8/19/18, revealed the resident needed limited assistance with her toileting needs. The resident was assessed as being occasionally incontinent of bladder and always continent of bowel. Review of the resident's care plan, dated 8/21/18, revealed staff were directed to provide incontinent care after incontinence episodes. Record review revealed Resident # 11 was transferred to the hospital on 8/30/18, secondary to sustaining a new stroke, and returned to the facility on 9/1/18. Interview with the facility MDS (minimum data set) assessment coordinator on 10/14/18 at 11 AM revealed the facility was working on a significant change assessment for Resident # 11. According to the MDS assessment coordinator, the resident was confused, totally incontinent, and	F 677	1. Activities of Daily Living (ADL) care was provided and the bed linens were changed, for Resident #11 by Nurse Aide (NA) #1 during the survey when it was noted that care was needed. NA#1 is no longer employed at the facility so no further follow up could be completed for this employee. Activities of Daily Living (ADL) care was provided and the bed linens were changed, for Resident #13 by Nurse Aide (NA) #2 during the survey when it was noted that care was needed. All residents assigned to NA#1 were checked by the administrative nursing team to see if they were in need of ADL assistance and assistance was provided as necessary. The shift supervisor on duty 10/12/18 was in-serviced by the Director of Nursing (DON) on 10/15/18 regarding notifying the DON when there is last minute staffing change for further instruction. 2. Any resident requiring assistance with ADLs assigned to NA#1 had the potential to be affected. The Nursing Staff was in-serviced by the Nursing Administration Team through 10/29/18 regarding the standards for providing timely incontinence care, the expectation of notifying a supervisor if a staff member	10/29/18

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

Electronically Signed | 10/25/2018

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F 677	Continued From page 1 needed total staff assistance with her activities of daily living following her return from the hospital on 9/1/18. Resident # 11 was observed on 10/13/18 at 7:30 AM as Nurse Aide (NA) # 1 checked the resident for incontinence needs. There was a strong odor of urine as the NA prepared to care for the resident. NA # 1 explained she was a night shift NA who was trying to complete her last night rounds after her shift ended. NA # 1 stated she had been assigned 27 residents during her night shift, and she had last given Resident # 11 incontinence care at 1 AM. According to the NA she had not been able to check on the resident during her 6 AM round because she had too much to do. As NA # 1 provided care to Resident # 11, it was observed that the resident's disposable brief, incontinent pad, draw sheet, and bottom sheet were heavily soiled with urine. The NA removed all of the linens from the bed, and urine was observed to have gone through the sheets onto the mattress. NA # 1 was observed to dry the urine from the mattress with a towel. NA # 2 entered to assist NA # 1 with a complete linen change. As they removed the linens, it was observed the top sheet was also soiled with urine. Interview with NA # 1 immediately following the 7:30 AM care revealed she had to assist another resident out of bed at 6 AM on 10/13/18 for an early morning appointment, and this had made it more difficult to make her last 6 AM rounds to check on residents and provide for their incontinence needs. The facility administrator was interviewed on 10/14/18 at 10:40 AM and reported the following. According to the administrator, prior to 10/12/18,	F 677	feels they are unable to meet the standard of timely incontinence care, and the responsibility of the supervisors checking to ensure timely care is being provided and providing assistance as necessary. 3. The shift supervisor will notify the DON when there is a last minute staffing change for further instruction. The shift supervisor and/or licensed nurse will check with the Certified Nursing Assistants (CNA) throughout the shift to ensure the residents are being provided care as needed and provide assistance as necessary. Audits will be conducted 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. 4. The Director of Nursing or designee will audit 5 residents per day for 4 weeks then 5 residents per month for 2 months to ensure incontinence care is provided timely. The findings of those audits will be reported to the monthly Quality Assurance Performance Improvement (QAPI) committee and the quality monitoring schedule will be assessed and modified based on findings. The QAPI committee will review the results of the audits monthly for three months and as needed thereafter. The administrator will be responsible for implementing the plan of correction.	

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F 677	Continued From page 2	F 677		

he had completed an acuity assessment on all of the residents who resided on Resident # 11's floor. According to the acuity assessment, residents' needs could be met with either two or three NAs on the 11:00 PM to 7:00 AM shift. The administrator considered three NAs to be optimal staffing, although two were sufficient according to his assessment. The administrator reported there had been a scheduled NA, who had not reported to work for the night shift which began at 11:00 PM on 10/12/18. The administrator stated the supervisor was supposed to have alerted administrative staff, but did not do so on 10/12/18. According to the administrator, the staff worked with two NAs on Resident # 11's floor rather than three as planned. The administrator also stated NA # 1's assignment had not been 27 residents on the night shift which began at 11:00 PM on 10/12/18. He was unsure why NA # 1 thought she had 27 residents, and why she had not been able to check on the resident at 6 AM rounds. The administrator presented NA # 1's assignment showing that she had 22 residents for the night shift which began at 11 PM on 10/12/18.

On 10/14/18 at 12:55 PM, a follow up interview was conducted with NA # 1 via phone. This interview revealed it had been her understanding that she had been assigned more than the 22 residents on the night shift which began at 11:00 PM on 10/12/18. The room numbers for the 22 resident assignment, which had been provided by the administrator, was reviewed with NA #1. Upon hearing the assigned rooms, the NA reported she had an additional room than noted on the assignment provided by the administrator. According to the NA that would have been an additional two residents, and she still thought

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F 677	Continued From page 3	F 677		

there had been 27 total residents on her assignment.

2. Record review revealed Resident # 13 was admitted to the facility on 4/22/15. The resident had a diagnosis of Lewy Body Dementia.

Review of the resident's Minimum Data Set (MDS) assessment, dated 8/23/18, revealed the resident was cognitively impaired, needed extensive assistance with his hygiene needs, and total assistance with his bathing needs. The resident was assessed to be incontinent of both bladder and bowel.

Review of the resident's care plan, dated 8/24/18, revealed staff were directed to check the resident for incontinence needs and provide incontinence care.

The resident was observed on 10/13/18 at 8:10 AM as Nurse Aide (NA) # 2 prepared to give the resident incontinence care. NA # 2 reported she was a day shift NA, and the 8:10 AM incontinent check was the first she had done for Resident # 13 on her 10/13/18 shift. There was a strong odor of urine prior to the start of care. During the care, the resident was observed to have a urine soiled brief insert, heavily urine soiled disposable brief, urine soiled incontinent pad, and urine soiled draw sheet. The resident was also observed to have dried feces between his buttock folds. NA was observed to have to wipe several times in order to remove the stool, and verified the stool was "caked on."

NA # 1 was the NA who had been assigned to care for Resident # 13 on the previous night shift before NA # 2 took over Resident # 13's care at 7

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F 677	Continued From page 4	F 677		

AM on 10/13/18. NA # 1 was interviewed on 10/13/18 at 7:29 AM, and a follow up interview was conducted with NA # 1 on 10/14/18 at 12:55 PM via phone. NA # 1 reported the following. She had looked in on Resident # 13 at 6 AM on 10/13/18 during her night shift, but had not had time to check and provide incontinent care during her last 6 AM round. According to the NA, she thought she had 27 residents for whom she cared on the shift which went from 11:00 PM on 10/12/18 to 7:00 AM on 10/13/18.

The facility administrator was interviewed on 10/14/18 at 10:40 AM and reported the following. According to the administrator, prior to 10/12/18, he had completed an acuity assessment on all of the residents who resided on Resident # 13's floor. According to the acuity assessment, residents' needs could be met with either two or three NAs on the 11:00 PM to 7:00 AM shift. The administrator stated he considered three NAs to be optimal staffing, although two were sufficient. The administrator further reported there had been a scheduled NA, who had not reported to work for the night shift which began at 11:00 PM on 10/12/18. The administrator stated the supervisor was supposed to have alerted administrative staff, but did not do so. According to the administrator, the staff worked with two NAs on Resident # 13's floor rather than three as planned. The administrator also stated NA # 1's assignment had not been 27 residents on the night shift which began at 11:00 PM on 10/12/18. He was unsure why NA # 1 thought she had 27 residents, and why she had not been able to check on the resident at 6 AM rounds. The administrator presented NA # 1's assignment showing that she had 22 residents for the night shift which began at 11 PM on 10/12/18.

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F 677	Continued From page 5 During the follow up interview on 10/14/18 at 12:55 PM with NA # 1, the room numbers for the 22 resident assignment, which had been provided by the administrator, was reviewed with NA #1. Upon hearing the assigned rooms, the NA reported she had an additional room than noted on the assignment provided by the administrator. According to the NA that would have been an additional two residents, and she still thought there had been 27 residents on her assignment.	F 677		
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 receives appropriate treatment and services to	F 690		10/29/18

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F 690	Continued From page 6 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 observation, record review, and staff interview the facility failed to provide services to prevent urinary tract infections for one (Resident # 11) of three sampled residents reviewed for urinary tract infections. The findings included: Record review revealed Resident # 11 was admitted to the facility on 3/15/17 with dementia, diabetes, cerebrovascular accident, and epilepsy. Review of Resident #11's quarterly minimum data set (MDS) assessment, dated 8/19/18, revealed the resident needed limited assistance with her toileting needs. The resident was assessed as being occasionally incontinent of bladder and always continent of bowel. Review of the resident's care plan, dated 8/21/18, revealed staff were directed to provide incontinent care after incontinence episodes. Record review revealed Resident # 11 was transferred to the hospital on 8/30/18, secondary to sustaining a new stroke, and returned to the facility on 9/1/18.	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 #11 is currently without signs or symptoms of a urinary tract infection status post treatment. Activities of Daily Living (ADL) care was provided and the bed linens were changed, for Resident #11 by Nurse Aide (NA) #1 during the survey when it was noted that care was needed. NA#1 is no longer employed at the facility so no further follow up could be completed for this employee. All residents assigned to NA#1 were checked by the administrative nursing team to see if they were in need of ADL assistance and assistance was provided as necessary. The shift supervisor on duty	

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F 690	Continued From page 7 Interview with the facility MDS (minimum data set) assessment coordinator on 10/14/18 at 11:00 AM revealed the facility was working on a significant change assessment for Resident # 11. According to the MDS assessment coordinator, the resident was confused, totally incontinent, and needed total staff assistance with her activities of daily living following her return from the hospital on 9/1/18. According to Resident # 11's record, a urinalysis on 9/12/18 revealed the resident had many bacteria in her urine. The urine culture was pending at that time. The resident began receiving antibiotics for a urinary tract infection on 9/13/18. A review of the final urine lab culture result, dated 9/17/18, revealed the resident's urine had grown greater than 100,000 colonies of the bacteria Klebsiella Pneumoniae. A repeat urine culture, completed on 9/21/18, revealed the resident's urine grew 50,000 colonies of Escherichia Coli. The resident was again prescribed antibiotics on 9/24/18. Resident # 11 was observed on 10/13/18 at 7:30 AM as Nurse Aide (NA) # 1 checked the resident for incontinence needs. There was a strong odor of urine as the NA prepared to care for the resident. As NA # 1 provided care to Resident # 11, it was observed that the resident's disposable brief, incontinent pad, draw sheet, and bottom sheet were heavily soiled with urine. The NA removed all of the linens from the bed, and urine was observed to have gone through the sheets onto the mattress. NA # 1 was observed to dry the urine from the mattress with a towel. NA # 2 entered to assist NA # 1 with a complete linen change. As they removed the linens, it was observed the top sheet was also soiled with urine.	F 690	10/12/18 was in-serviced by the Director of Nursing (DON) on 10/15/18 regarding notifying the DON when there is a last minute staffing change for further instruction. 2. Any resident requiring assistance with ADLs assigned to NA#1 had the potential to be affected. The Nursing Staff was in-serviced by the Nursing Administration Team through 10/29/18 regarding the standards for providing timely incontinence care, the importance of timely incontinence care in the prevention of urinary tract infections, the expectation of notifying a supervisor if a staff member feels they are unable to meet the standard of timely incontinence care, and the responsibility of the supervisors checking to ensure timely care is being provided and providing assistance as necessary. 3. The shift supervisor will notify the DON when there is a last minute staffing change for further instruction. The shift supervisor and/or licensed nurse will check with the Certified Nursing Assistants (CNA) throughout the shift to ensure the residents are being provided care as needed and provide assistance as necessary. Audits will be conducted 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. 4. The Director of Nursing or designee will audit 5 residents per day for 4 weeks	

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F 690	Continued From page 8 NA # 1 was interviewed directly before she started the care on 10/13/18 at 7:30 AM and again directly following the care. NA # 1 reported the following. She was a night shift NA who was trying to complete her last night rounds after her shift ended. NA # 1 stated she had last given Resident # 11 incontinence care at 1:00 AM. NA # 1 reported she had 27 residents for whom to care, and she had not been able to make her last 6 AM round completely. Interview with the facility Administrator on 10/14/18 at 10:30 AM revealed it was his expectation that the NA would have been able to make her last 6 AM round, and that keeping incontinent residents as dry as possible was a preventative measure in helping decrease urinary tract infections for residents. The administrator stated the NA had 22 residents rather than 27 residents.	F 690	then 5 residents per month for 2 months to ensure incontinence care is provided timely. The findings of those audits will be reported to the monthly QAPI committee and the quality monitoring schedule will be assessed and modified based on findings. The QAPI committee will review the results of the audits monthly for three months and as needed thereafter. The administrator will be responsible for implementing the plan of correction.	