STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345436	A. BUILDING _____ B. WING _____	C 06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON REHABILITATION AND HEALTHCARE	**1000 TANDAL PLACE KNIGHTDALE, NC 27545**

(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 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to remove and/or change a pressure dressing from a dialysis resident's arteriovenous (AV) fistula (Resident #2) for one of one dialysis residents reviewed. Findings included: A review of the medical record revealed Resident #2 was admitted 1/31/2018 with End Stage Renal Disease, Dementia with and without behaviors, Diabetes Mellitus and anxiety. The Quarterly Minimum Data Set (MDS) dated 5/11/2019 noted Resident #2 was severely impaired for cognition and needed extensive to total assistance for all care with the physical help of one to two persons. The MDS indicated rejection of care, wandering and behaviors often. The care plan dated 5/13/2018 noted a focus of a requirement for hemodialysis related to End Stage Renal Disease and the goal was Resident would be without complications related to hemodialysis, with no symptoms of infection. Interventions included: monitor & report t MD for signs of renal insufficiency. Work with Resident to relieve discomfort for side effects of treatment. Monitor labs and report to MD. Change dressing	F 698	F – 698 483.25(l) - Dialysis Corrective Action or the Resident Affected Nurse #1, Nurse #5, and Nurse #6 were in-serviced on 6/5/19 by the Director of Nursing on completion of the dialysis communication record, including assessing the AV Fistula site and removal of the pressure dressing. Resident #2 AV Fistula site was assessed and pressure dressing was removed. Corrective Action for the Resident Potentially Affected On 06/06/19, the Director of Nursing and Assistant Director of Nursing assessed residents that are receiving dialysis to ensure that their dialysis communication records were complete and that the pressure dressing on their AV Fistula site had been assessed and removed per MD orders. On 06/05/19 the Director of Clinical Services and RN Supervisor initiated an in-service for staff re-educating them on Ongoing assessment and oversight of the resident before, during and after dialysis treatments, including monitoring the resident's condition during treatments, monitoring for complications,	6/28/19

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

Electronically Signed | 06/18/2019

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F 698	Continued From page 1 as ordered and prn. Monitor for infection. Monitor shunt for bruit and thrill as needed. Remove dressing from shunt site as ordered. Communicate with dialysis facility as needed. A review of the Treatment Administration Record (TAR) dated May 2019 noted an order for dressing removal and/or change to arteriovenous (AV) fistula every shift for monitoring. The checks were documented. A review of the dialysis communication book noted instruction for removal of Resident #2's pressure dressing at bedtime or removal of pressure dressing 6 hours after hemodialysis (HD). On 6/4/2019 at 10:45 AM, Resident #2 was observed in her bed, having just awakened according to herself and Nurse #1. Resident #2 was in bed and observed to have a dressing on her right AV site. Nurse #1 stated Resident #2 would leave for dialysis at 11:10 AM. In an interview on 6/5/2019 at 11:20 AM, the manager at the dialysis center stated Resident #2 comes for hemodialysis on Tuesday, Thursday and Saturday. The manager stated that on several occasions Resident #2 returned to the dialysis center with the same pressure bandage on her right arm's AV fistula that was applied during her previous dialysis treatment, which was two days earlier. The manager stated the nurses at the dialysis center had requested the resident's pressure bandage be removed so the AV fistula would not clot and become inaccessible for dialysis. The manager indicated on May 21, 2019 the resident's AV fistula site was clotted and dialysis could not be performed. The manager	F 698	implementing appropriate interventions, and using appropriate infection control practices; The in-service also included the dialysis communication record, including assessing the AV Fistula site and removal of the pressure dressing. In-service will be completed as of 06/16/19, any in-house staff who did not receive in-service training as of this date will not be allowed to work until training has been completed, the Facility will incorporate this training in the orientation process for new hires. Systemic Changes The Director of Clinical Services and or RN Supervisor will monitor 3 dialysis resident weekly for 12 weeks to ensure the communication record has been completed and that the AV fistula site is assessed and the dressing removed per MD orders. Opportunities to be corrected by the Director of Nursing and or RN supervisor as identified during the Quality Monitoring. Quality Assurance The results of these reviews will be submitted to the QAPI Committee by the Director of Nursing and or RN Supervisor for review by IDT members each month. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate the effectiveness and amend as needed.	

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F 698	Continued From page 2	F 698		

noted the staff was unable to schedule an appointment to have the clot removed at the renal access center, and Resident #2 was sent to the hospital.

A review of the hospital record on 5/21/2019 revealed the diagnosis was: clotted renal dialysis arteriovenous graft. On 5/22/2019 Resident #2 underwent a procedure to visualize the AV fistula and, using a drug coated balloon, remove the clot from the fistula. Resident #2 returned to the facility.

On 6/5/2019 at 11:40 AM, Resident #2 was sitting in a wheelchair near the nurse's station. Nurse #5 took Resident #2's jacket off and Resident #2 was observed to have a bandage on the AV fistula site. Nurse #5 stated the bandage was from the resident's dialysis treatment on 6/4/2019.

In an interview on 6/5/2019 at 2:30 PM, Nurse #1 stated she was assigned to Resident #2 the previous evening (during the 3:00 PM to 11:00 PM shift on 6/4/2019). Nurse #1 indicated when she went to remove the AV fistula dressing there was bleeding, and she left the dressing intact. Nurse #1 stated it was pinpoint bleeding. Nurse #1 noted she reported off to night shift (11 PM to 7 AM) the dressing was intact because of the bleeding.

On 6/5/2019 at 4:00 PM, in a telephone interview, Nurse #6 stated she went into Resident #2's room to remove the AV pressure dressing around midnight, but the Resident was restless and moving around in bed. Nurse #6 noted she went back into the room 2 more times but Resident #2 was covered and she did not disturb her. Nurse

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F 698	Continued From page 3 #2 stated the dressing was intact when her shift ended at 7:00 AM. On 6/5/2019 at 2:00 PM, Nurse #5 stated on 6/5/2019 at 1:15 PM she removed the resident's AV pressure dressing that was applied during the resident's 6/4/2019 dialysis treatment. Nurse #5 stated there was "just a pinch of blood" on the resident's dressing. On 6/5/2019 at 3:45 PM, the Director of Nursing stated her expectation was the staff would follow orders. On 6/5/2019 at 3:50 PM, the facility Administrator stated her expectation was the staff would follow doctors' orders and assess for appropriateness.	F 698		