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 10/12/2023

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RALEIGH REHABILITATION CENTER	616 WADE AVENUE RALEIGH, NC 27605

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 10/09/23 through 10/12/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #I2XR11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/09/23 through 10/12/23. Event ID# I2XR11. The following intakes were investigated NC0020835, NC00206215, NC00206065, NC00206309, NC00207763 and NC00207602. 1 of the 10 complaint allegations resulted in deficiency.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care.	F 553		11/7/23

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

Electronically Signed | 11/03/2023

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F 553	Continued From page 1 (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and resident interviews, the facility failed to invite the resident or resident responsible party to participate in the care planning process for 1 of 27 residents whose care plans were reviewed (Resident #77). Findings included: Resident #77 was admitted to the facility on 4/5/22. Review of a Social Service progress note dated 12/6/22 at 1:47 PM revealed a quarterly care plan meeting was held with Resident #77. Review of a Social Service progress note dated 2/2/23 at 10:55 AM revealed the interdisciplinary team (IDT) met with Resident #77 about his care plan. His family member joined by phone halfway through the meeting. The most recent quarterly Minimum Data Set (MDS) assessment dated 7/13/23 revealed	F 553	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. F553 □ Rights to participate in care 1. The facility failed to invite the resident or resident□s responsible party to participate in the care planning process for Resident #77. Care plan for Resident #77 was held on 10/17/2023 with daughter present via phone. 2. The current care plan calendar was reviewed by Administrator, to ensure other residents with scheduled care plan reviews are aware and resident representative(s) have been notified. Review completed on 11/2/2023.	

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F 553	Continued From page 2 Resident #77 had been assessed as moderately cognitively intact. Review of Resident #77's care plan revealed it had been reviewed and revised on 7/14/23, but there was no indication that the resident or responsible party had participated in the care plan meeting. During an interview on 10/9/23 at 12:49 PM, Resident #77 stated he had not been invited to attend a care plan meeting and did not recall participating in developing his plan of care since his initial admission into the facility. The Social Services Assistant (SSA) was interviewed on 10/11/23 at 9:07 AM, and she revealed that she or the Social Worker (SW) coordinated care plan meetings. After a resident was admitted, care plan meetings were held every 90 days. Documentation of care plan meetings were in progress notes of the medical record. The SSA indicated that care plan meetings were not normally held without documentation. During a follow-up interview with the SSA on 10/11/23 at 10:35 AM, she revealed that she could not recall holding a care plan meeting with Resident #77 after 2/2/23. She stated she usually followed the MDS assessment calendar and used that as a guide to schedule care plan meetings. The SSA further stated Resident #77 was not included on the MDS calendar from March through July 2023, and therefore, was not invited to a care plan meeting during that time. She indicated residents were usually notified with a verbal invitation and resident representatives via telephone.	F 553	3. Social Services Director, Social Services Assistant, and Resident Care Specialist were educated by the facility Administrator regarding the care plan invite process including notification to resident and resident representative(s). Notification will be completed by verbal and written notification. Education completed by 11/7/2023. Newly hired SSM, SSA and RCS will be educated during Department Orientation. Audit of scheduled resident□s care plans will be completed by Administrator/designee 3 times a week for 4 weeks, then 2 times a week for 4 weeks, then 1 time a week for 4 weeks to ensure resident and resident representative(s) received written notice of scheduled care plan review. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A) Committee by the Administrator monthly x 3 months. At that time, the QA & A committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Administrator	

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F 553	Continued From page 3 During an interview with MDS Nurse #1 on 10/11/23 at 11:02 AM, she revealed she could not give details as to why Resident #77 was not included on the MDS assessment calendar referenced for care plan meetings. She indicated Resident #77 should have been on the MDS calendar for the months of April and July because that was when his quarterly assessments were due. The SW was interviewed on 10/11/23 at 10:11 AM. She revealed that care plan meetings were organized by herself, and the Social Services Assistant based on the MDS assessment calendar. The SSD indicated that care plan meetings were supposed to be held every 3 months, and the meeting activity was documented in progress notes of the medical record. There was a care plan meeting held with Resident #77 and the SSD back in April around his birthday but was not documented. Resident #77's responsible party was included via telephone. During an interview with the Director of Nursing (DON) on 10/11/23 at 12:09 PM, she revealed Resident #77 and the responsible party should have been invited to his scheduled care plan meeting. An interview was conducted with the Administrator on 10/11/23 at 2:34 PM, and he revealed Resident #77 should have been invited to a care plan meeting at least quarterly.	F 553		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8)	F 561		11/7/23

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F 561	Continued From page 4 §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to honor a resident's bathing preference when showers were not provided as scheduled for 1 of 4 dependent residents (Resident #71) reviewed for choices Findings included: Resident #71 was admitted to the facility on	F 561	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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F 561	Continued From page 5 1/21/23. The quarterly Minimum Data Set dated 8/2/23 revealed that Resident #71 was cognitively intact. He was also coded as physical help in part by 1 staff member for bathing and was not coded for rejection of care. Resident #71's care plan last revised on 7/28/23 revealed he had an activities of daily living (ADL) functional deficit due to impaired vision. Interventions included 1-person assistance with bathing. Review of the facility shower book revealed Resident #71 was scheduled for showers on Tuesday and Friday on the 3:00 PM - 11:00 PM shift. Review of the facility bathing history from 9/23/23 through 9/30/23 revealed Resident #71 was provided with a bed bath on 9/26/23 and 9/29/23 instead of his scheduled shower. There was no documentation that Resident #71 received any showers during that timeframe. An interview was conducted with Resident #71 on 10/09/23 at 11:44 AM. He revealed that he had not received his scheduled showers during the last week of September 2023 and was supposed to receive showers on Tuesday and Friday. He was unsure of why he didn't receive his showers as scheduled. During a follow-up interview with Resident #71 on 10/11/23 at 1:05 PM, he revealed he had never refused a shower and did not refuse a shower during the last week of September.	F 561	F 561 Self Determination 1. Facility failed to honor bathing preference for Resident #71 when a shower was not offered. Resident #71 was interviewed for preference on 10/13/2023 by Unit Manager, prefers showers and current schedule. 2. Nurse Management (Assistant Director of Nursing and Unit Managers) conducted an audit for bath/shower preference and updated bath/shower schedules to reflect resident preferences. Audit completed by 11/2/2023. 3. Education was provided by Director of Nursing/designee to all Certified Nursing Assistants (CNA) regarding review of resident□s bath/shower schedule preference, completing a bath/shower form, documenting bath/shower and/or refusal of bath/shower and presenting the form to the licensed nurse for review. Education completed by 11/7/2023. Education was provided by the Director of Nursing/designee to all Licensed Nurses regarding monitoring for completion of scheduled bath/showers per resident preference and documentation of bath/shower in resident electronic medical record. Education completed by 11/7/2023. New hires will be educated during Department Orientation.	

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F 561	Continued From page 6 Nurse Aide (NA) #3, who worked from 3:00 PM - 11:00 PM with Resident #71 on 9/26/23 (Tuesday) and 9/29/23 (Friday) from 7:00 PM - 11:00 PM, was interviewed. He revealed he could not recall if he gave Resident #71 a shower on 9/26 or 9/29. NA #3 indicated Resident #71 had never refused a shower from him. An interview was conducted with NA #1 on 10/11/23 at 3:14 PM. She worked with Resident #71 on 9/29/23 (Friday) from 3:00 PM - 7:00 PM. NA #1 revealed that she offered the resident a shower on 9/29 before 7:00 PM, but he was not ready yet. At 7:00 PM, there was a shift change in room assignments, and she was not sure what happened later that evening. NA #1 stated Resident #71 had never refused showers from her before. The Director of Nursing (DON) was interviewed on 10/11/23 at 12:14 PM, and she revealed that each floor had a shower schedule to provide showers to residents on specific days. The DON indicated staff should always ask if residents wanted their shower on their designated day and if they said no, then nursing staff should ask for it to be rescheduled or provide a bed bath instead. She stated that nursing staff were expected to document the bathing activity of each resident and notify the nurse on duty if they had refused or preferred another day/time for their shower. During a follow-up interview with the DON on 10/12/23 at 8:15 AM, she stated that if Resident #71 preferred showers as the bathing activity and wanted them on his regularly scheduled day, then he should have received them per his preference. If he wanted it later in the shift, that was not considered a refusal. Nursing staff should notify	F 561	A random audit of resident□s bathing preference/shower will be completed for 10 residents weekly x 4 weeks, 5 residents weekly x 4 weeks, then 2 residents weekly x 4 weeks by the Director of Nursing/designee. These audits will be performed both by reviewing documentation and resident interviews. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A) Committee by the Director of Nursing monthly x 3 months. At that time, the QA & A committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Director of Nursing	

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F 561	Continued From page 7 the nurse on duty of the shower status, whether he refused or wanted it later with accurate documentation of what really happened. An interview was conducted with the Administrator on 10/11/23 at 2:38 PM, and he revealed the facility should have fulfilled Resident #71's preference for a shower on his scheduled days.	F 561		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (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- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (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 clinical complications); (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 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (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. (iii) The facility must also promptly notify the	F 580		11/7/23

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F 580	Continued From page 8 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) 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). This REQUIREMENT is not met as evidenced by: Based on record review and staff and Responsible Party (RP) interviews, the facility failed to notify the RP of a new antidepressant medication and placement of an alert bracelet (an elopement alarm) for 1 of 1 resident reviewed for notification of change (Resident #109). The findings included: Resident #109 was admitted to the facility on 9/14/23 with a diagnosis of dementia. The Minimum Data Set (MDS) admission assessment dated 9/20/23 revealed Resident #109 had severely impaired cognition and was not coded for behaviors including wandering.	F 580	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. F580 Notification of Changes 1. Resident #109□s representative was not notified of a new antidepressant medication and placement of an alerting bracelet. Resident #109□s representative was updated on 10/17/2023 by the Unit	

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F 580	Continued From page 9 A physician order dated 9/25/23 for trazadone (antidepressant medication) 50 milligrams at bedtime for insomnia. Record review of the Elopement Risk Screen completed on 9/27/23 revealed Resident #109 was identified as an elopement risk. A physician order dated 9/28/23 for alert bracelet to be placed on left leg for dementia. A review of the nursing progress notes from 9/14/23 through 10/11/23 revealed there was no documentation that Resident #109's RP was notified of the new antidepressant medication or the application of the alert bracelet. An interview was conducted with Resident #109's RP #1 on 10/09/23 at 11:20 am who revealed he did not know why the alert bracelet was placed on her ankle but stated it was on her ankle when he arrived one day to visit. RP #1 stated Resident #109 was started on a new medication, and he was not notified until he asked the Director of Nursing (DON) a week ago about the psychiatric consultation that was ordered and was told she was on a new medication. An interview was conducted with Resident #109's RP #2 on 10/11/23 at 2:09 pm who revealed he was not notified of the alert bracelet placement until he saw it on her ankle when visiting. He stated he was not notified about new medications when they were started until they visited and asked if the psychiatric consultation had been completed. RP #2 stated the communication from the staff regarding the care and treatment provided at the facility was not consistent.	F 580	Manager. 2. An audit was conducted by the Director of Nursing/designee for current facility residents for the last 30 days of order changes to ensure notification to resident representative(s) was completed. This audit will be completed by 11/2/2023. 3. All Licensed nurses will be educated by the Director of Nursing/designee on notifying the resident and the resident representative of changes and documenting notification in the electronic medical record. This education will be completed by 11/7/2023. Newly licensed nurse hires will be educated during Department Orientation. Audit of resident□s order listing and 24/72-hour report will be reviewed in Clinical Morning Meeting (Monday- Friday) by the Director of Nursing/designee x 12 weeks to ensure that notification of changes to resident and resident representative(s) is documented in the resident□s electronic medical record. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A) Committee by the Director of Nursing monthly x 3 months. At that time, the QA & A committee will evaluate the effectiveness of the interventions to determine if continued auditing is	

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F 580	Continued From page 10 An interview was conducted on 10/12/23 at 9:50 am with the Unit Manager who revealed she entered Resident #109's physician orders for the antidepressant medication and alert bracelet. The Unit Manager stated Resident #109's RP should have been notified about the new medication and placement of the alert bracelet, but she was unable to remember if she had notified them when they were at the facility. During an interview on 10/11/23 at 1:39 pm the DON revealed Resident #109's RP should have been notified by the Unit Manager when the new medication and the alert bracelet were ordered.	F 580	necessary to maintain compliance. 5. Person Responsible: Director of Nursing	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		11/7/23

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F 656	Continued From page 11 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a written individualized person-centered care plan in the area of antidepressant medication use (Resident #100), and anticoagulant medication use (Resident #53) for 2 of 27 residents reviewed for care plans. The findings included: 1. Resident #100 was admitted to the facility on 4/26/23 with diagnoses which included anxiety and stroke.	F 656	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. F656 Develop/Implement Comprehensive Care Plan 1. The facility failed to develop a written	

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 10/12/2023

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

(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 656	Continued From page 12 A physician order dated 6/12/23 for fluoxetine 20 milligram (mg) capsule (medication used to treat depression) daily for mood disorder. Review of the Minimum Data Set (MDS) quarterly assessment dated 8/02/23 revealed Resident #100 had severe cognitive impairment and was coded for antidepressant medications. Review of Resident #100's care plan last reviewed 8/03/23 revealed there was not a care plan in place for antidepressant medication use. During an interview on 10/11/23 at 11:07 am MDS Nurse #1 revealed she was responsible for developing resident care plans. The MDS Nurse was unable to state why Resident #100's care plan was not developed for the antidepressant medication. An interview was conducted on 10/11/23 at 1:54 pm with the Director of Nursing (DON) who revealed the MDS Nurse #1 was responsible for developing Resident #100's care plan for the antidepressant medication. An interview was conducted with the Administrator on 10/12/23 at 11:57 am who revealed the MDS Nurse #1 was responsible to ensure Resident #100's care plan was in place for the antidepressant medication. 2. Resident #53 was admitted to the facility on 12/3/2022 with diagnoses that included Atrial Fibrillation. The active physician's orders revealed an order dated 5/17/2023 for Eliquis (anticoagulant medication) tablet 5 milligrams twice a day at	F 656	individualized care plan for Resident #100 for antidepressant use and Resident #53 for use of an anticoagulant. Resident #100 care plan was reviewed and updated on 10/12/2023 to reflect the use of antidepressant. Resident #53 care plan was reviewed updated on 10/10/2023 to reflect the use of anticoagulant. 2. All current residents on antidepressants and anticoagulation medications will be audited by the Director of Nursing/designee to ensure a care plan for use is present. This audit will be completed by 10/30/2023. Any discrepancies will be corrected. 3. Nursing department leadership and Resident Care Specialist will be educated by the Vice President of Operations on individualized care plans relating to specialty medications, such as, antidepressants and anticoagulants for the resident and updating the care plan with changes. This education will be completed by 11/7/2023. New hires will be educated during Department Orientation. Audit of resident□s order listing and 24/72-hour report will be reviewed in Clinical Morning Meeting (Monday- Friday) by the Director of Nursing/designee x 12 weeks to ensure resident□s care plan reflects person centered needs. 4. Data obtained during the audit	

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 10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656	Continued From page 13 8am/8pm. Resident #53's most recent Quarterly Minimum Data Set (MDS) assessment dated 8/9/2023 revealed Resident #53 was moderately cognitively impaired and coded for anticoagulant medication. The active comprehensive care plan last reviewed on 8/10/2023 revealed anticoagulant medication therapy was not referenced in the care plan. During an interview with the MDS Nurse #1 on 10/10/2023 at 12:38 P.M. she revealed she was not sure how she forgot to document Resident #53's anticoagulant therapy on the care plan during the quarterly review of the plan. An interview was conducted with the Director of Nursing (DON) on 10/11/2023 at 9:31 A.M. She revealed it was the responsibility of the MDS Nurse to ensure Resident #53's care plan to be comprehensive. During an interview on 10/11/2023 at 1:31P.M. the Administrator revealed a care plan was expected to be implemented for any medication or diagnosis that required monitoring or treatment.	F 656	process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A) Committee by the Director of Nursing monthly x 3 months. At that time, the QA & A committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Director of Nursing	
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of	F 679		11/7/23

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 10/12/2023

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 679	Continued From page 14 activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and Responsible Party (RP) interview, the facility failed to provide an ongoing resident centered activities program that included activities to meet the interests of a resident that did not participate in group activities for 1 of 1 residents reviewed for activities (Resident #100). The findings included: Resident #100 was admitted to the facility on 4/26/23 with diagnoses which included stroke and anxiety. Resident #100's care plan dated 7/28/23 revealed his past hobbies included watching college sports, golf, soccer, and football. The interventions included providing a program of activities to accommodate Resident #100's communication abilities which included listening to music, television, and conversation that required little to no response. Review of the Minimum Data Set (MDS) quarterly assessment dated 8/02/23 revealed Resident #100 had severely impaired cognition and unclear speech. Resident #100 was coded for depressed feelings during the look back period and anxiety. An observation on 10/09/23 at 12:00 pm revealed Resident #100 was alone in his room sitting in his	F 679	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. F679 Activities Meet Interest/Needs of Each Resident 1. The facility failed to provide activities to meet the interests of a resident that did not participate in group activities for Resident #100. Resident #100 and resident□s representative were interviewed on 10/30/2023 by Administrator to update preference of activities. 2. Current residents and resident representatives as applicable that do not participate in group activities were interviewed by Interdisciplinary Team (IDT) for activity preferences. Care plan updated with person centered activity program to meet to needs/interest of resident by Senior Resident Care Specialist. Audit will be completed by 10/31/2023.	

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 10/12/2023

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 679	Continued From page 15 wheelchair on the left side of the bed away from the window without the television or music on. During an interview on 10/09/23 at 12:23 pm with Resident #100's Responsible Party (RP) she revealed Resident #100 was unable to participate in group activities related to his anxiety. Resident #100's RP revealed she was present every day for extended periods of time and had not seen anyone from the activity department offer activities or engage in activities with Resident #100. An observation on 10/10/23 at 12:18 pm revealed Resident #100 was alone in his room sitting in his wheelchair on the left side of the bed away from the window without the television or music on. An interview was conducted on 10/10/23 at 3:17 pm with Activity Assistant #1 who revealed she had been in the position for a few months and had never provided activities for residents that did not participate in the planned group activities. She stated she delivered an activity calendar to all residents and encouraged attendance but did not provide individual activities for Resident #100. An interview was conducted on 10/10/23 at 3:19 pm with Activity Assistant #2 who revealed she was new to the position, and she had not provided any activities for resident #100. During an interview on 10/10/23 at 3:20 pm with the Corporate Activity Director she revealed she was assisting the facility until the new Activity Director arrived. She stated she discussed individualized activities for those residents that did not participate in group activity with the activity staff when she identified they were not provided,	F 679	3. All Licensed Nurses, Certified Nursing Assistants, and Activity staff will be educated by the Administrator on identifying residents with need/preference for in room activities and communicating with activity staff need/preference for in room activities. Education completed by 11/7/2023. Activity Staff will be educated by the Administrator regarding interviewing resident and resident representative(s) for activity preferences, documenting preferences in residents electronic medical record, and providing in room activities. Education completed 10/30/2023. New hires will be educated during Department Orientation Random audit of residents who□s preference is to not join group activities will be completed by the Administrator/Designee to ensure that residents with activity preference of in room activities are provided and documented. 10 residents per week x 4 weeks, 5 residents per week x 4 weeks, then 2 residents per week x 4 weeks. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A) Committee by the Administrator monthly x 3 months. At that time, the QA & A committee will evaluate the	

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F 679	Continued From page 16 and she updated the current activity calendar to include activities for those residents that do not attend group activities. An interview was conducted with the Administrator on 10/12/23 at 12:01 pm who revealed he was not aware the activities department did not offer individual activities to residents that did not participate in the planned group activities.	F 679	effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Administrator	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, resident interviews, and staff interviews, the facility failed to safely transport a resident back to her room via wheelchair (Resident #5) when she requested to be put back to bed. Resident #5's left leg got caught under the left side of her wheelchair without leg rests attached while being pushed by a Nurse Aide (NA) and resulted in a nondisplaced fracture of the left proximal (near the center of the body) tibial (shinbone) metaphysis (neck portion of the long bone) and plateau (cartilage that covers the top end of the tibia). As a result, the resident endured acute (short-term) pain that was treated with medication. This was for 1 of 4 residents reviewed for accidents (Resident #5).	F 689	Past noncompliance: no plan of correction required.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 17	F 689		

Findings included:

Resident #5 was readmitted to the facility on 4/29/23 with diagnoses which included end stage renal disease (ESRD) with hemodialysis (HD), osteoporosis, osteoarthritis of the left knee, and stroke with left sided weakness.

The Minimum Data Set (MDS) Quarterly Assessment dated 6/22/23 revealed Resident #5 was cognitively intact and required total dependence of 1 person for locomotion on the unit. Functional limitation in range of motion (ROM) of upper and lower extremities on one side. Resident #5 used a wheelchair as a mobility device.

A Change in Condition evaluation dated 7/22/23 and written by Nurse #5 revealed Resident #5 had new or worsening pain that started on 7/22/23 in the morning time. On a pain scale of 1-10, Resident expressed pain of 2/10 and then 5/10. Nurse #5 spoke with the provider on-call and received orders for an x-ray of the left knee. Resident #5's family member was notified at 2:50 PM.

Outpatient x-ray results taken at the facility on 7/22/23 revealed no dislocation or fracture to the left knee, tibia/fibula, or ankle. However, moderate osteoarthritis of the left knee was noted.

A Nursing Progress note dated 7/22/2023 written by Nurse #5 revealed Resident #5 was noted to be laying on her left side without pain. Resident #5 had a diagnosis of osteoarthritis in her left knee and was able to bend, move, turn side to

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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 689	Continued From page 18	F 689		

side without any pain or difficulty. X-rays were obtained of left knee, left tibia/fibula, left ankle and left foot all noted without dislocation or fracture. Resident and her family member were updated to results. Resident #5's family member called 911 from his home due to Resident #5 continually calling him in pain but was noted without issue at the facility in her bed. Report given to paramedics and emergency room (ER) nurse regarding situation and results sent. Resident was transferred to ER via stretcher in good spirits at 8:30 PM.

Review of the ER encounter notes dated 7/23/23 revealed Resident #5 had a computed tomography (CT) scan of the left lower extremity that resulted in a nondisplaced fracture of the proximal tibial metaphysis and plateau with osteopenia. The hospital provider documented that Resident #5 was placed in a knee immobilizer for comfort although she was not ambulatory. She will be given orthopedics information to follow-up with them as an outpatient and had home pain medications to take.

Resident #5 was interviewed on 10/09/23 at 10:59 AM. She revealed that she was in her wheelchair after hemodialysis about 6 weeks ago (7/22/23) and indicated she wanted to get back into bed. NA #4 came to her. She was out in the hall, and he was pushing her in the wheelchair fast back to her room. Her left leg was not on the leg rest. Her left foot got hung under the wheelchair, and she hollered out in pain. Resident #5 stated she was put back into the bed and Nurse #5 assessed her leg. An x-ray technician came to x-ray her left leg and told her that there was nothing wrong with her leg. The nursing staff

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 10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 19	F 689		

kept telling her nothing was wrong, but she said that her left leg kept hurting (10/10 on a pain scale). She had already received pain medication daily. That same evening, she requested to go to the hospital, but nursing staff kept telling her nothing was wrong and that it was just a sprain. At the hospital, she was told her left knee was broken.

During a follow-up interview with Resident #5 on 10/09/23 at 3:53 PM, she revealed nursing staff assisted her with mobility in the wheelchair due to left sided weakness. She stated she could move her left leg slightly before the incident on 7/22/23. Resident #5 revealed that when she went to hemodialysis, there were normally leg rests on both sides of the wheelchair, and she could not remember why the left leg rest was not on her wheelchair 7/22/23.

An interview was conducted with NA #4 on 10/09/23 at 12:03 PM. He revealed around 2-3 months ago (unsure of date), Resident #5 was ready to go to bed after lunch and wheeled herself out of her room. He pushed Resident #5 back to her room to put her back in bed. NA #4 stated he was not aware that the leg rests were not on the wheelchair and her left leg went under the wheelchair. He pulled back the wheelchair, and Resident #5 was crying. Then he got Nurse #1, who evaluated her. He then attached the leg rests and returned Resident #5 to her room and put her to bed. He submitted a statement to Nurse #1, and she provided her statement as well for the incident report. He stated an in-service was provided about having proper leg rests on the wheelchair, and he had a training session with the previous DON. After the incident, Resident #5 did not want him to give her care anymore.

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 10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 689	Continued From page 20	F 689		

During a follow-up interview with NA #4 on 10/10/23 at 10:03 AM, he revealed that while transporting Resident #5 in the past, both leg rests were usually on the wheelchair due to Resident #5 was not able to lift her legs for long periods of time. When she returned from hemodialysis, lunch was being served but she wanted to be put to bed right away. This incident did not occur at the end of his shift (3:00 PM). This incident occurred toward the end of lunch service which was around 1:30 - 2:00 PM. NA #4 indicated he was not in a rush.

Review of Nurse #1's witness statement dated 7/23/23 revealed the date of the incident was on 7/22/23 at 2:30 PM. The statement read: "She (Resident #5) came back from hemodialysis then ate her lunch. After she ate her lunch, she came out of her room asking to be put back to bed. She usually eats her lunch before going back to bed. Another resident had fallen so me and the NA were busy with that. After all that was done, the NA went to get the lift to put her back to bed. When NA went to push Resident #5 back, she said her leg got bent under her wheelchair. I did not hear her yell out at the time it happened. Right after she got back from hemodialysis, she had asked for pain medication like she usually does. After the incident, I could not give her anymore pain medication, but I put her Voltaren gel (topical pain gel) on. I went to assess her when I put the gel on her. We called the on-call provider, and they ordered x-rays. Results of the x-rays came back at the time EMS arrived; x-rays were negative."

Nurse #1 was interviewed on 10/10/23 at 2:15 PM. She revealed that she was not a direct

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 10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 689	Continued From page 21	F 689		

witness to the incident with Resident #5 on 7/22/23. However, Resident #5 told her that when NA #4 pushed her in the wheelchair, she put her left foot down and it got caught under the chair. Nurse #5 was the nurse who evaluated Resident #5 and completed the incident report. Nurse #1 stated she was the nurse assigned to Resident #5 and administered the pain medication. Resident #5 had chronic pain and when she was comfortable her pain was at a 6/10 and if she was crying it could be as high 10/10. X-rays were ordered and came to the facility.

Review of Nurse #5's witness statement dated 7/23/23 read: "She (Resident #5) returned from hemodialysis around her usual time. I was at the desk doing paperwork. The NA had gone to the kitchen to get food for another resident when she (Resident #5) came to the nurses' station asking to be put back to bed. I asked her who her NA was, and she said (NA #4). I told her he had just stepped downstairs for a minute for someone else and when he came back, I would help him put her to bed. She headed back to her room, and the NA got back to the floor, so I told her he was back, and we would get her to bed. NA took her to her room, and he told me he was ready. I went to the room to help and as we were putting her in bed, Resident #5 stated "watch my knee." I asked her what had happened, and she stated, "Oh I hit it on the bedside table." The NA told me her leg got caught under the chair when he was wheeling her back to her room. Resident #5 said, "Yeah, he ran over my foot." I assessed her left leg and there were no swelling/redness/marks of any kind. She had ROM and was able to lift her leg and she had rolled over on it trying to reach something while I was there..."

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 10/12/2023

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 689	Continued From page 22	F 689		

Nurse #5 was interviewed via telephone on 10/10/23 at 2:55 PM, and she requested to refer to her witness statement dated 7/23/23 because she could not recall all of the details from the incident on 7/22/23 with Resident #5.

The DON was interviewed on 10/11/23 at 12:02 PM, and she revealed she was employed with the facility since 8/7/23. She indicated that for all residents who needed a wheelchair, leg rests must be in place. For residents who had appointments the next day, staff were expected to ensure that the wheelchairs had leg rests in place. In response to the incident with Resident #5, if there was any complaint of pain then an x-ray would be ordered. If the pain continued, then a repeat x-ray was necessary. All staff involved should have been interviewed to find out what happened and provided in-service education as needed.

An interview was conducted with the previous DON via telephone on 10/11/23 at 12:26 PM. She revealed the incident with Resident #5 occurred on a weekend, and nursing staff notified her that she complained of pain and preliminary x-rays were ordered as a result. The x-rays were negative, but Resident #5 still complained of pain so they sent her out to the ER. She was notified a few days later that the CT scan at the hospital confirmed a fracture. The normal process was that the transport driver took off the leg rests, so that Resident #5 could propel herself around the hall. She requested to be put back to bed after hemodialysis on 7/22/23 and propelled herself into the hallway. When NA #4 was finished with his tasks, he pushed her back to the room and her left leg got caught up under the wheelchair. He then retrieved the leg rests and proceeded to

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 10/12/2023

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

(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 689	Continued From page 23	F 689		

bring Resident #5 back to her room. Nurse #1 assessed her, and an investigation was performed, which included statements from staff, education provided to staff, and evaluations of all residents to determine leg rest needs. The audits/monitoring was still going on when she left the facility in mid-August 2023. The only time that Resident #5 wanted to get out of bed was for hemodialysis and then wanted to be put right back to bed shortly after. The pain medication was changed/increased temporarily to get her comfortable post-acute fracture.

During an interview with the Administrator on 10/11/23 at 3:42 PM, he revealed that there was nothing further the facility could have done to prevent the incident with Resident #5 on 7/22/23. Through the investigation and plan of correction, he stated that he had discovered the leg rests were not on the wheelchair at the time. When Resident #5 was transported to/from hemodialysis, the leg rests were normally on the wheelchair. It was not found that NA #4 was rushing while pushing Resident #5 back to her room. An intervention that developed from the incident was to ensure leg rests were always in place on the wheelchair while mobile through the facility.

The facility provided the following corrective action plan with a completion date of 7/26/23.

Address how corrective action will be accomplished for resident found to have been affected:
On 7/22/2023, Resident #1 sustained a non-displaced fracture of the proximal tibia after her leg was caught under the wheelchair during transport. Resident was assessed by nurse.

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 10/12/2023

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RALEIGH REHABILITATION CENTER	616 WADE AVENUE RALEIGH, NC 27605

(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 689	Continued From page 24 There was no swelling or deformity. The resident complained of pain 2/10 and was medicated per MD orders. NP was notified on 7/22/2023 at approximately 4:30pm. Orders for x-rays were obtained at approx. 7:00pm. Resident #1 responsible party was notified. X-ray results were obtained at approx. 8:00pm. X-ray showed no dislocation or fracture. Resident continued complaints of pain. Resident was sent to the hospital for further evaluation. Address how corrective action will be accomplished for resident(s) having potential to be affected by the same issue needing to be addressed: All residents have the potential to be affected. On 7/23/23, nurse aide staff were reeducated on the need for residents' wheelchairs to be checked prior to pushing residents in the wheelchairs. The center's transport company requires residents in wheelchairs to have leg rests on as a safety requirement for transportation while in the transport vehicle. Staff educated on wheelchair safety techniques to include the use of leg rests for those that are unable to self-propel or for those that are unable to hold their legs up on command while being pushed in a wheelchair. Residents with wheelchairs are evaluated by the Rehab Team for the need of leg rests to aide in the resident's mobility via wheelchair. Residents that decline the use of leg rests will be educated regarding the use of leg rests and if continue to decline, preferences will be honored. Nurse aide staff were also educated on how to access the resident Kardex in PCC and the expectation of when to check the Kardex in order to identify if the resident requires leg rests prior to being pushed in the wheelchair.	F 689		

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 10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 25	F 689		

Any nurse aide staff that could not be reached within the initial reeducation timeframe of 24 hours will not take an assignment until they have received reeducation by the DON/designee.

Agency nurse aide staff and newly hired nurse aide staff will have this education in orientation period by the DON/Staff Development Coordinator/designee.

On 7/24/2023, a 30-day lookback of incidents involving residents dependent of wheelchairs with leg rests for mobility being transported by wheelchair was completed by the Regional Clinical Director with no findings identified.

On 7/24/2023, ad-hoc QAPI conducted with Medical Director included to review the incident and plan to correct.

On 7/25/2023, all wheelchairs will be checked by Maintenance and Therapy Director to ensure leg rests are available and appropriate leg rests are with each wheelchair. Any issues will be corrected immediately.

Address what measures will be put in place or systemic changes made to ensure that the identified issue does not occur in the future:
All CNA staff will review the Kardex prior to transporting resident in wheelchair to identify need for leg rests and they will ensure if leg rests are needed they are securely attached to the wheelchair.

Monitoring:
The DON/designee will perform random audits of 10 residents per week for who are in wheelchairs

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 10/12/2023

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 689	Continued From page 26 to ensure leg rests are available and applied to the wheelchair prior to staff pushing residents. Audits will occur 3x weekly x 4 weeks, then 2x weekly x 4 weeks, then 1x per week x 4 weeks. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Date of compliance: 7/26/2023 Observations made throughout the survey revealed the resident did not leave her bed unless she went out for dialysis. While she was in her bed, the wheelchair was always observed with footrests. Residents' that were mobile throughout the facility and needed them, had leg rests on their wheelchairs. The corrective action plan was verified through record review of the education logs, audit reports of the event reporting, root cause analysis, resident care guide audits, and observations. Based on the observations and record review, the facility's compliance date of 7/26/23 was verified.	F 689		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date.	F 732		11/7/23

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 10/12/2023

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

(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 732	Continued From page 27 (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to 1) post accurate licensed nurse staffing data for 10 of 10 days reviewed for sufficient staffing (10/01/23-10/10/23), and 2) failed to post accurate census data for 2 of the 4 days during the survey (10/09/23 and 10/10/23).	F 732	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by	

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 10/12/2023

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

(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 732	Continued From page 28 The findings included: A review of the posted nursing staffing data from 10/01/23 through 10/10/23 revealed the following: 1. a. A review of the Daily Staffing Hours data sheets for the 6:45 am-3:15 pm shift revealed the licensed nursing staff was not recorded accurately for the following days: 10/01/23-Daily Staffing Hours data sheet recorded 2 Registered Nurse (RN) and 4 Licensed Practical Nurse (LPN); staff assignment data recorded 1 RN and 4 LPN. 10/02/23-Daily Staffing Hours data sheet recorded 4 RN and 2 LPN; staff assignment data recorded 1 RN and 5 LPN. 10/03/23-Daily Staffing Hours data sheet recorded 2 RN and 4 LPN; staff assignment data recorded 1 RN and 5 LPN. 10/04/23-Daily Staffing Hours data sheet recorded 3 RN and 3 LPN; staff assignment data recorded 2 RN and 4 LPN. 10/05/23-Daily Staffing Hours data sheet recorded 3 RN and 2 LPN; staff assignment data recorded 0 RN and 6 LPN. 10/06/23- Daily Staffing Hours data sheet recorded 3 RN and 3 LPN; staff assignment data recorded 1 RN and 5 LPN. 10/07/23- Daily Staffing Hours data sheet recorded 3 RN and 5 LPN; staff assignment data recorded 0 RN and 7 LPN.	F 732	the provisions of federal and state law. F732 Posted Nurse Staffing 1. The facility failed to 1) post accurate licensed nurse staffing data for 10/01/23-10/10/23, and 2) failed to post accurate census data for 10/09/23 and 10/10/23. The staffing sheets requested during the survey were corrected. 2. No residents were affected. 3. The Administrator, Staffing Coordinator, and Clinical leadership team were educated on 10/27/23 by the Regional Clinical Director on the need for accuracy of posted Staffing and Census data. Newly hired clinical leadership team members will be educated during Department Orientation. An audit of the staff postings will be reviewed, reconciled, and validated as part of the daily labor meeting (Monday □ Friday) by the staffing coordinator. Once reviewed and verified the staffing sheets will be signed by the Administrator/designee filed. Audit will be completed x 12 weeks. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A) Committee by the Administrator monthly x 3 months. At that time, the QA	

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 10/12/2023

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 732	Continued From page 29 10/08/23- Daily Staffing Hours data sheet recorded 5 RN and 2 LPN; staff assignment data recorded 1 RN and 5 LPN. 10/09/23- Daily Staffing Hours data sheet recorded 4 RN and 3 LPN; staff assignment data recorded 1 RN and 6 LPN. 10/10/23- Daily Staffing Hours data sheet recorded 4 RN and 2 LPN; staff assignment data recorded 1 RN and 5 LPN. b. A review of the Daily Staffing Hours data sheets for the 2:45 pm-11:15 pm shift revealed the licensed nursing staff was not recorded accurately for the following days: 10/02/23- Daily Staffing Hours data sheet recorded 1 RN and 5 LPN; staff assignment data recorded 0 RN and 6 LPN. 10/03/23- Daily Staffing Hours data sheet recorded 2 RN and 4 LPN; staff assignment data recorded 0 RN and 6 LPN. 10/04/23- Daily Staffing Hours data sheet recorded 3 RN and 4 LPN; staff assignment data recorded 0 RN and 6 LPN. 10/05/23- Daily Staffing Hours data sheet recorded 3 RN and 3 LPN; staff assignment data recorded 1 RN and 5 LPN. 10/06/23- Daily Staffing Hours data sheet recorded 3 RN and 3 LPN; staff assignment data recorded 0 RN and 6 LPN. 10/07/23- Daily Staffing Hours data sheet recorded 2 RN and 5 LPN; staff assignment data	F 732	& A committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Administrator	

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 10/12/2023

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 732	Continued From page 30	F 732		

recorded 1 RN and 6 LPN.

10/08/23- Daily Staffing Hours data sheet recorded 4 RN and 2 LPN; staff assignment data recorded 3 RN and 3 LPN.

10/09/23- Daily Staffing Hours data sheet recorded 2 RN and 4 LPN; staff assignment data recorded 0 RN and 6 LPN.

10/10/23- Daily Staffing Hours data sheet recorded 4 RN and 2 LPN; staff assignment data recorded 1 RN and 5 LPN.

c. A review of the Daily Staffing Hours data sheets for the 10:45 pm-7:15 am shift revealed the licensed nursing staff was not recorded accurately for the following days:

10/01/23- Daily Staffing Hours data sheet recorded 3 RN and 2 LPN; staff assignment data recorded 1 RN and 4 LPN.

10/02/23- Daily Staffing Hours data sheet recorded 2 RN and 3 LPN; staff assignment data recorded 0 RN and 5 LPN.

10/03/23- Daily Staffing Hours data sheet recorded 2 RN and 3 LPN; staff assignment data recorded 1 RN and 4 LPN.

10/04/23- Daily Staffing Hours data sheet recorded 1 RN and 4 LPN; staff assignment data recorded 0 RN and 5 LPN.

10/05/23- Daily Staffing Hours data sheet recorded 2 RN and 3 LPN; staff assignment data recorded 0 RN and 5 LPN.

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 10/12/2023

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

(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 732	Continued From page 31	F 732		

10/06/23- Daily Staffing Hours data sheet recorded 3 RN and 2 LPN; staff assignment data recorded 0 RN and 5 LPN.

10/07/23- Daily Staffing Hours data sheet recorded 2 RN and 3 LPN; staff assignment data recorded 1 RN and 4 LPN.

10/08/23- Daily Staffing Hours data sheet recorded 2 RN and 2 LPN; staff assignment data recorded 1 RN and 3 LPN.

10/09/23- Daily Staffing Hours data sheet recorded 2 RN and 3 LPN; staff assignment data recorded 0 RN and 5 LPN.

10/10/23- Daily Staffing Hours data sheet recorded 2 RN and 3 LPN; staff assignment data recorded 0 RN and 5 LPN.

An interview was conducted with the Staffing Scheduler on 10/11/23 at 11:13 am who revealed she was responsible for completing the Daily Staffing Hours data sheets and confirmed the assignment data sheets were the actual staff that worked on a specific date. She stated she did not know why the licensed nursing data was incorrect but stated it may have been an error with the system. The Staffing Scheduler stated she could check the Daily Staffing Hours data sheets on the assignment data sheets for accuracy before she posted them, but she did not because she believed them to be correct when she printed them.

An interview on 10/11/23 at 1:59 pm with the Director of Nursing (DON) revealed the Staffing Scheduler was responsible to post accurate licensed nursing information on the Daily Staffing

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 10/12/2023

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

(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 732	Continued From page 32	F 732		

Hours data sheet.

During an interview on 10/12/23 at 12:03 pm the Administrator revealed the Staffing Scheduler was responsible for ensuring the Daily Staffing Hours data sheets were accurate for licensed nursing staff working.

2. Review of the Daily Staffing Hours data sheet dated 10/09/23 at 10:17 am revealed the facility census was listed as 120.

A review of the Daily Staffing Hours data sheet dated 10/10/23 at 9:08 am revealed the facility census was listed as 120.

Record review of the Resident List Report dated 10/09/23 provided by the Assistant Administrator revealed the facility census on 10/09/23 was 118.

Record review of the Facility Midnight Census Report dated 10/10/23 provided by the Assistant Administrator revealed the facility census on 10/10/23 was 121.

During an interview on 10/11/23 at 11:13 am the Staffing Scheduler revealed she was responsible for completing the Daily Staffing Hours data sheet. She stated she was normally given the facility census at the morning meeting, and she would update the sheets as needed. The Staffing Scheduler stated she completed and printed the Daily Staffing Hours Data sheets on Friday for Saturday through Monday with the information she had at that time, and the nursing supervisor posted the sheets. She stated she did not review the 10/09/23 or 10/10/23 Daily Staffing Hours data sheets for accurate facility census before they were printed.

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 10/12/2023

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 732	Continued From page 33 An interview on 10/11/23 at 1:59 pm with the DON revealed the Staffing Scheduler was responsible for posting accurate information on the Daily Staffing Hours data sheet. During an interview on 10/12/23 at 12:03 pm the Administrator revealed he was unsure who was responsible for ensuring the facility census was accurate on the Daily Staffing Hours data sheet.	F 732		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		11/7/23

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 10/12/2023

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 758	Continued From page 34 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete an Abnormal Involuntary Movement Scale (AIMS) assessment for a resident receiving an antipsychotic medication, which is used for medication monitoring of side effects of antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications (Resident #109). The findings included: Resident #109 was admitted to the facility on 9/14/23 with a diagnosis of dementia with agitation. The hospital discharge summary dated 9/14/23	F 758	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. F758 Free from Unnecessary Psychotropic Meds 1. The facility failed to complete an Abnormal Involuntary Movement Scale (AIMS) assessment for a resident receiving an antipsychotic medication for	

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 10/12/2023

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

(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 758	Continued From page 35 for Resident #109 revealed an order for risperidone (an antipsychotic medication) 0.5 milligrams (mg) at bedtime. There was no diagnosis listed for the risperidone medication on the hospital discharge summary. A physician order dated 9/14/23 for risperidone (an antipsychotic medication) 0.5 mg at bedtime for mood disorder. Resident #109's care plan initiated on 9/14/23 revealed she had impaired cognitive function related to dementia and use of psychotropic medications. The care plan interventions included to monitor for changes in function which included level of consciousness, memory recall, mental status, difficulty expressing self/understanding others. Review of the Psychotropic Medication Note dated 9/14/23 at 3:44 pm by the Unit Manager revealed the interdisciplinary team (IDT) reviewed and discussed Resident #109's psychotropic medication. Resident #109 was prescribed risperidone tablet 0.5 mg at bedtime for dementia without behavior disturbance, psychotic disturbance, and mood disturbance. The Minimum Data Set (MDS) admission assessment dated 9/20/23 revealed Resident #109 had severe cognitive impairment and was not coded for behaviors or rejection of care. Resident #109 received antipsychotic medication for 7 of 7 days during the assessment period. A review of Resident #109's electronic medical record from 9/14/23 through 10/11/23 revealed no documentation regarding the completion of an AIMS assessment since admission to the facility.	F 758	Resident #109. Resident #109 AIMS was completed on 10/12/2023. 2. An audit was conducted by the Regional Clinical Director (RCD) on 10/27/2023 of all current residents on antipsychotic medications for completion of AIMS, all discrepancies corrected. 3. All licensed staff were provided education by the Director of Nursing/designee regarding residents who receive antipsychotic medications are required to have AIMS assessment. Education completed by 11/7/2023. New licensed nurse hires will be educated during Department Orientation. Residents on antipsychotic medications will be audited weekly x 12 weeks by the Director of Nursing/designee for completion of AIMS. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A) Committee by the Director of Nursing monthly x 3 months. At that time, the QA & A committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Director of Nursing	

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 10/12/2023

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F 758	Continued From page 36	F 758		

The AIMS assessment was utilized to detect Tardive Dyskinesia in residents prescribed antipsychotic medications.

An attempt to interview the Nurse Practitioner on 10/11/23 at 2:30 pm was unsuccessful.

During an interview on 10/12/23 at 9:50 am the Unit Manager revealed she did review Resident #109's psychotropic medications upon admission but she was unable to state how the AIMS assessment was missed for the antipsychotic medication.

An interview was conducted on 10/12/23 at 11:13 am with Nurse #4, who completed Resident #109's admission, stated when a resident was on an antipsychotic medication upon admission the AIMS assessment would be triggered when the medication answer box was checked. She stated she did not trigger the AIMS assessment for Resident #109's risperidone medication by error.

An interview was conducted on 10/12/23 at 9:37 am with the Director of Nursing (DON) who revealed the AIMS assessment for Resident #109 should have been completed upon her admission to the facility. The DON stated the AIMS assessment was performed to monitor for side effects from antipsychotic medication and was required to be completed when a new antipsychotic medication was ordered or the dose was increased, and then repeated quarterly. The DON was unable to state how the AIMS assessment was missed during the chart review process for Resident #109's antipsychotic medication.

During an interview on 10/12/23 at 12:00 pm the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 758	Continued From page 37 Administrator revealed the AIMS assessment should have been identified as not completed during the new admission review which was completed by nursing management. The Administrator stated the DON was responsible to ensure the AIMS assessment was completed for Resident #109's antipsychotic medication.	F 758		
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to maintain the area surrounding the dumpsters free of debris and failed to close the doors to dumpsters that contained waste for 2 of 3 dumpsters observed. This practice had the potential to attract pests and rodents. The findings included: During an observation of the dumpster area with the Assistant Dietary Manager (DM) on 10/9/23 at 10:23 AM, 2 bags of trash and 2 empty cardboard boxes were found in between dumpster #1 and dumpster #2. A bag of trash was also found in front of dumpster #3. The top and left doors to dumpster #1 and the left door to dumpster #2 were found open. The assistant DM stated that the dumpster area was in this state upon arrival for her shift, and the housekeeping department was assigned to maintaining the dumpsters. During an interview with the assistant DM on 10/9/23 at 10:37 AM, she revealed that maintenance or housekeeping managed the	F 814	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. F814 Dispose of Garbage and Refuse Properly 1. The facility failed to maintain the area surrounding the dumpsters free of debris and failed to close the doors to dumpsters that contained waste. Debris was removed and doors closed upon notification. 2. No residents were affected. 3. Dietary Manager and Environmental Services Director were educated by the Administrator/designee regarding closing	11/7/23

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F 814	Continued From page 38 dumpster area. If anything was left on the ground, housekeeping usually cleaned it up. An interview was conducted with the Housekeeping Manager on 10/11/23 at 7:34 AM. She revealed that dietary and maintenance were responsible for managing the dumpster area. However, the housekeeping manager indicated that she instructed the housekeepers to take the initiative and pick up trash they may have seen around the dumpsters. During an interview with the Maintenance Director on 10/11/23 at 7:46 AM, he revealed that he made daily rounds to ensure items were picked up off the ground and all doors to the dumpsters were closed. He indicated trash was picked up on Monday/Wednesday/Friday and recycling removal was designated on Tuesday/Thursday. The Maintenance Director stated that he was notified by the Director of Nursing on 10/9/23 about the items on the ground, and he picked them up soon after. The Administrator was interviewed on 10/11/23 at 2:40 PM. He stated the dumpster area should have been clean and clear of all discarded items, and anyone that disposed of garbage should have been managing that area. The Administrator indicated that no single department was delegated to the dumpster area.	F 814	dumpster lids after use, and to not place any debris in the area surrounding the dumpsters. Education completed by 10/31/2023. Dumpsters will be audited 3 times a week x 4 weeks, 2 times a week x 4 weeks, then 1 time a week x 4 weeks by the Administrator/designee to ensure that lids/doors are closed and there is no debris in the area surrounding the dumpsters. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A) Committee by the Administrator monthly x 3 months. At that time, the QA & A committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Administrator	
F 867 SS=G	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data	F 867		11/7/23

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F 867	Continued From page 39	F 867		

collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 867	Continued From page 40	F 867		

aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 867	Continued From page 41 number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with resident and staff, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put into place in order to sustain compliance. This included a recited deficiency in the area of Supervision to Prevent Accidents (F689) as evidenced by repeat citations resulting in harm to residents. During the 7/16/21	F 867	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. F867 QAPI/QAA □	

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F 867	Continued From page 42 recertification and complaint investigation survey, deficient practice at F689 resulted in the resident sustaining a spleen laceration, subarachnoid hemorrhage (bleeding in the space between the brain and the surrounding membrane) and rib fractures. During the 3/22/23 complaint investigation survey, deficient practice at F689 resulted in the resident sustaining a subdural hematoma (collection of blood outside the brain), pain to her right thigh, and temporary amnesia. During the 7/18/23 complaint investigation survey, deficient practice at F689 resulted in the resident sustaining a hematoma (a pool of mostly clotted blood that forms in an organ, body tissue or body space) to the back of his head, shoulder pain, and left scalp pain. Prior to being evaluated at the emergency room the resident went into cardiac arrest and was unable to be revived. During the current recertification and complaint investigation survey of 10/12/23, deficient practice at F689 resulted in the resident sustaining a nondisplaced fracture of the left proximal (near the center of the body) tibial (shinbone) metaphysis (neck portion of the long bone) and plateau (cartilage that covers the top end of the tibia). In addition to the repeat deficiency at F689, the facility had 3 other repeat deficiencies in the in the areas of Notice Requirements Before Transfer/Discharge (F623) previously cited during the survey of 7/16/21, Develop/Implement Comprehensive Care Plan (F656) previously cited during the survey of 6/23/22, and Infection Prevention and Control (F880) previously cited during the survey of 6/23/22. The continued failure during two or more federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included:	F 867	1) The facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the re-certification and complaint investigation survey of 10/12/2023. This included recited deficiencies in the areas of: a) Supervision to Prevent Accidents(F689) as evidenced by repeat citations resulting in harm to residents on the dates of 7/16/2021, 3/22/2023, 7/18/2023, 10/12/2023. Resident #5 leg rests will be placed on wheelchair by staff when resident is mobile throughout the facility. b) Requirements Before Transfer/Discharge (F623) as evidenced by repeat citations on 7/16/2021 and 10/12/2023. No residents were negatively affected. c) Develop/Implement Comprehensive Care Plan (F656) as evidenced by repeat citations on 6/23/20222 and 10/12/2023. Resident #100 antidepressant care plan was updated by the Resident Care Specialist on 10/12/2023and Resident #53 anticoagulant care plan was updated by Resident Care Specialist on 10/10/2023. d) Infection Prevention and Control (F880) as evidenced by repeat citations on 6/23/2022 and 10/12/2023. Resident #95 was evaluated by Physicians Assistant on 10/12/2023. There was no negative outcome noted. Nurse #1 was educated by the Infection Prevention and Control Officer on 10/12/2023 regarding proper tracheostomy care technique.	

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F 867	Continued From page 43 This tag is cross-referenced to: a) F689: Based on record review, resident interviews, and staff interviews, the facility failed to safely transport a resident back to her room via wheelchair (Resident #5) when she requested to be put back to bed. Resident #5's left leg got caught under the left side of her wheelchair without leg rests attached while being pushed by a Nurse Aide (NA) and resulted in a nondisplaced fracture of the left proximal (near the center of the body) tibial (shinbone) metaphysis (neck portion of the long bone) and plateau (cartilage that covers the top end of the tibia). As a result, the resident endured acute (short-term) pain that was treated with medication. This was for 1 of 4 residents reviewed for accidents (Resident #5). During the 7/16/21 recertification and complaint investigation survey, an immediate jeopardy deficient practice was cited at F689 for failing to use 2 persons when transferring a resident with a mechanical lift according to the care plan resulting in the resident sliding out of the lift pad onto the floor during the transfer and sustaining multiple injuries that resulted in a spleen laceration, subarachnoid hemorrhage, and rib fractures. During the 3/22/23 complaint investigation survey, deficient practice was cited at F689 for failing to prevent a fall from bed during incontinence care resulting in a subdural hematoma, pain to her right thigh, and temporary amnesia. During the 7/18/23 complaint investigation survey, an immediate jeopardy deficient practice was cited at F689 for failing to provide care safely to a	F 867	2) All residents have the potential to be affected. 3) What measures will be put into place and what systemic change will be made to prevent re-occurrence: On 10/30/2023, the Vice President of Operations conducted education with the Quality Assurance Performance Improvement (QAPI) Committee on F867, F689, F623, F656, F880 with emphasis on ensuring sustained compliance when deficient practice has been identified and corrected. The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. Licensed and non-licensed staff were educated regarding Preventing Accidents (F689), Notice Requirements of Transfer/Discharge (F623), Implementation of Comprehensive Care Plans (F656), Trache Care Infection Prevention and Control (F880). Newly hired licensed and non-licensed staff will be educated regarding F689, F623, F656, and F880 as part of general orientation. Facility initiated discharges will be reviewed during daily clinical meeting to ensure appropriate discharge notification provided. Social Services Manager or designee will fax a list of facility-initiated discharges to the Ombudsman at least monthly. 4) How the corrective actions will be	

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	345049	A. BUILDING _____ B. WING _____	C 10/12/2023

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F 867	Continued From page 44 dependent resident resulting in the resident falling off the bed onto his back on the floor hitting his head causing a hematoma to the back of his head, shoulder pain, and left scalp pain. Prior to being evaluated at the emergency room the resident went into cardiac arrest and was unable to be revived. During an interview on 10/12/23 at 12:11 pm the Administrator revealed the facility had completed an investigation and identified wheelchair leg rests were not in place on the resident wheelchair at the time of the incident. He further stated education was completed for all nursing staff and auditing was completed to prevent future occurrences. An interview was conducted on 10/12/23 at 12:25 pm with the Vice President of Operations who revealed the facility's corporation had determined the current Administrator was not a good fit to lead the facility. He stated the corporation had taken their time to interview candidates and have found the right Administrator for the facility moving forward (following this survey). b) F623: Based on record review and staff interviews, the facility failed to notify the Ombudsman in writing of a resident discharge and failed to provide written notification for reason of discharge to hospital to the Resident or Responsible Party (RP) for 1 of 1 residents reviewed for hospitalization (Resident #104). During the recertification and complaint investigation survey of 7/16/21, the facility failed to send a written notice of the reason for discharge to the resident's Responsible Party.	F 867	monitored to ensure the deficient practice will not recur: Beginning 11/7/2023, random audits of care plans of residents receiving anticoagulants or antidepressants will be completed by Director of Nursing/designee daily x five (5) days for two (2) weeks, three (3) times weekly for two (2) weeks, then weekly for eight (8) weeks, then monthly for three (3) months. Beginning 11/7/2023 random audits of facility-initiated discharges being faxed to Ombudsman and notification of resident and/or responsible party regarding facility-initiated discharge will be completed by Director of Nursing/designee daily x five (5) days for two (2) weeks, three (3) times weekly for two (2) weeks, then weekly for eight (8) weeks, then monthly for three (3) months. Beginning 11/7/2023 , random facility tours for staff adherence to accident/incident prevention and trache care infection control guidelines will be completed by the Nursing Home Administrator, Director of Nursing, or designee to ensure compliance. These facility tours will occur across all shifts including weekends. A rounding tool will be utilized to perform the tours. Facility tours will be conducted daily x five (5) days for two (2) weeks, three (3) times weekly fortwo (2) weeks, then weekly for eight (8)weeks, then monthly for three (3) months . The results of audits will be submitted to the QAPI Committee by the NHA or DON monthly for six (6) months. These findings will be reviewed for trends to determine if further monitoring and/or	

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F 867	Continued From page 45 During an interview on 10/12/23 at 12:11 pm the Administrator revealed the facility had not identified discharge notification as a current concern from the QAA meetings. He further stated the facility had a lot of transition of management staff and the communication from previous to new staff was not consistent, so things were missed. c) F656: Based on record review and staff interviews, the facility failed to develop a written individualized person-centered care plan in the area of antidepressant medication use (Resident #100), and anticoagulant medication use (Resident #53) for 2 of 27 residents reviewed for care plans. During the recertification and complaint investigation survey of 6/23/22, the facility failed to develop a care plan for a resident with an indwelling urinary catheter. During an interview with the Administrator on 10/12/23 he revealed the facility had not identified care planning as a concern during the QAA meetings. He stated the Minimum Data Set (MDS) Nurse was responsible for resident care plans, but the position was previously covered by temporary staff and the communication was not consistent and things were missed during the transition. d) F880: Based on observation, staff interviews, and record review, the facility failed to remove soiled gloves before placing a clean inner cannula in Resident #95's tracheostomy (surgical opening in windpipe for air/oxygen) for 1 of 1 residents reviewed for tracheostomy care.	F 867	education is needed beyond the six (6) months. A review of audit findings will be conducted by the Regional Clinical Director or Vice President of Operations monthly for 6 months. Recommendations will be made (as applicable) to ensure the facility sustains substantial compliance. 5) This was completed by 11/07/2023.	

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F 867	Continued From page 46 During the recertification and complaint investigation survey of 6/23/22, the facility failed to ensure staff donned Personal Protective Equipment (PPE) when staff entered a resident's room that was under transmission-based precautions and failed to implement the facility's wound care policy during wound care when staff failed to change gloves and sanitize hands between resident's wound when cleaning and applying new dressings. During an interview on 10/12/23 at 12:11 pm the Administrator stated the facility had not identified a concern with tracheostomy care. He stated the Infection Preventionist (IP) role had a recent transition of staff, and the facility was behind with education and some errors were possible during the transition.	F 867		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		11/7/23

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	345049	A. BUILDING _____ B. WING _____	C 10/12/2023

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F 880	Continued From page 47	F 880		

and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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F 880	Continued From page 48 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review, the facility failed to remove soiled gloves before placing a clean inner cannula in Resident #95's tracheostomy (surgical opening in windpipe for air/oxygen) for 1 of 1 residents reviewed for tracheostomy care. The findings included: Record review of the Facility Infection Prevention and Control Program (IPCP) Policy last revised October 2018 revealed the program was based on accepted national infection control prevention and control standards. The policy further stated important facets of infection prevention included educating staff to adhere to proper techniques and procedures and communicating the importance of standard precautions. Review of the Facility Tracheostomy Care Policy last revised 4/24/18 revealed staff were to wash hands, put on clean gloves and remove the soiled dressing and inner cannula, then remove soiled gloves, discard in waste bag, and wash hands. The policy further directed staff to open sterile tracheostomy kit onto sterile drape then put on sterile gloves to clean the tracheostomy site and place new inner cannula.	F 880	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. F880 Infection Prevention and Control 1. The facility failed to remove soiled gloves before placing a clean inner cannula in Resident #95's tracheostomy. Resident #95 trach care was completed by Nurse #1. 2. Immediate 1:1 education was completed with Nurse #1 identified regarding tracheostomy care technique and competency performed to ensure understanding. 3. Education and competency evaluations will be completed with all licensed nurses on Trach Care by Director of Nursing/designee. Education will be completed by 11/6/2023.	

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F 880	Continued From page 49 Record review of Nurse #1's tracheostomy care competency dated 9/27/23 revealed she was found to be competent to perform tracheostomy care to residents. During a continuous observation of tracheostomy care on 10/11/23 at 10:17 am through 10:25 am Nurse #1 was observed to perform hand hygiene, open the sterile tracheostomy kit, place the sterile gloves on and place the supplies from the sterile tracheostomy kit onto the sterile drape. Nurse #1 was then observed to remove the inner cannula and the soiled drain sponge from Resident #95's tracheostomy and placed in the trash container. Nurse #1 then took the new inner cannula and placed it into Resident #95's tracheostomy, cleaned the tracheostomy site with saline soaked gauze, and then placed a new drain sponge dressing under the tracheostomy collar. Nurse #1 did not change the gloves and perform hand hygiene after the removal of the soiled tracheostomy drain sponge and used inner cannula before placing new inner cannula and cleaning the tracheostomy site. During an interview on 10/12/23 at 9:56 am Nurse #1 revealed she thought the sterile gloves were used for the entire tracheostomy care process including removal of soiled items, cleaning, and placing new inner cannula. She confirmed she did not change her gloves or perform hand hygiene before cleaning the tracheostomy site and placing the new inner cannula in Resident #95's tracheostomy. Nurse #1 stated received training on tracheostomy care annually at the facility. An interview was conducted on 10/12/23 at 10:03	F 880	New licensed nurses will be educated during Department Orientation. Director of nursing/designee with audit competency of tracheostomy care by observing 5 nurses weekly x 4 weeks, then 3 nurses weekly x 4 weeks, then 1 nurse weekly x 4 weeks to ensure care is completed accurately. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A) Committee by the Director of Nursing monthly x 3 months. At that time, the QA & A committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Director of Nursing	

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F 880	Continued From page 50 am with the Director of Nursing (DON) who revealed Nurse #1 was required to remove the soiled gloves and perform hand hygiene after she removed Resident #95's used inner cannula and soiled drain sponge. The DON stated after hand hygiene was completed the sterile gloves were to be used to place the new inner cannula and clean Resident #95's tracheostomy site. During an interview on 10/12/23 at 11:07 am with the Infection Preventionist (IP) revealed she completed Nurse #1's tracheostomy competency assessment which included return demonstration and education. The IP stated Nurse #1 was educated to use clean gloves for removal of the soiled items then perform hand hygiene before donning the sterile gloves for the placement of the new inner cannula.	F 880		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized	F 882		11/7/23

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F 882	Continued From page 51 training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to designate a qualified Infection Preventionist (IP), who had completed specialized training in infection prevention and control, to be responsible for the facility's Infection Prevention and Control Program. The findings included: During an interview with the Director of Nursing (DON) on 10/11/2023 at 9:16 A.M. she revealed the Infection Preventionist (IP) was responsible for the facility's Infection Prevention and Control Program. The DON stated the IP was new to the position and had not completed the required training program for the IP position yet. The DON stated did not have any staff members with specialized training to meet the qualifications for the IP role. An interview was conducted with the IP on 10/11/2023 at 11:04 A.M. She revealed she was new to the position and the facility planned for her to attend the next training session on 11/8/2023, to complete the required specialized training. She stated she was shown how to monitor infections in the facility but had not had the specialized training regarding the Infection Prevention and Control program. During an interview on 10/11/23 at 2:12 P.M. the Administrator revealed he was aware the IP had not completed the required training for the Infection Preventionist position. The Administrator stated he was aware the IP role required specialized training but thought the IP would	F 882	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. F882 Infection Preventionist 1. The facility failed to designate a qualified Infection Preventionist (IP), who had completed specialized training in infection prevention and control, to be responsible for the facility's Infection Prevention and Control Program. Infection Preventionist Nurse is scheduled to complete the NC State Program for Infection Control and Epidemiology (NC SPICE) program on 11/8/2023. 2. All residents have the potential to be affected by the alleged deficient practice. IP will complete the NC SPICE by 11/10/2023 3. Education was provided to the Human Resources Generalist and the Administrator by the Vice President of Operations that the facility is required to have IP complete specialized training. Education completed by 10/31/2023. Audit newly hired Infection Preventionist employee file to ensure NC SPICE	

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F 882	Continued From page 52 continue the position until she attends the specialized training on 11/8/2023.	F 882	Certificate of completion is present or enrollment is completed for next available class. Human Resources staff and Staff Development Staff will monitor and assist with Infection Preventionist enrollment in SPICE Program. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A) Committee by the Administrator monthly x 3 months. At that time, the QA & A committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Administrator	