PRINTED: 01/22/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
	345049 B. WING			С			
	ROVIDER OR SUPPLIER REHABILITATION CENT		B. WING	STREET ADDRESS, CITY, STATE, ZIP 0 616 WADE AVENUE RALEIGH, NC 27605	CODE	12/20/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA	DATE	
F 000	INITIAL COMMENTS	3	F 00	00			
5.000	complaint investigation	·				4040	
F 636 SS=D	l	_	F 6	36		1/8/18	
	a comprehensive, ac	duct initially and periodically					
	A facility must make a assessment of a resignals, life history and resident assessment by CMS. The assess the following:	ent Assessment Instrument.					
	(ii) Customary routine (iii) Cognitive pattern (iv) Communication. (v) Vision. (vi) Mood and behavi	s. for patterns.					
	(ix) Continence. (x) Disease diagnosis	ning and structural problems. s and health conditions.					
	<ul><li>(xi) Dental and nutriti</li><li>(xii) Skin Conditions.</li><li>(xiii) Activity pursuit.</li><li>(xiv) Medications.</li></ul>	onal status.					
	(xv) Special treatmer (xvi) Discharge plann						
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATU	JRE			(X6) DATE	

Electronically Signed

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

01/07/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			756.15.1.10			С		
		345049	B. WING			12/	20/2017	
NAME OF PROVIDER OR SUPPLIER  RALEIGH REHABILITATION CENTER			•	61	TREET ADDRESS, CITY, STATE, ZIP CODE 16 WADE AVENUE ALEIGH, NC 27605			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 636	on the care areas trig the Minimum Data Se (xviii) Documentation assessment. The assinclude direct observation with the resident, as a licensed and nonlicer members on all shifts §483.20(b)(2) When a timeframes prescribe chapter, a facility must assessment of a residing timeframes specified through (iii) of this seprescribed in §413.34 apply to CAHs. (i) Within 14 calendar excluding readmission significant change in mental condition. (Fo "readmission" means following a temporary or therapeutic leave.) (iii) Not less than once This REQUIREMENT by:  Based on record revifacility failed to comp summaries which incrisk factors and factor developing individual for 3 of 7 sampled resident.  The findings included	nal assessment performed gered by the completion of et (MDS). of participation in sessment process must ation and communication well as communication with used direct care staff.  required. Subject to the din §413.343(b) of this st conduct a comprehensive dent in accordance with the in paragraphs (b)(2)(i) etion. The timeframes (b)(2)(i) etion. The timeframes (b)(2)(i) etion. The timeframes (b)(a) of this chapter do not a days after admission, and in which there is no the resident's physical or a return to the facility absence for hospitalization are every 12 months. The is not met as evidenced the wand staff interviews the lete Care Area Assessment aluded underlying causes, as to be considered in itzed care plan interventions sidents (Resident #5, #3 and	F	636	The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies.  To remain in compliance with all federa and state regulations the facility has tal or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged	al ken		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		, , ,	(X3) DATE SURVEY COMPLETED	
	345049		B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	343043	1 2:	STREET ADDRESS, CITY, STATE, ZIP CC	•	2/20/2017	
NAIVIE OF P	ROVIDER OR SUPPLIER				'DE		
RALEIGH	REHABILITATION C	ENTER		616 WADE AVENUE			
				RALEIGH, NC 27605			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 636	Continued From p	page 2	F 6	36			
	10/30/17 and had	a diagnosis of multiple		deficiencies cited have beer	or will be		
		gia (difficulty swallowing),		corrected by the dates indica			
		Ilnutrition and dehydration.					
		•		F636			
	The Admission Mi	nimum Data Set (MDS)					
	Assessment date	d 11/6/17 noted the resident		Plan for correcting specific of	leficiency. The		
	was cognitively in	tact, required extensive		process that led to deficienc	y cited.		
		ivities of daily living (ADLs), was					
		vel and bladder, was at risk for		The facility failed to complet			
	1 '	nd received nutrition/hydration		Assessment summaries whi			
	to manage skin pr	roblems.		underlying causes, risk facto			
	The Advance of a NA	DC trimer and the fall accions		to be considered in developi	-		
		DS triggered the following care ussessment and factors to be		individualized care plan inte			
		eloping the resident 's Care		of 7 sampled residents (Res and #1).	ident #5, #5,		
	Plan: Visual Func	· ·		and #1).			
		ilitation Potential, Urinary		The assessments for reside	nt #5 #3 and		
		s, Nutritional Status,		#1 have been modified as of			
		Maintenance, Pressure Ulcers,		include CAA summary for tri	ggered areas		
	1 -	o Community Referral.		and care plans were develop			
				accordance to those triggers	<b>3</b> .		
	Review of the Car	re Area Assessment (CAA)					
		d and dated as complete on		Residents that reside in the			
		Nurse #1 revealed no		the potential to be affected by			
		ummaries regarding the above		deficient practice. The MDS			
		er to develop an individualized		will complete a quality review			
	care plan for the r	esident.		assessments submitted with	•		
	MDS Nurso #1 etc	ated in an interview on 12/19/17		days to ensure CAA summa completed for triggered area			
		ne started working at the facility		care plan development by 1			
		and she did not know to do CAA		care plan development by in	0/2017.		
		y did not do this where she		Procedure for implementing	the		
	came from.	,		acceptable plan of correction			
	On 12/20/17 at 12	2:52 PM the Administrator stated		The MDS nursing staff was	educated on		
		vas her expectation that any		12/20/2017 by the Regional			
		gered on the MDS would have a		information included comple			
	CAA summary do	_		summaries for triggered are			
				the development of care pla			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
		345049	B. WING			С	
NAME OF D	ROVIDER OR SUPPLIER	343043	1 5: 11:10	STREET ADDRESS, CITY, STATE, ZIP CC		2/20/2017	
NAME OF PI	ROVIDER OR SUPPLIER			, , ,	DE		
RALEIGH	REHABILITATION C	ENTER		616 WADE AVENUE			
				RALEIGH, NC 27605			
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 636	Continued From p	nage 3	F 6	36			
. 000	Continued From p	rage o	1 0				
	O Decident #2	and and the state of a silitary are		triggered areas.			
		as admitted to the facility on		Any in house staff members	who		
		a diagnosis of hip fracture, obstructive pulmonary disease		Any in-house staff member			
		al vascular disease and		completes the MDS assessr summaries who did not rece			
	generalized musc			training by 1/7/2017 will not			
	generalized musc	de Weakiless.		work until training has been			
	The Admission M	inimum Data Set (MDS)		This information has been in	•		
		d 10/26/17 revealed the resident		the standard orientation train	•		
		tact, had verbal behaviors		required in-service refresher	•		
		others 1-3 days and had		all employees and will be re-			
	behavioral symptom	oms not directed towards others		Quality Assurance process t			
	4-6 days of the 7	day assessment period. The		the change has been sustain	ned.		
	MDS revealed the	e resident had a fall prior to					
	admission and re	quired limited to total assistance		Monitoring Procedure to ens	sure that the		
		laily living (ADLs) and was		plan of correction is effective	e and that		
	frequently inconting	nent of bowel.		specific deficiency cited rem			
				and/or in compliance with re	gulatory		
		DS triggered the following care		requirements.			
		assessment and factors to be		The Decisional MDC Consults			
		reloping the resident 's Care pss/Dementia, ADL		The Regional MDS Consulta designee will monitor and au			
	_	ilitation Potential, Urinary		comprehensive assessment			
		chosocial Well-Being,		to ensure completion of CAA			
		toms, Falls, Nutritional Status,		and cross referenced to care			
		Pain and Return to Community		audits will include 5 random	•		
	Referral.			comprehensive assessment			
				and then monthly for 3 mont			
	Review of the Car	re Area Assessment (CAA)		resolved by QAPI committee			
		d and dated as complete on		MDS nurse will present repo			
		Nurse #1 revealed no		monthly QA committee to er			
	assessments or s	ummaries regarding the above		corrective action initiated as	appropriate.		
		er to develop an individualized		Compliance will be monitore			
	care plan for the r	esident.		ongoing auditing program re			
				monthly QA meeting. The n	-		
		ated in an interview on 12/19/17		meeting is attended by the A			
		ne started working at the facility		DON, MDS Coordinator, The	• • •		
		and she did not know to do CAA		Dietary Manager, and other			
	summaries as the	ey did not do this where she		representatives as appropria	ate to		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED		
	245040		B. WING_			С		
345049			B. WING _			12/20/2017		
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE			
RAI FIGH	REHABILITATION CENT	FR		616 WADE AVENUE				
IVALLION	REHABIEHAHOR GERT			RALEIGH, NC 27605				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE		
F 636	Continued From page	<u>.</u> 4	F 6	36				
	came from.	•	' '	conversation.				
	came nom.			conversation.				
	in an interview it was	PM the Administrator stated her expectation that any ed on the MDS would have a		The title of the person respo implementing the plan of cor  The Administrator is respons implementation and complet acceptable plan of correction	rection. sible for ion of the			
	10/10/16 and had a d	dmitted to the facility on iagnosis of generalized abetes mellitus and below						
	was cognitively intact symptoms directed to the 7 day assessmen	1/18/17 revealed the resident , had verbal behavioral wards others 1 to 3 days of						
	areas for further asse considered in develop Plan: Cognitive Loss/ Functional/Rehabilita Incontinence, Psychological Behavioral Symptoms	tion Potential, Urinary						
	worksheets signed ar 10/27/17 by MDS Nur assessments or sumr care areas in order to care plan for the resid	naries regarding the above develop an individualized						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245040				С	
		345049	B. WING			12/	20/2017
	ROVIDER OR SUPPLIER REHABILITATION CENT	ER		6	TREET ADDRESS, CITY, STATE, ZIP CODE  16 WADE AVENUE  RALEIGH, NC 27605		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 636 F 656 SS=D	at 1:15 PM that she s in October 2017 and summaries as they di came from.  On 12/20/17 at 12:52 in an interview it was care area that triggere CAA summary done.	tarted working at the facility she did not know to do CAA d not do this where she  PM the Administrator stated her expectation that any ed on the MDS would have a comprehensive Care Plan		636 656			1/8/18
	implement a compreh care plan for each res resident rights set for §483.10(c)(3), that incobjectives and timefra medical, nursing, and needs that are identificassessment. The condescribe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that under §483.24, §483. provided due to the reunder §483.10, including treatment under §483 (iii) Any specialized screhabilitative services provide as a result of	cility must develop and lensive person-centered sident, consistent with the sthat §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial led in the comprehensive aprehensive care plan must personal led in the strain lensies and provided the psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not lesident's exercise of rights ling the right to refuse 1.10(c)(6). Pervices or specialized at the nursing facility will PASARR a facility disagrees with the RR, it must indicate its					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345049		B. WING		C			
NAME OF D		343049	D. WING_	OTDEET ADDRE		12/2	20/2017	
NAME OF PI	ROVIDER OR SUPPLIER				ESS, CITY, STATE, ZIP CODE			
RALEIGH	REHABILITATION CEN	TER		616 WADE AVE				
RALEIGH REHABILITATION CENTER			RALEIGH, NO	2 27605				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD I DSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 656	Continued From pag	ge 6	F 6	56				
		ith the resident and the						
	resident's represent							
		oals for admission and						
	desired outcomes.	oais for admission and						
		reference and potential for						
		icilities 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.	ti iii paragrapii (c) oi tiiis						
		IT is not met as evidenced						
	by:	The flot flot de evidenced						
	_	view and staff interviews the		The state	ements made on this plan of			
		elop a Care plan for pressure			n are not an admission to and			
		dents reviewed for pressure			titute an agreement with the	u uo		
	ulcers (Resident #5)	•		I	deficiencies.			
	The findings include	ed:		To remain	n in compliance with all feder	ral		
	J			I	e regulations the facility has to			
	Resident #5 was ad	mitted to the facility on		I	ke the actions set forth in this			
		diagnosis of multiple			orrection. The plan of correcti			
		lorie malnutrition, dysphagia			es the facility's allegation of			
	(difficulty swallowing			I	nce such that all alleged			
	,	,,			cies cited have been or will be	•		
	The Admission Mini	mum Data Set (MDS)			d by the dates indicated.			
		11/6/17 revealed the resident			-			
		ct, required extensive to total		F656				
		of daily living (ADLs) was						
	incontinent of bowel and bladder and at risk for			Plan for o	correcting specific deficiency.	. The		
		e MDS revealed the resident			that led to deficiency cited.			
	•	facility with one Stage 2			•			
		one unstageable pressure		The facili	ity failed to develop a care pla	an		
	l ·	ed the resident had a			ure ulcers for 1 of 3 residents			
		evice to the bed and chair,		1 -	for pressure ulcers (resident			
	received nutrition/hydration to manage skin				`	-		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		345049	B. WING			C <b>12/20/2017</b>	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP	•	12/20/2017	
TW WILL OF T	NOVIDER OR OUT FIER			616 WADE AVENUE	CODE		
RALEIGH	REHABILITATION CEN	TER		RALEIGH, NC 27605			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	PLAN OF CORRECTION (X5) TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)  (X5) COMPLET DATE		
F 656	Continued From pag	ne 7	F 6	56			
	problems, and receive	ved pressure ulcer care.		Resident #5 has a pressu	ure ulcer care		
		·		plan and interventions in place			
	The Care Area Asse	ssment (CAA) summary		12/20/2017			
	sheet revealed press	sure ulcers triggered but					
	there was not a sum	mary written regarding the					
		ulcers and further risk for		All residents that reside in			
		e CAA worksheet for pressure		the potential to be affecte			
	,	S Nurse #1 as complete on		deficient practice. A quali			
		a checkmark to show that		residents with wounds wa			
	resident 's Care Pla	ld be addressed in the		Assistant Director of Nurs and care plans updated w	-		
	Tesident 5 Care Fla	11.		in place for residents beir			
	Plan dated 11/1/17 a	nt 's Comprehensive Care and revised on 11/13/17 ation or interventions		wounds.	ig treated for		
		ent or prevention of pressure		Procedure for implementi acceptable plan of correc			
	on 12/19/17 at 1:15 observed to review the #5. The MDS Nurse	nducted with MDS Nurse #1 PM. The MDS Nurse was he Care Plan for Resident stated she did not do a Care cers for the resident and		The MDS nursing staff wa 12/20/2017 by the Regior on the completion of CAA triggered areas as well as development of care plan triggered areas.	nal MDS Nurse, A summaries for s the		
	12/20/17 at 12:52 PM	ated in an interview on M she expected pressure nned per results of the Care		Any in-house staff member completes the MDS Asse CAA Summaries who did in-service training by 1/7/ allowed to work until train completed. This informati integrated into the standar training and in the requires refresher courses for all ewill be reviewed by the Q process to verify that the been sustained.	essments and not receive (2017 will not be ning has been ion has been ard orientation ed in-service employees and quality Assurance change has		
			Monitoring Procedure to 6	ensure that the			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTR IG	RUCTION	(X3) DATE SURVEY COMPLETED		
					С		
		345049	B. WING _	. WING			20/2017
NAME OF PROVIDER OR SUPPLIER  RALEIGH REHABILITATION CENTER				616 WADE	DDRESS, CITY, STATE, ZIP CODE E AVENUE H, NC 27605		
(X4) ID PREFIX TAG						(X5) COMPLETION DATE	
F 656	Continued From page	÷ 8	F	The I qualit week sched care comp week resolv  The to the corre and p mont Admi Coord Mana repre converting the I imple	of correction is effective and that iffic deficiency cited remains corrector in compliance with regulatory rements.  DON or designee will complete the ty review of 5 random care plans and the MDS completion dule to ensure implementation of plans. This quality review will be pleted for 5 care plans weekly for 4 as then monthly for 3 months until eved by QAPI committee.  DON or designee will present representative action initiated as appropriate to ensure active action initiated as appropriate to lan modified based on findings. The plan modified based on findings and the finistrator, DON, ADON, MDS dinator, Therapy, HIM, Dietary ager, and other facility esentatives as appropriate to ersation.  Administrator is responsible for ementation and completion of the ptable plan of correction.	orts e e Fhe	