STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345202	A. BUILDING _____ B. WING _____	C 03/02/2018

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CAPITAL NURSING AND REHABILITATION CENTER	3000 HOLSTON LANE RALEIGH, NC 27610

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F 000	INITIAL COMMENTS There were no deficienciencis as a result of the Complaint investigation of 3/2/18. Event ID#KYV711. Complaint Intake #'s NC00135515, NC001311992, NC00128792, NC00126554, NC00125931 and NC00125555.	F 000		
F 570 SS=C	Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on document review and interviews, the facility failed to provide a surety bond which named the residents of the facility as the obligee. The findings include: Review of the facility surety bond, dated 10/16/17, titled "Continuation Certificate," read in part, "To be attached to and form a part of the surety bond number 018012720. The bond cross reference bond number for patient trust bond., dated the 12th day of January, 2015, in the penal sum of $40,000.00 issued by named insurance company as surety on behalf of Liberty Commons Nursing and Rehab. Center of Wake County, LLC as principal in favor of residents of Facility Tarboro Care LLC, as obligee (the obligee)." Review of another facility surety bond dated 10/16/17, titled "Continuation Certificate," read in part, "To be attached to and form a part of surety bond number 018012720. The bond cross	F 570	F570 Surety Bond-Security of Personal Funds Based on document review and interviews, the facility failed to provide a surety bond which named the residents of the facility as the obligee. The plan for correcting the specific deficiency and the process that lead to the alleged deficiency: The surety bond was re-issued to the facility on 3/13/2018 that read, “on behalf of Liberty Commons Nursing and Rehab Center of Wake County, LLC as principal in favor or residents of Liberty Commons Nursing and Rehab Center of Wake County, LLC as obligee.” The procedure for implementing the acceptable plan of correction for the	3/13/18

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

Electronically Signed | 03/16/2018

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F 570	Continued From page 1 reference bond number to Patient Trust Bond, dated 12th day of January, 2015, in the penal sum of $40,000.00 issued by named insurance company as surety (the "Surety"), on behalf of the Liberty Commons Nursing and Rehabilitation Center of Wake County, LLC as principle (the "Principle"), in favor of Dept. of Human Resources, as obligee (the "Obligee")." The Dept. of Human Resources is not accountable for surety bonds. During an interview on 3/2/18 at 9:26 AM, the facility Business Office Manager (BOM) revealed she would check to see if there was a copy of the surety bond in the office. During an interview on 3/2/18 at 1:45 PM, the Administrator revealed the corporate office informed her the second surety bond was correct.	F 570	specific deficiency cited: The new surety bond will be maintained at the facility. The bond is updated annually. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The administrator will monitor the surety bond annually, when updated to ensure accuracy. The title of the person responsible for implementing the acceptable plan of correction: Administrator 03/13/2018	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		3/21/18

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F 656	Continued From page 2 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). (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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to include a hand roll for a contracture in a resident ' s comprehensive care plan for 1 of 2 residents reviewed for contractures (Resident #35). The findings included: Resident #35 was admitted to the facility on 10/4/17 and had a diagnosis of cerebrovascular	F 656	F656 Develop/Implement Comprehensive Care Plan Based on record review and staff interviews the facility failed to include a hand roll for a contracture in a resident's comprehensive care plan for 1 of 2 residents reviewed for contractures (Resident #35)	

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F 656	Continued From page 3 accident (stroke) with left hemiplegia (paralysis). A physician ' s order dated 10/26/17 noted the resident was provided with a rolled wash cloth which was to be changed and inserted daily into the palm to prevent skin breakdown and further contractures from forming, every day and evening shift. Monitor for skin breakdown. The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 1/12/18 revealed the resident had severe cognitive impairment and required extensive to total assistance with all activities of daily living and had functional limitation in range of motion of the upper and lower extremity on one side. The resident ' s Care Plan last updated on 1/15/18 revealed no information the resident had a hand contracture and was to have a rolled wash cloth in the palm of the left hand. On 3/2/18 at 9:22 AM, an interview was conducted with NA #1 who was assigned to the resident. The NA stated she did not care for this resident often and did not know if the resident used a hand roll to the left hand. When asked how she knew how to care for the resident, the NA stated the resident Kardex in the computer would tell them what the resident needed. On 3/2/18 at 9:42 AM an interview was conducted with the Rehab Director. The Rehab Director stated Resident #35 was evaluated by occupational therapy on admission and the resident had a significant contracture of the left hand and was unable to tolerate more than a hand roll to prevent moisture and nails from digging into the palm of the hand.	F 656	The plan for correcting the specific deficiency and the process that lead to the alleged deficiency: The MDS Coordinator updated the Care Plan for Resident # 35 to include the hand roll on 3/1/18. The hand roll was recorded on the Nurses' TAR each day, and the nurses had signed stating the resident's hand roll was placed as ordered. Furthermore, the MDS Coordinator did a complete audit of the building for any residents with splints/rolls ordered. This audit was completed on 3/16/18. No other concerns were noted during the audit. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 3/12/18, the Director of Nursing re-educated the MDS Coordinator on the need for all splints and or rolls to be on residents' Care Plans to ensure all staff is aware of these orders. The MDS assistant was also in-serviced on the need to check all Care Plans thoroughly when completing quarterly assessments. The MDS nurse will check all care plans thoroughly when completing OBRA MDS assessments (quarterlies, admissions, annuals, significant change) and when completing care plan reviews and updates. Additionally, the Rehab Director was educated on 3/12/18 on the need to communicate with nursing managers each time a hand roll and or splint is provided to a resident. This	

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F 656	Continued From page 4 On 3/2/18 at 9:51 AM an interview was conducted with MDS Nurse #1. The MDS Nurse stated she did not put the rolled wash cloth on the Care Plan but it was on the Treatment Administration Record. The MDS Nurse further stated the nurses did their own treatments and it was their responsibility to ensure the hand roll was in place. The MDS Nurse stated she added the rolled wash cloth to the resident ' s Care Plan yesterday (3/1/18) and it should not be on the nursing assistant ' s Kardex because the nurses did this. The Director of Nursing stated in an interview on 3/2/18 she would expect the rolled wash cloth to be Care Planned.	F 656	communication will occur during daily morning meetings. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Director of Nursing or Support Nurse will complete the Quality Assurance audit tools for as needed for Splint/Hand Roll orders weekly x 4 then monthly x 3. Reports will be presented to the Administrator weekly that in turn will be shared with the Quality Assurance Committee by the Director of Nursing, to ensure that corrective action for trends or ongoing concerns are initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Minimum Data Set Coordinator, Support Nurse, Therapy Manager, Health Information Manager, Dietary Manager, Administrator and Medical Director. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. The title of the person responsible for implementing the acceptable plan of correction: The Director of Nursing 3/21/2018	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		3/19/18

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F 880	Continued From page 5 §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 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:	F 880		

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F 880	Continued From page 6 (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. §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, record review and staff interviews, the facility failed to wear a mask when in the room of a resident on droplet precautions for 1 of 1 residents on droplet precautions (Resident #197). The findings included: The facility policy titled Droplet Precaution revised on 5/2014 read: "Droplet Precaution - in addition to Standard Precautions, use for a resident	F 880	F880 Infection Prevention and Control Based on observation, record review, and staff interviews, the facility failed to wear a mask when in the room of a resident on droplet precautions (Resident #197). The plan for correcting the specific deficiency and the process that lead to the alleged deficiency:	

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F 880	Continued From page 7 known or suspected to be infected with microorganisms transmitted by droplets that can be generated by the resident during coughing, sneezing, talking or the performance of procedures. b. Mask - in addition to standard precautions, wear a mask when working within 6 feet of the resident." Resident #197 was admitted to the facility on 2/13/18 and had a diagnosis of a fall with rib fractures. A nurse ' s note dated 2/24/18 revealed the resident told staff he had body aches and thought he had the flu. A laboratory report revealed the resident was tested for influenza on 2/24/18 and was positive. On 2/27/18 at 12:30 PM, a sign was observed posted on the door of Resident #197. The sign read: "Droplet-Contact Precautions. Perform hand hygiene, surgical mask while in room, gown when entering room, gloves when entering room." There was a cart by the door of the resident ' s room that contained gowns, gloves and masks. On 2/27/18 at 12:43 PM, NA #2 was observed to don a gown and gloves and enter the resident ' s room to deliver a meal tray. The NA did not put on a mask. The resident was observed to be sitting on the side of the bed with the over-bed table in front of the resident. The NA was observed to place the meal tray on the over-bed table, remove the gown and gloves, wash her hands and exit the room. On 2/27/18 at 12:50 PM NA #2 stated in an interview she was supposed to wear a mask when entering the room. When asked why she	F 880	NA#2 was re-educated on all contact isolation criteria. NA#2 had entered the resident's room just prior to incident observed. NA#2 reportedly followed Droplet Precaution policy on previous entrance into room therefore NA#2 is fully aware of policy and procedures for residents on Droplet Precautions. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 3/2/2018, the Director of Nursing and Infection Control Preventionist began re-education of all full time, part time and per-diem nursing staff on the Droplet Precaution policy and procedure on all shifts including weekends. Additionally, NA#2 was re-educated on Infection Control, utilizing the Infection Control course from our online learning software, Health Care Academy. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Infection Control Preventionist or Support Nurse will randomly observe staff practice and complete the Quality Assurance audit tool for adherence to Droplet Precaution Policy weekly x 4 then monthly x 3. The Infection Control Preventionist will present reports to the Administrator weekly, that in turn will be shared with the Quality Assurance	

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F 880	Continued From page 8 did not put on a mask she shrugged and stated she was in the room earlier and did wear a mask. The NA did not say why she did not put on a mask before entering the room to deliver the resident ' s meal tray. On 3/2/18 at 12:06 PM, an interview was conducted with the Infection Control Nurse. The Nurse stated the staff was supposed to wear a gown, gloves and a mask when entering the room of Resident #197. The Nurse further stated the resident ' s wife had the flu and when the resident complained of body aches and stated he thought he had the flu, he tested positive for the flu and was put on droplet precautions. On 3/2/18 at 12:20 PM the Director of Nursing stated in an interview she expected the staff to follow the instructions on the precautions sign on the door.	F 880	Committee to ensure that corrective action for any identified trends or ongoing concerns are initiated and monitored as appropriate. The Director of Nursing, Minimum Data Set Coordinator, Infection Control Preventionist, Support Nurse, Therapy Manager, Health Information Manager, Dietary Manager, Administrator and Medical Director attends the weekly Quality Assurance Meeting. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. The title of the person responsible for implementing the acceptable plan of correction: The Infection Control Preventionist 3/19/2018	