STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345077	A. BUILDING _____ B. WING _____	C 11/03/2018

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SUNNYBROOK REHABILITATION CENTER	25 SUNNYBROOK ROAD RALEIGH, NC 27610

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F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff and resident and family interviews the facility failed to keep a resident clean and dry and failed to use a clean washrag to wash the resident's back after providing urinary catheter care and washing the scrotum for 1 of 4 dependent residents reviewed for activities of daily living (Resident #1). Findings included: 1a. Resident #1 was admitted to the facility on 10/15/18 with the diagnoses of diabetes, neoplasm of the bladder, and atrial fibrillation. The resident's Minimum Data Set dated 10/22/18 revealed that the resident was cognitively intact and had no behaviors. The resident required extensive assistance with bed mobility, transfers, walking, locomotion, toilet use, personal hygiene and dressing. The resident required physical help with bathing activity with the assistance of 1 person. Resident #1 had a care plan dated 10/29/18 for an indwelling catheter, activities of daily living (ADL's) and skin integrity. Interventions for skin integrity included that the resident's bed linens were to be clean, dry and free of wrinkles. A wound care notes from the wound care nurse practitioner dated 10/29/18 revealed the resident	F 677	1a Interventions for affected resident Resident #1 had linen change, dressing change and ADL care provided on 11.1.18 Intervention put in place for every one hour checks to evaluate Resident #1 for moisture and turning and repositioning. Nursing Assistant #1 was in serviced on ADL care and proper bed bath procedure on 11.1.18 by DON. In-service for therapy staff regarding observation of patient dryness and to report any findings of moisture to the nursing department was started on 11/1/18 and completed on 11/6/18 by DON and Rehab Department Manager 1a Interventions for residents identified as having the potential to be affected All residents had the potential to be affected. Audit completed on 11/1/18 by DON of current residents for cleanliness and dryness. No other residents were affected. In-service for therapy staff on 11/1/18 regarding observation of patient dryness and to report any findings of moisture to the nursing department. In-service was completed on 11/6/18 Education provided for all Nursing Assistants started on 11.2.18 and ending same day on 11.2.18 which included ADL	11/7/18

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

Electronically Signed | 11/21/2018

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F 677	Continued From page 1 had a scrotum wound that had slightly increased in volume and had copious amounts of serous colored drainage present. The patient also has a sacral wound. The drainage of the scrotum wound appeared to be a contributing factor to the degradation of the sacral peri-wound. The ADL log for 11/1/18 at 2:59 PM revealed the resident required extensive assistance with toilet use with the assistance of 1 person. Resident #1 was observed in bed on 11/1/18 at 12:53 PM with physical therapist #1 in the room. Physical therapist #1 assisted the resident with lifting his legs and placing pillows under them. Physical therapist #1 then covered the patient's body up with a sheet and told Resident #1 he would be back to work with him after lunch. The fitted sheet, a folded sheet and towel under the resident's buttock had a yellow color to it and appeared wet. There was a demarcated, dried outline of a darker, yellow substance on the fitted sheet that rose up to the resident's midback. The resident's top sheet was clean. A shirt was also observed at the end of the left corner the resident's bed. Resident #1 was interviewed on 11/1/18 at 12:54 PM. He stated staff would come and help him if he needed. He stated today occupational therapy came and helped him with a bath around 7:30 AM or 8:00 AM and that was the last time he was changed. He stated the staff does not come and check his brief unless he calls them. He stated he uses the call bell if he has had a bowel movement and that he has a urinary catheter in place. He stated that the physical therapist came in and had just removed a shirt that was left behind his back from morning care and placed it at the end of his	F 677	care and bed bath procedures. Education completed by DON 1a Systemic changes Nursing Assistants and Licensed Staff will be educated during orientation and at least annually of the proper way to perform a bed bath and ADL care to include incontinence checks 1a Monitoring of the change to sustain system compliance ongoing Random Audits of ADL care, incontinence checks and observations of bed baths for 10% of residents will be performed weekly for 4 weeks and then monthly x3 months to insure proper ADL care The audits will be reviewed weekly in the clinical focus meetings times one month and monthly times three months. The DON will report ADL audits to the Quality Assurance and Performance Improvement (QAPI) Committee monthly times three months to ensure ongoing compliance and to determine the need for future audits. The Administrator will monitor the results presented to our QAPI Committee to ensure compliance. The Administrator is the person responsible for implementing the Plan of Correction. 1b Interventions for affected resident Nursing Assistant #1 was in serviced on ADL care and proper bed bath procedure. Return demonstration of proper procedure was performed by Nursing Assistant #1 with no issues observed by the DON on 11.3.18. 1b Interventions for residents identified as having the potential to be affected	

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F 677	Continued From page 2 bed. He stated that the shirt was wet due to sweat. He stated he doesn't sweat that much and that his bed must be wet from the wounds he has. He stated they haven't changed his dressing on his wounds today. He stated they didn't change his sheets or bedding this morning as the girl that gave him a bath worked with occupational therapy and he didn't think she noticed that he was wet. He stated he didn't think he was wet until physical therapy started working him and moved him around, which caused his wounds to leak. He had not asked staff to help him. He stated it's not ok with him to be wet and he was embarrassed now when asked about it. Resident #1 family was interviewed on 11/1/18 at 3:47 PM. She stated when she came to visit the resident today that he smelled of urine. She stated his brief was completely saturated when she saw it today and that was unusual for the resident as he was typically not like this when she visited. She stated she wasn't sure when the resident had last been changed. The resident stated on 11/1/18 at 3:47 PM that when his family member came in today, she smelled urine and they had to use a spray for the odor. He stated the staff changed him including the bed around 1:30 PM today. He stated his sheet was wet from urine because he had a wound on his scrotum that leaked urine. Nurse #1 was interviewed on 11/2/18 at 12:22 PM. She stated the resident was alert but had some confusion. She stated he could use the call bell and does not refuse care. From 7:15 AM to 9:50 AM yesterday, she stated she had to leave the facility due to an emergency. However, she came back at 12:30 PM yesterday. She stated	F 677	All residents had the potential to be affected. Audit completed on 11/1/18 by DON of current residents for cleanliness and dryness. No other residents were affected Education provided for Nursing Assistants started on 11.2.18 and ending same day on 11.2.18 which included ADL care and bed bath procedures 1b Systemic changes Nursing Assistants and Licensed Staff will be educated on orientation and at least annually of the proper way to perform a bed bath and ADL care to include incontinence checks 1b Monitoring of the change to sustain system compliance ongoing Random Audits of ADL care, incontinence checks and observations of bed baths for 10% of residents will be performed weekly for 4 weeks and then monthly x3 months to insure proper ADL care The audits will be reviewed weekly in the clinical focus meetings times one month and monthly times three months. The DON will report ADL audits to the Quality Assurance and Performance Improvement (QAPI) Committee monthly times three months to ensure ongoing compliance and to determine the need for future audits. The Administrator will monitor the results presented to our QAPI Committee to ensure compliance. The Administrator is the person responsible for implementing the Plan of Correction.	

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the resident was checked every 2 hours and if he needed something. She stated when she gave the resident his medications in the morning, she didn't check the resident for incontinence, but didn't notice any signs of incontinence. She stated when she got back to back to work yesterday around 12:30 PM or so, she thought a Nursing Assistant (NA) was assisting the resident. She stated she has never known a time where the resident's sheets or bedding were wet.

Physical Therapy Assistant #1 was interviewed on 11/2/18 at 1:20 PM. He stated he worked with the resident on 11/01/18. He stated the resident didn't smell or anything when he saw him yesterday but there was a wet shirt at the end of the resident's bed. He stated staff usually changed the resident around that time (when he went in initially) and then again around 3:00 PM.

Occupational therapy assistant #1 was interviewed on 11/2/18 at 3:37 PM. She stated she worked with the patient from 10:45 AM to 11:40 AM on 11/01/18. She stated they worked on bathing and dressing. She stated she skipped over his perineal area and did not change his brief. She stated she didn't notice if the sheet were wet or not. She stated she told Nursing Assistant #1 that he needed his perineal area washed. She was not sure when she told her but thought it was between 10:45 am and 11:00 AM.

Nursing Assistant #1 was interviewed on 11/2/18 at 9:08 AM. She stated the resident could be confused in the evening but was "pretty good during the day." She stated the resident was incontinent but would use the call bell when he needed to be changed. She stated the resident was wet a lot because he had a wound to his

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scrotum that leaked urine and it leaked often. She stated on 11/01/18, she checked on the resident around 8:00 AM and he was fine. Then she checked on the resident's roommate around 10:00 AM and then checked on Resident #1 around 10:30 AM. At that time, resident #1 was working with therapy and didn't have any concerns. She stated she went back before the resident ate lunch (the resident was the last person to eat lunch) and changed him. She stated his sheets were wet and she was surprised because he usually would use the call bell when he was wet but didn't yesterday. She stated he was wet, so she washed him and changed his sheets.

The nurse practitioner was interviewed on 11/2/18 at 10:04 AM and stated Resident #1 had cancer and a chronic urinary catheter in place. He stated he had not been made aware of any excessive drainage to the scrotum area.

The DON was interviewed on 11/2/18 at 5:16 PM. She stated she would expect for nursing and NAs to round every 2 hours and that resident should be checked and dry.

1b. Resident #1 was admitted to the facility on 10/15/18 with the diagnoses of diabetes, neoplasm of the bladder, and atrial fibrillation.

The resident's Minimum Data Set dated 10/22/18 revealed the resident was cognitively intact and had no behaviors. The resident required extensive assistance with bed mobility, transfers, walking, locomotion, toilet use, personal hygiene and dressing. The resident required physical help with bathing activity with the assistance of 1 person. The resident had an indwelling urinary

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catheter and was frequently incontinent of bowel. The resident had a stage 3 pressure ulcer that was present on admission and a stage 2 pressure ulcer, which was not present on admission.
Resident #1 had a care plan dated 10/29/18 for an indwelling catheter related to bladder cancer, activities of daily living and skin integrity. Interventions for skin integrity included that the resident's bed linens were to be clean, dry and free of wrinkles.

Resident #1 was observed being bathed by NA #1 on 11/2/18 at 10:48 AM. A basin was filled with water and non-rinse soap was added to the water and was placed on Resident #1 bed side table. Washrags were placed in the basin. The resident washed his upper chest and face with the washrags. NA #1 then proceeded to wash the resident's abdomen, legs and feet with washed rags and placed them back in the basin of water and soap. Then she took off the resident's brief, which was wet. NA #1 then washed around the resident's urinary catheter, scrotum and groin with washrags. The washrags used to clean the patient's scrotum and penis were placed back in the basin of water on the patient's bedside table. A brown substance was noted on one of the washrags in the basin that had been used to clean the resident's perineal area. The resident was then turned to his left side and the patient's back was washed with the same washrags in the basin. The resident's buttock had a smear of stool and it was cleaned with disposable wipes and then washed with wash rags. After the washrags were used on his buttock, they were placed in a dirty linen bag and were not reused.

NA #1 was interviewed on 11/2/18 at 12:40. NA

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F 677	Continued From page 6 #1 stated she usually would place the dirty rags in the linen bag after washing the resident's private areas. However, she wasn't sure why she didn't do that today when asked. She stated she knows after she cleaned his buttock that she put the washrags in the linen bag. She stated she thought she did this after washing the front side of the resident. The Director of Nursing was interviewed on 11/2/18 at 5:16 PM. She stated she would expect for the NAs not to cross contaminate when washing residents and to do what they learned in NA school. She also added that they should use a new rag when cleaning each body part.	F 677		