PRINTED: 01/14/2025 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION B	COMPLETED	
		345049	B. WING		C 12/19/2024	
NAME OF PROVIDER OR SUPPLIER RALEIGH REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 616 WADE AVENUE RALEIGH, NC 27605	12/13/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION	
E 000	Initial Comments		E 00	00		
F 000	investigation survey through 12/19/24. The compliance with the i	certification and complaint was conducted on 12/16/24 ne facility was found in requirement CFR 483.73, dness. Event ID #4YQL11.	F 00	00		
	survey was conducted 12/19/24. Event ID# intakes were investign NC00223437, NC002 NC00218511, NC002 NC00210914 and NC00210914	222702, NC00220134, 212440, NC00211008,				
F 641 SS=D	_	nents	F 64	11	1/10/25	
	resident's status. This REQUIREMENT by: Based on record rev	st accurately reflect the is not met as evidenced iew, resident and staff		Accuracy of Assessment		
	the Minimum Data So areas of vision (Resid a wander elopement (medications that hel people with diabetes	or failed to accurately code et (MDS) assessment in the dent #69), and for the use of alarm and hypoglycemic p lower blood sugar levels in medication (Resident #74) whose MDS assessments		Preparation and/or execution of this of correction does not constitute admission or agreement by the provide the truth of facts alleged or conclusions set forth in the statement of deficient. The plan of corrections is prepared a executed solely because it is require the provisions of federal and state la	ider of ons cies. and/or d by	
	The findings included 1. Resident #69 was	d: admitted to the facility on		1. On 12/18/24 Resident #69 Mini Data Set (MDS) significant change assessment dated 11/29/24 was more		
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR		TITLE	(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

01/10/2025

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.

Electronically Signed

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		SURVEY PLETED
		2.50.0	D MINO				С
		345049	B. WING _			12/	/19/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RAI FIGH	REHABILITATION CE	NTER		61	16 WADE AVENUE		
IVALLIGIT	REHABILITATION CE	NILK		R	ALEIGH, NC 27605		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 641	Continued From pa	age 1	F 6	341			
	· ·	noses which included diabetes			to reflect the resident blindness in sect	ion	
		pathy (eye condition that can			B1000: Vision by the MDS Nurse.	011	
	1	nd blindness in people with					
diabetes).		za.			On 12/18/24 Resident # 74 Minimum D)ata	
	,				Set (MDS) quarterly assessment dated	1	
	The vision provider	visit note dated 5/15/24			11/05/24 was modified to reflect the		
	revealed Resident	#69 was legally blind.			resident wander/elopement alarm in		
					section P0200.		
	The Minimum Data						
		11/29/24 revealed Resident			On 12/18/24 Resident #74 Minimum D		
		y intact and was coded for			Set (MDS) quarterly assessment dated		
	adequate vision.				11/05/2024 was modified to reflect the	use	
	An interview was conducted on 12/16/24 at 1:51				of hypoglycemic medication in section N0415.		
		69 who reported he was blind.			1104 15.		
	pin with resident #	os who reported he was billid.			2. On 1/10/24 MDS nurse completed	d an	
	An interview was o	onducted with Nurse Aid #2 on			audit of current residents identified with		
		om who revealed Resident #69			MDS completed in last thirty days to	•	
		n and he needed staff to tell			ensure section B1000, N0415, and P0	200	
		ere located. NA #2 stated she			were accurately coded. Completed on		
	made sure Resider	nt #69 had his personal items			1/10/24.		
	in reach and he kno	ew where they were prior to					
	leaving the room.		3. On 1/7/24 the facility Director of				
					Nursing provided education to the MDS		
		onducted on 12/19/24 at 2:19		department regarding accurately coding			
	·	e #1 who revealed she was			section B1000: Vision, N0415: High-Ri		
		#69's blindness. MDS Nurse			Drug Classes: Use and Indication , and	1	
		have coded Resident #69's			PO200: Alarms on the MDS.		
	assessment in erro	···			4. The facility Director of		
	During an interview	on 12/19/24 at 2:36 pm with			Nursing/designee will complete audit o	f 5	
	_	he stated the MDS Nurse was			sampled residents to ensure that section		
		ure the resident MDS			B1000: Vision, N0415:High-Risk Drug		
	assessments were				Classes: Use and Indication, and PO2	30 :	
		,			Alarms on the MDS are accurately cod		
	2. Resident #74 wa	as admitted to the facility on			The audit will be completed weekly tim		
		noses which included anxiety,			12 weeks.		
	post-traumatic stre	ss disorder, and diabetes.					
					Data obtained during the audit process	j	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION ((X3) DATE SURVEY COMPLETED	
		345049	B. WING				C 19/2024	
NAME OF P	ROVIDER OR SUPPLIER	0.00.0	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	121	19/2024	
NAME OF PROVIDER OR SUPPLIER				16 WADE AVENUE				
RALEIGH	REHABILITATION CENT	TER			ALEIGH, NC 27605			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 641	Continued From pag	e 2	F	341				
	assessment dated 9/ was at risk for eloper Resident #74 had a p	perment Risk Screening '11/24 revealed Resident #74 ment. physician order dated 9/24/24 to be placed on left ankle.			will be analyzed for patterns and trend and reported to the Quality Assessmer and Assurance (QA & A/QAPI) Commi by the Director of Nursing monthly x 3 months. At that time, the QA & A/QAPI committee will evaluate the effectivene	nt ttee		
	Resident #74 had a physician order dated 9/24/24 to check alerting bracelet everyday twice a shift for placement and function.				of the interventions to determine if continued auditing is necessary to maintain compliance.			
	Resident #74 was at evidence by cognitive	ewed on 10/23/24 revealed risk for elopement as e impairment and ability to tervention of alerting bracelet						
	The nursing progress pm revealed Resider elopement alarm on							
		rd (MAR) for November 2024 bracelet was in place and						
	assessment dated 1° #74 had moderate coindependent for mob	um Data Set (MDS) quarterly 1/05/24 revealed Resident ognitive impairment and was ility. Resident #74 was not elopement alarm (alerting 7-day lookback period.						
	on 12/18/24 at 2:15 p completed Resident He stated he utilized observations to comp	#74's quarterly assessment.						

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		COMPLETED
		345049	B. WING _			C 12/19/2024
	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE					12/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN		I		OULD BE	(X5) COMPLETION DATE
F 641	b. Resident #74 had a 11/03/24 for insulin 100 units per millilite bedtime for diabetes. Resident #74 had a 11/03/24 for insulin units/ml. Inject 3 un Review of Resident Administration Recordered the insulin were administered at Review of the Minimassessment dated 74 had moderate co #74 was not coded medication during the An interview was coon 12/18/24 at 2:15 completed Resident He stated he utilized medication use. MI Resident #74's insulthe 7-day look back stated he was not s #74's insulin. An interview was copm with the Administration was copm with the Administration.	ment alarm when he ssment. d a physician order dated glargine (long-acting insulin) er (ml). Inject 10 units at s management. physician order dated lispro (fast-acting insulin) 100 its before meals for diabetes. #74's Medication ord (MAR) for November 2024 glargine and insulin lispro as ordered. num Data Set (MDS) quarterly 11/05/24 revealed Resident # orgitive impairment. Resident for use of hypoglycemic ne 7-day lookback period. Inducted with MDS Nurse #2 pm who revealed he the #74's quarterly assessment. In direct record review to code for DS Nurse #2 confirmed lin was administered during period. MDS Nurse #2 ure how he missed Resident enducted on 12/19/24 at 2:36 strator who stated the MDS	F 6	41		
F 695 SS=D	assessments were	ble to ensure the resident accurately coded. ostomy Care and Suctioning	F 6	95		1/10/25

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
			A. BOILD	_		,	С
		345049	B. WING				19/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		-
DAI EICH	DELIABII ITATION CENT	TED.		6	16 WADE AVENUE		
KALEIGH	REHABILITATION CENT	EK		F	RALEIGH, NC 27605		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 695	Continued From page	e 4	F	695			
	CFR(s): 483.25(i)			000			
	§ 483.25(i) Respirato	ry care, including					
	tracheostomy care and tracheal suctioning. The facility must ensure that a resident who						
		re, including tracheostomy ctioning, is provided such					
		professional standards of					
		nensive person-centered					
	care plan, the residents' goals and preferences,						
	and 483.65 of this su	•					
		Γ is not met as evidenced					
	by:	on, record review, and staff			F695		
	interviews, the facility				Respiratory /Tracheotomy Care and		
		nula for 1 of 1 resident			Suctioning		
		stomy care (Resident #111).			Preparation and/or execution of this pla	an	
					of correction does not constitute		
	The findings included			admission or agreement by the provide			
	Resident #111 was a			the truth of facts alleged or conclusions set forth in the statement of deficiencie			
	1/30/23 with diagnose			The plan of corrections is prepared and			
		d tracheostomy (a surgical			executed solely because it is required l		
	opening through the	front of the neck into the			the provisions of federal and state law.	-	
	windpipe for an air pa	assage to help breathe).			1. On 12/1824 Nurse #1 was provide	s d	
	Resident #111 had ar	n active physician order			education regarding providing	, u	
		rform tracheostomy care			Tracheotomy Care and Suction for a		
	every shift and as ne	<u>-</u>			resident, to include changing the inner		
					cannula every shift.		
	The Minimum Data S				0 40/40/04 // ();;; 5;		
		1/08/24 revealed Resident			On 12/18/24 the facility Director of Nursing completed competency		
	#111 was coded for to	racheosioniy care.			observation of Care for a respiratory		
	The care plan last rev	viewed on 11/22/24 revealed			/Tracheotomy Care and Suctioning of		
		tracheostomy related to			Resident		
	impaired breathing m	•					
					2. The facility Director of Nursing wil		
	During a continuous of	observation of tracheostomy			complete an audit of residents identifie	d	

NAME OF PROVIDER OR SUPPLIER RALEIGH REHABILITATION CENTER (XA) ID PREFIX TAG COMPLETION (XA) ID PREFIX TAG COMPLETION COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 695 Continued From page 5 care on 12/18/24 at 11:01 am through 11:13 am Nurse #1 was observed to pen the sterile tracheostomy gauze and discard in trash. She then removed the soiled gloves and performed hand hygiene. Nurse #1 was then observed to open the sterile tracheostomy kit and put on sterile gloves and clean around Resident #111's tracheostomy site with sterile water and hydrogen peroxide solution. She was then observed to		DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
RALEIGH REHABILITATION CENTER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSc IDENTIFYING INFORMATION) F 695 Continued From page 5 care on 12/18/24 at 11:01 am through 11:13 am Nurse #1 was observed to open the sterile tracheostomy gauze and discard in trash. She then removed the soiled popen the sterile gloves and clean around Resident #111's tracheostomy site with sterile water and hydrogen peroxide solution. She was then observed to TAG STREET ADDRESS, CITY, STATE, ZIP CODE 616 WADE AVENUE RALEIGH, NC 27605 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) With the need for care of a Tracheotomy to ensure the physician orders are accurate to include changing of the inner cannula every shift. The audit will be completed by 1-10-25. 3. The Director of Nursing/designee will provide education to licensed nurses regarding Respiratory /Tracheotomy Care and Suction of a resident. The education							(3
RALEIGH REHABILITATION CENTER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 695 Continued From page 5 care on 12/18/24 at 11:01 am through 11:13 am Nurse #1 was observed to perform hand hygiene, put on clean gloves and remove the soiled tracheostomy gauze and discard in trash. She then removed the soiled gloves and performed hand hygiene. Nurse #1 was then observed to open the sterile tracheostomy kit and put on sterile gloves and clean around Resident #111's tracheostomy site with sterile water and hydrogen peroxide solution. She was then observed to Oxidented From Page 5 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 695 Continued From page 5 with the need for care of a Tracheotomy to ensure the physician orders are accurate to include changing of the inner cannula every shift. The audit will be completed by 1-10-25. 3. The Director of Nursing/designee will provide education to licensed nurses regarding Respiratory /Tracheotomy Care and Suction of a resident. The education			345049	B. WING _			12/	19/2024
RALEIGH, NC 27605 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 695 Continued From page 5 care on 12/18/24 at 11:01 am through 11:13 am Nurse #1 was observed to perform hand hygiene, put on clean gloves and remove the soiled tracheostomy gauze and discard in trash. She then removed the soiled gloves and performed hand hygiene. Nurse #1 was then observed to open the sterile tracheostomy kit and put on sterile gloves and clean around Resident #111's tracheostomy site with sterile water and hydrogen peroxide solution. She was then observed to	NAME OF PI	ROVIDER OR SUPPLIER				, , ,		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 695 Continued From page 5 care on 12/18/24 at 11:01 am through 11:13 am Nurse #1 was observed to perform hand hygiene, put on clean gloves and remove the soiled tracheostomy gauze and discard in trash. She then removed the soiled gloves and performed hand hygiene. Nurse #1 was then observed to open the sterile tracheostomy kit and put on sterile gloves and clean around Resident #111's tracheostomy site with sterile water and hydrogen peroxide solution. She was then observed to	RALEIGH	REHABILITATION CENT	ER					
care on 12/18/24 at 11:01 am through 11:13 am Nurse #1 was observed to perform hand hygiene, put on clean gloves and remove the soiled tracheostomy gauze and discard in trash. She then removed the soiled gloves and performed hand hygiene. Nurse #1 was then observed to open the sterile tracheostomy kit and put on sterile gloves and clean around Resident #111's tracheostomy site with sterile water and hydrogen peroxide solution. She was then observed to with the need for care of a Tracheotomy to ensure the physician orders are accurate to include changing of the inner cannula every shift. The audit will be completed by 1-10-25. 3. The Director of Nursing/designee will provide education to licensed nurses regarding Respiratory /Tracheotomy Care and Suction of a resident. The education	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	x	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
remove the sterile gloves and perform hand hygiene. Nurse #1 was observed to put on clean gloves and replace the gauze sponge around the tracheostomy site and placed a new tracheostomy tie holder. Nurse #2 removed the soiled gloves and performed hand hygiene. Nurse #1 reported Resident #111's tracheostomy care was complete because the disposable inner cannula did not have to be changed every day. An immediate interview was conducted on 12/18/24 at 11:14 am with Nurse #1 who revealed she changed Resident #111's inner cannula the day before when she completed tracheostomy care. Nurse #1 stated the inner cannula did not have to be changed every day and was only changed as needed. Nurse #1 was unable to state how often Resident #111's inner cannula was changed. During an interview on 12/18/24 at 2:26 pm with the Staff Development Coordinator she revealed tracheostomy care was provided per the physician order and was normally every shift and as needed. The Staff Development Coordinator stated the disposable inner cannula was to be replaced when tracheostomy care was completed. will be completed by 1-10-25. Any licensed nurse that is identified as not receiving the education will receive prior to working next scheduled shift. Newly hired licensed nurses will be provided the educated during Department Orientation by the Staff Development Coordinator the advance of Nursing/designee will complete audit of residents identified as not receiving the education will receive prior to working next scheduled shift. Newly hired licensed nurses will be provided the educated during Department Orientation by the Staff Development Coordinator derivation by the Staff Development Coordinator derivati	F 695	care on 12/18/24 at 1 Nurse #1 was observe put on clean gloves a tracheostomy gauze a then removed the soil hand hygiene. Nurse open the sterile trache sterile gloves and clea tracheostomy site with peroxide solution. Sh remove the sterile glo hygiene. Nurse #1 wa gloves and replace th tracheostomy site and tracheostomy site and tracheostomy tie hold soiled gloves and per Nurse #1 reported Re care was complete be cannula did not have An immediate intervie 12/18/24 at 11:14 am she changed Resider day before when she care. Nurse #1 stated have to be changed e changed as needed. I state how often Resid was changed. During an interview of the Staff Development tracheostomy care wa physician order and w as needed. The Staff stated the disposable replaced when trache	1:01 am through 11:13 am ed to perform hand hygiene, and remove the soiled and discard in trash. She led gloves and performed to eostomy kit and put on an around Resident #111's his terile water and hydrogen he was then observed to eves and perform hand as observed to put on clean he gauze sponge around the diplaced a new ler. Nurse #2 removed the formed hand hygiene. Esident #111's tracheostomy ecause the disposable inner to be changed every day. Ew was conducted on with Nurse #1 who revealed hat #111's inner cannula the completed tracheostomy dithe inner cannula did not every day and was only Nurse #1 was unable to dent #111's inner cannula In 12/18/24 at 2:26 pm with hit Coordinator she revealed as provided per the was normally every shift and find Development Coordinator inner cannula was to be	F	695	ensure the physician orders are accurate include changing of the inner cannulate every shift. The audit will be completed 1-10-25. 3. The Director of Nursing/designee provide education to licensed nurses regarding Respiratory /Tracheotomy Cand Suction of a resident. The education will be completed by 1-10-25. Any licensed nurse that is identified as not receiving the education will receive pricto working next scheduled shift. Newly hired licensed nurses will be provided the educated during Departmed Orientation by the Staff Development Coordinator/designee. 4. The Director of Nursing/designee complete audit of residents identified we tracheotomy Care to ensure that physician orders include changing the inner cannula every shift and documented. The audit will be complete weekly times 12 weeks. Data obtained during the audit process will be analyzed for patterns and trends and reported to the Quality Assessmen and Assurance (QA & A/QAPI) Commit by the Director of Nursing monthly x 3 months. At that time, the QA & A/QAPI committee will evaluate the effectivener of the interventions to determine if continued auditing is necessary to	will are on will will ed	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345049	B. WING		-		C 19/2024
NAME OF PROVIDER OR SUPPLIER RALEIGH REHABILITATION CENTER			61	REET ADDRESS, CITY, STATE, ZIP CODE 16 WADE AVENUE ALEIGH, NC 27605			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC 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 761 SS=D	the Director of Nursin Resident #111's disponsave to be changed of changed daily. She completed every shift exclude the inner care. A follow-up interview DON on 12/19/24 at Resident #111's disponsave been changed was completed. Label/Store Drugs and CFR(s): 483.45(g)(h) §483.45(g) Labeling Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the applicable. §483.45(h) Storage of §483.45(h)(1) In according to the property of the property	on 12/18/24 at 4:40 pm with a g (DON) she revealed osable inner cannula did not every shift but could be confirmed Resident #111's for tracheostomy care to be and that the order did not anula change. was conducted with the 2:28 pm who revealed osable inner cannula should when the tracheostomy care and Biologicals (1)(2) of Drugs and Biologicals is used in the facility must be evith currently accepted es, and include the ry and cautionary expiration date when		761	DETIGIENCY		1/10/25
	locked, permanently storage of controlled the Comprehensive [cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345049	B. WING		С
		345049			12/19/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
RAI FIGH	REHABILITATION CEI	NTFR		616 WADE AVENUE	
10 (22.01)				RALEIGH, NC 27605	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 761	Continued Frances	7	F 70.		
F /01	Continued From pa	- -	F 76	1	
		n the facility uses single unit bution systems in which the			
	quantity stored is more be readily detected	ninimal and a missing dose can l.			
	This REQUIREMED by:	NT is not met as evidenced			
	'	tions, record review and staff		F761	
		ity failed to: discard expired		Label/ Store Drugs and Biologicals	
		blets for 1 of 2 medication		Preparation and/or execution of this pl	an
	rooms (Unit 3 Medi	cation Storage Room), discard		of correction does not constitute	
		f aspirin that had no expiration		admission or agreement by the provid	
		ication carts (4 B Medication		the truth of facts alleged or conclusion	s
		of loose and unidentified pills		set forth in the statement of deficiencie	
	for 2 of 3 medication carts (Medication Cart 3A			The plan of corrections is prepared an	
		rt 4B) reviewed for medication		executed solely because it is required	•
	storage.			the provisions of federal and state law	
	The findings includ	ed:		1. On 12/18/24 The Director of Nurs	sing
				removed and discarded the unopened	ı
		of the Unit 3 medication		Zinc 50 mg (milligrams) 100 tablets f	rom
		2/18/24 at 3:50 PM revealed an		medication room (Unit 3 Medication	
	1	Zinc 50mg (milligrams) 100		Storage Room).	
	tablets with an expi	iration date of August 2022.			
		5.11 O.A. 11 11 11 11 11 11		On 12/18/24 the Director of Nursing	
		of the 3A medication cart with		removed and discarded one oblong	
		/24 at 3:27 PM revealed 3 pills		shaped pill, one round white pill and o	
		ill, one oblong shaped white		white capsule from 3 A medication car	ι.
		capsule) were loose in the urse #3 revealed she was not		On 12/18/24 the Director of Nursing	
		Is were in the cart. Nurse #3		removed and discarded an opened bo	.ttle
		ot identify the loose pills.		of Aspirin 81 mg(milligrams).	tile
		e loose medications were to be		or reprint or mg(mingrains).	
	discarded.	2.223 management word to be		On 12/18/24 the Director of Nursing	
				removed and discarded one oblong w	hite
	c. An observation of	of the 4B medication cart with		pill, one peach oval pill, and one white	
		/24 at 4:00 PM revealed an		round pill from 4 B medication cart.	
		spirin 81 mg (milligrams) with		,	
	·	The observation also revealed		2. On 12/18/24 the Director of Nurs	ing
		white pill, one peach oval pill,		/designee completed an audit of all	-

NAME OF PROVIDER OR SUPPLIER RALEIGH REHABILITATION CENTER (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 761 Continued From page 8 and one white round pill) were loose in the medication cart. Nurse #2 revealed she was not STREET ADDRESS, CITY, STATE, ZIP CODE 616 WADE AVENUE RALEIGH, NC 27605 ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 761 Continued From page 8 and one white round pill) were loose in the medication carts and medication rooms to validate that there were no loose pills or		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION (X3) DATE SURVEY COMPLETED		,
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medication cart. Nurse #2 revealed she was not validate that there were no loose pills or	F 761	Continued From page	e 8	F 7	61		
aware the loose pills were in the cart. Nurse #2 stated she could not identify the loose pills. Nurse #2 stated the loose medications, and Aspirin were to be discarded. An observation verifying there was no expiration date on the bottle of Aspirin was conducted with the Director of Nursing (DON) on 12/19/24 at 4:18 PM. An interview was conducted with the Director of Nursing (DON) on 12/19/24 at 3:16 PM. The Director of Nursing stated the unit managers and management team were responsible for completing a medication cart and medication room check each morning. The DON stated she would need to change the process and have the Staff Development Coordinator check each cart first thing in the morning. She additionally stated that she now sees that the unit managers need to check the carts each shift. Newly hired licensed nurses will be provided the educated during Department Orientation by the Staff Development Coordinator check each cart Goordinator/designee. 4. The Director of Nursing/designee will complete audit of medication storage rooms and medication carts three times week for 12 weeks. Data obtained during the audit process will be analyzed for patterns and trends and reported to the Quality Assessment and Assurance (OA & A/QAPI) Committee by the Director of Nursing monthly x 3 months. At that time, the QA & A/QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.		and one white round medication cart. Nurs aware the loose pills stated she could not i #2 stated the loose m to be discarded. An observation verify date on the bottle of A the Director of Nursin An interview was con Nursing (DON) on 12 Director of Nursing st management team w completing a medicat room check each more would need to change Staff Development Co first thing in the morn that she now sees the	pill) were loose in the e #2 revealed she was not were in the cart. Nurse #2 dentify the loose pills. Nurse edications, and Aspirin were and there was no expiration aspirin was conducted with g on 12/18/24 at 4:18 PM. ducted with the Director of /19/24 at 3:16 PM. The ated the unit managers and ere responsible for ion cart and medication raing. The DON stated she e the process and have the pordinator check each cart ing. She additionally stated at the unit managers need to		medication carts and medical validate that there were no lot expired medication in the fact further medications were identified the audit. 3. The Director of Nursing, provide education to all licen regarding labeling, storing medication with the audit. 3. The Director of Nursing, provide education to all licen regarding labeling, storing medication with the discontified as not received education will receive prior to scheduled shift. Newly hired licensed nurse provided the educated during Orientation by the Staff Develored Coordinator/designee. 4. The Director of Nursing, complete audit of medication rooms and medication carts week for 12 weeks. Data obtained during the audit will be analyzed for patterns and reported to the Quality A and Assurance (QA & A/QAF by the Director of Nursing medication to determine the continued auditing is necessive.	cose pills or bility. No ntified during designee we sed nurses edication and fill be consed nurse ving the converse working new designee we astorage three times dit process and trends assessment PI) Committee onthly x 3 & A/QAPI effectivenessenine if	g vill nd se ext nt vill