| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345049 | A. Building<br>B. Wing | 12/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Raleigh Rehabilitation Center | 616 Wade Avenue<br>Raleigh, NC 27605 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045<br><br>Based on record review, resident and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of vision (Resident #69), and for the use of a wander elopement alarm and hypoglycemic (medications that help lower blood sugar levels in people with diabetes) medication (Resident #74) for 2 of 26 residents whose MDS assessments were reviewed.<br><br>The findings included:<br><br>1. Resident #69 was admitted to the facility on [DATE] with diagnoses which included diabetes and diabetic retinopathy (eye condition that can cause vision loss and blindness in people with diabetes).<br><br>The vision provider visit note dated 5/15/24 revealed Resident #69 was legally blind.<br><br>The Minimum Data Set (MDS) significant change assessment dated [DATE] revealed Resident #69 was cognitively intact and was coded for adequate vision.<br><br>An interview was conducted on 12/16/24 at 1:51 pm with Resident #69 who reported he was blind.<br><br>An interview was conducted with Nurse Aid #2 on 12/18/24 at 12:27 pm who revealed Resident #69 had very poor vision and he needed staff to tell him where items were located. NA #2 stated she made sure Resident #69 had his personal items in reach and he knew where they were prior to leaving the room.<br><br>An interview was conducted on 12/19/24 at 2:19 pm with MDS Nurse #1 who revealed she was aware of Resident #69's blindness. MDS Nurse #1 stated she must have coded Resident #69's assessment in error.<br><br>During an interview on 12/19/24 at 2:36 pm with the Administrator she stated the MDS Nurse was responsible to ensure the resident MDS assessments were accurately coded.<br><br>2. Resident #74 was admitted to the facility on [DATE] with diagnoses which included anxiety, post-traumatic stress disorder, and diabetes.<br><br>a. Review of the Elopement Risk Screening assessment dated [DATE] revealed Resident #74 was at risk for elopement.<br><br>(continued on next page) |

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.

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

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #74 had a physician order dated 9/24/24 for alerting bracelet to be placed on left ankle.<br><br>Resident #74 had a physician order dated 9/24/24 to check alerting bracelet everyday twice a shift for placement and function.<br><br>A care plan last reviewed on 10/23/24 revealed Resident #74 was at risk for elopement as evidence by cognitive impairment and ability to self-propel with an intervention of alerting bracelet to left ankle.<br><br>The nursing progress note date 11/03/24 at 5:02 pm revealed Resident #74 had a wander elopement alarm on the left ankle.<br><br>Review of Resident #74's Medication Administration Record (MAR) for November 2024 revealed the alerting bracelet was in place and functioning as ordered.<br><br>Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #74 had moderate cognitive impairment and was independent for mobility. Resident #74 was not coded for a wander elopement alarm (alerting bracelet) during the 7-day lookback period.<br><br>An interview was conducted with MDS Nurse #2 on 12/18/24 at 2:15 pm who revealed he completed Resident #74's quarterly assessment. He stated he utilized order review and observations to complete resident assessments, but he stated he probably just missed Resident #74's wander elopement alarm when he completed the assessment.<br><br>b. Resident #74 had a physician order dated 11/03/24 for insulin glargine (long-acting insulin) 100 units per milliliter (ml). Inject 10 units at bedtime for diabetes management.<br><br>Resident #74 had a physician order dated 11/03/24 for insulin lispro (fast-acting insulin) 100 units/ml. Inject 3 units before meals for diabetes.<br><br>Review of Resident #74's Medication Administration Record (MAR) for November 2024 revealed the insulin glargine and insulin lispro were administered as ordered.<br><br>Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident # 74 had moderate cognitive impairment. Resident #74 was not coded for use of hypoglycemic medication during the 7-day lookback period.<br><br>An interview was conducted with MDS Nurse #2 on 12/18/24 at 2:15 pm who revealed he completed Resident #74's quarterly assessment. He stated he utilized record review to code for medication use. MDS Nurse #2 confirmed Resident #74's insulin was administered during the 7-day look back period. MDS Nurse #2 stated he was not sure how he missed Resident #74's insulin.<br><br>An interview was conducted on 12/19/24 at 2:36 pm with the Administrator who stated the MDS Nurse was responsible to ensure the resident assessments were accurately coded. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045<br><br>Based on observation, record review, and staff interviews, the facility failed to change the disposable inner cannula for 1 of 1 resident observed for tracheostomy care (Resident #111).<br><br>The findings included:<br><br>Resident #111 was admitted to the facility on [DATE] with diagnoses which included chronic respiratory failure and tracheostomy (a surgical opening through the front of the neck into the windpipe for an air passage to help breathe).<br><br>Resident #111 had an active physician order dated 11/14/23 to perform tracheostomy care every shift and as needed.<br><br>The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #111 was coded for tracheostomy care.<br><br>The care plan last reviewed on 11/22/24 revealed Resident #111 had a tracheostomy related to impaired breathing mechanics.<br><br>During a continuous observation of tracheostomy 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 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.<br><br>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.<br><br>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.<br><br>During an interview on 12/18/24 at 4:40 pm with the Director of Nursing (DON) she revealed Resident #111's disposable inner cannula did not have to be changed every shift but could be changed daily. She confirmed Resident #111's physician order was for tracheostomy care to be completed every shift and that the order did not exclude the inner cannula change.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A follow-up interview was conducted with the DON on 12/19/24 at 2:28 pm who revealed Resident #111's disposable inner cannula should have been changed when the tracheostomy care was completed. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41772<br><br>Based on observations, record review and staff interviews, the facility failed to: discard expired zinc supplement tablets for 1 of 2 medication rooms (Unit 3 Medication Storage Room), discard an opened bottle of aspirin that had no expiration date for 1 of 3 medication carts (4 B Medication Cart), and dispose of loose and unidentified pills for 2 of 3 medication carts (Medication Cart 3A and Medication Cart 4B) reviewed for medication storage.<br><br>The findings included:<br><br>a. An observation of the Unit 3 medication storage room on [DATE] at 3:50 PM revealed an unopened bottle of Zinc 50mg (milligrams) 100 tablets with an expiration date of [DATE].<br><br>b. An observation of the 3A medication cart with Nurse #3 on [DATE] at 3:27 PM revealed 3 pills (one round white pill, one oblong shaped white pill, and one white capsule) were loose in the medication cart. Nurse #3 revealed she was not aware the loose pills were in the cart. Nurse #3 stated she could not identify the loose pills. Nurse #3 stated the loose medications were to be discarded.<br><br>c. An observation of the 4B medication cart with Nurse #2 on [DATE] at 4:00 PM revealed an opened bottle of Aspirin 81 mg (milligrams) with no expiration date. The observation also revealed 3 pills (one oblong white pill, one peach oval pill, and one white round pill) were loose in the medication cart. Nurse #2 revealed she was not 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.<br><br>An observation verifying there was no expiration date on the bottle of Aspirin was conducted with the Director of Nursing on [DATE] at 4:18 PM.<br><br>An interview was conducted with the Director of Nursing (DON) on [DATE] 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. |