DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/11/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	346508	A. BUILDING _____ B. WING _____ AUG 23 2011	08/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REX REHAB & NURSING CARE CENTER OF APEX	911 SOUTH HUGHES STREET, APEX, NC 27502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain obstruction free fire exits on 2 of 4 nursing units (Units 200 and 400). On 8/2/11 at 4:00 pm and on 8/3/11 at 9:30 am and 2:45 pm a total mechanical lift was observed parked on the left side (when facing the exit) of an exit corridor on 400 hall across from the physical therapy gym. The exit corridor was adjacent to, and around the corner from rooms 406 and 407. No resident rooms exited directly onto the exit corridor. The lift was parked parallel to the wall with the back of the lift approximately four feet from the fire exit door. The path of egress to the fire door exit was partially obstructed by the lift. No staff was observed near the lift or fire exit door on the dates and times of observation. During a tour of the 400 hall on 8/3/11 at 2:45 pm the Maintenance Supervisor stated the total mechanical lift was not parked in an acceptable location and that the lift could not be parked in front of a fire exit door.	F 323	F 323 **Corrective Action for Residents Identified during Survey:** No residents were affected. Patient lift was moved from the exit corridor. Staff education provided. **Corrective Action for Residents with Potential to be Affected:** No residents were affected. Facility inspection completed for additional equipment in corridors. Staff education provided. **Systemic Changes to Prevent Deficient Practice:** Daily rounds by DON or designee x4 weeks. Monthly staff education during fire drills regarding the importance of unobstructed fire exit doors. **How will Corrective Action be monitored?**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR	8/23/2011

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.

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F 323	Continued From page 1 On 8/3/11 at 8:03 am a total mechanical lift was observed parked on the right side (when facing the exit) of the 200 hall adjacent to resident room 208. The lift was parked at an angle and the back of the lift protruded into the hallway and partially obstructed the path of egress to the fire door exit. The front of the lift was closest to the fire exit door and was approximately one foot from the fire exit door. No staff was observed near the lift or fire exit door on the date and time of observation. On 8/3/11 at 4:25 pm, Nurse Aide # 3 (NA# 3) stated when not in use, the lifts should be parked around the corner out of the way and not at the fire exit door. On 8/3/11 at 4:27 pm Nurse # 1 stated when not in use the lifts should be parked out of the way and that sometimes the lifts were pushed into the dining halls when not in use. Nurse # 1 stated the lifts should not be parked in front of fire exit doors.	F 323	Review of rounds results and reinforce education during monthly all staff meetings. **Dates when Corrective Action will be completed:** 8/19/2011	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441		

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F 441	Continued From page 2 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to put on contact precaution equipment (gown and gloves) for 1 of 1 resident (Resident #4) observed to be on contact precautions. Review of the infection prevention policy dated February 2010, read in part under contact precautions, "Contact Precautions are designed to reduce transmission of organisms that can be transmitted by direct contact with the	F 441	F441 **Corrective Action for Residents Identified during Survey:** Identified staff member was counseled and educated. Facility wide education completed regarding contact isolation precautions. **Corrective Action for Residents with Potential to be Affected:** Facility wide staff education completed regarding contact isolation precautions. Room audits for correct and proper PPE completed on current isolation patients. **Systemic Changes to Prevent Deficient Practice.** Quarterly infection control policy review and staff education. **How will Corrective Action be monitored?** DON or designee staff will monitor infection control practices during rounds daily x4 weeks. Infection control nurse will evaluate all isolation patients (current and newly	

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F 441	Continued From page 3 resident/patient or the environment. Gown and gloves must be worn when entering the room." Resident #4 was admitted on 7/13/11. Diagnoses included Clostridium Difficile (C-Diff). The admission Minimum Data Set completed on 7/23/11 indicated the resident was cognitively intact. The Care Area Assessment Summary completed on 7/26/11 indicated the resident was on isolation precautions for an infection (C-Diff). The care plan completed on 7/18/11, updated on 7/26/11, revealed the resident had an infection known as C-Diff. Additional approaches per the care plan included "Universal/Enteric precautions at all times." On 8/2/11 at 11:05 AM, staff #4 was observed in the resident's room positioned beside the bed. Staff #4 provided range of motion exercises to the resident, while the resident was lying in bed. Staff #4 directly touched the resident's skin (left arm) without gloves or an isolation gown. Upon completion of the exercises, staff #4 proceeded into the resident's bathroom, washed her hands and came out into the hallway and continued to the occupational therapy room. Posted on the wall beside the door before entering the resident's room was a sign that indicated, "Stop Contact Precautions: Wear gloves when entering the room or cubicle and whenever touching the patient intact skin, surfaces, or articles in close proximity. Wear gown when entering room or cubicle and whenever anticipating that clothing will touch patient items or potentially contaminated environmental surfaces." In an interview on 8/2/11 at 11:12 AM, with staff #4 revealed she only used gloves and isolation	F 441	admitted) for proper signage, PPE and staff education. Results will be reviewed monthly in PI committee meeting with practice changes made as necessary. **Dates when Corrective Action will be completed:** 8/19/2011	

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	345908	A. BUILDING _____ B. WING _____	08/04/2011

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REX REHAB & NURSING CARE CENTER OF APEX	911 SOUTH HUGHES STREET APEX, NC 27502

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F 441	Continued From page 4 gowns when she provided exercises to Resident #4's lower extremities. In an interview on 8/4/11 at 9:10 AM, with the Staff Development Coordinator (SDC) revealed she expected the staff to adhere to the contact precaution instructions as outlined on the sign outside the door, prior to entering the resident's room. The SDC elaborated she expected the staff to have on personal protective equipment every time he or she entered the resident's room. The SDC concluded this applied to all staff. In an interview on 8/4/11 at 9:15 AM, with staff #4 revealed she was aware that the resident was on contact precautions prior to entering the resident's room. Staff #4 elaborated she inadvertently forgot to put on the appropriate contact precaution equipment, prior to entering the resident ' s room and before she provided direct care. In an interview on 8/4/11 at 9:25 AM, with the Director of Nursing she stated she expected the staff to follow the contact precaution sign as posted outside the resident's room for appropriate contact precaution equipment (gown/gloves), prior to entering.	F 441		

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	345508	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	08/31/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 08/31/2011 the facility had NC Special Locking on the employee entrance that did not have an on and off switch. B. The employee entrance requires one to pass through two (2) different locking systems in order to exit the building. C. The exit doors relocked when the fire alarm was siliencéd. D. Based on observation on 08/31/2011 there was no master release switch at any nurses station for the NC Special Locking System. 42 CFR 483.70 (a)	K 038	K 038 **Corrective action to correct deficient practice:** - Honeywell Engineer and Rex Facilities personnel inspected site 9/2/2011 - Plan for installation of proper door release switches developed on identified doors. Equipment ordered 9/2/2011. - Completed by 9-30-11 **How will other life safety issues with potential to affect other residents by the same deficient practice be identified and corrective action taken:** - Honeywell Engineer and Rex Facilities personnel inspected site 9/2/2011 and developed a plan for installation of correct lock releasing switches on identified doors. - Complete by 9-30-11 **Systemic changes to ensure the deficient practice does not recur:** - Once installed the switches are installed, training of staff will be completed within one week. - Complete 10-7-11 - Door release switch testing will be implemented as part of monthly preventive maintenance **How will Corrective Action be Monitored:** - Proper door release will be monitored and recorded as part of monthly PM and reviewed during monthly PI meeting. x 3 starting 10-2011 **Dates when Corrective Action will be Completed:** (DATE) 9-30-11	
K 061 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 08/31/2011 the tamper alarms on the sprinkler systems ,PIV and the back-flow preventer in the pit could not tested due to the fire alarm control panel malfunction.	K 061		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dearie Hardy — TITLE: Interim Administrator — (X6) DATE: 9/15/11

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K 061	Continued From page 1 B. Based on observation on08/31/2011 the dry sprinkler system did not have a high and low air pressure alarm switch. C. Based on observation 08/31/2011the valves on the sprinkler system acceleraror and the flow switch were not supervised. 42 CFR 483.70 (a)	K 061	K061 Corrective action to correct deficient practice: - Appropriate high/low pressure alarm switches were installed by licensed sprinkler company. 9-9-11 - Sprinkler system certification was completed by licensed sprinkler company. How will other life safety issues with potential to affect other residents by the same deficient practice be identified and corrective action taken: - Sprinkler system was certified on 09-14-2011 by a licensed sprinkler company. Certification will be completed quarterly. Systemic changes to ensure the deficient practice does not recur: - High pressure will be tested annually and low pressure alarm will be added to the monthly PM and both will be done annually. . How will Corrective Action be Monitored: - High pressure and low pressure alarm switch testing will be added to the regular sprinkler system PM monthly and annual inspection. Dates when Corrective Action will be Completed: (DATE)09-30-11	