SEP 17 2012

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	346369	A. BUILDING _____ B. WING _____	08/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REX REHAB & NSG CARE CENTER	4420 LAKE BOONE TRAIL RALEIGH, NC 27607

(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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure urine in collection devices was not visible from outside the room for 3 of 3 sampled residents (Resident #379, #81 #380). The findings included: 1. Resident #379 was admitted into the facility on 8/16/12. Cumulative diagnoses included Acute Renal Failure, Urinary Tract Infection, and Urinary Retention. The Minimum Data Set was in progress of being completed for transmission. The admission level of care screening form (FL2) created on 8/15/12 indicated Resident #379's mental status was constant to person, place, and time. The FL2 also indicated Resident #379 was continent of bladder. The care plan completed on 8/19/12 indicated a urine collection device related to bladder outlet obstruction and urine retention. Interventions did not include concealing the urine collection device. On 8/27/12 at 9:45 am, a urine collection device was located on the foot of the bed mattress. Clear yellow urine was present inside the collection device and was visible from Resident #379's doorway. There was no privacy cover/bag.	F 241	**F 241** **Corrective Action for Resident Identified during Survey.** Privacy bags were obtained / or ensured in place for residents 379, 81, an d 380. Staff in serviced on 8/29/2012, 8/30/2012, and scheduled for 9/17/2012, 9/18/2012. Daily monitoring initiated on 8/29/2012. **Corrective Action for Those with Potential to be affected.** Audit completed for all residents with Foleys. Ensured all residents with Foleys had a privacy bag on the bed and their wheelchair 8/29/2012. Staff in serviced on 8/29/212, 8/30/2012, and scheduled for 9/17/2012, 9/18/2012. Careplans for residents with foley catherters were updated to include concealing the collection device, **Systemic Changes to Prevent Deficient Practice.** Staff in servicing conducted on 8/29/2012, 8/30/2012, and scheduled on 9/17/2012 and 9/18/2012. Audits conducted by DON or designee twice daily for two weeks, then daily for two weeks. **How will Corrective Action be monitored?**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan A Barker — TITLE: Administrator — (X6) DATE: 9-14-12

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 241	Continued From page 1 On 8/28/12 at 9:50 am, a urine collection device was observed secured to the front of the walker. Clear yellow urine was present inside the urine collection device and was visible from Resident #379's doorway. There was no privacy cover/bag. On 8/29/12 at 9:54 am, a urine collection device was observed secured to the front of the walker in Resident 379's room. The clinical manager was present in the room, walked out of the room at 10:00 am, and the collection device continued without a privacy cover/bag; and the urine contents was visible from the doorway. In an interview on 8/29/12 at 10:10 am, the Director of Nursing stated she expected the urine collection device to be located within a privacy bag. In an interview on 8/29/12 at 10:33 am, the clinical manager indicated she expected the urine collection device to be located within a privacy bag to prevent the urine contents from being observed by others. 2. Resident #81 was admitted into the facility on 8/9/12. Cumulative diagnoses included Urinary Tract Infection, Rehabilitation, and Paralysis Agitans. The admission Minimum Data Set (MDS) completed on 8/21/12 revealed Resident #81's mental status was severely impaired. The MDS indicated an indwelling catheter with no urinary toileting program. The care plan dated 8/22/12 indicated a urine collection device related to neurogenic bladder and benign prostatic hyperplasia. Interventions did not include concealing the urine collection device.	F 241	DON or designee will audit twice daily for two weeks then daily for two weeks. Audit findings will be reported to our QAPI committee. Committee will determine frequency of continued monitoring Weekly audit will be conducted by Team Leader or designee ongoing. **Dates when Corrective Action will be Completed.** **9/18/2012**	

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F 241	Continued From page 2 On 8/29/12 at 3:45 pm, a urine collection device was observed secured to the lower frame of Resident #81's bed with clear yellow urine visible from the doorway. A privacy bag was attached to the lower frame of the bed, but the urine collection device was not located within the privacy bag. On 8/29/12 at 4:16 pm, nursing assistant (NA) #2 entered the room repositioned Resident #81 and exited the room at 4:17 pm. The urine collection device remained visible with clear yellow urine from the doorway. At 4:18 pm, Nurse #2 entered the room during a medication pass and placed the urine collection device within the privacy bag and exited the room. In an interview on 8/29/12 at 4:20 pm, Nurse #2 indicated she placed the urine collection device within the privacy bag because the urine content was exposed to others view. In an interview on 8/29/12 at 4:25 pm, NA #2 stated when she entered Resident #81's room she did not notice the urine collection device was not within the privacy bag. NA #2 concluded she had entered Resident #81's room twice since she received shift report. In an interview on 8/29/12 at 5:03 pm, the Staff Development Coordinator (SDC) revealed the staff was trained to put the urine collection devices within the privacy bag. The SDC explained the rationale was to prevent persons not involved in the care of the residents, from seeing the urine contents in the collective device. The SDC concluded that privacy bags were	F 241		

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F 241	Continued From page 3 readily available and expected to be used at all times. 3. Resident #380 was admitted into the facility on 8/23/12. Cumulative diagnoses included Multiple Sclerosis and Neurogenic Bladder. The admission Minimum Data Set was in progress of being completed for transmission. The admission level of care screening form (FL2) dated 8/22/12 indicated Resident #380's mental status was alert and oriented to person, place and time. The FL2 also indicated she was incontinent of bladder. The care plan completed on 8/26/12 identified urinary catheter use as a problem. Interventions did not include concealing the urine collection device. On 8/29/12 at 9:12 am, Resident #380's urine collection device was observed uncovered and visible from the hallway. The urine collection device was secured to the left side of the bed facing the doorway and there was no cover or privacy bag on the device. Clear yellow urine was noted in the urine collection device. In an interview on 8/29/12 at 10:10 am, the Director of Nursing stated she expected the urine collection device to be located within a privacy bag. In an interview on 8/29/12 at 10:33 am, the clinical manager indicated she expected the urine collection device to be in a privacy bag to prevent urine from being observed by others. In an interview on 8/29/12 at 5:03 pm, the Staff Development Coordinator (SDC) revealed the staff was trained to put the urine collection	F 241		

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F 241	Continued From page 4 devices within the privacy bag. The SDC explained the rationale was to prevent persons not involved in the care of the residents, from seeing the urine contents in the collective device. The SDC concluded that privacy bags were readily available and expected to be used at all times.	F 241	**F 247** **Corrective Action for Resident Identified during Survey.** Resident #137 and #223 made aware of process change to notify patients on 9/10/2012.	
F 247 SS=B	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, the facility failed to notify residents before a roommate changes in 2 (resident # 137 and resident # 223) of 10 residents. Findings include: 1. Resident #223 was admitted to the facility 8/1/11 with diagnosis of anxiety, cardio-pulmonary obstructive disease, hyperlipidemia, depression and asthma. On 7/31/12, her quarterly minimum data set (MDS) revealed the resident was cognitively intact and required limited to extensive assistance with activities of daily living. On 8/27/12 at 2:43 pm, resident # 223 stated not given any notice about a new roommate until right before they are brought into the room. Resident #223 stated on one occasion, she did receive notice in the afternoon that a new resident would	F 247	**Corrective Action for Those with Potential to be affected.** New procedure created on 8/29/2012. Admissions Coordinator or designee will notify responsible party of roommate changes. Admissions nurse will notify patient/resident of new roommate. Admission Nurse will leave a notification card with patient/resident informing of new roommate. **Systemic Changes to Prevent Deficient Practice.** Staff in serviced on 8/30/2012. Staff in service scheduled on new procedure 9/17/2012 and 9/18/2012. A log will be maintained in the Admission Office to document notifications to patient/residents and responsible parties. **How will Corrective Action be monitored?**	

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F 247	Continued From page 5 arrive in the next morning. Resident #223 stated it was upsetting to not know until right before a new person comes in. Also stated the facility did not let her daughter know either. 2. Resident #137 was admitted 7/10/12 with diagnosis of anemia, hip fracture, diabetes, hypertension and hyperlipidemia. On 8/8/12, the residents 30 day minimum data set (MDS) revealed the resident was cognitively intact and required extensive assistance with activities of daily living. On 8/27/12 at 3:47 pm, the resident stated not given any notice about a new roommate until right before they are brought into the room. Resident #137 stated this was upsetting for her. On 8/29/12 at 3:51 pm, the social worker stated the admission nurse and the admission coordinator are the people responsible for notifying residents and families. On 8/29/12 at 4:15 pm, the admission coordinator stated she emailed out a listed of admissions scheduled for the next day. This is emailed to all the staff who have access to email. This is how she conveys admissions. On 8/29/12 at 4:35 pm, the admission nurse stated she tells the roommate the day of the admission and leaves information for the staff on the bulletin board in room. Stated she does not notify family or responsible party. Stated if the resident is not cognitively intact, she still tells that resident and does not notify the responsible party. On 8/29/12 at 4:50 pm, the administrator stated	F 247	**How will Corrective Action be monitored?** Administrator or designee will check log weekly to ensure procedure is being followed. Administrator or designee will initial log each week. Results will be shared at QAPI meeting monthly for 3 months. Procedure will remain in effect indefinitely. QAPI committee will determine need for further reporting. **Dates when Corrective Action will be Completed.** 9/18/2012	

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F 247	Continued From page 6 expectation of notifying residents and responsible parties in a timely manner.	F 247	F 431 **Corrective Action for Resident Identified during Survey.** No residents were identified **Corrective Action for Those with Potential to be affected.** All residents with potential to be affected. Bottle of PPD solution removed immediately on 8/30/2012. Staff in service scheduled for 9/17/12 and 9/18/2012. Audit tool implemented on 9/6/2012. **Systemic Changes to Prevent Deficient Practice.** Staff in serviced on new procedure scheduled on 9/17/2012 and 9/18/2012. A PPD vial audit tool will be checked daily by DON or designee to ensure vials are dated .	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		

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F 431	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review and staff interviews the facility failed to date 1 of 3 open multi-dose vials of Tuberculin Purified Protein Derivative. Findings included: The facilities policy for "Vials and Ampules of Injectable Medications" last revised 4/9/99 was reviewed. The policy stated; "Vials and ampules of injectable medications are used in accordance with the manufacturer's recommendations or the provider pharmacy's directions for storage, use and disposal." Procedure #2 stated; "The date opened and the initials of the first person to use the vial are recorded on multi-dose vials." An observation of the A and B hall medication room was made on 8/30/12 at 5:55 PM. There was one multi-dose vial of Tuberculin Purified Protein Derivative (PPD) that was opened and undated. The manufacturer insert for PPD revealed the injection should be discarded in thirty days once opened. On 8/30/12 at 5:56 PM the Assistant Director of Nursing (ADON) indicated she expected all opened PPD vials to be dated. She stated it was the responsibility of the nurse that opened the PPD vial to date the medication. On 8/30/12 at 6:00 PM the Director of Nursing (DON) and the Administrator indicated their	F 431	**How will Corrective Action be monitored?** DON or designee will report results from audit findings to the QAPI committee monthly for three months. QAPI committee will determine need for further reporting. Audit tool will be utilized indefinitely. **Dates when Corrective Action will be Completed.** 9/18/2012	

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F 431	Continued From page 8 expectation was for all PPD vials to be dated when opened and discarded thirty days after being opened.	F 431	**F 441** **Corrective Action for Resident Identified during Survey.** No residents were identified. **Corrective Action for Those with Potential to be affected.** Residents who receive laundry services by the facility are at risk. Letter sent to families explaining new procedure and use of chemical disinfectant use with each wash 10/1/2012 Privacy curtains were placed in closed plastic bins on 8/29/2012. **Systemic Changes to Prevent Deficient Practice.** A Procedure was written for handling personal laundry, Hoyer pads, and privacy curtains. Disinfectant unit to be installed by EcoLab in laundry room to be used with each wash. Laundry aide will test water with test strips for accurate disinfectant level and log results Staff scheduled for in-service education on 9/17/2012 and 9/18/2012.	
F 441 SS=E	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, 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	F 441		

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F 441	Continued From page 9 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to properly clean, store privacy curtains and clean lift pads at the required temperature of 160 degrees for 25 minutes or with low temperature water setting with the use of a product containing disinfectant properties in 2 of 2 washing machines. The facility also failed to provide a policy for the handling of the laundry. . Findings include: On 8/30/12 at 9:30 am, an environmental tour included the laundry room at which time personal items were being washed in two washing machines. It was noted that no chemical was being pumped into the back of the machine and no temperature valve was seen. On 8/30/12 at 11:00 am the laundry room was again observed in use washing personal laundry for the residents. Detergent packets were in use for washing the resident ' s clothes as well as the dirty lift pads and dirty privacy curtains. A review of the Material Safety Data Sheet (MSDS) for the laundry detergent in use dated 7/10/12 revealed no disinfectant as a composition ingredient. Clean privacy curtains were noted to be folded and piled up on a cardboard box next to one of the washing machines in proximity to where NA	F 441	**How will Corrective Action be monitored?** Administrator or designee will check log weekly for three weeks and initial log to ensure compliance. QAPI committee will determine frequency of continued monitoring of water test log. **Dates when Corrective Action will be Completed.** 10/1/2012 9/28/12 (NA)	

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F 441	Continued From page 10 #1 would put dirty laundry into top of the washing machine. When questioned about the privacy curtains, NA #1 stated those were clean and ready for use. NA #1 stated there were totes somewhere that the privacy curtains were supposed to be placed in. On 8/30/12 at 1:50 pm, the director of nursing (DON) stated the privacy curtains should be stored in plastic bins away from the dirty laundry to prevent cross contamination. On 8/30/12 at 2:45 pm, the administrator provided the temperature logs for the laundry room. A review of the weekly water temperature logs indicated the building water temperature ran between 100 to 117 degrees. The administrator stated this is the water used in the laundry room. There was no policy regarding the handling of laundry and a review of the Infection Prevention policy did not address specific laundry practices. The administrator stated understanding the laundry items such as lift pad and privacy curtains required a temperature of 160 degrees for 25 minutes or low temperature washing using a disinfectant. The administrator stated that once washed, the privacy curtains should be stored in plastic bins away from the dirty laundry to prevent cross contamination.	F 441		

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K 000	INITIAL COMMENTS. This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type III construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	K 029 Corrective action to correct deficient practice: -Linen carts removed from shower room on D hall; Staff educated on 10-17-2012 not to use shower room for storage How will other life safety issues with potential to affect other residents by the same deficient practice be identified and corrective action taken: -Daily audit of shower rooms to ensure area not being used for storage for one week, then weekly for 4 weeks Systemic changes to ensure the deficient practice does not recur; -Staff educated on 10-17-2012 not to use shower room for storage. Staff educated on the proper place to store linen carts. Each cart assigned specific area for storage when not in use. Daily audit of shower room for one week, then weekly for 4 weeks to ensure compliance How will Corrective Action be Monitored: -Daily audit of shower room for one week, then weekly for 4 weeks to ensure compliance -Findings will be reported to the Performance Improvement Committee who will determine need for further monitoring. Dates when Corrective Action will be Completed: 10/31/2012	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 10/10/12 at approximately noon the hazardous area was non-compliant, specific findings include shower/tub room, D hall, was used for storage.	K 029		

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

Susan L Baker — Administrator — 10/23/12

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.