STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345508	A. BUILDING _____ B. WING _____	C 06/05/2014

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 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observations, record and policy reviews, and staff interviews, the facility failed to follow its Resident Abuse/Neglect Prevention Policy to immediately report and to assess the resident after an allegation of physical abuse reported by one of one resident, Resident #1. Findings included: A review of the facility ' s Resident Abuse/Neglect Prevention Policy, origin 06/01/2000, revised May 2008, revealed that concern reports from the resident, family, or staff which allege an occurrence of potential or actual abuse should be included in the screening fro signs and symptoms of abuse. Section "C. 7" of the policy indicated that there should be immediate reporting of all falls or injuries, no matter how minor they may seem initially." Section "E. 3" of the policy indicated that in the event of resident abuse, "The resident is assessed for physical injury." Section "F." of the same policy revealed, "In the event that abuse/neglect/exploitation is alleged and/or identified, [facility] will initiate an immediate investigation, by the Administrator and/or designee ..." Resident #1 was initially admitted to the facility on	F 226	Corrective action for Resident #1: Investigation initiated on 5/26/14. 24 Hour report sent on 5/27/14. Investigation completed and 5 day report sent on 5/30/14. Re-education on facility's Resident Abuse/Neglect Prevention Policy was provided to nurse #1 by DON on 5/27/14. Nurse #1'□s failure to follow policy was identified by the DON during the investigation of resident injury interview on 5/27/14. Identification of other residents that have potential to be affected by same deficient practice: All interviewable residents were interviewed using CMS Form 20050 regarding abuse and staff treatment by the DON or designee with a completion date of 6/20/14. There were no reports suggestive of abuse/neglect.	6/20/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/17/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345508	A. BUILDING _____ B. WING _____	C 06/05/2014

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 226	Continued From page 1 07/03/2012 and had cumulative diagnoses including, but not limited to, coronary artery disease, hypertension, dementia, hemiplegia, depression, and anxiety disorder. A review of the annual Minimum Data Set (MDS) Assessment dated 04/24/2014 revealed Resident #1 was totally dependent upon staff for bed mobility, dressing, personal hygiene, and toilet use, and that she was severely cognitively impaired. During an observation of Resident #1 on 06/03/2014 at 9:30 AM, a red and dark bluish purple bruise was noted on the top occipital bone and in the crease of the right eyelid, extending over most of the eyelid crease. In an interview with a family member on 06/03/2014 at 4:02 PM, she stated that she discovered the bruise to the resident's right eye when she came to visit at about 3:00 PM on 05/26/2014. She explained that she always visited her mother on a daily basis, and that when she had left her mother on 05/25/2014 at approximately 3:00 PM or 4:00 PM, her mother was fine and had no bruises. In addition, she reported that she was the one who notified the police department after she discovered the bruise, not the facility. She also stated that Resident #1 was at times confused and forgetful, but often had moments of mental clarity, especially when she was talking with family members and others with whom she was familiar. A review of the facility's 24-Hour Initial Report for an incident dated 05/26/2014 at 3:15 PM revealed that a family member discovered a bruise in the crease of Resident #1 ' s right eye while visiting	F 226	All non-interviewable residents were observed for signs of abuse by the DON, ADON or designee using CMS Form 20050 with a completion date of 6/20/14. There were no concerns observed regarding abuse/neglect. Family interviews were conducted by the ADON with 3 families who have residents residing on the same unit where Resident #1 resides. CMS Form 20049 was used to interview with a completion date of 6/2/14. There were no reports suggestive of abuse/neglect. Direct-care staff interviews were completed for 10 staff members by the DON or designee using CMS Form 20059 with a completion date of 6/17/14. All interviewed staff voiced acceptable knowledge of policy and appropriate action should concern arise. Front-line Supervisor Interviews were completed for 4 staff members by the Administrator using CMS Form 20059 with a completion date of 6/2/14. All interviewed supervisors voiced acceptable knowledge of policy and appropriate action should concern arise. Skin assessments were completed by the Wound Care Nurse on all residents with a completion date of 5/30/14. There were no findings of unexplainable injury. Measures put into place/systemic	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345508	A. BUILDING _____ B. WING _____	C 06/05/2014

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 226	Continued From page 2 on 05/26/2014, and that the local police department had been notified. The description of the injury included on the report indicated there was a 2 centimeter (cm) by 2 cm bruise to the right eyelid. The report was signed by the Director of Nursing on 05/27/2014. A review of the 5-Working Day Report signed by the Director of Nursing (DON) on 05/30/2014 for the same incident indicated the bruise was located in the crease of the right eye measured 3 cm by 2.5 cm and was signed by the Director of Nursing. The same 5-Working Day Report included, but were not limited to, a summary of the investigation and a summary of the interviews with each staff member who was interviewed during the investigation. On 06/03/2014 at 5:15 PM, an interview was conducted with a Nursing Assistant (NA), NA #1 who was on duty during the 3:00 PM to 11:00 PM shift on 05/25/2014. During the interview she stated that late on 05/25/2014, perhaps about 7:30 PM or 8:00 PM, the resident reported to her that she had been hit several times on the left side of her head. NA #1 stated she then reported the resident ' s allegation to the nurse who was on duty, Nurse #1. A telephone interview was conducted with Nurse #1 on 06/04/2014 at 4:45 PM. During the interview, she stated she was on duty starting at 7:00 PM on 05/25/2014 through 7:00 AM on 05/26/2014, and that she did not learn about the bruise on Resident #1's right eye until she came to work at 7:00 PM on 05/26/2014. A review of the Nurse's Notes revealed there were no notes or assessments documented for	F 226	changes made to ensure that the deficient practice will not recur: Re-education on Resident Abuse/Neglect Prevention Policy was provided to all staff by DON or designee with a completion date of 6/5/14. How the facility plans to monitor its performance to ensure solutions are sustained: Facility DON or designee will monitor compliance with Resident Abuse/Neglect Prevention Policy by interviewing a minimum of 5 Direct-care staff weekly using CMS Form 20059 for the next 4 weeks beginning 6/16/14. After that, a minimum of 5 Direct-care staff will be interviewed biweekly for 2 months. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly. Any deviation from policy identified in interviews will be immediately reported to the Administrator or designee for further investigation. Facility DON or designee will monitor compliance with Resident Abuse/Neglect Prevention Policy by interviewing and/or observing a minimum of 10 residents weekly using CMS Form 20050 for the next 4 weeks beginning 6/16/14. After that, a minimum of 10 residents will be interviewed or observed biweekly for 2 months. Findings will be reported to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345508	A. BUILDING _____ B. WING _____	C 06/05/2014

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 226	Continued From page 3 Resident #1 between the dates of 05/20/2014 at 9:00 AM and 05/26/2014 at 3:15 PM. In an interview conducted via telephone at 4:33 PM on 06/03/2014 with the Team Leader who was on duty on 05/25/2014 and 05/26/2014, she stated she learned of the resident ' s bruise on 05/26/2014 when the resident's family member discovered the bruise at approximately 3:00 PM. She also stated there had been no allegation of abuse reported to her by a nurse. She stated she then completed a Variance Report and that the Director of Nursing filled out the 24 Hour Initial Report following the discovery of the bruise on 05/26/2014. A second review of the 5-Day Investigation for the alleged incident revealed the Nurse #1 was interviewed by the DON regarding the incident. The summary of the interview included the following: "Coworker [Nurse #1] states that she did get a report from another caregiver that [Resident #1] stated that someone hit her. Coworker stated that after she was given this information she did go back to assess [Resident #1] who did not show any signs of distress and was not visibly injured. [Resident #1] did not communicate the same information to [Nurse #1] during the assessment or any time after that during the shift ..." In second telephone interview with Nurse #1 on 06/05/2014, she stated that when NA #1 reported to her on the evening of 05/25/2014 that Resident #1 had made an allegation that someone had hit her, she went into the resident's room and asked her what was wrong, and that the resident did not respond to her verbally, but simply stared at her. She stated she "looked at her" and did not see an	F 226	Quality Assurance Performance Improvement Committee monthly. Any deviation from policy identified on interview or observed will be immediately reported to the Administrator or designee for further investigation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345508	A. BUILDING _____ B. WING _____	C 06/05/2014

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 226	Continued From page 4 injury, but added she did not assess her completely for injuries and did not look on both sides of her face, eyes, or neck area for injuries. She stated she did not document an assessment in Nurse ' s Notes or on any other form. She also stated that she did not report the resident ' s allegation of abuse to her Team Leader and did not complete a Variance Report because she felt the allegation was insignificant due to the resident ' s history of occasional hallucinations. She explained that she felt the resident would not be cognitively able to make a legitimate allegation of abuse. In addition, she stated she realized in retrospect that she should have reported the allegation of abuse immediately after the allegation was made by Resident #1 on the evening of 05/25/2014, and that she should have completed and documented an assessment at that time. In an interview with the Director of Nursing on 06/05/2014 at 11:10 AM, she stated that she understood that Nurse #1 should have reported the allegation of abuse on 05/25/2014 to her team leader, and that a full assessment should have been completed and documented by Nurse #1 after the allegation was made.	F 226		