		AND HUMAN SERVICES		FOI	RM APPROVED
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION (X3) [IO. 0938-0391 DATE SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G C	OMPLETED
		345369	B. WING		C)9/03/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
REX REF	IAB & NSG CARE CE	NTER		4420 LAKE BOONE TRAIL RALEIGH, NC 27607	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC 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 000	INITIAL COMMENT	ſS	F 000		
	complaint investiga ID # VKU611	ere cited as a result of the tion survey of 9/3/2015. Event			
F 280 SS=D		0(k)(2) RIGHT TO NNING CARE-REVISE CP	F 280		10/1/15
	incompetent or othe incapacitated under	r the laws of the State, to ing care and treatment or			
	within 7 days after t comprehensive ass interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p the resident, the resi legal representative	are plan must be developed the completion of the sessment; prepared by an m, that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, racticable, the participation of sident's family or the resident's e; and periodically reviewed am of qualified persons after			
	by: Based on observat and staff interviews care plan to addres anticoagulation (blo of 5 sampled reside	ood thinner) medication for 2 ents (Resident #14 and iewed for unnecessary		 As noted, the MDS nurse provided a updated care plan for residents #14 and #153 that included anticoagulation thera and precautions. The MDS nurses will conduct an auc for all residents on anticoagulation thera and will ensure the anticoagulation 	ру it
ABORATORY	(DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	VATURE	TITLE	(X6) DATE

Electronically Signed

09/24/2015

PRINTED: 10/07/2015

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.

		AND HUMAN SERVICES					APPROVEI <u>0938-039</u>
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING		X3) DATE COMF	SURVEY PLETED
		345369	B. WING			C 09/0) 3/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REI	HAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIOI DATE
F 280	Continued From pa	age 1	F 2	80			
	 Resident #14 wa 10/11/12 with cumu fibrillation (an abno cerebral vascular a The quarterly Minin 6/16/15 indicated R cognitive impairme assistive all of her a except supervision assessment also in an anticoagulant m days. A review of Resider revealed on 8/26/19 Coumadin (anticoa given Mondays, Tu and Sundays and 8 and Thursdays with A review of Resider 9/11/12 and last rev problem area relate medication. Howev planned for falls ris pain. In an interview on S assistant (NA) #1 a she had worked at months and she tra Instructions taped t door. NA #1 verified on the Caregiver In Resident #14 was t medication and she 	is admitted to the facility on Ilative diagnoses of atrial rmal heart rhythm) and a			therapy and precautions are care pla for those residents. 3. All nurses will be inserviced by the Clinical Educator/DON/Clinical Mana on the need and the facility expectatic care plan anticoagulation therapy an precautions and also to include those precautions and things to look for wh resident is on an anticoagulant on the Caregiver instructions for the nurse at to follow. The RN Admission Nurses be inserviced by the Clinical Educator the need to implement a care plan for anticoagulation therapy upon admiss for new admits who are on an anticoagulant. All nurse aides will be inserviced by the Clinical Educator/DON/Clinical Manager rega checking the Caregiver instructions for each resident and following the instructions for residents on anticoagulation therapy including kno precautions and what to look for whe resident is on an anticoagulant medication. An Anticoagulant-Care Plan/Care Guide Audit tool has been created. The DON will receive a list residents on anti-coagulants weekly the pharmacy. The DON/Clinical Manager/RN Team Leader will review list and complete the Audit tool week 4 weeks and monthly thereafter for 3 months. Any discrepencies will be corrected upon finding and reinservice education provided as needed. 4. The facility Quality Assurance and Performance Improvement Committe (QAPI) will review the results of the A tool monthly in the monthly QAPI me	e ager ion to d e hen a e aides s will or on or sion e arding for owing en a of from w the cly for } ce d ee Audit	

Facility ID: 923427

		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345369	B. WING				C 03/2015
NAME OF	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REI	HAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	Resident #14. NA # have observed brui arms when she sho assigned Resident resident was on and the September phy nothing on the care way the aides would blood thinner was if Nurse #1 stated it v rendering care to kn look for when a res medication. In an interview on 9 stated she had wor she was not aware an anticoagulant m information would b precaution when ca In an interview on 9 supervisor stated if plan anticoagulant no on the Caregiver In know. She stated th the aide who was o In an interview on 9 nurse #1 stated she considered stable of medication. The MI the medical record lab work weekly to ability and anticoag ordered weekly by the	 ¹ stated Resident #14 did sing to her bilateral lower owered her this morning. ⁹/2/15 at 12:25 PM, Nurse #1 #14 verified no mention that ticoagulation precautions on sician orders and also noted plan. Nurse #1 stated the only d know a resident was on a f the nurse informed them. vas important for the aides now precautions and things to ident was on an anticoagulant ⁹/2/15 at 12:52 PM, NA #2 ked at facility for ten years and that Resident #14 was taking edication but stated that be important to know as a aring for Resident #14. ⁹/2/15 at 2:20 PM, the floor the MDS nurse did not care medications, she did not put it structions for the aides to be nurse would have to inform 	F 2	280	to monitor for compliance.		

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		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345369	B. WING				C 03/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REF	IAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	interview stated it w know any resident of order to watch for th bruising, blood in un razors. In an interview on 9 #2 stated all resident should be care plar nurse #2 provided a Resident #14 for an precautions. In an interview on 9 NA #4 both working Caregiver Instruction when rendering car stated they were un taking a blood thinm information for them care. In an interview on 9 of nursing (DON) of taking an anticoagu care planned and th include information precautions to take thinner. 2. Resident #153 w diagnosis of atrial fi dated 6/9/15 indicat moderate cognitive assistance with all A MDS assessment at	ge 3 Jurse #16 present during this vas important for the aides to on anticoagulation therapy in hings like falls, bumps, rine/stool and the use of 0/2/15 at 2:42 PM, MDS nurse ints on anticoagulation therapy and. It was at this time, MDS an updated care plan for inticoagulation therapy and 0/2/15 at 3:30 PM, NA # 3 and g on F hall confirmed using the on sheet as what they used the to Resident #14. Both aides haware Resident #14. Both aides haware Resident #14 was her and felt it was important in to know when providing 0/3/15 at 12:47 PM, the director confirmed that any resident ulant medication should be the Caregiver Instructions for the aide to look for and for any resident on a blood as admitted on 7/16/13 with a brillation. The quarterly MDS ted Resident #153 had impairment extensive ADLs except for eating. The also indicated Resident #153 agulant medication 7 out of 7	F 2	280			

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIF	PLE CONSTRUCTION		E SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	INC	3		PLETED
		345369	B. WING				C 03/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
REX REI	HAB & NSG CARE CE	NTER			4420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 280	Continued From pa	ge 4	F 2	280	D		
	A review of Resider revealed on 8/31/15 Coumadin (anticoag Tuesdays, Wednes Sundays and 4 mg Thursdays with lab The September Me Record also read th ANTICOAGUALTIC A review of Resider 7/16/13 and last rev problem area relate medication but Res for falls risk due uns Parkinson 's diseas In an observation a #153 on 9/1/15 at 2 the top of her right I very easily because In an interview on 9 assistant (NA) #1 a she had worked at 1 months and she tra Instructions taped to door. NA #1 verified on the Caregiver In Resident #153 was medication and she specified bleeding p Resident #153. In an interview on 9 assigned Resident precautions on the	nt #153's medical record 5 orders included the following: gulant) 3 mg to be given days, Fridays, Saturdays and to be given on Tuesdays and work to be repeated 9/4/15. dication Administration he following: DN ALERT. Int #153's care plan (initiated vised 7/29/15 revealed no ed the use of an anticoagulant ident #153 was care planned steady gait related to					

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PRINTED: 10/07/2015

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		345369	B. WING	;			C 03/2015
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
REX REF	IAB & NSG CARE CE	NTER			4420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 280	a blood thinner was Nurse #1 stated it w rendering care to kn look for when a resi medication. In an interview on 9 stated she had word she was not aware an anticoagulant me information would b precaution when ca In an interview on 9 supervisor stated if plan anticoagulant n on the Caregiver In know. She stated th the aide who was o In an interview on 9 nurse #1 stated she considered stable of medication. The MI the medical record having lab work we clotting ability and a adjustment ordered MDS nurse also ver Resident #153 for fa present during this important for the aid anticoagulation ther things like falls, bur urine/stool and the	would know a resident was on if the nurse informed them. vas important for the aides now precautions and things to ident was on an anticoagulant /2/15 at 12:52 PM, NA #2 ked at facility for ten years and that Resident #153 was taking edication but stated that e important to know as a ring for Resident #153. /2/15 at 2:20 PM, the floor the MDS nurse did not care medications, she did not put it structions for the aides to he nurse would have to inform in a blood thinner. /2/15 at 2:30 PM, the MDS e did not care plan residents in their anticoagulant DS nurse verified by review of that Resident #153 was ekly to determine her blood inticoagulant medication weekly by the physician. The rified she care planned alls on 6/17/15. Nurse #16 interview stated it was des to know any resident on rapy in order to watch for mps, bruising, blood in	F	280			
	In an interview on 9						

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED
		345369	B. WING				C 03/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REF	IAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL ALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280 F 333 SS=D	nurse #2 provided a Resident #153 for a precautions. In an interview on 9 NA #4 both working Caregiver Instruction when rendering car aides stated they w was taking a blood important information providing care. In an interview on 9 of nursing (DON) con taking an anticoague care planned and the include information precautions to take thinner. 483.25(m)(2) RESII SIGNIFICANT MED The facility must en any significant med This REQUIREMEN by: Based on record ref facility failed to adm medication as order 15 residents (Resid received a controlle borrowed from anot	 An updated care plan for an updated care plan for anticoagulation therapy and All 2/15 at 3:30 PM, NA # 3 and on F hall confirmed using the on sheet as what they used e to Resident #153. Both ere unaware Resident #14 thinner and felt it was on for them to know when All 3/15 at 12:47 PM, the director confirmed that any resident and for any resident and for any resident on a blood DENTS FREE OF DERRORS Asure that residents are free of ication errors. AT is not met as evidenced eview and staff interviews, the ninister the correct pain red by the physician for 1 of lent #381) identified as having ed substance (medication) ther resident. 	F 2		1. As noted, resident #381 denied experiencing any identifiable side et from the pain medication she was g while at the facility. The DON initial medication error report and notified resident #381's physician and respo party.	jiven ted a onsible	10/1/15
	The findings include	.			2. The DON/Clinical Manager/Clini	Cal	

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				ייסוד			0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
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		345369	B. WING				03/2015
NAME OF	PROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REI	HAB & NSG CARE CE	INTER			420 LAKE BOONE TRAIL ALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 333	Continued From pa	age 7	F 3	33			
	Resident #381 was 8/29/15 from a hos diagnoses which in knee replacement. Set (MDS) assess date of the review (Resident #381 ' s n Nursing Notes and resident was asses oriented. Resident #381 ' s a 8/29/15 included: hydrocodone / ace narcotic medicatior severe pain) to be every four hours as one tablet. A review of the Cor another resident (F mg oxycodone / ace combination narcot used for severe pa #381 on four occas On 8/30/15 at 9:5 mg oxycodone/ace from Resident #363 on the Controlled D assignment only); On 8/30/15 at 2:0 mg oxycodone/ace from Resident #363 on the Controlled D assignment only);	a admitted to the facility on pital with a cumulative cluded status post left total An admission Minimum Data ment was yet due as of the (9/3/15). Based on a review of nedical record (which included a 7-day Flow Record), the seed by staff as being alert and admission medications dated 10/325 milligrams (mg) taminophen (a combination n typically used for moderate to given as two tablets by mouth a needed for pain; may refuse htrolled Drug Records for Resident #363) revealed 10/325 etaminophen (a different tic pain medication typically in) was borrowed for Resident			Educator will conduct a 100% in he audit of the Medication Administrat Records by 10/1/15 to determine if other medication errors occurred a result of the borrowing and will creat medication error reports if any error found. 3. Nurses #13 and #14 will be give one to one inservice by the Clinical Educator on the facility's policy on Medication Administration Guidelin including information that controlled medications may not be borrowed. other nurses and new nurses will be inserviced as well. All nurses and nurses will be inserviced by the Ph Consultant/Clinical Educator/DON eight rights of medication administ include ensuring the right medication given to the right resident. All inse will be completed by 10/1/15. The DON/Clinical Manager/Team Lead conduct a random audit of 5 Media Administration Records per hall da one week then weekly for eight we check for medication errors and/or documentation of borrowing. They utilize the newly created Narcotic Documentation Audit. Any discrep will be corrected upon finding and reinservice education provided as 14. The facility's QAPI Committee w review the results of the Narcotic Documentation Audit tool monthly in monthly QAPI meeting to monitor for compliance for three months. The consultant pharmacist will also mo	ion ion any s a ate rs are en a es d All re new armacy on the ration to on is rvices er will cation ily for eks to will encies needed. vill	

Facility ID: 923427

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TATEMEN	ERS FOR MEDICARE & MEDICAID SERVICES NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA I OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE	0938-039 E SURVEY PLETED
		345369	B. WING	_		с	
NAME OF	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE	09/0	03/2015
	HAB & NSG CARE C			44 R/			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 333	on the Controlled I assignment only); On 8/31/15 at 10 mg oxycodone/ace from Resident #36 on the Controlled I assignment only). An interview was c Director of Nursing The DON reported were concerns in r controlled substant the DON, part of th having a delay in th ordered and having backup pharmacy, admissions on the facility. She noted in-house Pyxis ma substance medicat use; and, these medicat use; and, these medicat another, the DON practice or our poli identifying the nurs Controlled Drug Re determining which were borrowed. Th borrowed medicati Controlled Drug Re only (not a name). A follow up intervie facility 's DON on identification of Re	Drug Record by a room 15 AM, one tablet of 10/325 taminophen was borrowed 3 for Resident #381 (identified Drug Record by a room conducted with the facility ' s 9 (DON) on 9/2/15 at 11:20 AM. The facility recognized there egards to the borrowing of ce medications. According to he problem was identified as he receipt of medications g " some issues " with the particularly for new rehabilitation halls of the the facility had a small chine containing controlled tions intended for emergency edications could be used when in the delivery of a resident ' s regards to borrowing controlled tions from one resident to stated, " That is not our ty." The DON assisted in ses ' signatures on the ecord and began the process of resident the medication(s) he resident receiving the on(s) was identified on the ecord by the room assignment	F 3	33	Consultant Pharmacist Activity Rep notify the DON/Administrator of his findings during monthly exit meetin	6	

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		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		345369	B. WING	;			C 03/2015
NAME OF	PROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
REX REI	HAB & NSG CARE CE	NTER			4420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 333	resident had been p hydrocodone / acet medication (not the acetaminophen bor separate occasions the use of oxycodor medication error for the facility would ini notify Resident #38 Responsible Party, measures as neede the nurse who adm acetaminophen on been interviewed by admitted to making Interviews were cor and 2:20 PM with N identified as the nur oxycodone / acetan Resident #363 and #381 on three of the (8/30/15 at 9:55 AN 8/31/15 at 10:15 AN acknowledged she medical record with had made an error wrong pain medication occasions. The nur When asked, Nurse recall the resident the experiencing any ac pain medication giv An interview was co with Resident #381 did experience sign which was effective	prescribed 10/325 mg caminophen as a pain a 10/325 mg oxycodone / rrowed for the resident on four s). The DON acknowledged ne/acetaminophen was a r this resident. She reported itiate a medication error report, and implement corrective ed. The DON also indicated inistered the oxycodone / 3 of the 4 occasions had just y her (the DON) and reportedly	F	333			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 345369 B. WING 09/03/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4420 LAKE BOONE TRAIL RALEIGH, NC 27607 5 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)			AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
JAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE REX REHAR & NSG CARE CENTER SUMMANY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZP CODE 4420 LAKE BOONE TRAIL RALEICH, NC 27607 CORECORES (INC.) COMPARING STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST STREET RECEIPED BY FULL (EACH DEFICIENCY MUST BE PRECEIPED BY FULL REGULATORY OR LSC DENTFYING INFORMATION) PREFIX (EACH DEFICIENCY MUST BE PRECEIPED BY FULL (EACH DEFICIENCY MUST BE PRECEIPED BY FULL (EACH DEFICIENCY MUST BE PRECEIPED BY FULL (EACH DEFICIENCY) PREFIX (EACH DEFICIENCY) COMPARING (EACH DEFICIENCY) F 333 F 333 Continued From page 10 resident Administration (Recount #361 on #30115 at 11:00 PM. Upon inquiry, Nurse #14 recaliel DOW or ony deficient of Administration (Recount #3	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
420 LAKE BOONE TRAIL RALEIGH, NC 27607 (Y4) D PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES INCLUSTORY OR LSC DENTEYING INFORMATION) 120 PREFIX TAG CONTINUE OF DEFICIENCIES INCLUSTORY OR LSC DENTEYING INFORMATION) DEFICIENCY MUST BE PRECEDED BY FULL RECULTORY OR LSC DENTEYING INFORMATION) DEFICIENCY MUST BE PRECEDED BY FULL RECULTORY OR LSC DENTEYING INFORMATION) DEFICIENCY MUST BE PRECEDED BY FULL RECULTORY OR LSC DENTEYING INFORMATION) DEFICIENCY MUST BE PRECEDED BY FULL RECULTORY OR LSC DENTIFYING INFORMATION) DEFICIENCY MUST BE PRECEDED BY FULL RECULTORY OR LSC DENTIFYING INFORMATION) DEFICIENCY MUST BE PLAN OF CORRECTION (EACH CORRECTING ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) CONTAINT OF THE PLAN RECULTORY OR LSC DENTIFYING INFORMATION) DEFICIENCY MUST BE PLAN OF CORRECTION (EACH CORRECTING ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) CONTAINED THE APPROPRIATE DEFICIENCY F 333 Continued From page 10 resident devised new as conducted on 9/3/2015 at 11:00 PM. Upon inquiry, Nurse #14 recalled borrowing the pain medication for Resident #381 just prior to the conclusion of her shift that night. The nurse stated she was not and ware that the wrong medication as administered to Resident #381 at that time. However, she reported she Knew hydroccodne / acetaminophen and oxycodone / acetaminophen and to chock each medication as for a nurse to follow the physician 's medication orders and to chock each medication as an unse to follow the physician 's medication orders and to chock each medication Administrat			345369	B. WING				
REX. REHAB & NSG CARE CENTER PALEIGH, NC 27607 (Ma) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WUST EXERCEDED BY PULL RECULATORY OR LSC. DENTIFYING INFORMATION) ID PROVIDENTS PLAN OF CORRECTIVE ACTORN SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Commentation Deficiency (Commentation) Commentation) F 333 Continued From page 10 resident #363 and administering it to Resident #363 and Administering it conclusion of her shift that night. The nurse stated she was not aware that the wrong medication was or a nurse to follow the physician 's medication orders and to check each medication with the resident 's Medication Administration Record (MAR) to ensure accuracy prior to medication administration. F 425 F 425 483.60(a)(b) PHARMACEUTICAL SVC - SSEE F 425	NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PIEERX TAG LEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PREFX TAG CEACH CORRECTIVE ACTION FHOULD BE CROSS-REFERENCED TO THE APPOORNATE COMMETTION DEFICIENCY F 333 Continued From page 10 resident denied experiencing any identifiable side effects (including sedation) from the pain medication she was given while at the facility. F 333 F 333 F 333 F 333 A telephone interview was conducted on 9/3/2015 at 3:18 PM with Nurse #14. Nurse #14 was the nurse identified as borrowing to approximation for Resident #381 on 8/30/15 at 11:00 PM. Upon inquiry, Nurse #14 recalled borrowing the pain medication for Resident #381 10 storio must administered to Resident #381 inst prior to the conclusion of her shift that light. The nurse stated she was not aware that the wrong medication was administered to Resident #381 at that time. However, she reported she knew hydrocodone / acetaminophen were different medications and were not interchangeable. F 425 An interview was conducted on 9/3/2015 at 3:54 PM with the facility 's DON. During the interview, the DON stated her expectation orders and to check each medication with the resident 's Medication Administration Record (MAR) to ensure accuracy prior to medication administration. F 425 SS=E The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in § 483.75(h) of this part. The facility may permit unicensed personnel to administret dugs if State law permits, but only under the general F 425	REX REF	IAB & NSG CARE CE	NTER					
resident denied experiencing any identifiable side effects (including sedation) from the pain medication she was given while at the facility. A telephone interview was conducted on 9/3/2015 at 3:18 PM with Nurse #14. Nurse #14 was the nurse identified as borrowing oxycodone / acetaminophen from Resident #363 and administering it to Resident #381 on 8/30/15 at 11:00 PM. Upon inquiry, Nurse #14 recalled borrowing the pain medication for Resident #381 just prior to the conclusion of her shift that night. The nurse stated she was not aware that the wrong medication was administered to Resident #381 at that time. However, she reported she knew hydrocodone / acetaminophen were different medications and were not interchangeable. An interview was conducted on 9/3/2015 at 3:54 PM with the facility 's DON. During the interview, the DON stated her expectation was for a nurse to follow the physician 's medication orders and to check each medication Record (MAR) to ensure accuracy prior to medication administration. F 425 F 425 483.60(a),(b) PHARMACEUTICAL SVC - SS=E F 425 The facility must provide routine and emergency drugs and biologicals to its resident, or obtain the munder an agreement described in § 483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general F 425	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETION
	F 425	resident denied exp effects (including se medication she was A telephone intervie at 3:18 PM with Nur nurse identified as b acetaminophen fror administering it to F 11:00 PM. Upon ind borrowing the pain b just prior to the cond The nurse stated sh wrong medication w #381 at that time. H knew hydrocodone oxycodone / acetan medications and we An interview was co PM with the facility the DON stated her to follow the physici to check each medi Medication Adminis ensure accuracy pri administration. 483.60(a),(b) PHAF ACCURATE PROC The facility must pro drugs and biologicat them under an agre §483.75(h) of this p unlicensed personn law permits, but onl	beriencing any identifiable side edation) from the pain is given while at the facility. wwas conducted on 9/3/2015 rse #14. Nurse #14 was the borrowing oxycodone / m Resident #363 and Resident #381 on 8/30/15 at quiry, Nurse #14 recalled medication for Resident #381 clusion of her shift that night. he was not aware that the vas administered to Resident However, she reported she / acetaminophen and ninophen were different ere not interchangeable. onducted on 9/3/2015 at 3:54 ' s DON. During the interview, r expectation was for a nurse ian ' s medication orders and ication with the resident ' s stration Record (MAR) to ior to medication RMACEUTICAL SVC - EDURES, RPH ovide routine and emergency als to its residents, or obtain eement described in wart. The facility may permit hel to administer drugs if State ly under the general					10/1/15

Facility ID: 923427

If continuation sheet Page 11 of 87

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	PLE CONSTRUCTION		0938-039 E SURVEY		
	F CORRECTION	IDENTIFICATION NUMBER:		G		PLETED		
			-		(С		
		345369	B. WING	NG		03/2015		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	E			
REX REF	IAB & NSG CARE CE	INTER	4420 LAKE BOONE TRAIL RALEIGH, NC 27607					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE		
F 425		ide pharmaceutical services	F 42	5				
	acquiring, receiving	drugs and biologicals) to meet						
	a licensed pharma	mploy or obtain the services of cist who provides consultation e provision of pharmacy lity.						
	by: Based on observa pharmacy staff inter facility failed to follo the acquisition of n that controlled subse belonging to one re- or used for adminis 15 of 69 residents #384, #38, #380, # #375, #378, #215, substances at the to investigation. The findings includ 1) A review of the f Medication Adminis January 2013) inclu-	ed: acility ' s policy on " stration Guidelines " (revised uded a section titled, II. nich read, in part: neduled But Not Administered		 None of the residents ident suffered any known untoward as as a result of receiving "borrow medications or having medicat "borrowed" from them. The Clinical Educator condu- inservice education for the nur notification of the findings by th surveyors. The inservice inclu- requirement that controlled me- may not be borrowed and the p to follow if a controlled medica available such as use the Pyxi- call the back up pharmacy, not for an available alternative. Ei- nurses received the inservice on 9/2 and 9/3/15. All nurses including Nurses #2,#3,#4,#5,#7,#8,#9, and #15 inserviced on the facility's polic Medication Administration Guid 	side effects ved" ions ucted ses upon he ded the edications procedures tion is not s system, tify doctor ghteen education			

Facility ID: 923427

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CONSTRUCTION		SURVEY	
ND PLAN C	F CORRECTION	DENTIFICATION NUMBER:		IG	COM	PLETED	
						2	
		345369	B. WING _			03/2015	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT 4420 LAKE BOONE TRAIL	E, ZIP CODE		
REX REF	IAB & NSG CARE CE	INTER					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE	
F 425	Continued From pa	age 12	F 42	25			
		he facility ' s controlled		an emergency." All n inserviced on the prot for ordering or reorde	ocol and procedures		
	8/5/15. A review of	admitted to the facility on f the resident ' s medical medication orders included		medications in the even of the medication inclusion	ent a resident is out uding utilizing the		
	the following: 5/32 acetaminophen (a	5 milligrams (mg) oxycodone / combination narcotic pain		Pyxis machine to obta All inservices will be o 10/1/15. An audit too	completed by I for "Controlled		
		as two tablets by mouth every for pain; may refuse one tablet).		Substances/Ordering been created which ir name,date of prescrip	ncludes residents otion, date and time		
	Records revealed t	nt #363 ' s Controlled Drug hat the last tablet of the		prescription sent to th and time medication r was the follow up if th	eceived, and what e medication was		
	was used on 8/18/ Drug Records also	ng oxycodone/acetaminophen 15 at 6:40 PM. The Controlled indicated a refill of the 5/325		not received. The auc controlled substance obtained during the 7-	prescriptions		
		taminophen tablets was bharmacy on 8/18/15 (no time		3-11PM shift RN Tear complete the audit da then twice a week for	ily for one week, eight weeks. Any		
	Records revealed of	nt #376 ' s Controlled Drug on 8/18/15 at 7:30 PM, one		discrepenices identifie with the medication ne Pixys not being used	ot arriving or the to obtain the		
	dispensed for Residual nurse and noted as	oxycodone/acetaminophen dent #376 was signed out by a borrowed for (Resident		medication will be cor via inservices and/or medication from the b	obtaining the back up pharmacy.		
	Controlled Drug Re 11:00 PM, two table			The DON/Clincal Mar Leaders will audit the records via the new "I	controlled drug Narcotic		
	Resident #376 wer	inophen dispensed for e signed out by a nurse and ed for (Resident #363). "		Documentation Audit" week, then twice a we to ensure there are no instances of "borrowir	eek for eight weeks o documented		
	Director of Nursing	onducted with the facility ' s (DON) on 9/2/15 at 11:20 AM. the facility recognized there		4. The facility's QAPI review the results of t Substance audit tool a	Committee will he Contolled		
	were concerns in re controlled substance	egards to the borrowing of ce medications. According to e problem was identified as		Documentation Audit QAPI committed mee compliance for three	tool in the monthly ting to monitor for		

Facility ID: 923427

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION		E SURVEY		
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG		IPLETED		
		345369	B. WING			C 03/2015		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		03/2013		
REX REI	IAB & NSG CARE CE	ENTER		4420 LAKE BOONE TRAIL RALEIGH, NC 27607				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIC DATE		
F 425	having a delay in the ordered and having backup pharmacy, admissions on the facility. The DON of procedure for the of narcotic medication small in-house Pyx controlled substance emergency use; an used when there we resident 's medica reported the facility a different contract pharmacy) between In regards to borroor medications from of DON stated, "The policy." The DON nurse 's signature Record. A telephone intervite at 1:34 PM with the Pharmacist. Upon inquiry, the p discussed concern controlled substance He reported address March 2015 (with the DON. He recalled 2015 when he, "m acceptable to borroor controlled substance	he receipt of medications g " some issues " with the particularly for new rehabilitation halls of the discussed the facility ' s ordering (and re-ordering) of hs. She noted the facility had a dis machine containing ce medications intended for hd, these medications could be vas a delay in the delivery of a tion(s). The DON also v had plans to transition over to c pharmacy (and back-up n January and March of 2016. wing controlled substance one resident to another, the at is not our practice or our assisted in identifying the on the Controlled Drug ew was conducted on 9/2/2015 e facility ' s Consultant wharmacist reported he had s regarding the borrowing of ces with the DON in the past. ssing the issue in February and he former DON), and most d August 2015 with the current having an in-service in June nade it loud and clear it was not pow medications, especially	F 4:	25 consultant pharmacist will compliance for three moni monthly visits utilizing the Consultant Pharmacist Ac notify the DON/Administra	ths during his Monthly tivity Report and			

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DEPAR	FMENT OF HEALTH	AND HUMAN SERVICES			P		APPROVED
		& MEDICAID SERVICES	. 		0		0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		PLE CONSTRUCTION	`́сом	E SURVEY PLETED
		345369	B. WING				C 03/2015
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
REX REI	HAB & NSG CARE CE	NTER			4420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG				IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	of "borrowed" narco medications), but di A telephone intervie 4:04 PM with the As for the facility ' s cot this interview, the A reviewed the proceer reordering controlle residents. The Ass process involved fa hard copy of the sig received, the medic indicated the cut-off controlled substanc 6:30 PM. Unless th as a STAT (urgent) would be received b PM. If the order for after 6:30 PM, the p automatically roll ov service. This servic courier pick up the I and take it to a cont inquiry as to how lot before the medicati Realistically, maybe up to a couple of ho Manager also repor in-house Pyxis mac machine contained medications for em- to help meet the im A telephone intervie 1:06 PM with Nurse identified by the sig Record as having b	bics (controlled substance id not realize it was "that bad." ew was conducted on 9/2/15 at ssistant Pharmacy Manager ntracted pharmacy. During ssistant Pharmacy Manager dures for ordering or ed substance medications for istant Manager reported the xing the pharmacy a written or gned prescription. Once cation would be sent out. He f time for request of a ce for same-day delivery was ne medication was requested medication, the medication by the facility around 10:00 a medication was placed oharmacy phone would ver to an on-call pharmacy ce could arrange to have a hard copy of the prescription tracted retail pharmacy. Upon ng this process would take on was received, he stated, " e 1 and 1/2 hours or soand ours." The Assistant rted the facility had an chine. He noted the Pyxis a stock of certain controlled ergency use and was intended mediate needs of a resident.	F 4	125	5		

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PRINTED: 10/07/2015

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
AND FLAN C	of correction	IDENTIFICATION NOMBER.	A. BUILD	DING	3		C			
		345369	B. WING	B. WING			03/2015			
NAME OF I	PROVIDER OR SUPPLIER									
REX REF	REX REHAB & NSG CARE CENTER			4420 LAKE BOONE TRAIL RALEIGH, NC 27607						
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 425	Resident #363 on the 8/18/15. Upon inqui she had borrowed of medications from of occasions. Nurse # procedures for obta medication. She st physician-ordered r currently available for the medication in the the medication in the the medication. Nut of controlled substa practice. " Howeve pain medication or available from the F timely manner, she medication from an acknowledged she to borrow medication another. 2) A review of the fa Medication Adminis January 2013) inclu Documentation, wh B. Medications Not (a) " Controlled Me borrowed even in a In an emergency, th substance kit shoul Resident #377 was 8/18/15. A review of record revealed her the following: 5/328 acetaminophen (a control of the fall and the following for the fall of the following for the fall of the the following for the fall of the fall of the fall of the the following for the fall of the fall of the fall of the the following for the fall of the fall of the fall of the following for the fall of the fall of the fall of the fall of the following for the fall of the fall o	wo separate occasions on iry, the nurse acknowledged controlled substance ne resident to another on #2 outlined the facility ' s aining a resident ' s ated if a resident needed a nedication that was not for him/her, she first looked for ne facility ' s Pyxis machine; backup pharmacy to request irse #2 reported the borrowing once medications, " was not a r, the nurse indicated if the dered for a resident was not Pyxis or backup pharmacy in a would go ahead and borrow a other resident. Nurse #2 knew she was not supposed ons from one resident to acility ' s policy on " tration Guidelines " (revised ided a section titled, II. ich read, in part: eduled But Not Administered Available edications - May not be n emergency. ne facility ' s controlled	F 4	425						

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PRINTED: 10/07/2015

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATI COM	E SURVEY IPLETED
		345369	B. WING				C 03/2015
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
REX REF	HAB & NSG CARE CE	NTER			1420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 425	Continued From pa	ge 16	F4	125			
	4 hours as needed (ordered on 8/18/15	for pain; may refuse one tablet 5).					
	Records revealed of two-5/325 mg oxyo dispensed for Resid a nurse and noted a #377). " An interview was co Director of Nursing The DON reported were concerns in re- controlled substance the DON, part of the having a delay in th ordered and having backup pharmacy, admissions on the re- facility. The DON of procedure for the o narcotic medication small in-house Pyxi controlled substance emergency use; an used when there wa resident 's medication small in-house Pyxi controlled substance emergency use; an used when there wa resident 's medication pharmacy) betweer In regards to borrow medications from o DON stated, "That policy." The DON nurse 's signature of Record.	ht #376 's Controlled Drug on 8/18/15 at 10:15 PM, codone/acetaminophen tablets dent #376 were signed out by as " borrowed for (Resident onducted with the facility 's (DON) on 9/2/15 at 11:20 AM. the facility recognized there egards to the borrowing of the medications. According to e problem was identified as e receipt of medications " some issues " with the particularly for new rehabilitation halls of the liscussed the facility 's rdering (and re-ordering) of the medications intended for d, these medications could be as a delay in the delivery of a tion(s). The DON also had plans to transition over to pharmacy (and back-up n January and March of 2016. wing controlled substance ne resident to another, the t is not our practice or our assisted in identifying the on the Controlled Drug					

Facility ID: 923427

If continuation sheet Page 17 of 87

		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		345369	B. WING			C 09/03/2015	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
	AB & NSG CARE CE	NTED		4	420 LAKE BOONE TRAIL		
	IAD & NOG CARE CE	NIER		F	RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	Continued From pa at 1:34 PM with the Pharmacist. Upon inquiry, the pl discussed concerns controlled substance He reported address March 2015 (with the recently in July and DON. He recalled 2015 when he, " m acceptable to borro controlled substance A follow-up interview at 3:10 PM with the acknowledged she of "borrowed" narco medications), but d A telephone interview 4:04 PM with the As for the facility ' s co this interview, the A reviewed the proce- reordering controller residents. The Ass process involved fa hard copy of the sig received, the medic indicated the cut-of controlled substance 6:30 PM. Unless thas a STAT (urgent) would be received the PM. If the order for after 6:30 PM, the p	ge 17 facility ' s Consultant harmacist reported he had s regarding the borrowing of ses with the DON in the past. using the issue in February and he former DON), and most August 2015 with the current having an in-service in June ade it loud and clear it was not w medications, especially	1	125	DEFICIENCY)		
	service. This service	ce could arrange to have a hard copy of the prescription					

Facility ID: 923427

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		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		345369	B. WING				C 03/2015
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
REX REF	IAB & NSG CARE CE	NTER			4420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 425	inquiry as to how lo before the medicati Realistically, maybe up to a couple of ho Manager also repor in-house Pyxis mad machine contained medications for em to help meet the im A telephone intervie 1:06 PM with Nurse identified by the sig Record as having b oxycodone/acetami Resident #377 on 8 inquiry, the nurse a borrowed controlled one resident to ano outlined the facility resident 's medication not currently availal for the medication i then would call the the medication. Nu of controlled substa practice. " Howeve pain medication from an acknowledged she to borrow medicatio another. 3) A review of the facility	tracted retail pharmacy. Upon ng this process would take on was received, he stated, " a 1 and 1/2 hours or soand ours." The Assistant rted the facility had an chine. He noted the Pyxis a stock of certain controlled ergency use and was intended mediate needs of a resident. a was conducted on 9/3/15 at a #2. Nurse #2 was the nurse nature on the Controlled Drug orrowed inophen from Resident #376 to 8/18/15 at 10:15 PM. Upon cknowledged she had d substance medications from ther on occasions. Nurse #2 ' s procedures for obtaining a tion. She stated if a resident -ordered medication that was ble for him/her, she first looked n the facility ' s Pyxis machine; backup pharmacy to request urse #2 reported the borrowing ance medications, " was not a er, the nurse indicated if the dered for a resident was not Pyxis or backup pharmacy in a would go ahead and borrow a other resident. Nurse #2 knew she was not supposed ons from one resident to	F 4	125			
		stration Guidelines " (revised					

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	-	AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES				1	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		PLE CONSTRUCTION		E SURVEY PLETED
		345369	B. WING				C 03/2015
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				4	4420 LAKE BOONE TRAIL		
	REX REHAB & NSG CARE CENTER			F	RALEIGH, NC 27607		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PROVIDER'S PLAN OF CORRECTION ULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				(X5) COMPLETION
PREFIX TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPR		DATE
					DEFICIENCY)		
F 425	Cantinued From no	40		· ~ r	_		
F 425		-	F 4	20			
	Documentation, wh	uded a section titled, II. hich read, in part:					
		reduled But Not Administered					
	3. Medications Not						
		edications - May not be					
	borrowed even in a	n emergency. he facility ' s controlled					
	substance kit shoul						
		admitted to the facility on					
		of the resident ' s medical r medication orders included					
		5 milligrams (mg) oxycodone /					
	acetaminophen (a d	combination narcotic pain					
	medication) given a	as one tablet by mouth twice					
	daily as needed tor	pain (ordered on 8/19/15).					
	A review of Resider	nt #363 's Controlled Drug					
		on 8/19/15 at 9:00 PM, one					
	5/325 mg hydrocod	done/acetaminophen tablet					
		dent #363 was signed out by a					
	nurse and noted as #383). "	s "borrowed for (Resident					
	#303).						
	An interview was co	onducted with the facility ' s					
		(DON) on 9/2/15 at 11:20 AM.					
		the facility recognized there					
		egards to the borrowing of ce medications. According to					
		e problem was identified as					
	having a delay in th	e receipt of medications					
		"some issues " with the					
	backup pharmacy,	particularly for new rehabilitation halls of the					
		discussed the facility 's					
		ordering (and re-ordering) of					
		ns. She noted the facility had a					
		is machine containing					
	controlled substance	ce medications intended for					

Facility ID: 923427

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PRINTED: 10/07/2015

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		345369	B. WING				C 03/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REI	IAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL ALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	used when there wa resident ' s medicat reported the facility a different contract pharmacy) betweer In regards to borrow medications from o DON stated, " That policy. " The DON nurse ' s signature of Record. A telephone intervier at 1:34 PM with the Pharmacist. Upon inquiry, the pl discussed concerns controlled substance He reported address March 2015 (with the recently in July and DON. He recalled I 2015 when he, " m acceptable to borro controlled substance A follow-up intervier at 3:10 PM with the acknowledged she of "borrowed" narco medications), but d A telephone intervier 4:04 PM with the As for the facility ' s co this interview, the A reviewed the proces	d, these medications could be as a delay in the delivery of a tion(s). The DON also had plans to transition over to pharmacy (and back-up n January and March of 2016. wing controlled substance ne resident to another, the t is not our practice or our assisted in identifying the on the Controlled Drug ew was conducted on 9/2/2015 facility ' s Consultant narmacist reported he had as regarding the borrowing of the issue in February and he former DON), and most August 2015 with the current having an in-service in June ade it loud and clear it was not w medications, especially	F 4	25			

If continuation sheet Page 21 of 87

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COM	E SURVEY IPLETED
		345369	B. WING	i		C 09/03/2015	
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
REX REI	HAB & NSG CARE CE	NTER			1420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	residents. The Ass process involved fa hard copy of the sig received, the medic indicated the cut-of controlled substance 6:30 PM. Unless th as a STAT (urgent) would be received b PM. If the order for after 6:30 PM, the p automatically roll ov service. This servic courier pick up the and take it to a com- inquiry as to how lo before the medicati Realistically, maybe up to a couple of how Manager also report in-house Pyxis mac machine contained medications for em to help meet the im A telephone intervice 1:06 PM with Nurse identified by the sig Record as having b acetaminophen fror #383 on 8/19/15. U acknowledged she substance medicati another on occasio facility ' s procedure medication. She st physician-ordered r currently available f	age 21 sistant Manager reported the axing the pharmacy a written or gned prescription. Once cation would be sent out. He if time for request of a ce for same-day delivery was ne medication was requested medication, the medication by the facility around 10:00 r a medication was placed pharmacy phone would ver to an on-call pharmacy ce could arrange to have a hard copy of the prescription tracted retail pharmacy. Upon ong this process would take ion was received, he stated, " e 1 and 1/2 hours or soand ours." The Assistant rted the facility had an chine. He noted the Pyxis a stock of certain controlled aregency use and was intended amediate needs of a resident. ew was conducted on 9/3/15 at e #2. Nurse #2 was the nurse pature on the Controlled Drug porrowed oxycodone / m Resident #363 to Resident pon inquiry, the nurse had borrowed controlled ions from one resident to ons. Nurse #2 outlined the es for obtaining a resident ' s tated if a resident needed a medication that was not for him/her, she first looked for ne facility ' s Pyxis machine;		425			

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		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED C
		345369	B. WING				03/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REF	HAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	then would call the the medication. Nu of controlled substa practice. " Howeve pain medication or available from the F timely manner, she medication from an acknowledged she to borrow medication another. 4) A review of the fa Medication Adminis January 2013) inclu Documentation, wh B. Medications Sch 3. Medications Not. (a) " Controlled Me borrowed even in a In an emergency, th substance kit shoul Resident #384 was 8/19/15. A review of record revealed her the following: 5/325 acetaminophen (a c medication) given a every four hours as ½ or one tablet (or A review of Resider Records revealed of 5/325 mg oxycodor dispensed for Resider	backup pharmacy to request irse #2 reported the borrowing ance medications, " was not a er, the nurse indicated if the dered for a resident was not Pyxis or backup pharmacy in a would go ahead and borrow a other resident. Nurse #2 knew she was not supposed ons from one resident to actility 's policy on " stration Guidelines " (revised uded a section titled, II. ich read, in part: eduled But Not Administered Available edications - May not be n emergency. he facility 's controlled d be utilized. " admitted to the facility on of the resident 's medical r medication orders included 5 milligrams (mg) oxycodone / combination narcotic pain as one and ½ tablets by mouth a needed for pain; may refuse	F 4	425			

If continuation sheet Page 23 of 87

		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345369	B. WING				C 03/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REI	HAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 425	An interview was co Director of Nursing The DON reported were concerns in re- controlled substance the DON, part of the having a delay in the ordered and having backup pharmacy, admissions on the re- facility. The DON of procedure for the on narcotic medication small in-house Pyxic controlled substance emergency use; an used when there was resident ' s medicate reported the facility a different contract pharmacy) betweer In regards to borrow medications from on DON stated, " That policy." The DON nurse ' s signature of Record. A telephone intervie at 1:34 PM with the Pharmacist. Upon inquiry, the pl discussed concerns controlled substance He reported address March 2015 (with the recently in July and DON. He recalled	onducted with the facility 's (DON) on 9/2/15 at 11:20 AM. the facility recognized there egards to the borrowing of e medications. According to e problem was identified as e receipt of medications	F 4	125			

If continuation sheet Page 24 of 87

		& MEDICAID SERVICES				0. 0938-039		
	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA LAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION		TE SURVEY MPLETED		
		345369	B. WING _	WING		C / 03/2015		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE			
	IAB & NSG CARE CE	INTER		4420 LAKE BOONE TRAIL RALEIGH, NC 27607				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
F 425	Continued From pa	ige 24	F 42	5				
	acceptable to borro controlled substance	w medications, especially ces. "						
	at 3:10 PM with the acknowledged she	w was conducted on 9/2/2015 DON. At that time, the DON had been aware of the issues btics (controlled substance						
	medications), but d	id not realize it was "that bad."						
	4:04 PM with the As for the facility ' s co this interview, the A	ew was conducted on 9/2/15 at ssistant Pharmacy Manager ntracted pharmacy. During ssistant Pharmacy Manager dures for ordering or						
	reordering controller residents. The Ass process involved fa hard copy of the sig	ed substance medications for istant Manager reported the ixing the pharmacy a written or gned prescription. Once						
	indicated the cut-of controlled substance 6:30 PM. Unless th	cation would be sent out. He if time for request of a ce for same-day delivery was ne medication was requested medication, the medication						
	would be received PM. If the order for after 6:30 PM, the	by the facility around 10:00 r a medication was placed bharmacy phone would ver to an on-call pharmacy						
	service. This servic courier pick up the and take it to a con	ce could arrange to have a hard copy of the prescription tracted retail pharmacy. Upon ng this process would take						
	before the medicati Realistically, maybe up to a couple of he	ion was received, he stated, " e 1 and 1/2 hours or soand burs. " The Assistant						
	in-house Pyxis mad	rted the facility had an chine. He noted the Pyxis a stock of certain controlled						

Facility ID: 923427

If continuation sheet Page 25 of 87

		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345369	B. WING			C 09/03/2015	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REI	HAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL ALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 425	Continued From pa	ge 25	F 4	25			
	 1:06 PM with Nurse identified by the sig Record as having b oxycodone/acetamic Resident #384 on 8 inquiry, the nurse a borrowed controlled one resident to ano outlined the facility resident 's medication outlined the facility resident 's medication in then would call the the medication. Nu of controlled substapractice. " Howeve pain medication from an acknowledged she to borrow medication from an acknowledged she to borrow medication another. 5) A review of the f Medication Administ January 2013) inclu Documentation, wh B. Medications Not (a) " Controlled Medications Not (a) " Controlled Medication from an an emergency, the substance kit should be the form the final for	inophen from Resident #363 to 8/19/15 at 10:00 PM. Upon cknowledged she had d substance medications from ther on occasions. Nurse #2 ' s procedures for obtaining a tion. She stated if a resident i-ordered medication that was ble for him/her, she first looked n the facility ' s Pyxis machine; backup pharmacy to request irse #2 reported the borrowing ance medications, " was not a er, the nurse indicated if the dered for a resident was not Pyxis or backup pharmacy in a would go ahead and borrow a other resident. Nurse #2 knew she was not supposed ons from one resident to facility ' s policy on " stration Guidelines " (revised uded a section titled, II. ich read, in part: reduled But Not Administered Available edications - May not be n emergency. ne facility ' s controlled					

Facility ID: 923427

If continuation sheet Page 26 of 87

		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		345369	B. WING				C 03/2015
NAME OF	NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REI	HAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 425	8/1/15. A review of record revealed his the following: 5 (my medication) given a hours as needed for A review of Resider Records revealed co one-half tablets (co each) dispensed fo out by a nurse and (Resident #38)." An interview was co Director of Nursing The DON reported were concerns in re controlled substance the DON, part of the having a delay in the ordered and having backup pharmacy, admissions on the of facility. The DON co procedure for the of narcotic medication small in-house Pyxic controlled substance emergency use; an used when there was resident 's medication pharmacy) betweer In regards to borrow medications from of DON stated, "Tha policy." The DON	the resident 's medical medication orders included g) oxycodone (a narcotic pain as 1 tablet by mouth every 4 or pain (ordered on 8/14/15). ht #240 's Controlled Drug on 8/22/15 at 10:20 PM, 2 intaining 2.5 mg oxycodone r Resident #240 were signed noted as "borrowed for onducted with the facility 's (DON) on 9/2/15 at 11:20 AM. the facility recognized there egards to the borrowing of ce medications. According to e problem was identified as he receipt of medications g "some issues" with the	F	125			

Facility ID: 923427

If continuation sheet Page 27 of 87

		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		345369	B. WING				C 03/2015
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REF	HAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL ALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 425	Continued From pa Record.	ige 27	F4	125			
	at 1:34 PM with the Pharmacist. Upon inquiry, the pl discussed concerns controlled substance He reported address March 2015 (with the recently in July and DON. He recalled 2015 when he, " m acceptable to borro controlled substance A follow-up interview at 3:10 PM with the acknowledged she of "borrowed" narco medications), but d A telephone interview 4:04 PM with the As for the facility 's co this interview, the A reviewed the proce reordering controller residents. The Ass process involved fa hard copy of the sig received, the medic indicated the cut-of controlled substance 6:30 PM. Unless the as a STAT (urgent) would be received IPM. If the order for	ew was conducted on 9/2/2015 e facility 's Consultant harmacist reported he had is regarding the borrowing of ces with the DON in the past. Using the issue in February and he former DON), and most August 2015 with the current having an in-service in June hade it loud and clear it was not by medications, especially ces." w was conducted on 9/2/2015 e DON. At that time, the DON had been aware of the issues bits (controlled substance id not realize it was "that bad." ew was conducted on 9/2/15 at ssistant Pharmacy Manager intracted pharmacy. During wasistant Pharmacy Manager dures for ordering or ed substance medications for sistant Manager reported the axing the pharmacy a written or gned prescription. Once cation would be sent out. He f time for request of a ce for same-day delivery was he medication was requested medication, the medication by the facility around 10:00 r a medication was placed oharmacy phone would					

If continuation sheet Page 28 of 87

		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345369	B. WING				_ 03/2015
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
REX REI	HAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	automatically roll ov service. This servic courier pick up the and take it to a con- inquiry as to how lo before the medicati Realistically, maybe up to a couple of ho Manager also repor in-house Pyxis mac machine contained medications for em- to help meet the im A telephone intervie 1:06 PM with Nurse identified by the sig Record as having b Resident #240 to R inquiry, the nurse ar borrowed controlled one resident to ano outlined the facility resident 's medication not currently available for the medication. Nu of controlled substa practice. " Howeve pain medication from an acknowledged she	Age 28 Ver to an on-call pharmacy ce could arrange to have a hard copy of the prescription tracted retail pharmacy. Upon ing this process would take ion was received, he stated, " e 1 and 1/2 hours or soand burs." The Assistant rted the facility had an chine. He noted the Pyxis a stock of certain controlled ergency use and was intended mediate needs of a resident. We was conducted on 9/3/15 at e #2. Nurse #2 was the nurse inature on the Controlled Drug porrowed oxycodone from tesident #38 on 8/22/15. Upon cknowledged she had d substance medications from other on occasions. Nurse #2 's procedures for obtaining a tion. She stated if a resident h-ordered medication that was ble for him/her, she first looked n the facility 's Pyxis machine; backup pharmacy to request urse #2 reported the borrowing ance medications, " was not a er, the nurse indicated if the dered for a resident was not Pyxis or backup pharmacy in a would go ahead and borrow a other resident. Nurse #2 knew she was not supposed ons from one resident to	F 4	425			

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		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COM	E SURVEY IPLETED
		345369	B. WING	;		C 09/03/2015	
NAME OF	PROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
REX REI	HAB & NSG CARE CE	INTER			1420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 425	January 2013) inclu Documentation, wh B. Medications Sch 3. Medications Not (a) "Controlled Me borrowed even in a In an emergency, th substance kit shoul Resident #380 was 8/15/15. A review of record revealed her the following: 10/32 hydrocodone / acet narcotic pain medic mouth every 6 hour on 8/15/15). A review of Resider Records revealed of tablet of 10/325 mg dispensed for Resider nurse and noted as #380). " An interview was co Director of Nursing The DON reported were concerns in re controlled substand the DON, part of th having a delay in th ordered and having backup pharmacy, admissions on the facility. The DON of	acility 's policy on " acility 's policy on " atration Guidelines " (revised uded a section titled, II. ich read, in part: leduled But Not Administered Available edications - May not be n emergency. the facility 's controlled d be utilized. " admitted to the facility on of the resident 's medical r medication orders included 25 milligrams (mg) aminophen (a combination cation) given as one tablet by rs as needed for pain (ordered th #379 's Controlled Drug on 8/16/15 at 1:30 PM, one hydrocodone/acetaminophen dent #379 was signed out by a s "borrowed for (Resident ponducted with the facility 's (DON) on 9/2/15 at 11:20 AM. the facility recognized there egards to the borrowing of the medications. According to the problem was identified as the receipt of medications y "some issues" with the	F	425			

Facility ID: 923427

If continuation sheet Page 30 of 87

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES		TID		MB NO. 0938-0391 (X3) DATE SURVEY	
STATEMENT AND PLAN C	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		E SURVEY PLETED	
			A. BUILD	ing	2		C
		345369	B. WING				03/2015
NAME OF F	PROVIDER OR SUPPLIER	-		ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
	EX REHAB & NSG CARE CENTER				4420 LAKE BOONE TRAIL		
				F	RALEIGH, NC 27607		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIZ TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
IAG			170		DEFICIENCY)		
			1				
F 425	Continued From pa	ae 30	F 4	25	5		
		is. She noted the facility had a					
		is machine containing					
		e medications intended for					
		d, these medications could be					
		as a delay in the delivery of a					
		tion(s). The DON also					
		had plans to transition over to pharmacy (and back-up					
		January and March of 2016.					
		wing controlled substance					
		ne resident to another, the					
		t is not our practice or our					
		assisted in identifying the					
		on the Controlled Drug					
	Record.						
	A telephone intervie	ew was conducted on 9/2/2015					
		facility 's Consultant					
	Pharmacist.	-					
		harmacist reported he had					
		s regarding the borrowing of					
		es with the DON in the past. using the issue in February and					
		ne former DON), and most					
		August 2015 with the current					
	5 5	having an in-service in June					
		ade it loud and clear it was not					
		w medications, especially					
	controlled substance	ces. "					
	A follow up intonviou	www.aa.aanductad.an.0/2/2015					
		w was conducted on 9/2/2015 DON. At that time, the DON					
		had been aware of the issues					
		otics (controlled substance					
		id not realize it was "that bad."					
		ew was conducted on 9/2/15 at					
		ssistant Pharmacy Manager ntracted pharmacy. During					

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PRINTED: 10/07/2015

		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			. ,			(X3) DATE COM	E SURVEY IPLETED
		345369	B. WING				C 03/2015
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
REX REF	HAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 425	this interview, the A reviewed the proce reordering controller residents. The Ass process involved fa hard copy of the sig received, the medic indicated the cut-of controlled substance 6:30 PM. Unless that as a STAT (urgent) would be received H PM. If the order for after 6:30 PM, the p automatically roll of service. This servic courier pick up the and take it to a con inquiry as to how lo before the medicati Realistically, maybe up to a couple of ho Manager also repor in-house Pyxis mac machine contained medications for em to help meet the im An interview was ma telephone on 9/3/18 for return call; the c #4 was the nurse ic the Controlled Drug hydrocodone / acet #379 to Resident #	ssistant Pharmacy Manager dures for ordering or ed substance medications for istant Manager reported the xing the pharmacy a written or gned prescription. Once cation would be sent out. He f time for request of a se for same-day delivery was he medication was requested medication, the medication by the facility around 10:00 a medication was placed oharmacy phone would ver to an on-call pharmacy ce could arrange to have a hard copy of the prescription tracted retail pharmacy. Upon ng this process would take on was received, he stated, " e 1 and 1/2 hours or soand ours. " The Assistant ted the facility had an chine. He noted the Pyxis a stock of certain controlled ergency use and was intended mediate needs of a resident. of conducted with Nurse #4. de to contact the nurse by 5 at 11:20 AM with a request all was not returned. Nurse lentified by the signature on g Record as having borrowed aminophen from Resident 380 on 8/16/15.	F	425			

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	-	AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
STATEMENT AND PLAN O	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION		E SURVEY IPLETED	
			A. BUILD	ING		С	
		345369	B. WING	B. WING			03/2015
NAME OF F	PROVIDER OR SUPPLIER			ç	STREET ADDRESS, CITY, STATE, ZIP CODE		
	HAB & NSG CARE CE	NTER			4420 LAKE BOONE TRAIL		
				F	RALEIGH, NC 27607		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIZ TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
					DEFICIENCY)		
F 425	Continued From pa	ige 32	F 4	25	5		
		uded a section titled, II.					
	Documentation, wh						
		eduled But Not Administered					
	3. Medications Not						
		edications - May not be					
	borrowed even in a						
		he facility 's controlled					
	substance kit shoul	d be utilized.					
	Resident #382 was	admitted to the facility on					
		of the resident 's medical					
		r medication orders included					
	the following: 10/32	25 milligrams (mg)					
		aminophen (a combination					
		cation) given as one tablet by					
		s needed for pain (ordered on					
	8/26/15).						
	A review of Resider	nt #379 's Controlled Drug					
		on 8/26/15 at 8:00 PM, one					
		odone/acetaminophen tablet					
		dent #379 was signed out by a					
		borrowed for (Resident					
	#382). "	Ϋ́,					
		onducted with the facility 's					
	•	(DON) on 9/2/15 at 11:20 AM.					
		the facility recognized there					
		egards to the borrowing of					
		ce medications. According to e problem was identified as					
		e receipt of medications					
		g "some issues " with the					
	backup pharmacy,						
		rehabilitation halls of the					
	facility. The DON d	liscussed the facility ' s					
		rdering (and re-ordering) of					
		ns. She noted the facility had a					
	small in-house Pvxi	is machine containing					

Facility ID: 923427

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		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345369	B. WING				C 03/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REI	HAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 425	controlled substance emergency use; an used when there wa resident 's medicat reported the facility a different contract pharmacy) betweer In regards to borrow medications from o DON stated, "Tha policy." The DON nurse 's signature Record. A telephone intervie at 1:34 PM with the Pharmacist. Upon inquiry, the pl discussed concerns controlled substance He reported address March 2015 (with the recently in July and DON. He recalled 2015 when he, " m acceptable to borro controlled substance A follow-up interview at 3:10 PM with the acknowledged she of "borrowed" narco medications), but d A telephone interview 4:04 PM with the As for the facility 's co this interview, the A	ce medications intended for d, these medications could be as a delay in the delivery of a tion(s). The DON also had plans to transition over to pharmacy (and back-up n January and March of 2016. wing controlled substance ne resident to another, the t is not our practice or our assisted in identifying the on the Controlled Drug ew was conducted on 9/2/2015 efacility ' s Consultant harmacist reported he had s regarding the borrowing of ces with the DON in the past. asing the issue in February and he former DON), and most August 2015 with the current having an in-service in June hade it loud and clear it was not by medications, especially		125			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		345369	B. WING				C 03/2015
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
REX REI	HAB & NSG CARE CE	NTER			4420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 425	reordering controller residents. The Ass process involved fa hard copy of the sig received, the medic indicated the cut-of controlled substance 6:30 PM. Unless th as a STAT (urgent) would be received b PM. If the order for after 6:30 PM, the p automatically roll ov service. This servic courier pick up the and take it to a com- inquiry as to how lo before the medicati Realistically, maybe up to a couple of ho Manager also repor in-house Pyxis mac machine contained medications for em to help meet the im An interview was co PM with Nurse #9. identified by the sig Record as having b acetaminophen fror #382 on 8/26/15. E described the proce resident 's controller not available for use indicated she would cart for the med 's check the Pyxis mat	ge 34 d substance medications for istant Manager reported the xing the pharmacy a written or med prescription. Once cation would be sent out. He f time for request of a e for same-day delivery was ne medication was requested medication, the medication by the facility around 10:00 a medication was placed oharmacy phone would ver to an on-call pharmacy ce could arrange to have a hard copy of the prescription tracted retail pharmacy. Upon ng this process would take on was received, he stated, " e 1 and 1/2 hours or soand ours." The Assistant ted the facility had an chine. He noted the Pyxis a stock of certain controlled ergency use and was intended mediate needs of a resident.	F	125			

Facility ID: 923427

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		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345369	B. WING	i		C 09/03/2015	
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REI	HAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	 backup pharmacy ta also noted she coull physician to see if a would be appropriat nurse reported she she contacted the p 8/26/15. Nurse #9 allowed for a control be borrowed from o indicated she opted was in pain. 8) A review of the fa Medication Adminis January 2013) inclu Documentation, wh B. Medications Sch 3. Medications Not. (a) " Controlled Ma borrowed even in a In an emergency, th substance kit shoul Resident #387 was 8/17/15. A review of record revealed her the following: 5/325 / acetaminophen (a medication) given a 4 hours as needed (ordered on 8/17/15) A review of Resider Records revealed of two-5/325 mg hydr tablets dispensed for 	o request delivery. Nurse #9 ld call the resident 's an alternative pain medication te for use. However, the could not recall whether or not obysician for Resident #382 on stated she knew it was not olled substance medication to one resident to another, but to do so because the resident acility 's policy on " stration Guidelines " (revised uded a section titled, II. ich read, in part: leduled But Not Administered Available edications - May not be n emergency. he facility 's controlled d be utilized. " admitted to the facility on of the resident 's medical r medication orders included 5 milligrams (mg) hydrocodone a combination narcotic pain as two tablets by mouth every for pain; may refuse one tablet		425			

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		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345369	B. WING				C 03/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REF	HAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 425	An interview was co Director of Nursing The DON reported were concerns in re- controlled substance the DON, part of the having a delay in the ordered and having backup pharmacy, admissions on the re- facility. The DON of procedure for the on narcotic medication small in-house Pyxic controlled substance emergency use; an used when there was resident ' s medicate reported the facility a different contract pharmacy) betweer In regards to borrow medications from on DON stated, " That policy." The DON nurse ' s signature of Record. A telephone intervie at 1:34 PM with the Pharmacist. Upon inquiry, the pl discussed concerns controlled substance He reported address March 2015 (with the recently in July and DON. He recalled	onducted with the facility 's (DON) on 9/2/15 at 11:20 AM. the facility recognized there egards to the borrowing of e medications. According to e problem was identified as e receipt of medications	F 4	125			

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		. 0938-039 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		IPLETED
						С
		345369	B. WING			03/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
REX REI	HAB & NSG CARE CE	INTER		4420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 425	Continued From pa	age 37	F 42	25		
	0 0 1 1 1 0 0 1 P 0	w medications, especially				
	at 3:10 PM with the acknowledged she of "borrowed" narco medications), but d	w was conducted on 9/2/2015 b DON. At that time, the DON had been aware of the issues otics (controlled substance lid not realize it was "that bad."				
	4:04 PM with the As for the facility 's co this interview, the A reviewed the proce reordering controlle residents. The Ass process involved fa	ssistant Pharmacy Manager ontracted pharmacy. During Assistant Pharmacy Manager edures for ordering or ed substance medications for sistant Manager reported the axing the pharmacy a written or gned prescription. Once				
	received, the medic indicated the cut-of controlled substance 6:30 PM. Unless th as a STAT (urgent) would be received	cation would be sent out. He ff time for request of a ce for same-day delivery was ne medication was requested medication, the medication by the facility around 10:00 r a medication was placed				
	automatically roll of service. This servic courier pick up the and take it to a con	pharmacy phone would ver to an on-call pharmacy ce could arrange to have a hard copy of the prescription tracted retail pharmacy. Upon ong this process would take				
	before the medicati Realistically, maybe up to a couple of he Manager also repo in-house Pyxis mad	ion was received, he stated, " e 1 and 1/2 hours or soand ours." The Assistant rted the facility had an chine. He noted the Pyxis				
	machine contained medications for em	a stock of certain controlled bergency use and was intended benediate needs of a resident.				

Facility ID: 923427

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		AND HUMAN SERVICES				FORM	APPROVED
	CS FOR MEDICARE	& MEDICAID SERVICES	(X2) MUL	TIPI	E CONSTRUCTION		0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
				-		(С
		345369	B. WING			09/0	03/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REF	HAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL		
				R	RALEIGH, NC 27607	 	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	v	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG	ì	CROSS-REFERENCED TO THE APPR		DATE
					DEFICIENCY)		
F 425	Continued From pa	ige 38	F 4	25			
						l	
		ew was conducted on 9/3/2015 rse #5. Nurse #5 was the				İ	
		the signature on the Controlled				l	
		ving borrowed hydrocodone /				l	
		m Resident #64 to Resident					
		12:20 AM. During the					
		e recalled this incident of					
		ic pain medication. The nurse				İ	
		s there were problems when a tions had not yet come in from				İ	
		e indicated when this				l	
		uld check the Pyxis machine to				İ	
	see if the resident '	s prescribed medication was				l	
		not, she would call the backup				l	
		rse stated sometimes it could				l	
		bre the medication was				l	
		backup pharmacy. In this ication ordered was not				l	
		esident was requesting it; so				l	
		nedication from another				l	
	resident.					l	
		···· · ·				l	
		acility 's policy on "				l	
		stration Guidelines " (revised				l	
	Documentation, wh	uded a section titled, II.				İ	
		neduled But Not Administered				l	
	3. Medications Not					l	
		edications - May not be				l	
	borrowed even in a						
		he facility 's controlled					
	substance kit shoul	d be utilized.					
	Resident #381 was	admitted to the facility on					
		of the resident 's medical					
		r medication orders included					
		5 milligrams (mg) hydrocodone					
	/ acetaminophen (a	a combination narcotic pain					

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PRINTED: 10/07/2015

		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345369	B. WING				C 03/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REI	HAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	medication) given a 4 hours as needed may refuse one tab A review of Resider Records revealed of two-5/325 mg hydr tablets dispensed fo out by a nurse and (Resident #381). " An interview was co Director of Nursing The DON reported were concerns in re controlled substand the DON, part of the having a delay in th ordered and having backup pharmacy, admissions on the re facility. The DON of procedure for the o narcotic medication small in-house Pyxic controlled substand emergency use; an used when there way resident ' s medicat reported the facility a different contract pharmacy) betweer In regards to borrow medications from o DON stated, "That policy." The DON	as two tablets by mouth every for moderate-severe pain; olet (ordered on 8/31/15). Int #366 ' s Controlled Drug on 8/31/15 at 9:50 PM, rocodone/acetaminophen or Resident #366 were signed noted as " borrowed for onducted with the facility ' s (DON) on 9/2/15 at 11:20 AM. the facility recognized there egards to the borrowing of ce medications. According to e problem was identified as the receipt of medications g " some issues " with the	F 4	425			

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		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		345369	B. WING				C 03/2015
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REF	HAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL ALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 425	Continued From pa A telephone intervie at 1:34 PM with the Pharmacist. Upon inquiry, the pl discussed concerns controlled substance He reported address March 2015 (with the recently in July and DON. He recalled 1 2015 when he, " m acceptable to borro controlled substance A follow-up interview at 3:10 PM with the acknowledged she of "borrowed" narco medications), but d A telephone interview 4:04 PM with the As for the facility ' s co this interview, the A reviewed the proce- reordering controlle residents. The Ass process involved fa hard copy of the sig-	age 40 ew was conducted on 9/2/2015 a facility's Consultant harmacist reported he had is regarding the borrowing of ces with the DON in the past. Using the issue in February and he former DON), and most August 2015 with the current having an in-service in June hade it loud and clear it was not bow medications, especially ces." w was conducted on 9/2/2015 a DON. At that time, the DON had been aware of the issues offics (controlled substance id not realize it was "that bad." ew was conducted on 9/2/15 at ssistant Pharmacy Manager ntracted pharmacy. During assistant Pharmacy Manager dures for ordering or ed substance medications for istant Manager reported the twing the pharmacy a written or gned prescription. Once cation would be sent out. He	F 4	-25			
	controlled substance 6:30 PM. Unless the as a STAT (urgent) would be received to PM. If the order for after 6:30 PM, the p automatically roll over	f time for request of a ce for same-day delivery was ne medication was requested medication, the medication by the facility around 10:00 r a medication was placed bharmacy phone would ver to an on-call pharmacy ce could arrange to have a					

		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED C
		345369	B. WING				03/2015
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
REX REF	IAB & NSG CARE CE	NTER			1420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	courier pick up the l and take it to a cont inquiry as to how lo before the medicati Realistically, maybe up to a couple of ho Manager also repor in-house Pyxis mad medications for em- to help meet the im An interview was no An attempt was ma telephone on 9/3/15 for a return call; the #4 was the nurse id the Controlled Drug hydrocodone / acet #366 to Resident #3 10) A review of the Medication Adminis January 2013) inclu Documentation, wh B. Medications Sch 3. Medications Not (a) " Controlled Me borrowed even in a In an emergency, th substance kit shoul Resident #174 was 8/22/15. A review of record revealed her the following: 50 m	hard copy of the prescription tracted retail pharmacy. Upon ng this process would take on was received, he stated, " e 1 and 1/2 hours or soand ours." The Assistant rted the facility had an chine. He noted the Pyxis a stock of certain controlled ergency use and was intended mediate needs of a resident. of conducted with Nurse #4. de to contact the nurse by 5 at 11:20 AM with a request e call was not returned. Nurse lentified by the signature on g Record as having borrowed aminophen from Resident 381 on 8/31/15. facility ' s policy on " stration Guidelines " (revised uded a section titled, II. ich read, in part: eduled But Not Administered Available edications - May not be n emergency. ne facility ' s controlled d be utilized. " admitted to the facility on of the resident ' s medical r medication orders included iilligrams (mg) tramadol given 6 hours as needed for pain	F 4	425			

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		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		345369	B. WING				C 03/2015
NAME OF F	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REF	HAB & NSG CARE CE	INTER			420 LAKE BOONE TRAIL ALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	Records revealed of mg tablet of tramace #386 was signed on borrowed for (Reside An interview was con- Director of Nursing The DON reported were concerns in re- controlled substance the DON, part of the having a delay in the ordered and having backup pharmacy, admissions on the re- facility. The DON of procedure for the on narcotic medication small in-house Pyxic controlled substance emergency use; an used when there was resident 's medicate reported the facility a different contract pharmacy) between In regards to borrow medications from on DON stated, "Tha policy." The DON nurse 's signature Record. A telephone intervie at 1:34 PM with the Pharmacist. Upon inquiry, the pla	ht #386 ' s Controlled Drug on 8/23/15 at 3:15 PM, a 50 dol dispensed for Resident ut by a nurse and noted as " dent #174). " onducted with the facility ' s (DON) on 9/2/15 at 11:20 AM. the facility recognized there egards to the borrowing of ce medications. According to e problem was identified as the receipt of medications y " some issues " with the	F 4	.25			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		345369	B. WING				C 03/2015
NAME OF I	PROVIDER OR SUPPLIER			00	STREET ADDRESS, CITY, STATE, ZIP CODE		
REX REI	HAB & NSG CARE CE	NTER			4420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 425	controlled substance He reported address March 2015 (with the recently in July and DON. He recalled I 2015 when he, " m acceptable to borron controlled substance A follow-up interview at 3:10 PM with the acknowledged she of "borrowed" narcos medications), but d A telephone interview 4:04 PM with the Ass for the facility ' s co this interview, the A reviewed the process reordering controller residents. The Ass process involved fa hard copy of the sig received, the medic indicated the cut-of controlled substance 6:30 PM. Unless thas a STAT (urgent) would be received the PM. If the order for after 6:30 PM, the p automatically roll ov service. This servic courier pick up the and take it to a com- inquiry as to how lo before the medicati	es with the DON in the past. sing the issue in February and he former DON), and most August 2015 with the current having an in-service in June ade it loud and clear it was not w medications, especially	F	425			

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		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		345369	B. WING				C 03/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REI	HAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL ALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	up to a couple of ho Manager also report in-house Pyxis made medications for emit to help meet the imit An interview was not during the on-site reattempt was made telephone on 9/3/18 was left with a requival was not returned print Nurse #8 was the misignature on the Co having borrowed tra Resident #174 on 8 11) A review of the Medication Adminis January 2013) inclu Documentation, wh B. Medications Not (a) "Controlled Me borrowed even in a In an emergency, the substance kit shoul Resident #134 was 8/19/15. A review of record revealed her the following: 50 misin opioid pain medication mouth every 6 hour on 8/19/15). A review of Resider	burs. " The Assistant red the facility had an chine. He noted the Pyxis a stock of certain controlled ergency use and was intended mediate needs of a resident. The conducted with Nurse #8 eccrtification survey. An to contact the nurse by 5 at 10:38 AM and a message est for a return call. The call rior to exit from the facility. Surse identified by the pontrolled Drug Record as amadol from Resident #386 to 3/23/15. facility 's policy on " stration Guidelines " (revised uded a section titled, II. ich read, in part: eduled But Not Administered Available edications - May not be n emergency. the facility 's controlled	F 4	.25			

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CENTER STATEMENT AND PLAN C	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER HAB & NSG CARE CE SUMMARY STA	AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345369 NTER TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	. ,	S S S F		FORM MB NO. (X3) DATE COM (09/0	10/07/2015 APPROVED 0938-0391 E SURVEY PLETED C 03/2015
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	DATE
F 425	mg tablet of tramad #379 was signed ou borrowed for (Resid Director of Nursing The DON reported were concerns in re- controlled substance the DON, part of the having a delay in th ordered and having backup pharmacy, admissions on the re- facility. The DON de procedure for the of narcotic medication small in-house Pyxic controlled substance emergency use; an- used when there was resident 's medicate reported the facility a different contract pharmacy) betweer In regards to borrow medications from o DON stated, "That policy." The DON nurse 's signature of Record. A telephone intervie at 1:34 PM with the Pharmacist. Upon inquiry, the ph discussed concerns controlled substance	ol dispensed for Resident at by a nurse and noted as " dent #134). " onducted with the facility ' s (DON) on 9/2/15 at 11:20 AM. the facility recognized there egards to the borrowing of the medications. According to the problem was identified as the receipt of medications " some issues " with the	F 4	125			

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		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345369	B. WING				C 03/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REI	HAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 425	March 2015 (with the recently in July and DON. He recalled I 2015 when he, " m acceptable to borron controlled substance A follow-up interview at 3:10 PM with the acknowledged she of "borrowed" narcor medications), but d A telephone interview 4:04 PM with the Ast for the facility ' s co this interview, the A reviewed the procea- reordering controller residents. The Ass process involved fa hard copy of the sig received, the medic indicated the cut-of controlled substance 6:30 PM. Unless thas a STAT (urgent) would be received the PM. If the order for after 6:30 PM, the p automatically roll ov service. This servic courier pick up the and take it to a com- inquiry as to how lo before the medicati Realistically, maybe up to a couple of home	he former DON), and most August 2015 with the current having an in-service in June hade it loud and clear it was not by medications, especially		425			

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CENTE		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPL		FORM MB NO.	10/07/2015 APPROVED 0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	• •			COM	PLETED
		345369	B. WING				C 03/2015
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
REX REI	HAB & NSG CARE CE	NTER			1420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 425	in-house Pyxis mac machine contained medications for em to help meet the im A telephone intervie at 9:24 AM with Nur nurse identified by f Drug Record as har Resident #379 to R During the interview incident of borrowin The nurse reported problems when a re yet come in from th when this happened machine to see if th medication was ava call the backup pha sometimes it could medication was del pharmacy. In this co ordered was not av requesting it, so she from another reside 12) A review of the Medications Sch 3. Medications Not (a) " Controlled Me borrowed even in a In an emergency, th substance kit shoul Resident #375 was	chine. He noted the Pyxis a stock of certain controlled ergency use and was intended mediate needs of a resident. www.as conducted on 9/3/2015 rse #5. Nurse #5 was the the signature on the Controlled ving borrowed tramadol from esident #134 on 8/25/15. v, the nurse recalled this ag a narcotic pain medication. sometimes there were esident 's medications had not e pharmacy. She indicated d, she would check the Pyxis he resident 's prescribed ailable; if it was not, she would irmacy. The nurse stated be " a while " before the ivered from the backup case, the pain medication ailable and the resident was e borrowed the medication ent. facility 's policy on " stration Guidelines " (revised ided a section titled, II. ich read, in part: eduled But Not Administered Available edications - May not be n emergency. he facility 's controlled	F	425			

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		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345369	B. WING				C 03/2015
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
REX REI	HAB & NSG CARE CE	NTER			1420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 425	record revealed her the following: 50 m opioid pain medicat mouth every 6 hour on 8/25/15). A review of Resider Records revealed c one-half tablets (co dispensed for Resid a nurse and noted a #375). "Further re Records revealed c one-half tablets (co dispensed for Resid a nurse and noted a #375). "Further re Records revealed c one-half tablets (co dispensed for Resid a nurse and noted a #375). " An interview was co Director of Nursing The DON reported were concerns in re controlled substance the DON, part of the having a delay in th ordered and having backup pharmacy, admissions on the net facility. The DON of procedure for the o narcotic medication small in-house Pyxi controlled substance emergency use; an used when there wa resident 's medicat	r medication orders included iilligrams (mg) tramadol (an tion) given as one tablet by 's as needed for pain (ordered ht #374 ' s Controlled Drug on 8/26/15 at 2:00 PM, 2 ntaining 25 mg tramadol each) dent #374 were signed out by as " borrowed for (Resident eview of the Controlled Drug on 8/26/15 at 9:00 PM, 2 ntaining 25 mg tramadol each) dent #374 were signed out by as " borrowed for (Resident eview of the Controlled Drug on 8/26/15 at 9:00 PM, 2 ntaining 25 mg tramadol each) dent #374 were signed out by as " borrowed for (Resident borducted with the facility ' s (DON) on 9/2/15 at 11:20 AM. the facility recognized there egards to the borrowing of the medications. According to e problem was identified as e receipt of medications " some issues " with the	F 4	125			

Facility ID: 923427

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		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391			
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G		(X3) DATE COM	E SURVEY PLETED			
		345369	B. WING _				C 0 3/2015			
NAME OF I	PROVIDER OR SUPPLIER	•	STREET ADDRESS, CITY, STATE, ZIP CODE							
REX REF	HAB & NSG CARE CE	NTER		4420 LAKE BOONE TR RALEIGH, NC 27607						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD NCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 425	In regards to borrow medications from o DON stated, "That policy." The DON nurses' signatures Record. A telephone intervite at 1:34 PM with the Pharmacist. Upon inquiry, the pl discussed concerns controlled substance He reported address March 2015 (with the recently in July and DON. He recalled 2015 when he, "m acceptable to borrow controlled substance A follow-up interview at 3:10 PM with the acknowledged she of "borrowed" narco- medications), but d A telephone interview 4:04 PM with the As- for the facility's co- this interview, the A- reviewed the proce- reordering controller residents. The Ass- process involved fa hard copy of the sig- received, the medic- indicated the cut-of	wing controlled substance one resident to another, the t is not our practice or our assisted in identifying the s on the Controlled Drug ew was conducted on 9/2/2015 e facility ' s Consultant harmacist reported he had s regarding the borrowing of ces with the DON in the past. asing the issue in February and he former DON), and most I August 2015 with the current having an in-service in June hade it loud and clear it was not ow medications, especially								

Facility ID: 923427

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		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COM	E SURVEY IPLETED
		345369	B. WING				C 03/2015
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
REX REF	IAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 425	6:30 PM. Unless thas a STAT (urgent) would be received to PM. If the order for after 6:30 PM, the p automatically roll ov service. This servic courier pick up the and take it to a com- inquiry as to how lo before the medicati Realistically, maybe up to a couple of how Manager also repor in-house Pyxis mac machine contained medications for em to help meet the im An interview was co AM with Nurse #3. identified by the sig Record as having b Resident #374 to R 2:00 PM. Upon inquirecalled borrowing medication for Resi acknowledged the in contained controlled emergency use. How nurses were required substances out of the sometimes the 2nd assist with obtaining reported time const prohibited her from for the medication a backup pharmacy p	ge 50 ne medication was requested medication, the medication by the facility around 10:00 a medication was placed oharmacy phone would ver to an on-call pharmacy ce could arrange to have a hard copy of the prescription tracted retail pharmacy. Upon ng this process would take on was received, he stated, " e 1 and 1/2 hours or soand ours." The Assistant ted the facility had an chine. He noted the Pyxis a stock of certain controlled ergency use and was intended mediate needs of a resident. Onducted on 9/3/2015 at 9:32 Nurse #3 was the nurse nature on the Controlled Drug orrowed tramadol from esident #375 on 8/26/15 at uiry, the nurse stated she a controlled substance ident #375. Nurse #3 n-house Pyxis machine d substance medications for owever, she reported two ed to sign controlled he Pyxis machine and nurse wasn't available to g the medication. Nurse #3 traints may have occasionally checking the Pyxis machine availability and/or calling the prior to borrowing a controlled ions from another resident.	F	125			

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA				MB NO. 0938-0391	
	OF DEFICIENCIES	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С	
		345369	B. WING				03/2015
NAME OF F	PROVIDER OR SUPPLIER		·	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
REX REHAB & NSG CARE CENTER				4	4420 LAKE BOONE TRAIL		
				F	RALEIGH, NC 27607		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTIO		(X5) COMPLETION
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	K	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		DATE
					DEFICIENCY)		
			1				
F 425	Continued From pa	ge 51	F 4	25			
	A talanhana intan <i>i</i> ia	0/2/15 at					
		ew was conducted on 9/3/15 at #2. Nurse #2 was the nurse					
		nature on the Controlled Drug					
		orrowed tramadol from					
		esident #375 on 8/26/15 at uiry, the nurse acknowledged					
		controlled substance					
	medications from o	ne resident to another on					
		#2 outlined the facility 's					
	procedures for obta	ated if a resident ' s					
		nedication that was not					
		or him/her, she first looked for					
		e facility ' s Pyxis machine;					
		backup pharmacy to request					
		rse #2 reported the borrowing ince medications, " was not a					
		r, the nurse indicated if the					
		lered for a resident was not					
		Pyxis or backup pharmacy in a					
		would go ahead and borrow a other resident. Nurse #2					
		knew she was not supposed					
	to borrow medication	ons from one resident to					
	another.						
	13a) A review of th	e facility 's policy on "					
		tration Guidelines " (revised					
	January 2013) inclu	ided a section titled, II.					
	Documentation, wh	•					
		eduled But Not Administered					
	3. Medications Not	Available edications - May not be					
	borrowed even in a						
	In an emergency, th	ne facility ' s controlled					
	substance kit shoul	d be utilized. "					
	Resident #378 was	admitted to the facility on					

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PRINTED: 10/07/2015

		AND HUMAN SERVICES				FORM	: 10/07/2015 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		345369	B. WING				C 03/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
				44	420 LAKE BOONE TRAIL		
	IAB & NSG CARE CE	NIER		R	ALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
	Continued From pa 8/8/15. A review of record revealed her the following: 50 mi as one tablet every may use own suppl A review of Resider Records revealed of mg tablet of tramad #365 was signed ou borrowed for (Resid of the Controlled Dr revealed on 8/23/15 tramadol dispensed signed out by a nur- for (Resident #378) An interview was co Director of Nursing The DON reported were concerns in re controlled substance the DON, part of the having a delay in th ordered and having backup pharmacy, admissions on ther facility. The DON d procedure for the of narcotic medication small in-house Pyxi controlled substance emergency use; an used when there wa resident 's medicati	SC IDENTIFYING INFORMATION) age 52 The resident 's medical r medication orders included illigrams (mg) tramadol given 6 hours as needed for pain; by (ordered on 8/8/15). The #365 's Controlled Drug on 8/22/15 at 5:30 AM, a 50 dol dispensed for Resident at by a nurse and noted as " dent #378). "Further review rug Records for Resident #365 5 at 8:20 PM, a 50 mg tablet of d for Resident #365 was se and noted as "borrowed)." onducted with the facility 's (DON) on 9/2/15 at 11:20 AM. the facility recognized there egards to the borrowing of ce medications. According to e problem was identified as the receipt of medications g " some issues " with the particularly for new rehabilitation halls of the discussed the facility 's rdering (and re-ordering) of as. She noted the facility had a is machine containing ce medications intended for d, these medications could be as a delay in the delivery of a tion(s). The DON also had plans to transition over to	TAG		CROSS-REFERENCED TO THE APPROF		DATE
	a different contract pharmacy) betweer	pharmacy (and back-up n January and March of 2016. wing controlled substance					

Facility ID: 923427

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		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			COM	E SURVEY PLETED C
		345369	B. WING				03/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
REX REI	HAB & NSG CARE CE	NTER			1420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	medications from o DON stated, "That policy." The DON nurses' signatures Record. A telephone intervie at 1:34 PM with the Pharmacist. Upon inquiry, the pl discussed concerns controlled substance He reported address March 2015 (with the recently in July and DON. He recalled I 2015 when he, "m acceptable to borro controlled substance A follow-up interview at 3:10 PM with the acknowledged she of "borrowed" narco medications), but d A telephone interview 4:04 PM with the As for the facility's co this interview, the A reviewed the proce- reordering controller residents. The Ass process involved fa hard copy of the sig- received, the medic- indicated the cut-of- controlled substance	ne resident to another, the t is not our practice or our assisted in identifying the s on the Controlled Drug ew was conducted on 9/2/2015 facility ' s Consultant harmacist reported he had s regarding the borrowing of ces with the DON in the past. asing the issue in February and he former DON), and most August 2015 with the current having an in-service in June ade it loud and clear it was not w medications, especially	F 4	425			

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		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		345369	B. WING _				C 03/2015
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REI	HAB & NSG CARE CE	NTER			20 LAKE BOONE TRAIL ALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	as a STAT (urgent) would be received to PM. If the order for after 6:30 PM, the p automatically roll ov service. This servic courier pick up the and take it to a com- inquiry as to how lo before the medicati Realistically, maybe up to a couple of ho Manager also repor in-house Pyxis mac machine contained medications for em to help meet the im A telephone intervie 10:23 AM with Nurs- identified by the sig Record DON as ha Resident #365 to R Upon inquiry, Nurse borrowing a control from one resident to he had checked the see if the tramadol not. He also report pharmacy to reques However, the nurse he knew it typically controlled substance back-up pharmacy. knew he wasn't sup resident needed the not wait for the bac	nge 54 medication, the medication by the facility around 10:00 r a medication was placed oharmacy phone would ver to an on-call pharmacy ce could arrange to have a hard copy of the prescription tracted retail pharmacy. Upon ing this process would take ion was received, he stated, " e 1 and 1/2 hours or soand ours." The Assistant rted the facility had an chine. He noted the Pyxis a stock of certain controlled ergency use and was intended mediate needs of a resident. We was conducted on 9/3/15 at se #7. Nurse #7 was the nurse inature on the Controlled Drug ving borrowed tramadol from tesident #378 on 8/22/15. e #7 recalled the instance of led substance medication o another. The nurse recalled e facility 's Pyxis machine to was available there and it was ted calling the backup st a delivery of the medication. e stated from past experience took 2-4 hours to receive a ce medication from the . The nurse stated that he oposed to, but he felt the e pain medication and could k-up pharmacy to deliver it.	F 42	25			

		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATI COM	E SURVEY PLETED
		345369	B. WING				C 03/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REI	HAB & NSG CARE CE	INTER			420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 425	during the on-site re attempt was made telephone on 9/3/18 was left with a requivas not returned pr Nurse #8 was the m signature on the Co having borrowed tra Resident #378 on 8 13b) A review of the Medication Adminis January 2013) inclu Documentation, wh B. Medications Sch 3. Medications Not (a) "Controlled Me borrowed even in a In an emergency, th substance kit shoul Resident #378 was 8/8/15. A review of record revealed her the following: 0.25 (an antianxiety med daily as needed for A review of Resider Records revealed co mg tablet of alprazo #385 was signed on borrowed for (Resider An interview was co Director of Nursing The DON reported were concerns in re	ecertification survey. An to contact the nurse by 5 at 10:38 AM and a message est for a return call. The call rior to exit from the facility. hurse identified by the pontrolled Drug Record as amadol from Resident #365 to 3/23/15. e facility 's policy on " stration Guidelines " (revised uded a section titled, II. ich read, in part: reduled But Not Administered Available edications - May not be n emergency. ne facility 's controlled d be utilized. " admitted to the facility on the resident 's medical r medication orders included milligrams (mg) alprazolam dication) given by mouth twice anxiety (ordered on 8/8/15). ht #385 's Controlled Drug on 8/24/15 at 1:00 PM, a 0.25 olam dispensed for Resident ut by a nurse and noted as "	F	425			

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		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345369	B. WING				C 03/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REI	HAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 425	the DON, part of the having a delay in the ordered and having backup pharmacy, admissions on the re- facility. The DON of procedure for the of narcotic medication small in-house Pyxic controlled substance emergency use; an used when there way resident 's medicat reported the facility a different contract pharmacy) between In regards to borrow medications from of DON stated, "Tha policy." The DON nurse 's signature Record. A telephone intervise at 1:34 PM with the Pharmacist. Upon inquiry, the pl discussed concerns controlled substance He reported address March 2015 (with the recently in July and DON. He recalled 2015 when he, " m acceptable to borroy controlled substance A follow-up interview	e problem was identified as he receipt of medications g " some issues " with the particularly for new rehabilitation halls of the discussed the facility ' s ordering (and re-ordering) of hs. She noted the facility had a is machine containing ce medications intended for id, these medications could be as a delay in the delivery of a tion(s). The DON also ' had plans to transition over to pharmacy (and back-up n January and March of 2016. wing controlled substance one resident to another, the t is not our practice or our assisted in identifying the on the Controlled Drug ew was conducted on 9/2/2015 e facility ' s Consultant harmacist reported he had s regarding the borrowing of ces with the DON in the past. ssing the issue in February and he former DON), and most I August 2015 with the current having an in-service in June hade it loud and clear it was not ow medications, especially		425			

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		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345369	B. WING				C 03/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REI	HAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 425	acknowledged she of "borrowed" narco medications), but d An interview was co PM with Nurse #6. identified by the sig Record as having b Resident #385 to R 1:00 PM. During the the procedures follo not available for ad Nurse #6 stated if ti substance medication cart for a resident, fi to the Pyxis machine the medication from in the Pyxis machine to call the pharmace delivery of the medic that depending on to she may have opter substance from and requiring the medic wait for it. A telephone interview 4:04 PM with the Ass for the facility ' s co this interview, the A reviewed the proce- reordering controller residents. The Ass process involved fa hard copy of the sig received, the medic indicated the cut-of controlled substance	nge 57 had been aware of the issues bics (controlled substance id not realize it was "that bad." onducted on 9/2/2015 at 3:25 Nurse #6 was the nurse nature on the Controlled Drug porrowed alprazolam from tesident #378 on 8/24/15 at e interview, the nurse outlined owed when a medication was ministration to a resident. he ordered controlled ion was not in the medication the nurse was supposed to go ne to see if she could obtain in there. If it was not available the, then the nurse would need y or backup pharmacy for ication. Nurse #6 reported the severity of the situation, d to borrow a controlled other resident if the resident ation did not feel he/she could ew was conducted on 9/2/15 at ssistant Pharmacy Manager ntracted pharmacy. During ussistant Pharmacy Manager dures for ordering or ed substance medications for istant Manager reported the xing the pharmacy a written or gned prescription. Once cation would be sent out. He f time for request of a the for same-day delivery was ne medication was requested	F 4	125			

Facility ID: 923427

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		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345369	B. WING				C 03/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REI	HAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	as a STAT (urgent) would be received I PM. If the order for after 6:30 PM, the p automatically roll ov service. This servic courier pick up the and take it to a con- inquiry as to how lo before the medicati Realistically, maybe up to a couple of ho Manager also repor in-house Pyxis mad machine contained medications for em to help meet the im 14) A review of the Medication Adminis January 2013) inclu Documentation, wh B. Medications Sch 3. Medications Not (a) " Controlled Me borrowed even in a In an emergency, th substance kit shoul Resident #215 was 8/14/15. A review of record revealed her the following: 0.25 (an antianxiety medication A review of Resider Records revealed of	medication, the medication by the facility around 10:00 r a medication was placed oharmacy phone would ver to an on-call pharmacy ce could arrange to have a hard copy of the prescription tracted retail pharmacy. Upon ing this process would take ion was received, he stated, " e 1 and 1/2 hours or soand ours." The Assistant rted the facility had an chine. He noted the Pyxis a stock of certain controlled aregency use and was intended mediate needs of a resident. e facility 's policy on " stration Guidelines " (revised uded a section titled, II. hich read, in part: neduled But Not Administered Available edications - May not be in emergency. he facility 's controlled ld be utilized. " a re-admitted to the facility on of the resident 's medical r medication orders included milligrams (mg) lorazepam dication) given by mouth twice	F 4	125			

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		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345369	B. WING				C 03/2015
NAME OF F	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
REX REF	AB & NSG CARE CE	INTER			420 LAKE BOONE TRAIL ALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 425	nurse and noted as #215). " An interview was co Director of Nursing The DON reported were concerns in re- controlled substance the DON, part of the having a delay in the ordered and having backup pharmacy, admissions on the re- facility. The DON co procedure for the o narcotic medication small in-house Pyxic controlled substance emergency use; an used when there was resident 's medicat reported the facility a different contract pharmacy) betweer In regards to borrow medications from o DON stated, "Tha policy." The DON nurse 's signature Record. An interview was co AM with Nurse #15 identified by the sig Record as having b Resident #71 to Re During the interview	dent #71 was signed out by a borrowed for (Resident conducted with the facility ' s (DON) on 9/2/15 at 11:20 AM. the facility recognized there egards to the borrowing of the medications. According to the problem was identified as the receipt of medications y " some issues " with the	F 4	125			

Facility ID: 923427

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345369	B. WING				C 03/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REF	IAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL ALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 425	supposed to let the the Pyxis machine to required a second re medication out. Ho medication was not another patient that medication from hir the Controlled Drug her understanding to medications was ac "Yeah." She added not supposed to bo we go ahead and b A telephone intervise at 1:34 PM with the Pharmacist. Upon inquiry, the pl discussed concerns controlled substance He reported address March 2015 (with the recently in July and DON. He recalled I 2015 when he, " macceptable to borro controlled substance A follow-up interview at 3:10 PM with the acknowledged she of "borrowed" narce medications), but d A telephone interview 4:04 PM with the As	medication cart, she was team leader know and go to to acquire it. This procedure nurse 's signature to sign the wever, if the controlled in the Pyxis, she looked for had it and borrowed the n/her, noting the borrowing on Record. When asked if it was he borrowing of narcotic cceptable, the nurse stated, , "The pharmacy said we are rrow, but if a patient needs it orrow it." wwwas conducted on 9/2/2015 facility 's Consultant narmacist reported he had s regarding the borrowing of the issue in February and he former DON), and most August 2015 with the current naving an in-service in June ade it loud and clear it was not w medications, especially	F 4	125			
	for the facility 's co						

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		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		345369	B. WING				C 03/2015
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REI	HAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL ALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 425	reviewed the proce reordering controller residents. The Ass process involved fa hard copy of the sig received, the medic indicated the cut-of controlled substance 6:30 PM. Unless th as a STAT (urgent) would be received H PM. If the order for after 6:30 PM, the p automatically roll ov service. This servic courier pick up the and take it to a con inquiry as to how lo before the medicati Realistically, maybe up to a couple of ho Manager also repor in-house Pyxis mac machine contained medications for em to help meet the im 15) A review of the Medication Adminis January 2013) inclu Documentation, wh B. Medications Sch 3. Medications Not (a) " Controlled Me borrowed even in a In an emergency, th substance kit shoul	dures for ordering or ed substance medications for distant Manager reported the exing the pharmacy a written or gned prescription. Once cation would be sent out. He f time for request of a ce for same-day delivery was ne medication was requested medication, the medication by the facility around 10:00 r a medication was placed oharmacy phone would ver to an on-call pharmacy ce could arrange to have a hard copy of the prescription tracted retail pharmacy. Upon ing this process would take fon was received, he stated, " e 1 and 1/2 hours or soand ours." The Assistant rted the facility had an chine. He noted the Pyxis a stock of certain controlled ergency use and was intended mediate needs of a resident. facility 's policy on " stration Guidelines" (revised uded a section titled, II. ich read, in part: neduled But Not Administered Available edications - May not be n emergency. he facility 's controlled	F 4	.25			

Facility ID: 923427

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STATEMEN	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DA) <u>. 0938-039</u> TE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	COI	MPLETED
		345369	B. WING		09	C / 03/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
REX REI	HAB & NSG CARE CE	INTER		4420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 425	7/7/15. A review of record revealed hei the following: 5 mil hypnotic medication mg) by mouth at be (ordered on 7/8/15) A review of Resider Records revealed of one-half of a 5 mg 3 Resident #1 was si as " borrowed for (An interview was co Director of Nursing The DON reported were concerns in re controlled substand the DON, part of th having a delay in th ordered and having backup pharmacy, admissions on the facility. The DON of procedure for the o narcotic medication small in-house Pyx controlled substand emergency use; an used when there way resident ' s medication reported the facility a different contract pharmacy) betweer In regards to borrow medications from o DON stated, " Tha	the resident 's medical r medication orders included ligrams (mg) zolpidem (a n) given as one-half tablet (2.5 edtime as needed for sleep on 8/14/15 at 12:00 AM, zolpidem tablet dispensed for gned out by a nurse and noted Resident #150). " onducted with the facility 's (DON) on 9/2/15 at 11:20 AM. the facility recognized there egards to the borrowing of the medications. According to e problem was identified as e receipt of medications 1 " some issues " with the particularly for new rehabilitation halls of the discussed the facility 's rdering (and re-ordering) of its. She noted the facility had a is machine containing the medications could be as a delay in the delivery of a tion(s). The DON also had plans to transition over to pharmacy (and back-up n January and March of 2016. wing controlled substance ne resident to another, the t is not our practice or our assisted in identifying the	F 42	25		

Facility ID: 923427

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		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		345369	B. WING				C 03/2015
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REF	HAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL ALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 425	Continued From pa Record.	ige 63	F4	125			
	at 1:34 PM with the Pharmacist. Upon inquiry, the pl discussed concerns controlled substance He reported address March 2015 (with the recently in July and DON. He recalled 2015 when he, " m acceptable to borro controlled substance A follow-up interview at 3:10 PM with the acknowledged she of "borrowed" narco medications), but d A telephone interview 4:04 PM with the As for the facility 's co this interview, the A reviewed the proce reordering controller residents. The Ass process involved fa hard copy of the sig received, the medic indicated the cut-of controlled substance 6:30 PM. Unless the as a STAT (urgent) would be received IPM. If the order for	ew was conducted on 9/2/2015 e facility 's Consultant harmacist reported he had is regarding the borrowing of ces with the DON in the past. Using the issue in February and he former DON), and most August 2015 with the current having an in-service in June hade it loud and clear it was not by medications, especially ces." w was conducted on 9/2/2015 e DON. At that time, the DON had been aware of the issues bits (controlled substance id not realize it was "that bad." ew was conducted on 9/2/15 at ssistant Pharmacy Manager intracted pharmacy. During wasistant Pharmacy Manager dures for ordering or ed substance medications for sistant Manager reported the axing the pharmacy a written or gned prescription. Once cation would be sent out. He f time for request of a ce for same-day delivery was he medication was requested medication, the medication by the facility around 10:00 r a medication was placed oharmacy phone would					

If continuation sheet Page 64 of 87

		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE Com	E SURVEY PLETED
		345369	B. WING				C 03/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REF	HAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425 F 431 SS=E	automatically roll ov service. This servic courier pick up the l and take it to a cont inquiry as to how lot before the medicati Realistically, maybe up to a couple of ho Manager also repor in-house Pyxis mac machine contained medications for em- to help meet the im Nurse #10 was no l and was not availab was the nurse ident signature on the Co having borrowed zo Resident #150 on 8 483.60(b), (d), (e) D LABEL/STORE DR The facility must em a licensed pharmac of records of receip controlled drugs in s accurate reconciliat records are in order controlled drugs is n reconciled. Drugs and biological labeled in accordan professional princip appropriate access	ver to an on-call pharmacy ce could arrange to have a hard copy of the prescription tracted retail pharmacy. Upon ng this process would take on was received, he stated, " a 1 and 1/2 hours or soand ours." The Assistant red the facility had an chine. He noted the Pyxis a stock of certain controlled ergency use and was intended mediate needs of a resident. onger employed by the facility ole for interview. Nurse #10 tified by the DON from his ontrolled Drug Record as olpidem from Resident #1 to 3/14/15. DRUG RECORDS, UGS & BIOLOGICALS nploy or obtain the services of cist who establishes a system at and disposition of all sufficient detail to enable an tion; and determines that drug r and that an account of all maintained and periodically	F 4	125			10/1/15

Facility ID: 923427

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		СОМІ	
		345369	B. WING _) 3/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REF	AB & NSG CARE CE	NTER		4 R			
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE
F 431	Continued From pa	ge 65	F 43	31			
	facility must store a locked compartmer	State and Federal laws, the Il drugs and biologicals in hts under proper temperature t only authorized personnel to keys.					
	permanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except wher package drug distri	ovide separately locked, I compartments for storage of red in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the inimal and a missing dose can					
	by: Based on observation interview, the facility established proceduc controlled substance sampled residents of receiving controlled as needed basis. 1a) Resident #252 8/27/14. A review of orders included the oxycodone (an opic one tablet by mouth Oxycodone is a cor A review of Resider Medication Adminis	NT is not met as evidenced ions, record review and staff y failed to consistently follow ures for the accounting of the medications for 2 of 4 (Resident #252, and #176) substances prescribed on an was admitted to the facility on f Resident #252 ' s medication following: 5 milligrams (mg) oid pain medication) given as n every 4 hours as needed. htrolled substance medication. ht #252 ' s August 2015 tration Record (MAR) e was administered to			 Resident's #252 and #176 experno untoward side effects as a result failure to follow procedures for the accounting of controlled substances. Both residents received their medicas prescribed. All residents have the potential to effected by not following proper procedures for the accounting of controlled substances. Nurses #11, and #15 were instructed on the prop procedures for accounting of control substances by the Clinical Educator 9/3/15, 9/22/15, and 9/9/15 respectives. Nurses #11,#12, and #15 along worker nurses will be inserviced by 10 by the Clinical Educator on the facili policy and procedure for Medication 	of the ations be #12, ber lled on vely. will all D/1/15 ty's	

Facility ID: 923427

PRINTED: 10/07/2015

STATEMEN [®]	OF DEFICIENCIES	KOMPANY KANA ANA ANA ANA ANA ANA ANA ANA ANA	```	IPLE CONSTRUCTION	(X3) DATE COM	0938-039 E SURVEY PLETED
		345369	B. WING _			C 03/2015
NAME OF	PROVIDER OR SUPPLIER	•	·	STREET ADDRESS, CITY, STATE, ZIP CODE		
REX RE	HAB & NSG CARE CE	NTER		4420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETIO DATE
F 431	Resident #252 on t On 8/5/15, nurse front of the MAR to medication was adu back of the MAR in 2:30 PM to indicate for pain. A review of the resi Record (a declining referred to as a Nai revealed 5 mg of or inventory for Reside month of August 20 dates/times: 8/5/15 at 2:15 PM 8/5/15 at 2:15 PM 8/5/15 at 10:30 PI 8/19/15 at 2:00 PI 8/26/15 at 1:00 PI 8/28/15 at 1:30 PI 8/28/15 at 1:30 PI An interview was co AM Nurse #11. Nu shift nurse assigned Upon request, the r employed for the ad as needed (PRN) n resident. Nurse #1 assessed and then dates/times of prior would be reviewed. medication would b cart and document the resident ' s Con medication was giv	he following date: ' s initials were placed on the designate the date the ministered to the resident; the cluded a note dated 8/5/15 at a 5 mg of oxycodone was given dent ' s Controlled Drug g inventory record which is also rcotic Sheet) for oxycodone xycodone was taken from the ent #252 six times during the 015 on the following M M M M M M M Donducted on 9/2/2015 at 10:27 rse #11 was the D Wing 1st d to care for Resident #252. nurse discussed the process dministration/documentation of harcotic medications to a 1 stated a resident would be the physician orders and the receipt of the medications . The nurse indicated the be pulled from the medication ed as having been pulled on htrolled Drug Record. After the en to the resident, its Id then be noted on both the	F 43	 Administration to include the prop procedure for documenting the administration of a controlled sub medication on the medication administration record (MAR) and Controlled Drug Record. The DON/Clinical Manager/RN Team will audit 5 MAR's and 5 Controlle Records per hall via the new "Na Documentation Audit" tool daily for week, then twice a week for eight to ensure controlled substance administration is documented on and controlled drug record per por procedure. Any discrepencies wi corrected at that time via one to o inservice education. The facility's QAPI Committee review the results of the Narcotic Documentation Audit tools in the QAPI Committee meeting to mon compliance for three months. Th consultant pharmacist will also m compliance for three months duri monthly consultant visits utilizing monthly consultant pharmacy rep notify the DON/Administrator of h findings during monthly exit meet 	stance Leader ed Drug rootic or one weeks the MAR licy and li be one will monthly itor for e onitor for ng his the ort and is	

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		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	TIPLE CONSTRUCTION		(X3) DATE COM	E SURVEY IPLETED
		345369	B. WING _				C 03/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
REX REI	HAB & NSG CARE CE	NTER		4420 LAKE BOONE TRAIL RALEIGH, NC 27607			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD	BE	(X5) COMPLETION DATE
F 431	An interview was co AM with the facility Upon review of Res Drug/Record and M there were inconsis records. Upon inqu facility 's procedure administration of a medication to a res would expect docur both the Controlled 's MAR. The DON for the medication a required on the fror preferable to also ir administration on th The DON identified pulled/administered his/her signature or and MAR. A follow-up interview at 11:55 AM with Ne DON. Nurse #11 w administering Resid 8/5/15 at 2:30 PM. as documenting its add the MAR (on 8/19/1 1:00 PM, and on 8/1 interview, the DON giving the oxycodor nurse stated she did no administration was #252 's MAR. She medication should I	bonducted on 9/2/2015 at 11:20 's Director of Nursing (DON). sident #252 's Controlled MAR, the DON acknowledged stencies between the two uiry, the DON outlined the es for documenting the controlled substance ident. The DON reported she mentation to be completed on Drug Record and the resident indicated the documentation administration was primarily to f the MAR, although it was nclude a notation of this ne back of the MAR as well.	F 43				

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	-	AND HUMAN SERVICES				FORM	APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP		ſ	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,		<u> </u>		PLETED
		345369	B. WING				C 03/2015
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
REX REI	HAB & NSG CARE CE	NTER			4420 LAKE BOONE TRAIL		
				F	RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	Continued From pa	ge 68	F 4	31			
	1:34 PM with the fa Pharmacist. Upon he expected docum substance medicati Controlled Drug Re taken from the med He indicated it was sign on the resident was administered to date the medication 1b) Resident #252 v 8/27/14. A review of medication orders in milligrams (mg) lora medication) given a	inquiry, the pharmacist stated nentation of a controlled ion to be completed on the cord when the medication was lication cart for the resident. also expected for the nurse to t 's MAR after the medication o the resident, indicating the n was given. was admitted to the facility on f Resident #252 's current ncluded the following: 0.5 azepam (an antianxiety as one tablet by mouth every 6 or anxiety. Lorazepam is a					
	Medication Adminis indicated lorazepan Resident #252 on th On 8/1/15, nurse ' front of the MAR to medication was adr back of the MAR ind 1:00 PM to indicate given for agitation. A review of the resid Record (a declining referred to as a Nar revealed 0.5 mg of inventory to be give	s initials were placed on the designate the date the ministered to the resident; the cluded a note dated 8/1/15 at 0.5 mg of lorazepam was dent 's Controlled Drug inventory record which is also rcotic Sheet) for lorazepam lorazepam was taken from the en to Resident #252 three onth of August 2015 on the					

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PRINTED: 10/07/2015

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345369	B. WING				C 03/2015
NAME OF	PROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
				44	420 LAKE BOONE TRAIL		
	HAB & NSG CARE CE	INTER		R	ALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	8/19/15 at 2:00 PI 8/26/15 at 1:00 PI 8/28/15 at 1:30 PI 8/28/15 at 1:30 PI An interview was co AM Nurse #11. Nu shift nurse assigned Upon request, the re employed for the ac as needed (PRN) no resident. Nurse #1 assessed and then dates/times of prior would be reviewed. medication would be cart and documented the resident ' s Con medication was giv administration would front and back of the An interview was co AM with the facility Upon review of Res Drug/Record and M there were inconsis records. Upon inque facility ' s procedure administration of a medication to a res would expect docum both the Controlled ' s MAR. The DON for the medication a required on the fror preferable to also in administration on the The DON identified	M M M M M M M M M M M M M M M M M M M	F 4	.31			

Facility ID: 923427

If continuation sheet Page 70 of 87

		AND HUMAN SERVICES				FORM	APPROVED
	TOF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUL	TIP	LE CONSTRUCTION		. 0938-0391 E SURVEY
-	OF CORRECTION	IDENTIFICATION NUMBER:	```				IPLETED
		345369	B. WING				C 103/2015
NAME OF I	PROVIDER OR SUPPLIER		T	ξ	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
REX REF	HAB & NSG CARE CE	NTER			4420 LAKE BOONE TRAIL		
				F	RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 431	Continued From pa	ae 70	F 4	131			
		h the Controlled Drug Record					
	A follow-up interview at 11:55 AM with Nu DON. Nurse #11 w administering Resid 8/1/15. This nurse documenting that R was pulled from the Drug Record withou administration to the 8/19/15 at 2:00 PM on 8/28/15 at 1:30 F DON inquired if Nur lorazepam to Resid she did and noted t particularly anxious indicated she did no administration was #252 ' s MAR. She medication should R given on the front a A telephone intervie 1:34 PM with the fa Pharmacist. Upon he expected docum substance medication He indicated it was sign on the resident was administered to date the medication 2) Resident #176 w 1/21/15. The reside	e resident on the MAR (on , on 8/26/15 at 1:00 PM, and PM). During the interview, the rse #11 recalled giving the lent #252. The nurse stated that the resident was on these dates. Nurse #11 ot know why the medication not documented on Resident e stated all doses of the have been documented as and back of the MAR. ew was conducted on 9/2/15 at ncility 's Consultant inquiry, the pharmacist stated nentation of a controlled ion to be completed on the ecord when the medication was dication cart for the resident. also expected for the nurse to t 's MAR after the medication the other resident, indicating the					

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PRINTED: 10/07/2015

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/07/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	СОМ	E SURVEY PLETED C
		345369	B. WING				。 03/2015
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
REX REF	IAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 431	antianxiety medicat mg) by mouth every anxiety (ordered 5/2 controlled substance A review of Resider Medication Adminis indicated lorazepan Resident #176 on th On 8/8/15, a chec of the MAR to desig was administered to MAR included a not 0.25 mg of lorazepa notation was not tim On 8/24/15, a nurs the front of the MAF administered to Res were placed on the administration. On 8/25/15, a nota back of the MAR to was given to the resid Record (a declining referred to as a Nar revealed 0.25 mg o inventory for Reside	ion) given as ½ tablet (0.25 / 6 hours as needed for 22/15). Lorazepam is a re medication. At #176 ' s August 2015 tration Record (MAR) n was administered to ne following dates: kmark was placed on the front ynate the date the medication to the resident; the back of the te dated 8/8/15 to indicate am was given for anxiety. The ned. se ' s initials were placed on R to indicate lorazepam was sident #176. No notations back of the MAR for this ation was made only on the indicate 0.25 mg lorazepam sident for anxiety. dent ' s Controlled Drug inventory record which is also rcotic Sheet) for lorazepam f lorazepam taken from the ent #176 nine times during the 15 on the following dates and	F 4	131			

Facility ID: 923427

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		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED	
		345369	B. WING				C 03/2015
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
REX REH	AB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
	AM Nurse #11. Nurse shift nurse assigned Upon request, the remployed for the actions to a remedications to a remedications to a remedications to a remedications to a remedication orders and receipt of the medication orders and receipt of the medication the medication the medication the medication the medication the medication the nurse indicated pulled from the medication the rest then be noted on both MAR. An interview was consistent was given to the rest then be noted on both the facility Upon review of Rest Drug/Record and N there were inconsistent of a medication to a rest would expect docur both the Controlled 's MAR. The DON for the medication arequired on the from preferable to also in administration on the The DON identified pulled/administered or the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of term of term of the term of term of the term of the term of term of term of term of the term of the term of the term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term of term	A onducted on 9/2/2015 at 10:27 rse #11 was the D Wing 1st d to care for Resident #176. hurse discussed the process dministration/documentation of ontrolled substance sident. Nurse #11 stated a assessed and then the d the dates/times of prior cations would be reviewed. d the medication would be dication cart and documented led on the resident ' s cord. After the medication sident, its administration would oth the front and back of the onducted on 9/2/2015 at 11:20 ' s Director of Nursing (DON). sident #176 ' s Controlled MAR, the DON acknowledged stencies between the two uiry, the DON outlined the es for documenting the controlled substance ident. The DON reported she mentation to be completed on Drug Record and the resident indicated the documentation administration was primarily t of the MAR, although it was helude a notation of this he back of the MAR as well.	F 4	131	DEFICIENCY)		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		345369	B. WING				C 03/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REF	IAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 431	Record and MAR.	-	F4	431			
	AM with Nurse #15 Nurse #15 was the documented that R was pulled on the C documenting its add 8/22/15 at 9:50 PM During the interview documentation of th needed to be comp Record, as well as MAR. Upon inquiry	onducted on 9/2/2015 at 11:50 in the presence of the DON. nurse identified as having esident #176 ' s lorazepam controlled Drug Record without ministration on the MAR (on and on 8/25/15 at 8:00 PM). V, Nurse #15 reported ne medication administration leted on the Controlled Drug on the front and back of the v, the nurse indicated she ed the administration of the					
	documented in all 3 A follow-up interview at 11:55 AM with Nu DON. Nurse #11 w having documented lorazepam was pull Record without doc the MAR (on 8/25/1 indicated she did no administration was #176 ' s MAR. She medication should I given on the front a A telephone intervie at 1:58 PM with Nu nurse identified as I Resident #176 ' s Io Controlled Drug Re administration on th on 8/23/15 at 9:00 /						

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345369	B. WING	i			C 03/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REF	IAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431 F 441 SS=D	documented on the they were removed required the medica documented on bot resident ' s MAR. V discrepancies of the #176 on 8/8/15, 8/2 stated, " That must A telephone intervie 1:34 PM with the fa Pharmacist. Upon he expected docum substance medicati Controlled Drug Re taken from the med He indicated it was sign on the resident was administered to date the medication 483.65 INFECTION SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and o to help prevent the of disease and infect (1) Investigates, con in the facility; (2) Decides what pr should be applied to	e medications needed to be Controlled Drug Record when for a resident; and, it was ation administration to be h the front and back of the Vhen asked about the e documentation with Resident 3/15 and 8/24/15, the nurse have been a mishap." wwas conducted on 9/2/15 at cility 's Consultant inquiry, the pharmacist stated tentation of a controlled on to be completed on the cord when the medication was lication cart for the resident. also expected for the nurse to t's MAR after the medication of the resident, indicating the twas given. I CONTROL, PREVENT tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction.		431			10/1/15

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		AND HUMAN SERVICES & MEDICAID SERVICES	PRINTED: 10/07/2 FORM APPROV OMB NO. 0938-03					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED C		
		345369	B. WING		09	/03/2015		
NAME OF	PROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
REX REI	HAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL RALEIGH, NC 27607			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
F 441	actions related to in (b) Preventing Spre (1) When the Infect determines that a re prevent the spread isolate the resident. (2) The facility mus communicable dise from direct contact direct contact will tr (3) The facility mus hands after each di hand washing is inc professional practic (c) Linens Personnel must han	fections. ead of Infection ion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ase or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their rect resident contact for which dicated by accepted	F 4	141				
	by: Based on observat and staff interviews infection control pro of infection during t wound treatment fo #252) reviewed for Findings included: Observation was m wound treatment pr right and left pressu treatment nurse. O wound treatment we the physician. The	NT is not met as evidenced ion, record review, resident , the facility failed to follow ocedures to prevent the spread he provision of pressure ulcer r 1 of 1 resident (Resident wound care. ade on 9/02/15 at 9:15 AM of rovided to Resident #252 ' s ure ulcers by the facility Observation revealed the as administered as ordered by right outer ankle dressing was ft outer ankle dressing was			 Resident #252 has suffered no untoward side effects from the improper procedures to prevent infection during the observed wound treatment. All residents with wounds are at risk for infection from not following the proper procedures for infection control during wound treatments. The Wound Treatment Nurse was given a one to one inservice by the Clinical Educator on the proper procedures for infection control during wound treatment upon notification by the surveyor of the error. The Wound Treatment Nurse and all 			

Facility ID: 923427

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED	
	ST CORRECTION	IDENTIFICATION NONDER.	A. BUILDING	3		C	
		345369	B. WING		09/	09/03/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
REX REI	HAB & NSG CARE CE	NTER		4420 LAKE BOONE TRAIL RALEIGH, NC 27607			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE	
F 441	saline from a newly sterile gauze, Santy a cotton tipped applicator wa medicine cup conta dated dry gauze dra cover the right ankl lifted using clean gl cleaned with norma and blotted dry usir ointment was applie applicator swab tha cup after use on the wound. An interview was co with the infection co pointed out to the tr replaced a contami the Santyl Ointmen same cotton applica- to two separate wo nervous. I should h applicators to apply should not have pla applicator back into cup which was inter wound. " An interview was co AM with the Director revealed her expect that she provide wo nursing practice inf facility policy for infw was not satisfied w provided by the wo further stated that in	age 76 und was cleansed with normal opened bottle, blotted dry with of ointment was applied using licator (it was noted the cotton as placed back into the aining the Santyl ointment), a ressing was applied securely to e wound. The left ankle was oved hands. The wound was al saline using sterile gauze og sterile gauze. Santyl ed using the same cotton at had been left in the medicine e resident 's right ankle onducted on 9/02/15 at 9:25 ontrol nurse. When it was reatment nurse that she had nated cotton applicator into t medicine cup and used the ator to apply Santyl Ointment unds she responded: " I was nave used two separate of the Santyl Ointment and I aced the contaminated of the Santyl Ointment medicine nded to be used on a separate of Nursing (DON) which tation of the treatment nurse is ound treatment according to ection control. She stated she ith the wound treatment und reatment nurse. She n June, 2015 she had hired a Control nurse to oversee all	F 44	 other nurses will be inserviced by Clinical Educator on the proper procedures for infection control a following aseptic technique when providing wound treatments. Ne will be inserviced as well. The C Educator will observe the treatment providing one wound treatment p for four weeks to ensure the propi infection control procedures cont be followed. The Clinical Educat Team Leader will randomly audit other nurses providing wound treatment clinical Educator/RN Team Lead utilize the newly created "Dressin Change Competency Audit Tool" wound treatment audits. The Clinical Educator will reinservice as need findings of improper procedures followed. 4. The facility's QAPI Committee review the results of the wound treatment audits during the monthly QAPI Committee meetings to monitor for compliance. 	nd w nurses linical ent nurse er week ber inue to or/RN three atments oroper being ts. The er will g for nical ed upon being e will reatment		

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		AND HUMAN SERVICES & MEDICAID SERVICES		FORI	D: 10/07/2015 M APPROVED D. 0938-0391				
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED				
		345369	B. WING	0	C 9/03/2015				
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						
REX REF	IAB & NSG CARE CE	NTER	4420 LAKE BOONE TRAIL RALEIGH, NC 27607						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC 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 441	AM with the Certifie She stated it was he treatment nurse pro- according to profess infection control and control nurse provid meet these standar 483.75(I)(1) RES RECORDS-COMPILE The facility must ma- resident in accorda standards and prac- accurately document systematically orga The clinical record n information to ident resident's assessm services provided; to preadmission screet and progress notes This REQUIREMENT by: Based on observation interview, the facility procedures for the documentation of the medications on the Records and Controls	onducted on 9/02/15 at 11:10 ad Infection Control Nurse. er expectation that the wound ovide wound treatment sional nursing standards for d the facility policy for infection the care that the infection ded to Resident #252 did not ds. LETE/ACCURATE/ACCESSIB aintain clinical records on each nce with accepted professional tices that are complete; nted; readily accessible; and nized. must contain sufficient ify the resident; a record of the ents; the plan of care and the results of any ening conducted by the State;	F 44	1					

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	-	AND HUMAN SERVICES			FORM	10/07/201 APPROVE 0938-039
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	()	PLE CONSTRUCTION G	(X3) DATE COM	E SURVEY PLETED
		345369	B. WING _			C 03/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
REX REF	IAB & NSG CARE CE	NTER		4420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIOI DATE
F 514	Continued From pa	ige 78	F 51	4		
	Medication Adminis January 2013) inclu Documentation, wh "Controlled Su 1. More documer dose given - MAR, count and documer A review of Resider Record (a declining known as a Narcoti milligrams (mg) oxy medication) were re cart for Resident #2 August, 2015. A do documented as ren Resident #252 on e dates/times: 8/5/15 PM; 8/5/15 at 10:30 8/26/15 at 1:00 PM Documentation on Medication Adminis indicated 5 mg oxy the resident one tim	facility ' s policy on " stration Guidelines " (revised uded a section titled, iich read, in part: bstances: ntation is required for each Declining Inventory sheet, shift		procedures for the documentation controlled substances on the mediadministration records and control records. Nurses #11,#12, and #1 instructed on the proper procedur documentation of the controlled substances on the medication administration records and control records by the Clinical Educator of 9/3/15, 9/22/15, and 9/9/15 respe 3. Nurses #11,#12, and #15 alon other nurses and new hire nurses inserviced by the Clinical Educator facility's policy and procedure for Medication Administration to inclu proper procedures for documenti administration of a controlled sub medication on the medication administration record (MAR) and controlled drug record. All inserv be completed by 10/1/15. The DON/Clinical Manager/RN Team will conduct a random audit of 5 N and 5 Controlled Drug Records p via the new "Narcotic Documenta Audit" tool daily for one week, the week for eight weeks to ensure c substance administration is docu on the MAR and controlled drug r per policy and procedure. Any	dication bled drug 5 were res for bled drug on actively. Ig with all s will be or on the ude the ng the stance ices will Leader MAR's er hall ttion en twice a ontrolled mented	
	PM. An interview was co AM Nurse #11. Nu shift nurse assigned Upon request, the r employed for the ac	e resident on 8/5/15 at 2:30 onducted on 9/2/2015 at 10:27 rse #11 was the D Wing 1st d to care for Resident #252. nurse discussed the process dministration/documentation of parcotic medications to a		discrepancies will be corrected at time via one to one inservice edu 4. The facility's QAPI Committee review the results of the Narcotic Documentation Audit tools in the QAPI Committee meeting to mon compliance for three months. Th consultant pharmacist will also m compliance for three months duri	cation. will monthly itor for le onitor for	

Facility ID: 923427

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STATEMEN	T OF DEFICIENCIES DF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DAT	. 0938-039 E SURVEY PLETED	
			A. BUILDIN	G		С	
		345369		STREET ADDRESS, CITY, STATE, ZIP CODE	09/03/2015		
	PROVIDER OR SUPPLIER	INTER		4420 LAKE BOONE TRAIL RALEIGH, NC 27607			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
F 514	resident. Nurse #1 assessed and then dates/times of prior would be reviewed, medication would be cart and document the resident 's Cor medication was giv administration wou front and back of th An interview was co AM with the facility Upon review of Res Drug/Record and N there were inconsis records. Upon inque facility 's procedure administration of a medication to a res would expect docut both the Controlled 's MAR. The DON for the medication a required on the from preferable to also in administration on the The DON identified pulled/administered his/her signature of and MAR. A follow-up intervie at 11:55 AM with N DON. Nurse #11 w administering Resid 8/5/15 at 2:30 PM. as documenting Resident	1 stated a resident would be the physician orders and the receipt of the medications . The nurse indicated the be pulled from the medication ed as having been pulled on ntrolled Drug Record. After the ren to the resident, its ld then be noted on both the ne MAR. onducted on 9/2/2015 at 11:20 's Director of Nursing (DON). sident #252 's Controlled /AR, the DON acknowledged stencies between the two uiry, the DON outlined the es for documenting the controlled substance sident. The DON reported she mentation to be completed on I Drug Record and the resident I indicated the documentation administration was primarily nt of the MAR, although it was nclude a notation of this he back of the MAR as well.	F 51	4 monthly consultant visits utilizin Monthly Consultant Pharmacisi Report and notify the DON/Adm of his findings during monthly e meetings.	Activity		

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	MENT OF HEALTH		FORM APPROVED OMB NO. 0938-0391				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mul A. Build		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345369	B. WING			C 09/03/2015	
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	AB & NSG CARE CE	NTER		4	4420 LAKE BOONE TRAIL		
				I	RALEIGH, NC 27607		
(X4) ID PREFIX TAG			ID PREF TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 514	the MAR (on 8/19/1 1:00 PM, and on 8/2 interview, the DON giving the oxycodor nurse stated she did indicated she did no administration was #252 ' s MAR. She medication should H given on the front a A telephone intervie 1:34 PM with the fa Pharmacist. Upon he expected docum substance medicati Controlled Drug Re taken from the medication He indicated it was sign on the resident was administered to date the medication 1b) A review of the Medication Adminis January 2013) inclu Documentation, wh "Controlled Su 1. More documer dose given - MAR, count and documer A review of Resider Record (a declining known as a Narcoti 0.5 milligrams (mg) medication) were re	ministration to the resident on 5 at 2:00 PM, on 8/26/15 at 28/15 at 1:30 PM). During the inquired if Nurse #11 recalled be to Resident #252. The d. However, Nurse #11 of know why the medication not documented on Resident stated all doses of the have been documented as nd back of the MAR. wwas conducted on 9/2/15 at cility's Consultant inquiry, the pharmacist stated bentation of a controlled on to be completed on the cord when the medication was lication cart for the resident. also expected for the nurse to t's MAR after the medication of the resident, indicating the n was given. facility's policy on " tration Guidelines " (revised ided a section titled, ich read, in part: bstances: nation is required for each Declining Inventory sheet, shift nation. " ht #252 's Controlled Drug inventory record which is also c Log) revealed three doses of lorazepam (an antianxiety emoved from the medication	F	514			
	medication) were re						

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345369	B. WING			C 09/03/2015	
NAME OF F	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REF	HAB & NSG CARE CE	INTER			420 LAKE BOONE TRAIL ALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 514	August, 2015 on ea dates/times: 8/19/1 PM; and, 8/28/15 a Documentation on Medication Adminis indicated 0.5 mg lot the resident one tim According to the M administered to the PM. An interview was co AM Nurse #11. Nu shift nurse assigned Upon request, the r employed for the ac as needed (PRN) n resident. Nurse #11 assessed and then dates/times of prior would be reviewed. medication would b cart and documente the resident ' s Con medication was giv administration woul front and back of th An interview was co AM with the facility Upon review of Res Drug/Record and M there were inconsis records. Upon inqu facility ' s procedure administration of a medication to a res	ach of the following 15 at 2:00 PM; 8/26/15 at 1:00 t 1:30 PM. Resident #252 ' s August 2015 stration Record (MAR) razepam was administered to ne during the month. AR, a dose of lorazepam was e resident on 8/1/15 at 1:00 onducted on 9/2/2015 at 10:27 rrse #11 was the D Wing 1st d to care for Resident #252. nurse discussed the process dministration/documentation of harcotic medications to a 1 stated a resident would be the physician orders and the r receipt of the medications . The nurse indicated the be pulled from the medication ed as having been pulled on htrolled Drug Record. After the ren to the resident, its Id then be noted on both the	F 5	14			

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		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345369	B. WING				C 03/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REF	HAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL ALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 514	both the Controlled 's MAR. The DON for the medication a required on the from preferable to also in administration on th The DON identified pulled/administered his/her signature or and MAR. A follow-up interview at 11:55 AM with Ne DON. Nurse #11 w administering Resid 8/1/15. This nurse documenting that R was pulled on the C documenting its add the MAR (on 8/19/1 1:00 PM, and on 8/2 interview, the DON giving the lorazepar nurse stated she di was particularly any #11 indicated she d medication adminis on Resident #252 ' of the medication sh as given on the from A telephone interviet 1:34 PM with the fa Pharmacist. Upon he expected docum substance medication	Drug Record and the resident indicated the documentation administration was primarily and of the MAR, although it was include a notation of this the back of the MAR as well. I the nurses who d the resident 's medication by in the Controlled Drug Record w was conducted on 9/2/2015 urse #11 in the presence of the vas the nurse identified as dent #252 's lorazepam on was also identified as Resident #252 's lorazepam Controlled Drug Record without ministration to the resident on 15 at 2:00 PM, on 8/26/15 at 28/15 at 1:30 PM). During the inquired if Nurse #11 recalled m to Resident #252. The d and noted that the resident kious on these dates. Nurse lid not know why the stration was not documented s MAR. She stated all doses hould have been documented and back of the MAR.	F 5	514			

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		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345369	B. WING			C 09/03/2015	
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REI	HAB & NSG CARE CE	NTER			420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 514	sign on the residen was administered to date the medication 2) A review of the f Medication Adminis January 2013) inclu Documentation, wh "Controlled Su 1. More documer dose given - MAR, count and documer A review of Resider Record (a declining known as a Narcoti 0.25 milligrams (mg medication) were re (med) cart for Resid August, 2015 on ea dates/times: 8/8/15 PM; 8/22/15 at 9:50 8/23/15 at 9:00 PM at 9:00 PM; 8/25/15 8:00 PM. Documentation on Medication Adminis indicated 0.25 mg la the resident three to According to the Ma administered to the notation was not tim was not timed); and made on the back of Am interview was co AM Nurse #11. Nu	t 's MAR after the medication o the resident, indicating the n was given. facility 's policy on " stration Guidelines " (revised uded a section titled, nich read, in part: bstances: ntation is required for each Declining Inventory sheet, shift ntation. " ht #176 's Controlled Drug g inventory record which is also ic Log) revealed nine doses of g) lorazepam (an antianxiety emoved from the medication dent #176 during the month of ach of the following 5 at 9:00 AM; 8/8/15 at 4:00 0 PM; 8/23/15 at 9:00 AM; ; 8/24/15 at 12:00 PM; 8/24/15 5 at 8:00 AM; and, 8/25/15 at Resident #176 's August 2015 stration Record (MAR) orazepam was administered to imes during the month. AR, a dose of lorazepam was a resident on 8/8/15 (the ned); 8/24/15 (the notation d, 8/25/15 (a notation was		514			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FC CENTERS FOR MEDICARE & MEDICAID SERVICES OMB								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		PLE CONSTRUCTION	MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION		DENTIFICATION NOMBER.	A. BUILDI		3	C		
		345369	345369 B. WING 09/03/2		03/2015			
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
REX REH	IAB & NSG CARE CE	NTER			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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	(X5) COMPLETION DATE		
F 514	HAB & NSG CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 5	514				

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PRINTED: 10/07/2015

	RINTED: 10/07/2015 FORM APPROVED MB NO. 0938-0391								
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,			(X3) DATE SURVEY COMPLETED				
345369		B. WING	i		C 09/03/2015				
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE				
REX REF	HAB & NSG CARE CE	NTER	4420 LAKE BOONE TRAIL RALEIGH, NC 27607						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE		
F 514	was pulled on the C documenting its adi 8/22/15 at 9:50 PM Nurse #15 reported medication adminis completed on the C as on the front and inquiry, the nurse in expected the admir substance medicati places. A follow-up interview at 11:55 AM with Nu DON. Nurse #11 w having documented lorazepam was pull Record without doc the MAR (on 8/25/1 indicated she did no administration was #176's MAR. She medication should I given on the front a A telephone intervie at 1:58 PM with Nu nurse identified as I Resident #176's Ic Controlled Drug Re administration on th on 8/23/15 at 9:00 / PM). During the int narcotic medication on the Controlled D removed for a resid medication adminis both the front and b	age 85 Controlled Drug Record without ministration on the MAR (on and on 8/25/15 at 8:00 PM). I documentation of the stration needed to be Controlled Drug Record, as well back of the MAR. Upon indicated she would have histration of the controlled ion to be documented in all 3 w was conducted on 9/2/2015 urse #11 in the presence of the vas the nurse identified as d that Resident #176 ' s led on the Controlled Drug sumenting its administration on 5 at 8:00 AM). Nurse #11 of know why the medication not documented on Resident e stated all doses of the have been documented as and back of the MAR. Ew was conducted on 9/2/2015 rse #12. Nurse #12 was the having documented that orazepam was pulled on the scord without documenting its he MAR (on 8/8/15 at 9:00 AM, AM, and on 8/24/15 at 9:00 terview, the nurse indicated as needed to be documented rug Record when they were lent; and, it was required the stration be documented on back of the resident ' s MAR. the discrepancies of the		514					

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		AND HUMAN SERVICES				FORM	10/07/2015 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
	345369		B. WING	;		C 09/03/2015		
NAME OF F	PROVIDER OR SUPPLIER		-		STREET ADDRESS, CITY, STATE, ZIP CODE			
REX REF	HAB & NSG CARE CE	NTER	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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 514	on 8/8/15, 8/23/15 a "That must have be A telephone intervite 1:34 PM with the fa Pharmacist. Upon he expected docum substance medicati Controlled Drug Re taken from the med He indicated it was sign on the residen	A Resident #176 ' s lorazepam and 8/24/15, the nurse stated, een a mishap." We was conducted on 9/2/15 at acility ' s Consultant inquiry, the pharmacist stated nentation of a controlled ion to be completed on the cord when the medication was dication cart for the resident. also expected for the nurse to t ' s MAR after the medication o the resident, indicating the	F	514				

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