STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345369	A. BUILDING _____ B. WING _____	C 04/29/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based upon record review and resident, staff and physician interviews, the facility failed to notify the physician immediately after a fall for one of three	F 157	1. As noted, Resident #1's physician was notified of the residents' fall at 5:40 PM on 4/21/16. As noted, AC#1 and AC#2 had	5/27/16

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

Electronically Signed | 05/13/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345369	A. BUILDING _____ B. WING _____	C 04/29/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1 residents reviewed for falls with injury, Resident #1. Findings included: A review of the quarterly assessment dated 02/23/2016 revealed Resident #1 was cognitively intact and had a partial list of diagnoses which included anemia, heart failure, hypertension, chronic obstructive pulmonary disease, and rheumatoid arthritis. The same quarterly assessment also indicated Resident #1 had no complaint of pain and received no scheduled pain medications. A review of the nursing care plan last updated on 02/23/16 revealed Resident #1 had a goal and interventions in place to address her risk for falls due to her history of falls. The goal included on the care plan was to minimize risk of injury from falls over the next 90 days. On 04/26/16 at 4:30 PM, Resident #1 was observed resting in bed with the head of the bed elevated wearing a black boot on her right lower leg. In an interview with Resident #1 at the time of the observation, Resident #1 explained she had injured her right foot and ankle on 04/21/16 when she fell when she was transferring from her wheelchair to the facility bus seat during an activity outing. Resident #1 stated one of the activity coordinators was assisting her with the transfer, but she felt her own knees "buckle up," as she slowly fell on the floor of the bus. Resident #1 stated her right knee and ankle were very painful, but she did not report her pain to the activities coordinators. Resident #1 stated she was seen on 04/25/16 by the orthopedic specialist who told her she would need to wear the boot on her right lower leg and ankle for about a month. A nurse's progress note dated 04/21/16 at 5:45 PM documented that Resident #1 reported to the nurse she had fallen during an outing on the	F 157	been provided with in-service education about reporting falls/incidents. 2. Physicians will be notified immediately after a fall for all residents as required and as per facility policy. A chart review of all residents who have had a fall in the last 30 days will be conducted by the DON/Clinical Manager by 5/20/16 to ensure physicians have been notified of the fall. The physician will be immediately notified of any findings of non-compliance. 3. All staff will be inserviced by the Clinical Educator/Clinical Manager/DON on the facility Fall Prevention Program including the requirement that the physician must be immediately notified after a fall by 5/27/16. All new hires will be inserviced upon hire by the Clinical Educator on the facility Fall Prevention Program. The facility has created a new Recreational Outings Safety Policy for resident outings which includes actions to be taken during an emergency on outings including notifying a nurse immediately should a resident require emergency medical attention. AC#1 and AC#2 will be inserviced on the new policy by the Clincal Educator by 5/20/16. All new AC's will be inserviced upon hire by the Clinical Educator. Any other employee who participates on outings will be inserviced by the Clinical Educator prior to going on the outing. 4. The DON/Clinical Manager will review the 24 hour report and the facility Variance Reports Monday through Friday (5 days per week) in the clinical meeting for one month and monitor for notification of the physician after a fall. The weekend RN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345369	A. BUILDING _____ B. WING _____	C 04/29/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 2 activity bus during a transfer and that she had twisted her right ankle. The writer of the note documented that two activity coordinators confirmed the Resident #1 had fallen on the floor in the bus while transferring her from the bus chair to her wheelchair. The writer further documented that upon her return to the facility, Resident #1 was assisted to her bed and was assessed by the nurse. The same nurse's note documented there was some bruising and swelling to Resident #1's right ankle, that the nurse then notified her physician at 5:40 PM and received new orders for x-rays to the right ankle, right knee, and left shoulder. The writer of the note indicated an attempt was made to call the resident ' s daughter at 5:45 PM, and that the resident ' s son was notified at 5:49 PM. In an interview conducted with one of the activities coordinators (AC) #1 on 04/27/16 at 11:50 AM, she explained that she and the other activity coordinator, AC #2, were assisting residents onto the activity bus to travel to an out-of-town music festival on the morning of 04/21/16. AC #1 explained Resident #1 fell when she (AC #1) was assisting Resident #1 to transfer from her wheelchair to the bus seat. AC #1 stated she immediately called out for AC #2 to come provide assistance as Resident #1 fell, and that AC #2 came and lifted Resident #1 off the bus floor and into the seat. AC #1 stated she asked Resident #1 if she wanted to stay on the bus to go on the outing, or if she would like to get off the bus to stay at the facility. AC #1 stated Resident #1 replied she would prefer to stay on the bus and go to the music festival. AC #1 also stated Resident #1 reported she was "okay" after the fall and that she did not complain of any pain until after they returned from the music festival around 5:30 PM the same day. AC #1 stated she	F 157	Team Leader will monitor those reports on the weekends (Saturday and Sunday) for one month to monitor for notification of the physician after a fall. A chart review will be conducted by the DON/Clinical Manager/RN Team Leader to confirm documentation in the nurses notes regarding physician notification of any fall. The chart reviews will be done 7 days per week by the DON/Clinical Manager/RN Team Leader for one month. All findings of non-compliance will be immediately corrected via physician notification and follow up inservice education or disciplinary action. The facility Quality Assurance and Performance Improvement Committee (QAPI) will review the falls data and chart audit findings in the monthly QAPI Committee meetings for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345369	A. BUILDING _____ B. WING _____	C 04/29/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 3	F 157		

did not think to call into the facility right after the incident to report Resident #1 had fallen. She also stated Resident #1 was cognitively intact and capable of making her own decisions about her care.
AC #2 stated in an interview on 04/27/16 at 12:12 PM that he observed Resident #1 down on the bus floor when he responded to AC #1's call for help. AC #2 explained Resident #1's weight was resting primarily on the heels of her feet while when he saw her, and that she yelled out, "My foot!" AC #2 also stated he lifted Resident #1 off the bus floor and onto the seat, then asked her if she was okay. AC #2 stated Resident #1 replied she was okay and that she wanted to stay on the bus to go on the outing. AC #2 stated he did not report the fall to anyone in the facility at that time.

In an interview on 04/27/16 at 1:00 PM with the nurse who was on duty when Resident #1 returned to the facility after the bus outing, Nurse #1, stated she was completely unaware the resident had fallen. Nurse #1 explained the resident reported to her upon return to the facility at about 5:30 PM on 04/21/16 she had fallen and twisted her ankle while she was on the outing. Nurse #1 stated at first, she thought Resident #1 had fallen on her way back into the facility after the out-of-town outing, but then learned from the activities coordinators she had fallen when she was boarding the bus before it left the facility for the outing. Nurse #1 stated she immediately assessed Resident #1, then called the physician to report the incident and her assessment findings. Nurse #1 added that she called her son and daughter right after she notified the physician. Nurse #1 stated she called her physician a second time after Resident #1 reported she needed something stronger than

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345369	A. BUILDING _____ B. WING _____	C 04/29/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 4	F 157		

acetaminophen (Tylenol) for her pain. Nurse #1 stated the policy for reporting a resident fall was to report it immediately so that a nursing assessment could take place. Nurse #1 added that the nurse should call the physician immediately after assessing the resident to receive any necessary orders.
A review of physician's telephone orders dated 04/21/16 and 04/22/16:
04/21/16: X-ray right ankle and right knee and left shoulder, complaint of pain
04/21/16: Norco (hydrocodone) 5 milligram/325 milligram, one tablet by mouth every 6 hours as needed for pain.
04/22/16: Transfer to [hospital] for x-ray of right knee, right ankle, foot full
04/22/16: Schedule appointment with orthopedic specialist follow/up right ankle

In an interview with the orthopedic physician on 04/27/16 at 3:29 PM, he confirmed he had been consulted to see Resident #1 status post a fall on 04/21/16. The orthopedic physician stated Resident #1's x-ray results revealed an old fibula fracture and a new non-displaced medial malleolar fracture. He stated Resident #1 would need to wear a specialized boot at all times for the next 6 weeks to maintain alignment of her ankle and that she should remain "non-weight bearing" until that time.

In an interview with the Director of Nursing (DON) on 04/27/16 at 4:00 PM, she stated that Resident #1's fall should have been reported immediately after the fall so that a nurse could assess the resident at that time, report her findings to the physician, and receive orders for diagnostic tests and treatment. The DON stated the nurse was not able to complete an assessment at the time

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345369	A. BUILDING _____ B. WING _____	C 04/29/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 5 of the fall because the activity staff did not report the fall until after the residents returned from the outing around 5:30 PM. In an interview with the Administrator and DON on 04/28/16 at 5:00 PM, the Administrator stated the facility had identified the staff's failure to report Resident #1's fall as a problem. The Administrator stated the activity bus was still on the facility grounds when the fall occurred, and that the facility was responsible for her care. The Administrator also stated the two recreation/activities coordinators had been provided with in-service education about reporting falls/incidents, and that Resident #1's nursing care plan had been updated with an intervention for her to remain in her wheelchair for all outings. The Administrator added that there is a rough outline for a plan of correction to address reporting of fall/accidents, but that it was not yet complete. An interview was conducted with Resident #1's primary physician on 04/29/16 at 2:10 PM. The primary physician stated that he would have expected to receive notification of Resident #1's fall immediately after her fall so that he could have provided orders for treatment at that time rather than five or six hours later when she returned to the facility.	F 157		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309		5/27/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345369	A. BUILDING _____ B. WING _____	C 04/29/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 6 and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff, and physician interviews, the facility failed to provide a nursing assessment immediately after a fall for one of three residents reviewed for accidents with injury, Resident # 1. Findings included: A review of the quarterly assessment dated 02/23/2016 revealed Resident #1 was cognitively intact and had a partial list of diagnoses which included anemia, heart failure, hypertension, chronic obstructive pulmonary disease, and rheumatoid arthritis. The same quarterly assessment also indicated Resident #1 had no complaint of pain and received no scheduled pain medications. A review of the nursing care plan last updated on 02/23/16 revealed Resident #1 had a goal and interventions in place to address her risk for falls due to her history of falls. The goal included on the care plan was to minimize risk of injury from falls over the next 90 days. On 04/26/16 at 4:30 PM, Resident #1 was observed resting in bed with the head of the bed elevated wearing a black boot on her right lower leg. In an interview with Resident #1 at the time of the observation, Resident #1 explained she had injured her right foot and ankle on 04/21/16 when she fell when she was transferring from her wheelchair to the facility bus seat during an activity outing. Resident #1 stated one of the activity coordinators was assisting her with the transfer, but she felt her own knees "buckle up,"	F 309	1. As noted, Nurse #1 immediately assessed Resident #1 upon return to the facility. The physician was also notified and follow up treatment orders were given and carried out. 2. All residents will be provided with a nursing assessment immediately after a fall. A chart review of all residents who have had a fall in the last 30 days will be conducted by the DON/Clinical Manager by 5/20/16 to ensure a nursing assessment was provided immediately after the fall. Any findings of non-compliance will be corrected via a nusing assessment being provided and inservice education. 3. All staff will be inserviced by the Clinical Educator/Clinical Manager/DON on the facility Fall Prevention Program including the requirement that a nursing assessment must be provided immediately after a fall by 5/27/16. All new hires will be inserviced upon hire by the Clinical Educator on the facility Fall Prevention Program. 4. The DON/Clinical Manager will review the 24 hour report and the facility Variance Reports Monday through Friday (5 days per week) in the clinical meeting for one month to monitor for a nursing assessment being provided immediately after a fall. The weekend RN Team Leader will monitor those reports on the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345369	A. BUILDING _____ B. WING _____	C 04/29/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 7 as she slowly fell on the floor of the bus. Resident #1 stated her right knee and ankle were very painful, but she did not report her pain to the activities coordinators at that time. She explained she did not want to "hold up everyone else" who was planning to attend the outing, so she told the activities coordinators she was okay. Resident #1 stated she was seen on 04/25/16 by the orthopedic specialist who told her she would need to wear the boot on her right lower leg and ankle for about a month. A nurse's progress note dated 04/21/16 documented that Resident #1 returned to the facility after an activities outing and that Resident #1 reported she had fallen in the activity bus and had twisted her ankle. The writer further documented that two activity coordinators confirmed that Resident #1 had fallen on the floor of the bus while transferring her from the bus chair to her wheelchair. The note also indicated Resident #1 was assisted to her bed and was assessed by the nurse upon return to the facility. According to the same nurse's progress note, there was some bruising and swelling to Resident #1's right ankle, and the nurse notified her physician and received new orders for x-rays to the right ankle, left knee, and right shoulder. The writer of the note indicated an attempt was made to call the resident ' s daughter at 5:45 PM, and that the resident's son was notified at 5:49 PM. The nurse's progress note was signed by Nurse #1. A review of physician orders revealed the following telephone orders on 04/21/16 and 04/22/16: 04/21/16: X-ray right ankle and right knee and left shoulder, complaint of pain 04/21/16: Norco (hydrocodone) 5 milligram/325 milligram, one tablet by mouth every 6 hours as	F 309	weekends (Saturday and Sunday) for one month to monitor for a nursing assessment being provided immediately after a fall. A chart review will be conducted by the DON/Clinical Manager/RN Team Leader to confirm documentation in the nurses notes regarding a nursing assessment being provided immediately after the fall. The chart reviews will be done 7 days a week by the DON/Clinical Manager/RN Team Leader for one month. All findings of non-compliance will be immediately corrected via a nursing assessment being provided and follow up inservice education and/or disciplinary action. The facility Quality Assurance and Performance Improvement Committee (QAPI) will review the falls data and chart audit findings in the monthly QAPI Committee meetings for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345369	A. BUILDING _____ B. WING _____	C 04/29/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 8	F 309		

needed for pain.
04/22/16: Transfer to [hospital] for x-ray of right knee, right ankle, foot full
04/22/16: Schedule appointment with orthopedic specialist follow/up right ankle

In an interview conducted with one of the activity coordinators (AC) #1 on 04/27/16 at 11:50 AM, she stated Resident #1 fell during a transfer from her wheelchair to the activity bus seat when she was preparing to go on an out-of-town outing on 04/21/16 at about 11:30 AM. AC #1 explained Resident #1 was secured in her wheelchair on the bus's lift and was elevated to the bus door level via the hydraulic lift per standard procedure. AC #1 stated Resident #1 was then wheeled onto the bus where her wheelchair was locked next to the bus seat. AC #1 stated Resident #1 grasped around her body per her instruction, then she (AC #1) lifted Resident #1 under her arms to transfer her to the bus seat. AC #1 stated she felt Resident #1 start to lose her grasp around her body, and that she slid down to the floor of the bus as she (AC #1) was supporting her. AC #1 stated she immediately called for assistance from the other activities coordinator (AC #2), who came and lifted Resident #1 off the floor and onto the bus seat. AC #1 stated she had never had any problem with assisting Resident #1 using this method during transfers in the past. AC #1 stated she asked Resident #1 if she was okay after the fall and if she wanted to remain at the facility, but Resident #1 replied she was okay and preferred to stay on the bus to continue on the outing. AC #1 explained she did not think about getting a nurse to assess her before the bus left the facility to go out of town. AC #1 added that she checked on Resident #1 throughout the trip, and that Resident #1 never complained of any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345369	A. BUILDING _____ B. WING _____	C 04/29/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 9	F 309		

pain until they returned to the facility between 5:00 PM and 5:30 PM.

AC #2 stated in an interview on 04/27/16 at 12:12 PM that he observed Resident #1 down on the bus floor when he responded to AC #1's call for help. AC #2 explained Resident #1's weight was resting primarily on the heels of her feet while when he saw her, and that she yelled out, "My foot!" AC #2 also stated he lifted Resident #1 off the bus floor and onto the seat, then asked her if she was okay. AC #2 stated Resident #1 replied she was okay and that she wanted to stay on the bus to go on the outing. AC #2 stated he did not notify anyone in the facility of the fall until the residents returned from their outing late in the afternoon.

In an interview on 04/27/16 at 1:00 PM with the nurse who was on duty when Resident #1 returned to the facility after the bus outing, Nurse #1, she stated she was completely unaware the resident had fallen. Nurse #1 explained Resident #1 reported to her upon return to the facility at about 5:30 PM on 04/21/16 she had fallen and twisted her ankle while she was on the outing. Nurse #1 stated she thought Resident #1 had fallen on her way back into the facility after the out-of-town outing, but then learned from the activities coordinators she had fallen when she was boarding the bus before the outing while the bus was still at the facility. Nurse #1 stated she immediately assessed Resident #1, then called the physician to report the incident and assessment findings. She added that she called her son and daughter right after she notified the physician. Nurse #1 stated she called her physician a second time after Resident #1 reported she needed something stronger than

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345369	A. BUILDING _____ B. WING _____	C 04/29/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 10	F 309		

acetaminophen (Tylenol) for her pain. Nurse #1 stated the policy for reporting a resident fall was to report it immediately so that a nursing assessment could take place. Nurse #1 added that the nurse should call the physician immediately after assessing the resident to receive any necessary orders.
An orthopedic physician progress note (no date on note) revealed Resident #1 had a new medial malleolar (inner ankle) fracture, nondisplaced, and that the plan was for her to be non-ambulatory and to wear a walking boot to maintain alignment at all times.

In an interview with the orthopedic physician on 04/27/16 at 3:29 PM, he confirmed he wrote the progress note on 04/25/16 and that he had been consulted to see Resident #1 status post a fall. The orthopedic physician stated Resident #1's x-ray results showed an old fibula fracture and a new non-displaced medial malleolar fracture. He stated Resident #1 would need to wear a specialized boot at all times for the next 6 weeks to maintain alignment of her ankle and that she should remain "non-weight bearing" until that time.

In an interview with the Director of Nursing (DON) on 04/27/16 at 4:00 PM, she stated that an assessment should been completed by the assigned nurse immediately after Resident #1's fall per the facility's falls policy. The DON stated the purpose of the assessment was to determine possible injuries so the nurse could report the assessment findings upon notification of the physician. The DON stated the nurse was not able to complete an assessment at the time of the fall because the activity staff did not report the fall until after the residents returned from the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345369	A. BUILDING _____ B. WING _____	C 04/29/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 11 outing around 5:30 PM. In an interview with the Administrator and DON on 04/28/16 at 5:00 PM, the Administrator stated the facility had identified the failure to obtain a nursing assessment immediately after Resident #1's fall was due to the activities coordinators' lack of reporting the fall. The Administrator stated the activity bus was still on the facility grounds when the fall occurred, and that the facility was responsible for her care. The Administrator also stated the two activities coordinators had been provided with in-service education about the need to immediately report falls so that a nursing assessment could take place. He added that Resident #1's nursing care plan had been updated on 04/22/16 with an intervention for her to remain in her wheelchair for all outings. The Administrator added that there is a rough outline for a plan of correction related to reporting falls and the need for an immediate nursing assessment, but it had not yet been fully developed. An interview was conducted with Resident #1's primary physician on 04/29/16 at 2:10 PM. The primary physician stated Resident #1's fall should have been reported by the staff at the time of the fall in order for a nurse to provide an immediate assessment for injuries. The primary physician stated he did not think Resident #1's right ankle injury was complicated by the delay in assessment and treatment.	F 309		