STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345508	A. BUILDING _____ B. WING _____	C 12/06/2017

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

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F 000	INITIAL COMMENTS The surveyor entered the facility on 12/4/17 to conduct a complaint survey and exited on 12/5/17. Additional information was obtained on 12/6/17. Therefore, the exit date was changed to 12/6/17.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (Resident # 2) of three sampled residents with indwelling catheters the facility failed to follow standards of practice for monitoring the resident per her plan of care. The staff failed to obtain a rectal temperature when the resident's temperature would not register by other routes. The findings included: Record review revealed Resident # 2 was admitted to the facility on 8/19/17. The resident had diagnoses of chronic congestive heart failure, cardiomegaly, Stage III chronic kidney disease, diabetes, hypertension, anemia, history of stroke, osteoarthritis, and hypothyroidism. Also, according to the record the resident was admitted with a urinary catheter secondary to a diagnosis of urinary retention. Review of the resident's admission minimum data set (MDS), dated 8/31/17, revealed the resident was cognitively intact and had an indwelling	F 658	The facility exhibited a failure to follow standards of practice related to resident #2's indwelling catheter plan of care as evidenced by failure to obtain a temperature. The nurse failed to obtain a rectal temperature when the residents' temperature would not register by other routes. The Clinical Educator and/or Nursing Team Leader will educate all nurses on standards of practice related to obtaining a temperature. The Director of Nursing, Assistant Director of Nursing, Clinical Educator and/or Nursing Team Leader will monitor all residents with indwelling catheters to ensure that temperatures are obtained per standards of practice. The Director of Nursing, Assistant Director of Nursing, Clinical Educator and/or the Nursing Team Leader will audit	1/2/18

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

Electronically Signed | 12/13/2017

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F 658	Continued From page 1 urinary catheter. Review of the resident's care plan, last revised on 10/17/17, revealed it included interventions for the resident's urinary catheter. One of the interventions was to monitor the resident for infection. Review of nursing notes revealed on 10/26/17 at 12 noon, Nurse # 2 documented the following information. The resident had been up in her wheelchair and ambulating with a rolling walker. The resident's catheter was draining clear yellow urine. On 10/26/17 at 2:15 PM, Nurse # 2 documented the resident had lost her balance while "transferring/walking" with the rolling walker, and she had been lowered to the floor without injury by a nurse aide (NA). Nurse # 2 documented the resident's vital signs as: B/P (blood pressure) 145/67; respirations 24; heart rate 40; and oxygen saturation 91 percent. There was no documented temperature reading. There was documentation the physician was notified. Interview with Nurse # 2 on 12/4/17 at 2:45 PM revealed the physician/ nurse practitioner had been making changes in one of the resident's cardiac medications during this time, and she had called to inform them of the heart rate on 10/26/17. According to the nurse the resident varied daily in how well she felt, and a urine specimen had been obtained recently due to an isolated occurrence of some blood clots on 10/25/17. According to the nurse, as of dayshift on 10/26/17, she had not noted a significant change in the resident's status, and although the resident's heart rate was low the physician/nurse	F 658	all residents with indwelling catheters to ensure temperatures are obtained per standards of practice. The audits will be conducted weekly times one month, bi-monthly times one month and monthly times one month. The Administrator, Director of Nursing, Assistant Director of Nursing, Clinical Educator and the Nursing Team Leader will be responsible for ensuring the implementation of this plan of correction.	

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practitioner was aware and addressing the issue. The nurse could not recall the resident's temperature reading for her day shift of 10/26/17.

Review of the resident's nursing notes revealed, on 10/26/17 at 5:30 PM, Nurse # 3 documented the following information. The nurse aide had not been able to obtain Resident # 2's vital signs at the beginning of the shift. A new blood pressure machine was used and there was no reading. The resident's temperature would not register an oral or axillary temperature. The registered nurse team leader (RNTL) was notified. At the time of the 5:30 PM nursing entry, the RNTL obtained a manual blood pressure of 138/48 and a manual heart rate of 40. The resident's oxygen saturation was 95 percent, and her blood sugar had registered 111 at 4 PM. The resident was sitting up in bed, verbally responsive, and eating her meal. There were no signs of physical distress noted, and the RN team leader stated she would call the physician.

On 10/26/17 at 10:15 PM Nurse # 3 documented the following information in the nursing notes. She had been called to Resident # 2's room by the NA. The NA reported to Nurse # 3 that she (the NA) had been washing the resident and talking with the resident when her breathing changed, and the resident became unresponsive. Nurse # 3 shook the resident, shouted to the resident, and performed a sternal rub without response. The team leader was called and obtained a manual blood pressure of 152/54, heart rate of 40, oxygen saturation of 97%, and blood sugar of 155. There was no temperature reading. The resident mumbled and would not open her eyes.

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On 10/26/17 at 10:30 PM, Nurse # 3 documented the physician was notified by the team leader, and EMS (emergency medical services) had been called and was present. Nurse # 3 documented EMS was unable to obtain a temperature also.

Record review revealed the resident was transferred to the hospital where she was found to have hypothermia secondary to sepsis. According to hospital records, the resident's temperature on 10/27/17 at 12:57 AM was 89.2 degrees Fahrenheit.

Nurse aide (NA) # 1 was the nurse aide, who had cared for Resident # 2, on 10/26/17 during the 3 PM to 11 PM shift. NA # 1 was interviewed on 12/4/17 at 3:30 PM and reported the following. She tried to obtain the resident's temperature three different times and tried both orally and axillary. When it did not register, she informed Nurse # 3. The resident was a little quieter during the shift, but appeared okay. The resident ate her evening meal, and didn't seem any different until she was washing the resident at the end of the shift. During the care the resident had been talking to her, and then suddenly she started having trouble breathing. NA # 1 stated, "it was as if the resident was fine one second and then the next she wasn't." The NA reported she immediately went to get the nurse when she noticed the change.

Nurse # 3 was interviewed on 12/5/17 at 12:05 PM. Nurse # 3 reported the following information. It had been reported to Nurse # 3 by the dayshift nurse that Resident # 2's temperature had been low normal during the dayshift. The 3 PM- 11 PM NA informed Nurse # 3 around 3:30 to 4 PM the

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resident's temperature would not register. Nurse # 3 checked the resident and the resident didn't open her mouth well, and so she tried to obtain the temperature by the axillary route with three or four different thermometers. The thermometers would blink or show an "E," but would not register a reading. She placed a blanket on the resident to warm her. She told Nurse # 4, who was the RN supervisor, that she was having trouble getting the resident's vital signs. Nurse # 4 came to check the resident. Nurse # 4 obtained the manual B/P that was documented in the record and stated she would call the physician. Nurse # 3 felt the resident's evening was "her normal evening" otherwise. The nurse reported she did not try to obtain a rectal temperature because the resident was large, and she kept hoping the resident would warm up so that the temperature would register. The nurse also reported she did not recall trying to retake the resident's temperature after 7 PM. When the NA alerted her near the end of the shift the resident was having trouble, she immediately went, found the resident to be unresponsive, and called EMS.

Nurse # 4 was interviewed on 12/5/17 at 11:35 AM. This interview revealed the following information. "A little after 5 PM," Nurse # 3 told her she could not get the B/P pressure machine to work for Resident # 2. Nurse # 4 was aware the resident was being monitored for bradycardia (low heart rate) episodes that week. When she entered the room to check the resident, the resident was eating, responding appropriately, and verbalized she was okay. The resident did not appear in distress. She checked her blood pressure manually and obtained a reading which was within normal limits. Her apical heart rate was 40. She immediately called NP # 1, who told

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Nurse # 4 she was aware the resident had been having problems and to schedule a cardiology consult in the morning. It was Nurse # 4's understanding that the B/P had not registered on the machine, and Nurse # 4 did not recall Nurse # 3 telling her the resident's temperature did not register. Therefore she did not try to obtain the resident's temperature or report this to the following team leader. Nurse # 4 left around 7 PM and was replaced by Nurse # 5 as team leader.

Nurse # 5 was interviewed on 12/5/17 at 12:35 PM. Nurse # 5 reported the following information. After obtaining report from Nurse # 4, she looked in on the resident, who appeared without distress and was observed by her to be visiting with family members and watching television. Therefore she did not check the resident's temperature or do a further physical assessment until she was notified near the end of the shift the resident was not responding. Nurse # 5 had not been made aware the resident's temperature was not registering earlier.

Interview with NP # 1 on 12/4/17 at 3:20 PM revealed the staff had talked with her regarding the resident's heart rate, and she had been evaluating and addressing this. The NP stated she was not made aware the resident's temperature would not register.

Interview with the director of nursing on 12/5/17 at 10:40 AM revealed it was expectation as a standard of practices that if a temperature did not register then her staff should change the probe and try again to take it. If the temperature still did not register, then it was her expectation the staff member should obtain a rectal temperature.

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F 658	Continued From page 6 Interview with Resident # 2's physician on 12/6/17 at 1:15 PM revealed the following. On rare occurrences, a resident's temperature will decrease as they become septic rather than suddenly spike to a high reading. The temperature change can occur very rapidly. It was his medical opinion that although the nursing staff had not followed standards of practice in obtaining the temperature rectally, Resident # 2's course of treatment and outcome would have been unchanged considering the complexity of her medical conditions.	F 658		