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 04/06/2023

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**

(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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 04/03/2023 through 04/06/2023. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #5K4411.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 04/03/2023 through 04/06/2023. Event ID# 5K4411. The following intakes were investigated NC00196254, NC00195901, NC00195303, NC00192833 and NC00192230. Three of the nine complaint allegations resulted in deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		5/4/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/26/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with residents and facility staff and record review the facility failed to maintain residents' dignity by not providing assistance when requested while a resident was in the shower room(Resident #3) and when staff did not announce their presence prior to entering the Resident's room (Resident # 272) for 2 of 4 residents reviewed for dignity. Resident #3 stated this made her feel "angry" and "like a piece of trash". The findings included: 1. Resident #3 was admitted to the facility on 5/06/10.	F 550	1) Nurse #4 failed to meet 483.10 Resident□s Rights by failing to knock and announce her presence upon entering the room of resident #272 on 4/3/23. Director of Nursing (DON) met with resident #272 on afternoon of 4/3/23 to discuss surveyor observation that hall nurse did not knock and introduce herself before entering the room. DON reassured resident #272 that it is leadership□s expectation that everyone announce their presence prior to entering her room. Resident expressed appreciation for her follow-up. DON also met with nurse #4 and provided 1:1 education to revisit the	

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F 550	Continued From page 2 The quarterly Minimum Data Set assessment dated 1/23/23 indicated Resident #3 was cognitively intact. On 4/4/23 at 9:46 AM Resident #3 said she was in the shower room for her shower on 4/1/23 when Nursing Assistant (NA) #6 went back to Resident #3's room to make her bed. Resident #3 said she told the NA to do it quickly and to come back to the shower room to get her. She said she pulled the call light when she was finished with her shower, but no one came so she began to call out. She said no one could hear her calling out for assistance. She said she thought the call light was not working so she started hollering. She said it was about an hour she thought. She said she did not see a clock in the shower room. On 4/6/23 at 11:05 AM Resident #3 reported having to holler and wait for someone to come and get her from the shower room on 4/1/23 made her feel "angry" and "like a piece of trash". On 4/6/23 at 10:28 AM NA #6 stated she was the NA assigned to Resident #3 on 4/1/23. NA #6 said she took Resident #3 to the shower room. She said Resident #3 was able to complete her own shower after everything was set up for her. She said Resident #3 gave her permission to go back to the Resident's room to make her bed. She said she did go to make up the bed, but she needed some other supplies, so she went to the supply room to obtain the needed items. She said when she returned to the hall and was going to the shower room, she could hear Resident #3 calling her, so she went straight into the shower room. NA #6 said it was about 15 minutes from the time she left Resident #3.	F 550	regulation 483.10 regarding resident rights and knocking/introducing self upon entry to every resident room. Nurse #4 expressed understanding and states this will be her consistent practice moving forward. Facility has identified that all residents have the potential to be affected by this deficient practice as it is fundamental resident right. Through a root cause analysis, we determined that re-education of staff and routine monitoring will ensure that the deficient practice does not recur. Education on Resident Rights, including the expectation of knocking and introducing self prior to entering each resident room, is completed by the Clinical Educator upon new hire orientation for all nursing staff and repeated yearly during Annual Skills. Reinforcement of education provided by the Clinical Educator, DON, and Clinical Manger during April monthly nursing staff meetings. Anyone who did not attend the staff meetings was given the information in writing. All education was completed by 4/20/23. Facility leadership, including the RN Team Leaders, Clinical Manger, Director of Nursing, Educator, Therapy Manager, and/or Administrator will conduct audits to observe staff entering rooms, ensuring that they are announcing their presence by knocking and introducing themselves. If any deficient practice is observed, the staff member will be counseled 1:1 by the leadership member that observed the interaction. Audits will include three	

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F 550

Continued From page 3

On 4/6/23 at 10:58 AM NA #7 who was also working on 4/1/23 stated she was not aware of the call bell not working in the shower room until Resident #3 told her she was not able to get help while in the shower room because the call light was not working and there were no staff members at the nursing station just across from the shower room.

On 4/6/23 the Director of Nursing was not available to interview.
2. Resident #272 was admitted to the facility on 3/30/23.

Review of Resident #272's admission health and physical dated 3/31/23 revealed the resident was alert and oriented to person, place, and time.

During observation on 4/3/23 at 10:31 AM Nurse #4 was observed to enter Resident #272's room through the open door without knocking or announcing her presence.

During an interview on 4/3/23 at 10:33 AM Resident #272 stated it bothered her when staff entered her room and did not knock or announce her presence.

During an interview on 4/3/23 at 10:38 AM Nurse #4 stated it was facility culture to knock or announce presence prior to entering resident rooms to provided privacy and dignity to the residents. She concluded she thought she had announced her presence at the door and should have done so.

During an interview on 4/4/23 at 9:22 AM the Director of Nursing stated staff were to announce

F 550

interactions per hall (12 total) per week for 4 weeks, bi-monthly for 1 month, then monthly for 1 month. Audits will begin on 5/5/23 and be completed by 8/5/23.
The results of the audits will be reviewed by the Clinical Educator in the Quality Assurance Performance Improvement (QAPI) meeting each month.
2) Facility failed to meet 483.10 Resident’s Rights by not providing assistance when requested to resident #3 when she was in the shower. Per resident #3’s report, this occurred on 4/1/23. On 4/6/23, it was observed that the shower call bell was not functioning properly. Facilities Maintenance Coordinator contacted a third-party contractor for the call bell repair, and 100 hall shower call bell returned to working order on 4/6/23. Facilities Maintenance Coordinator checked all call bells throughout facility to ensure they were in proper working order, and this was completed on 4/6/23 as well. Director of Nursing (DON) met with resident #3 on 4/11/23 regarding the shower call bell and notified resident that it was now in proper working order.
Facility has identified that all residents have the potential to be affected by this deficient practice as it is fundamental resident right.
Through a root cause analysis, we determined that re-education of staff and routine monitoring will ensure that the deficient practice does not recur.
Education on Resident Rights, including the right to dignity and respect as evidenced by the facility providing assistance when requested, is completed

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F 550	Continued From page 4 their presence prior to entering the resident's room for privacy and dignity.	F 550	by the Clinical Educator upon new hire orientation for all nursing staff and repeated yearly during Annual Skills. Education by the Clinical Educator also addressed the nursing department's response to non-functioning equipment. Staff educated that if they find a call bell not working, they may utilize the following interventions: move resident to a different location with a working call bell, stay within range to monitor resident while in shower, provide resident with an alternative calling method (i.e. a handheld bell). Education stressed the importance of finding alternative methods to ensure the residents can access staff assistance when needed to preserve their dignity. Education also provided on how to place a work order so the non-functioning equipment can be fixed. Reinforcement of education provided by the Clinical Educator, DON, and Clinical Manger during April monthly nursing staff meetings. Anyone who did not attend the staff meetings was given the information in writing. All education was completed by 4/20/23. The Administrator will complete call bell audits to ensure proper functioning. If any call bell is found to be not working, a work order will be placed through the electronic work order system and the Facility Maintenance Coordinator will contact a third-party contractor to initiate repair immediately. The Administrator will also notify nursing leadership so another intervention can be implemented. The intervention will ensure that resident dignity is preserved and there is a method	

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F 550	Continued From page 5	F 550	for any affected resident to call staff and receive assistance. Audits will include 100% of call bells within the facility and be conducted once per week for 4 weeks, bi-monthly for 1 month, then monthly for 1 month. Audits will begin on 5/5/23 and be completed by 8/5/23. The results of the audits will be reviewed by the Clinical Educator in the Quality Assurance Performance Improvement (QAPI) meeting each month.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 584		5/4/23

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F 584	Continued From page 6 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to provide a working Packaged Terminal Air Conditioner (PTAC) unit (a type of heating and air conditioning system used in a single living space) in the resident's room for 1 of 1 resident (Resident #281) reviewed for a clean and homelike environment. Findings included: Resident #281 was admitted to the facility on 3/22/23. The physician's history and physical for Resident #281 dated 3/22/23 read in part that he was alert and oriented to person, place, and time. An observation on 4/03/23 at 11:33 AM Resident #281 was observed to be sitting in a wheelchair in his room. He was observed to be wearing a	F 584	Facility failed to provide a working Packaged Terminal Air Conditioner (PTAC) unit in the room of resident #281. This was observed on 4/3/23. Resident #281's PTAC unit was fixed by the Facilities Maintenance Coordinator as soon as the issue was identified on 4/3/2023. Facilities Maintenance Coordinator reset the trip switch and plugged in the unit, and unit was in working order by 11:55am that same day. Director of Nursing (DON) met with resident #281 on the afternoon of 4/3/23 to discuss his experience at the facility. DON noted the heater to be working and the room was warm, even though resident was still wearing his jacket and toboggan. Resident #281 stated he was comfortable with the temperature of his room and expressed appreciation for addressing the issue. The Facilities Maintenance Coordinator rounded on each resident	

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F 584	Continued From page 7 toboggan, shirt, hooded sweatshirt with the hood pulled over his head, and a jacket. He was not observed to be shivering. There were no other sources of heat noted in the room and the PTAC unit under the window was not plugged in. An interview on 4/03/23 at 11:33 AM with Resident #281 revealed his PTAC had not worked since he was admitted to the facility. He stated he did not remember which staff members he had notified but had told several staff members. He also stated he was very "cold natured." A review of www.wunderground.com revealed the outside temperature on 4/3/23 was 45 degrees Fahrenheit at 1:51 AM and was 64 degrees Fahrenheit at 10:51 AM. An observation and interview on 4/03/23 at 11:43 AM with the Facilities Maintenance Coordinator revealed the PTAC unit was unplugged. He also revealed he was unaware the PTAC unit in Resident #281's room was not functioning and had not received a work order or any other type of notification that the unit needed repair. Another interview on 4/03/23 at 11:55 AM with the Facilities Maintenance Coordinator revealed the PTAC unit in Resident #281's room heating element trip switch had been "tripped." He revealed he reset the trip switch, plugged in the unit and it was now working. An interview on 4/03/23 at 2:43 PM with Nurse #1 revealed when Resident #281 had told her he was cold, she opened the window blinds so he could get sunshine to get warm. She stated she had not attempted to turn on his heat or noticed	F 584	room on 100, 200, and 300 hall to ensure all PTAC units were in proper working condition. All found to be working properly on 4/3/23. Facility has identified that all residents have the potential to be affected by this deficient practice as PTAC units are present in all resident rooms on 100, 200, and 300 halls. Through a root cause analysis, we determined that re-education of staff and routine monitoring will ensure that the deficient practice does not recur. Clinical Educator created a tip sheet on how to find and place work orders through our internal system. Tip sheet was disseminated to all facility staff on 4/3/23. Education on how to place a work order will be added to new hire orientation by the Clinical Educator. Reinforcement of education provided by the Clinical Educator, DON, and Clinical Manger during April monthly nursing staff meetings. Anyone who did not attend the staff meetings, including those not in the nursing department, was given the information in writing. All education was completed by 4/20/23. The Facility Administrator will conduct audits to ensure all PTAC units are functioning properly. If any are observed not to be working, a work order will be placed through the electronic work order system for Facilities Maintenance Coordinator to repair/replace. The Administrator will also coordinate with nursing leadership to relocate any resident that may be affected to a room with a working PTAC unit. Audits will	

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F 584	Continued From page 8 his PTAC unit was not working. She had not notified maintenance or entered a work order or notified maintenance. An interview on 4/03/23 at 2:56 PM with the Director of Nursing (DON) revealed the facility process was for staff to enter a work order for maintenance for repairs or to move the resident to a room with a functional heater. She was unaware if a work order had been entered for the heating unit in Resident #281's room. An interview on 4/05/23 at 11:22 AM with the Administrator revealed he did not know why the work order process did not go "as planned" for notification of maintenance for the PTAC unit in Resident #281's room. An interview on 4/06/23 at 8:44 AM with Nursing Assistant #1 revealed that Resident #281 had told her he was cold, and she had offered him another jacket. She also revealed she was aware the PTAC unit was not plugged in or working and thought maintenance knew.	F 584	include three rooms per hall (9 total as only 3 halls have PTAC units) per week for 4 weeks, bi-monthly for 1 month, then monthly for 1 month. Audits will begin on 5/5/23 and be completed by 8/5/23. The results of the audits will be reviewed by the Administrator in the Quality Assurance Performance Improvement (QAPI) meeting each month.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761		5/4/23

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F 761	Continued From page 9 Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to lock a treatment cart while unattended for 1 of 2 treatment carts observed (Treatment Cart #1). Findings included: During a continuous observation on 4/4/23 from 7:50 AM until 7:55 AM Treatment Cart #1 was observed next to the 300-hall nursing station unlocked and unattended. No residents were observed passing by the treatment cart during the observation. During an interview on 4/4/23 at 7:55 AM Nurse #3 stated the treatment cart was the responsibility of herself and the other hall nurse on 300-hall. The nurse stated they had not needed the treatment cart that morning and she did not notice the cart was unlocked. She concluded Treatment Cart #1 should have been locked when unattended.	F 761	The facility failed to meet 483.45 Label/Store Drugs and Biologicals as the treatment cart #1 was observed to be unlocked and unattended on 4/4/23. No residents were affected by this deficient practice. No residents were observed passing by the treatment cart, which was unlocked, during the observation. Treatment cart #1 was locked immediately after observation on 4/4/23. All drugs must be stored in locked compartments and only authorized personnel may have access. When a treatment cart that contains medications (prescribed creams) is left unlocked, it creates the opportunity for any resident passing by to access these drugs. All treatment and medication carts were checked on 4/4/23 after this observation, and all were found to be locked appropriately. Through a root cause analysis, we	

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UNC REX REHAB & NURSING CARE CENTER OF APEX	911 SOUTH HUGHES STREET APEX, NC 27502

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F 761	Continued From page 10 During observation with Nurse #3 on 4/4/23 at 7:56 AM the treatment cart was observed to contain items including triamcinolone cream 0.1%, gold bond cream 1-1%, hydrocortisone cream 1%, 10% povidone-Iodine, and triple antibiotic cream. During an interview on 4/4/23 at 9:22 AM the Director of Nursing stated treatment carts should be locked when unattended.	F 761	determined that re-education of staff and routine monitoring will ensure that the deficient practice does not recur. Education on Medication Storage, including the expectation of locking the treatment carts after each use, is completed by the Clinical Educator upon orientation for all licensed nursing staff and repeated yearly during Annual Skills. Reinforcement of education provided by the Clinical Educator, Director of Nursing (DON), and Clinical Manger during April monthly nursing staff meetings. Anyone who did not attend the staff meetings was given the information in writing. All education was completed by 4/20/23. The facility’s treatment nurse will conduct audits to ensure all treatment carts remain locked when unattended. If any deficient practice is observed, the treatment nurse will notify the DON or Clinical Manager so nurses on the particular hall with the unsecured cart can be counseled. Audits will include 100% of the treatment carts in the facility once per week for 4 weeks, bi-monthly for 1 month, then monthly for 1 month. Audits will begin on 5/5/23 and be completed by 8/5/23. The results of the audits will be reviewed by the Clinical Educator in the Quality Assurance Performance Improvement (QAPI) meeting each month.	
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced	F 814		5/4/23

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	345508	A. BUILDING ______ B. WING ______	C 04/06/2023

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F 814	Continued From page 11 by: Based on observations and interviews with facility staff the facility failed to keep the dumpster area free of debris for 1 of 1 enclosed dumpster area observed. The findings included: An observation of the dumpster area was conducted on 4/5/23 at 12:20 PM with the Dietary Coordinator and the Administrator. The observation revealed there were 4 wheelchairs located behind the dumpster on the right side of the enclosed dumpster area. Behind the middle dumpster was a broken metal office desk. There was also a 6-foot-tall wall cabinet with the top sagging from being wet and the shelves were broken and had the appearance of being wet. The back of the wall cabinet had fallen off and was laying on the ground behind the wall cabinet. It also appeared to have been wet. There was a 6-foot-long piece of countertop behind the dumpster on the left side of the enclosure. During the observation on 4/5/23 at 12:20 PM the Administrator stated the items appeared to be discarded from the Occupational Therapy (OT) room renovation. He said the items were too large to fit into the dumpster, so they needed to have a dump truck from the main facility to come to this facility to pick up the items. On 4/6/23 at 9:20 AM the Occupational Therapist stated the OT room was demolished in November 2022. On 4/6/23 at 9:30 AM the Facilities Maintenance Coordinator said the desk was put into the dumpster area in November 2022 and the	F 814	The facility failed to meet 483.60 Dispose Garbage and Refuse Properly as the area around the dumpster contained construction debris as observed on 4/5/23. The garbage and debris was removed on 4/5/23 for those affected by the deficient practice. Through a root cause analysis, we determined that re-education of staff and routine monitoring will ensure that the deficient practice does not recur. The Facility Administrator educated the Facility Maintenance Coordinator about proper disposal practices on 4/5/23. The Facility Maintenance Coordinator will provide education to the third party contractors regarding proper disposal practices and time frames for bulk materials. This education will be completed by 5/4/23. The Facility Administrator will conduct audits of the dumpster and surrounding area. If any deficient practice is observed, a work order will be placed through the electronic work order system for Facilities Maintenance Coordinator to have items removed. Audits will include a twice weekly visual audit of the area for 4 weeks, once weekly for 1 month, then bi-monthly for 1 month. Audits will begin on 5/5/23 and be completed by 8/5/23. The results of the audits will be reviewed by the Administrator in the Quality Assurance Performance Improvement (QAPI) meeting each month.	

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F 814	Continued From page 12 6-foot-tall wall cabinet was placed there in early December 2022. He said he was responsible to call for the dump truck to pick up the items that would not fit into the dumpster but he was waiting until he had a full load before he called for the dump truck. The Facilities Maintenance Coordinator said he thought placing the items in the dumpster area was better than just having them sitting in the parking lot. On 4/6/23 at 9:53 AM the Administrator said he was not aware the items had been in the dumpster area since November 2022. He said he had them removed.	F 814		
F 919 SS=E	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with facility staff and record review the facility failed to maintain the call light in working condition which caused a Resident (Resident #3) to be unable to obtain assistance while in the shower room for 1 of 1 shower room with a malfunctioning call system. The findings included:	F 919	The facility failed to meet 483.90 Resident Call System as the call bell system in the 100 hall shower room was observed to be malfunctioning on 4/6/23. Facilities Maintenance Coordinator contacted a third party contractor for the call bell repair, and 100 hall shower call bell returned to working order on 4/6/23. Facilities Maintenance Coordinator checked all call bells throughout facility to	5/4/23

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Resident #3 was admitted to the facility on 5/06/10. Her diagnoses included spinal cord dysfunction and diabetes.

The quarterly Minimum Data Set assessment dated 1/23/23 indicated Resident #3 was cognitively intact.

On 4/4/23 at 9:46 AM Resident #3 said she was in the shower room for her shower on 4/1/23 when the Nursing Assistant (NA) went back to Resident #3's room to make her bed. Resident #3 said she told the NA to do it quickly and to come back to the shower room to get her. She said when she finished her shower she pulled the call light, but no one came so she began to call out. She said no one could hear her calling out for assistance. She said she thought the call light was not working so that was the reason she started hollering out for help. Resident #3 said it took a long time, but the NA finally came back.

On 4/6/23 at 10:14 AM an observation of the shower room used by Resident #3 revealed there were 2 call pull stations. One was in the shower area near the rear of the room and the other was near the front of the shower room near the entry door. During this observation the call lights were activated. The activation of the call lights did not light up call light system in the hall on the outside the shower room. No sound from the alarm was heard coming from the nursing station located just across the hall from the shower room door.

On 4/6/23 at 10:20 AM the Facilities Maintenance Coordinator stated he was aware the call light in the shower room was not functioning. He added the call light in the resident room to the left of the shower room was also not functioning and the

F 919

ensure they were in proper working order, and this was completed on 4/6/23 as well.
Facility has identified that all residents have the potential to be affected by this deficient practice.
Through a root cause analysis, we determined that re-education of staff (including specific education for the Facilities Maintenance Coordinator) and routine monitoring will ensure that the deficient practice does not recur. We also found that the work order went to the UNC Rex BioMed department and not to the appropriate third party contractor that could repair the system. The Facility Administrator educated the Facility Maintenance Coordinator about his response to critical systems failures on 4/6/23, including how and when to escalate repairs with the appropriate third party contractor. The Facility Maintenance Coordinator now understands that he must contact the third party contractor directly. Education by the Clinical Educator addressed the nursing department’s response to non-functioning equipment. Staff educated that if they find a call bell not working, they may utilize the following interventions: move resident to a different location with a working call bell, stay within range to monitor resident while in shower, provide resident with an alternative calling method (i.e. a handheld bell). Education also provided on how to place a work order so the non-functioning equipment can be fixed. Clinical Educator created a tip sheet on how to find and place work orders through our internal system. Tip sheet was disseminated to all

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resident had an alternative means of communication since his call light did not work. He stated the call lights had not been working for about 1 month. He added he had tried to determine why the call light was not working and was unable to fix it. He said he had an email to verify he had contacted the biomed support person when he was not able to repair the call light.

A review of the email from the Facilities Maintenance Coordinator to the biomed engineering department was dated 3/9/23 and read "the call bell is not working in the wall. Attempted multiple call bells that were verified to work. The system is not making any noises/alerts on the system in the wall, visible alert in the hall or audible alert at the nursing station."

On 4/6/23 at 10:28 AM NA #6 stated she was the NA assigned to resident #3 on 4/1/23. NA #6 said she took Resident #3 to the shower room. She said Resident #3 was able to complete her own shower after everything was set up for her. She said Resident #3 gave her permission to go back to the Resident's room to make her bed. She said she did go to make up the bed, but she needed some other supplies, so she went to the supply room to obtain the needed items. She said when she returned to the hall and as she was going to the shower room, she could hear Resident #3 calling her, so she went straight into the shower room. NA #6 said it was about 15 minutes from the time she left Resident #3. NA #6 said she was not aware the call light in the shower room was not working.

On 4/6/23 at 10:58 AM NA #7 said she worked on 4/1/23 and she was not aware the call light in the

F 919

facility staff on 4/3/23. Education on how to place a work order will be added to new hire orientation by the Clinical Educator. Reinforcement of education provided by the Clinical Educator, DON, and Clinical Manger during April monthly nursing staff meetings. Anyone who did not attend the staff meetings, including those not in the nursing department, was given the information in writing. All education was completed by 4/20/23.
The Administrator will complete call bell audits to ensure proper functioning. If any call bell is found to be not working, a work order will be placed through the electronic work order system and the Facility Maintenance Coordinator will contact a third party contractor to initiate repair immediately. The Administrator will also notify nursing leadership so another intervention can be implemented. The intervention will ensure there is a method for any affected resident to call staff and receive assistance when needed. Audits will include 100% of call bells within the facility and be conducted once per week for 4 weeks, bi-monthly for 1 month, then monthly for 1 month. Audits will begin on 5/5/23 and be completed by 8/5/23.
The results of the audits will be reviewed by the Clinical Educator in the Quality Assurance Performance Improvement (QAPI) meeting each month.

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shower room was not working until 4/1/23 when Resident #3 was in the shower room.

On 4/6/23 at 10:38 AM the Administrator stated he was aware the call light in the shower room was not working and he was aware that someone came and looked at the call light. The Administrator said he was told the unit needed to be replaced but it had not been replaced yet. He added if someone needed assistance they could just call out because the shower room was just across the hall from the nursing station.

The Facilities Maintenance Coordinator was interviewed again on 4/6/23 at 10:38 AM and stated it was in January or February 2023 when he replaced the call light in both the shower room and the room to the left of the shower room but that did not fix the problem. He said he asked the biomed engineer for assistance because he thought the problem could be related to the moisture from when the pipe in the shower room ceiling burst and flooded the whole hall on 12/25/2022.

On 4/6/23 at 11:00 AM the Clinical Manager stated they began moving residents back onto the hall at the end of February 2023, but the shower room was not in use until 2 weeks ago because the floor in the shower room was not finished until then.

On 4/6/23 at 11:24 AM the Administrator said the biomed engineer had received emails about the shower room call light not working and the Vice President of the health care system was now trying to get this worked on.

During the interview with the Administrator on

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F 919	Continued From page 16 4/6/23 at 11:24 AM the Facilities Maintenance Coordinator was also present. He said had called a consulting clinical engineering biotechnology service and they were on the way to look at the shower room call light system.	F 919		