This plan of correction is not an admission that any deficiency existed at the time of the survey in question, or of the accuracy of any of the allegations contained in the CMS 2567 survey report. This plan of correction is the facility's allegation of compliance with all applicable state and federal requirements and is being submitted to meet requirements of state and federal law for skilled nursing facilities.

F152

During the 12/23/13 complaint survey, the surveyor alleged that the facility didn't notify the physician that a psychiatric consult was not provided and that behaviors continued after trazodone was started for 1 of 1 resident reviewed for a traumatic experience. The facility discharged the resident on 12/18/13 to Arkansas per family request prior to the surveyor presenting these findings. [12/18/13]
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<tr>
<th>(X3) PROVIDER/USER/CLINIC NAME</th>
<th>346369</th>
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</thead>
<tbody>
<tr>
<td>NAME OF PROVIDER OR SUPPLIER</td>
<td>REX REHAB &amp; NSG CARE CENTER</td>
</tr>
<tr>
<td>STREET ADDRESS, CITY, STATE, ZIP CODE</td>
<td>4622 LAKE BOONE TRAIL, RALEIGH, NC 27607</td>
</tr>
<tr>
<td>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</td>
<td>F 157 Continued From page 1</td>
</tr>
</tbody>
</table>

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 on record review, staff, and physician interviews, the facility failed to notify the physician that a psychiatric consult was not provided and that behaviors continued after treatment was started for 1 of 1 sampled resident reviewed for a traumatic experience (Resident #485). The findings included:

  - Resident #485 was admitted into the facility on 11/18/13 from the hospital. Diagnosis included Dementia. The admission minimum data set completed on 12/3/13 indicated Resident #485 cognitive status was moderately impaired.
  - Inattention and disorganized thinking was listed as present/undetected. Trouble falling asleep or staying asleep or sleeping too much and delusions was indicated as occurring. Extensive assistance of one personal physical assist was required with dressing and toilet use. Urinary and bowel was listed as frequently incontinent.

- Psychological therapy was not indicated as received. The care plan dated 12/14/13 listed altered thought process related to age and change in environment as a problem concern. As an approach, the care plan read "refer to physician orders for update of interventions."

- A review of the physician telephone order dated 12/2/13 revealed an order was obtained for trazadone 25 milligram (mg) to be administered.

F 157

To determine whether any other residents were affected by the alleged deficient practice, the facility audited all records of all residents for physician orders for psychiatric consults and/or medications designed to address psychiatric/mental behaviors to determine if ordered referrals were timely made and the consults provided, and whether the behaviors at issue continued notwithstanding ordered medications and whether the residents' physicians were notified as appropriate. 1/9/14

Preventive measures implemented include the following:

The Clinical Nursing Managers have provided training to all nurses regarding when and how to notify the MD/PA/NP of episodic events. This training specifically included the duty to notify the physician of missed referrals for psychiatric disorders.
F 157 Continued from page 2
by mouth at bed time for insomnia.

A review of the physician telephone order dated 12/4/13 revealed an order that read "psych consult - status post traumatic cath in emergency room, patient crying out in the night and refusing care."

A review of the psychiatrist referral dated 12/4/13 listed Resident #405 to be evaluated for "traumatic cath in the emergency room, patient crying out at night and refusing care."

A review of the physician assistant assessment and plan of care co-signed by the physician on 12/9/13 revealed the purpose of the psychological consult ordered on 12/4/13 was to address "trauma and why patient will not allow herself to be touched."

A review of the nurse's note revealed on 12/8/13 at 4:00 am, Resident #405 reported that someone was "molesting her and touching her private parts."

A review of the medication administration record revealed trazodone 25 mg was administered by mouth at 9:00 pm on 12/2, 12/3, 12/4, 12/5, 12/6, 12/7, 12/8 (not signed as administered), 12/9, 12/10, 12/11, 12/12, 12/13, 12/14, 12/16, and 12/17/13 with improved sleep pattern.

In an interview on 12/23/13 at 11:37 am, the administrator, when questioned regarding the psychiatric consult that was ordered on 12/4/13 stated that per her review of the clinical record from 12/4/13 to 12/18/13 (date of discharge to another facility) she did not see where services were provided. The administrator stated that she or other specialty consultations and ongoing psychiatric/mental behaviors that persist after initiation of ordered medications designed to address those behaviors. This training will be completed by 1/9/14 for all staff on duty. Any staff nurse not educated on this process on or before 1/8/14 will be educated on an individual basis prior to returning to work. [1/9/14]

A review of resident changes in condition, as communicated within the 24-hour nurses' report, will be conducted daily by the supervising nurse on duty to ensure that appropriate and timely notifications were made for all residents who have had significant changes. "Timely" notification means as soon as staff become aware of the change through the processes described herein. In addition, a review of resident charts will be completed to identify any failures to make
| F 157 | Continued from page 3
|       | expected the resident to have been evaluated as ordered.
|       | In an interview on 12/23/13 at 12:00 noon, the social worker when questioned regarding Resident #485 stated that she was the primary social worker for the resident. The social worker acknowledged that she was aware that there was a pending psychiatric consult; however, she was not aware that the consult service was not provided.
|       | During a telephone interview on 12/30/13 at 9:23 am, the physician when questioned regarding Resident #485 stated that she was not aware that after trazodone was started on 12/2/13, that continued statements were made by the resident to the facility staff on 12/9/13, of thoughts that someone touched her private parts and molested her. She indicated that she was under the impression that after trazodone was started the resident's behavior improved. The physician acknowledged that she was aware that the initial psychiatric consult was ordered as a result of a traumatic urinal catheterization completed in the emergency room, followed by the resident crying out in the night and refusing care while she resided in the nursing facility.
|       | 483.25(I)(1) TXSVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES

| F 319 | Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.

| F 157 | appropriate notifications for significant changes in resident condition per the following schedule: 100% of resident charts each day for five days; then a 20% random sample each month, to continue until no incidents of failure to notify of significant changes are identified. Additionally a weekly audit will be completed by the Clinical Manager comparing the team leader report to the physician communication log. If anything on the team leader report is missed on the physician communication report, the Clinical Manager will re-evaluate the nurse completing the team leader report and notify the physician of the patient change/episode event. The Director of Nursing will be monitoring the weekly reports on a monthly basis. (1/9/14 & Ongoing)
Any discrepancies from the monthly monitoring of the audits will be reviewed at the monthly QAPI Meeting for 3 months and quarterly thereafter, until there have been two consecutive quarters with no discrepancies. [1/9/14 & Ongoing]

During the complaint survey on 12/23/13 the surveyor alleged that the facility failed to obtain a psychiatric evaluation for a resident who presented with signs and symptoms of a traumatic encounter for 1 of 1 resident reviewed for a traumatic experience. The facility discharged the resident on 12/18/13 to Arkansas per family request prior to the surveyor presenting these findings. [12/18/13]

To determine whether any other residents were affected by the alleged deficient practice, the facility audited all records of all
<table>
<thead>
<tr>
<th>Facility Tag</th>
<th>Summary of Deficiency</th>
<th>Provider's Plan of Correction</th>
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</thead>
<tbody>
<tr>
<td>F 319</td>
<td>Facility staff also indicated as &quot;agitated and grabbed her genital area under the covers with her hands.&quot; After much reassurance the resident was indicated as &quot;finally calmed down.&quot; It was noted that a friend who came to the facility informed the facility that the resident had a traumatic catheterization completed in the emergency room by a male nurse. It was further noted that the resident was very private, never married, nor had any male relationship. Upon further assessment by the nursing staff it was assessed that the resident firmly believed that a man was hurting her, even when left alone and no one was with her the resident would &quot;suddenly and spontaneously&quot; start yelling that &quot;she is being attacked.&quot; Recommendation was for no male nursing assistants to provide personal care. On 11/29/13 at 11:20 am, when care was attempted Resident #465 stated repeatedly &quot;you should be ashamed of yourselves what you have done to me&quot; and yelled out &quot;get away from me.&quot; The resident refused to allow the nursing staff to wash her or blood to be drawn. Continue to monitor the resident was indicated. On 11/29/13 at 11:20 am, it was noted that Resident #465 was &quot;agitated, unable to be redirected, yelling out, having delusions of man in her room trying to touch her private parts, covering her groin area, even though there had been no men around or in her room.&quot; It was indicated that the resident stated &quot;I am so ashamed, this will kill me, I'll never get over this.&quot; It was further documented that the resident had been awake for the majority of the 3 pm - 11 pm shift with this delusion, vital signs and morning needs not obtained, administration got order to allow resident to sleep, physician assistant aware. On 12/1/13 at 8:30 pm, the resident yelled out &quot;get these men out of my room; they're trying to touch my privates.&quot; It was further...</td>
<td>F 319 residents for physician orders for psychiatric consults and/or medications designed to address psychiatric/mental behaviors to determine if ordered referrals were timely made and the consults provided, and whether the behaviors at issue continued notwithstanding ordered medications and whether the residents' physicians were notified as appropriate. [1/9/14] Preventive measures implemented include the following: Under her existing contract with Rex, the facility engaged Elena Matthews, MD to provide routine and consultant psychiatric services. Dr. Matthews made her first visit to the facility on December 27, 2013. [12/27/13] In addition to Dr. Matthews' services, we also re-instated our previous contract with Dr.</td>
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<td>F319</td>
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<td>noted that the resident was redirected and</td>
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<td></td>
<td>reassured that there were no men in her room</td>
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<td>and that the resident refused to eat. The nurse's</td>
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<td>note dated 12/2/13 (time not specified) stated that</td>
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|      | "Resident 1485 had not slept all night."

A review of the physician telephone order dated 12/2/13 revealed an order was obtained for 
trazodone 25 milligram (mg) to be administered by mouth at bed time for insomnia.

A review of the physician telephone order dated 12/4/13 revealed an order that read "psych 
consult - status post traumatic cath in emergency room, patient crying out in the night and refusing 
care."

A review of the psychiatrist referral dated 12/4/13 listed Resident 1485 to be evaluated for 
"traumatic cath in the emergency room, patient crying out at night and refusing care."

A review of the physician assistant assessment and plan of care co-signed by the physician on 
12/6/13 revealed the purpose of the psychological consult ordered on 12/4/13 was to address 
"trauma and why patient will not allow herself to be touched."

A review of the nurse's note revealed on 12/9/13 at 4:00 am, the resident reported that someone 
was "molesting her, and touching her private parts." The resident requested that the facility call 
a friend, who was indicated as spoke with the resident, and informed her that she would come 
and stay all night with her, and that no acute concerns were observed while the friend was 
present at the bedside of the resident.

Kamdar effective 12/31/13. [12/31/13]

The Clinical Nurse Managers immediately faxed any outstanding psychiatric consult 
orders to the psychiatrist for referral. [12/27/13]

Nursing already conducts chart 
reviews on a daily basis, 
including a review of orders for 
psychiatric consults ensuring 
referrals have been made. 
Discrepancies identified will be 
communicated via the 24-hour 
report and during the M-F AM 
stand-up meetings. 
Additionally, a new process has 
been implemented for retrieval 
of psych orders. Upon receipt 
of an order for psych services, 
the nurse will log the order in
Continued from page 7

A review of the physician assistant assessment and plan of care co-signed by the physician on 12/11/13 indicated "patient refusing to be touched."

A review of the medication administration record revealed trazodone 25 mg was administered by mouth at 9:00 pm on 12/7, 12/9, 12/11, 12/12, 12/16, and 12/17/13 with improved sleep pattern.

A review of the social worker progress notes completed on 11/28, 12/2, 12/5, 12/10, 12/11, 12/16, and 12/18/13 (date of discharge) revealed no specific approaches that addressed Resident #485's needs for effective coping, per behaviors indicated in the nurses notes from 11/28/13 to 12/9/13, nor a follow up on the ordered psychiatric consult.

A review of the physician statement dated 12/27/13 in part read "acute events of 12/2/13 with delirium, patient refusing contact, cleared. Baseline dementia history. We added trazodone at night which lead to much improved sleep and improved behavior reported - acute psychiatric evaluation not necessary with improvements - though we never canceled consult (oversight)."

In an interview on 12/23/13 at 11:11 am NA (nursing assistant) #1 when questioned regarding Resident #485 stated "I overheard that Resident #485 was resistant to care in the morning, would not allow the NAs to wash between her legs and would fight the NAs when care was attempted."

NA #1 stated she recalled once when the resident had a bowel movement she was resistant to allow her to provide care to clean her. She added that the psych referral binder and notify the social worker. The social worker will initiate the referral to psych by faxing the order to the psychiatrist and will document the date the referral was sent. When the psychiatrist visits the patient he/she will sign and date the psych communication binder as well as complete any necessary documentation/physician orders. [1/9/14]

The Clinical Nursing Managers have provided training to all nurses and social workers regarding the process change. This training will be completed by 1/9/14 for all staff on duty. Any staff nurse or social worker not educated on this process on or before 1/9/14 will be educated on an individual basis prior to returning to work. [1/9/14]

The social work office will conduct weekly audits of the psych communication binder. The social work office will re-fax to the psychiatrist any
F 319 Continued From page 8

the resident required lots of reassurance regarding what type of care was going to be provided to her. NA #1 stated that when she touched the resident to provide care, the resident jumped and was startled. NA #1 added that she had to constantly explain and reassure the resident the type of care that she was going to provide to her, and the resident would allow her to clean her quickly. NA #1 concluded that the nursing staff was aware of the resident’s behavior and her resistant to allow care to be provided.

In an interview on 12/23/13 at 11:25 am Nurse #1 when questioned regarding Resident #485 statements that her private parts were touched in a manner in which she was uncomfortable, resistant to allow care to be provided, stated that she recalled the resident screamed and yelled when care was attempted by the nursing staff to her private area “genital area”. She added that she recalled a particular incident in which a male NA assisted the resident while she ambulated to the toilet and the male nursing assistant assisted with snapping the brief around the resident and she screamed that the male nursing assistant touched her private parts. Nurse #1 added upon becoming aware of the statement made by the resident, she questioned the resident regarding where the man was and the resident indicated he was under the covers. She added that as a result she assigned a female NA to provide care to the resident. Nurse #1 acknowledged that she was aware that the resident screamed and yelled whenever care was attempted to her genital area, was resistant to care, and that the resident required increased reassurance and encouragement by the nursing staff, before care could be provided. Nurse #1 did not acknowledge that she was aware of the ordered psychiatric orders for consults that are more than one week old and not yet completed. The social work office will notify the resident’s attending physician, and the DON or Administrator, of any delays in service greater than ten business days and will document such notification in the psych communication binder. [1/9/14 & Ongoing]

Any discrepancies from the monthly review of the audits will be assessed at the monthly QAPI Meeting for 3 months and quarterly thereafter, until there have been two consecutive quarters with no discrepancies. [1/9/14 & Ongoing]
<table>
<thead>
<tr>
<th>IDENTIFICATION NUMBER</th>
<th>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</th>
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**NAME OF PROVIDER OR SUPPLIER**

**REX REHAB & NSG CARE CENTER**

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<th>F 319</th>
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<tr>
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<td>Consult.</td>
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<td>In an interview on 12/23/13 at 11:31 am, NA #2 when questioned regarding Resident #485 indicated &quot;It was a challenge to provide care to her due to the resident screamed, yelled, and fought, when attempting to provide care to her.&quot; NA #2 stated &quot;even if you touched her hand she screamed loudly.&quot; NA #2 concluded the nurses were aware of this behavior.</td>
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<td>In an interview on 12/23/13 at 11:37 am, the administrator when questioned regarding the psychiatric consult that was ordered on 12/4/13 stated that per her review of the clinical record from 12/4/13 to 12/19/13 (date of discharge to another facility) she did not see where services were provided. She added that the process for a resident to be seen is that once a physician order was written for needed services, the resident name is written in the psychiatric referral book and the resident is evaluated when the clinician is onsite. The administrator indicated that she identified there was a problem with the contracted psychiatric provider services on November 3, 2013, which has continued to date with delayed visits, which contributed to Resident #485 not being evaluated during her stay. She elaborated that she expected the resident to have been evaluated as ordered. The administrator concluded that if residents presented with acute psychiatric concerns in which the facility was unable to manage, residents would be expected to be transported to the hospital to be evaluated.</td>
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<td>In an interview on 12/23/13 at 12:00 noon, the social worker when questioned regarding Resident #485 stated that she was the primary social worker for the resident. The social worker</td>
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Continued From page 10

indicated typically when a psychiatric consult was
ordered, if nursing obtained the order for needed
consultation, the nursing department was
responsible for ensuring that the ordered services
was completed. She added that if a consult order
was physically presented to her, then she would
write the resident's name in the psychiatric
referral book. The social worker acknowledged
that she was aware that there was a pending
psychiatric consult; however, she was not aware
that the consult service was not provided.

During a telephone interview on 12/30/13 at 9:23
am, the physician when questioned regarding
Resident #485 stated that she was not aware that
after trazodone was started on 12/2/13, that
continued statements were made by the resident
to the facility staff on 12/28/13, of thoughts that
someone touched her private parts and molested
her. She indicated that she was under the
impression that after trazodone was started the
resident's behavior improved. The physician
added that it was not uncommon for residents
with delirium to become agitated, and the goal
would be to provide direction guidance and
reassurance. When further questioned regarding
the psychiatric consult that was ordered, the
physician stated that if the resident physical
condition could not be managed by the staff, the
resident could have been sent to the emergency
room, however, she felt the resident condition
did not warrant such an action, being the resident
behaviors improved, after the trazodone was
started. She further added that it was hard to say
if the psychiatric consult should have been
carried out, considering the resident condition
improved during stay. The physician
concluded that she was aware that the initial
psychiatric consult was ordered as a result of a
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<th>Item</th>
<th>Description</th>
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<tr>
<td>F 319</td>
<td>Continued From page 11 traumatic urine catheterization completed in the emergency room, followed by the resident crying out in the night and refusing care while she resided in the nursing facility.</td>
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<td>F 319</td>
<td>F 319</td>
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