DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				· · · · · · · - ·	M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u>). 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	COM	E SURVEY PLETED
		345369	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER	040000		ST	REET ADDRESS, CITY, STATE, ZIP CODE	04	/29/2016
		_		442	20 LAKE BOONE TRAIL		
REX REH	AB & NSG CARE CENTE	ĸ		RA	ALEIGH, NC 27607		
(X4) ID PREFIX TAG			ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTIO		ON SHOULD BE CC IE APPROPRIATE	
F 157 SS=D			F 1	57			5/27/16
	consult with the resid known, notify the resi or an interested famil accident involving the injury and has the por intervention; a signific physical, mental, or p deterioration in health status in either life the clinical complications significantly (i.e., a ne existing form of treath consequences, or to	nent due to adverse commence a new form of ion to transfer or discharge					
	and, if known, the res or interested family m change in room or roo specified in §483.150 resident rights under	promptly notify the resident ident's legal representative nember when there is a commate assignment as e)(2); or a change in Federal or State law or ed in paragraph (b)(1) of					
	the address and phor	rd and periodically update ne number of the resident's r interested family member.					
	This REQUIREMENT	is not met as evidenced					
	Based upon record r physician interviews,	eview and resident, staff and the facility failed to notify the y after a fall for one of three			1. As noted, Resident #1's physician notified of the residents' fall at 5:40 PM 4/21/16. As noted, AC#1 and AC#2 has	on	
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E		TITLE		(X6) DATE
	cally Signed						05/13/2016

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.

			E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	IDENTIFICATION NUMBER:	. ,		COMPLETED
				с
	345369	B. WING		04/29/2016
OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	_		4420 LAKE BOONE TRAIL	
3 & NSG CARE CENTE	ĸ		RALEIGH, NC 27607	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETIC
Continued From page	e 1	F 157	7	
residents reviewed fo #1. Findings included A review of the quarte 02/23/2016 revealed intact and had a partial ncluded anemia, heat chronic obstructive put rheumatoid arthritis. assessment also india complaint of pain and medications. A review of the nursin 02/23/16 revealed Re- interventions in place due to her history of f the care plan was to re falls over the next 90 On 04/26/16 at 4:30 F observed resting in bu- elevated wearing a bl eg. In an interview with R observation, Residen injured her right foot a she fell when she was wheelchair to the faci activity outing. Resid activity coordinators w transfer, but she felt h as she slowly fell on t Resident #1 stated her very painful, but she of who told her she wou her right lower leg and	r falls with injury, Resident d: erly assessment dated Resident #1 was cognitively al list of diagnoses which int failure, hypertension, ulmonary disease, and The same quarterly cated Resident #1 had no I received no scheduled pain ag care plan last updated on esident #1 had a goal and to address her risk for falls falls. The goal included on minimize risk of injury from days. PM, Resident #1 was ed with the head of the bed fack boot on her right lower resident #1 at the time of the t #1 explained she had and ankle on 04/21/16 when s transferring from her lity bus seat during an lent #1 stated one of the was assisting her with the her own knees "buckle up," the floor of the bus. er right knee and ankle were did not report her pain to the s. Resident #1 stated she 6 by the orthopedic specialist Id need to wear the boot on d ankle for about a month.	F 157	 been provided with in-service educational operations of the provided with in-service education operations will be notified immerative after a fall for all residents as requires as per facility policy. A chart revier residents who have had a fall in the 30 days will be conducted by the DON/Clinical Manager by 5/20/16 ensure physicians have been notified of any findings of non-common tified of any findings of non-common the facility Fall Prevention Program. Act and Act and Act and Act are program. Act and Act and Act are program on the new policy by the Educator by 5/20/16. All new Act are policy by the Clinical Educator prior to go the outing. 4. The DON/Clinical Manager will the 24 hour report and the facility from the facility for the prevention. 	ediately ired and w of all e last to fied of hediately upliance. e f/DON yram tified es will hical htion a new y for stions to outings ately ty 2 will be e Clincal s will be e Clincal s will be all o erviced bing on review Variance 5 days
	FOR MEDICARE & DEFICIENCIES CORRECTION DVIDER OR SUPPLIER 3 & NSG CARE CENTE SUMMARY ST (EACH DEFICIENC REGULATORY OR I Continued From page residents reviewed for #1. Findings included A review of the quarte D2/23/2016 revealed intact and had a parti included anemia, hea chronic obstructive put theumatoid arthritis. assessment also indi complaint of pain and medications. A review of the nursin D2/23/16 revealed Re interventions in place due to her history of f the care plan was to b falls over the next 90 On 04/26/16 at 4:30 F observed resting in b elevated wearing a bl eg. In an interview with R observed resting in b elevated wearing a bl eg. In an interview with R observed resting in b elevated wearing a bl eg. In an interview with R observed resting in b elevated wearing a bl eg. In an interview with R observed resting in b elevated wearing a bl eg. In an interview with R observed resting in b elevated wearing a bl eg. In an interview with R observed resting in b elevated wearing a bl eg. In an interview with R observed resting in b elevated wearing a bl eg. In an interview with R observed resting in b elevated wearing a bl eg. In an interview with R observed resting in b elevated wearing a bl eg. In an interview with R observed resting in b elevated wearing a bl eg.	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345369 DVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 residents reviewed for falls with injury, Resident #1. Findings included: A review of the quarterly assessment dated D2/23/2016 revealed Resident #1 was cognitively intact and had a partial list of diagnoses which included anemia, heart failure, hypertension, chronic obstructive pulmonary disease, and theumatoid 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	FOR MEDICARE & MEDICAID SERVICES DEFICIENCIES DORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPL A BUILDING 345369 B. WING JUDER OR SUPPLIER 345369 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PIE FRGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 F 157 residents reviewed for falls with injury, Resident #1. Findings included: F 157 A review of the quarterly assessment dated D2/23/2016 revealed Resident #1 was cognitively intact and had a partial list of diagnoses which included anemia, heart failure, hypertension, chronic obstructive pulmonary disease, and theumatoid 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 D2/23/16 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 eg. In an interview with Resident #1 at the time of the observation, Resident #1 stated one of the activity coordinators was assisting her with the transfer, but she fell 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 pa	FOR MEDICARE & MEDICAID SERVICES DEFICIENCIES DEFICIENCIES (X1) PROVIDER/BUPPLIERCLIA LIDENTIFICATION NUMBER: 343369 B. WING STREET ADDRESS. CITY. STATE, ZIP CODE 420 LAKE BOONE TRAIL RALEIGH, NC 27607 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECIDED BY FULL REGULATORY OR LSC IDENTFYING INFORMATION) D PREVIX TABLE STATES Continued From page 1 F 157 residents reviewed for falls with injury, Resident #1. Findings included: A review of the quarterly assessment dated D2/23/2016 revealed Resident #1 was cognitively intact and had a partial list of diagnoses which ncluded anemi, heart failure, hypertension, chrewew of the nursing care plan last updated on D2/23/16 revealed Resident #1 had a goal and nerverwitons in place to address her risk for falls the care plan was to minimize risk of injury from falls over the next 90 days. F 157 De have had a fall in the care fall was to minimize risk of injury from falls over the next 90 days. F 157 Diagnose which nedications. F 157 Diagnose which necture physicians was be minimized by the Clinical Manager by 5/20/16 ensure physician swite been noth the fall. The physical must be immediately no conducing the revealed Resident #1 had a goal and not interview with Resident #1 had a goal and the care plan was to minimize risk of injury from falls over the next 90 days. F 167 Di OH/2016 at 4.30 PM, Resident #1 was observere tersing in bed with the head of the bed levated wearin

Facility ID: 923427

STATENAENIT -					
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					с
		345369	B. WING		04/29/2016
NAME OF P	ROVIDER OR SUPPLIER	•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	•
	AB & NSG CARE CENTE	B	4	1420 LAKE BOONE TRAIL	
	AD & NOG CARE CENTE		F	RALEIGH, NC 27607	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES SY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE COMPLE
F 157	Continued From pag	e 2	F 157		
	activity bus during a twisted her right ankl documented that two confirmed the Reside in the bus while trans chair to her wheelcha documented that upo Resident #1 was ass assessed by the nurs documented there was swelling to Resident nurse then notified her received new orders right knee, and left st note indicated an atter resident 's daughter resident 's son was n In an interview condu- activities coordinator 11:50 AM, she explai activity coordinator, A residents onto the ac- out-of-town music fes 04/21/16. AC #1 exp she (AC #1) was ass from her wheelchair stated she immediate come provide assista that AC #2 came and bus floor and into the asked Resident #1 if bus to go on the outio off the bus to stay at	transfer and that she had e. The writer of the note o activity coordinators ent #1 had fallen on the floor sferring her from the bus air. The writer further on her return to the facility, isted to her bed and was se. The same nurse's note as some bruising and #1's right ankle, that the er physician at 5:40 PM and for x-rays to the right ankle, houlder. The writer of the empt was made to call the at 5:45 PM, and that the notified at 5:49 PM.	F 15/	Team Leader will monitor those re- the weekends (Saturday and Sun one month to monitor for notificati the physician after a fall. A chart will be conducted by the DON/Cli Manager/RN Team Leader to con documentation in the nurses note regarding physician notification of The chart reviews will be done 7 of week by the DON/Clinical Manage Team Leader for one month. All f of non-compliance will be immedia corrected via physician notification follow up inservice education or disciplinary action. The facility Qu Assurance and Performance Improvement Committee (QAPI) or review the falls data and chart aud findings in the monthly QAPI Com- meetings for 3 months.	day) for on of review inical firm s fany fall. days per er/RN indings ately n and uality will dit

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	: 05/16/2016 APPROVED . 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE COMPI	SURVEY LETED
		345369	B. WING			04/2	, 29/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE		
	AB & NSG CARE CENTE	P	4	420 LAKE BOONE TRAIL			
	AB & NGO CARE CENTE	n in the second s	1	RALEIGH, NC 27607			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 157	Continued From page	3	F 157				
	did not think to call int incident to report Res also stated Resident a capable of making he care. AC #2 stated in an int PM that he observed bus floor when he res help. AC #2 explained resting primarily on the when he saw her, and foot!" AC #2 explained resting primarily on the when he saw her, and foot!" AC #2 also state the bus floor and onto she was okay. AC #2 she was okay. AC #2 she was okay and that bus to go on the outing report the fall to anyout In an interview on 04/ nurse who was on dur returned to the facility #1, stated she was co resident had fallen. N resident reported to h at about 5:30 PM on 0 twisted her ankle whill Nurse #1 stated at first had fallen on her way the out-of-town outing activities coordinators was boarding the bus the outing. Nurse #1 assessed Resident #7 to report the incident a findings. Nurse #1 ac and daughter right aft physician. Nurse #1 at	to the facility right after the ident #1 had fallen. She #1 was cognitively intact and r own decisions about her erview on 04/27/16 at 12:12 Resident #1 down on the ponded to AC #1's call for d Resident #1's weight was e heels of her feet while d that she yelled out, "My ed he lifted Resident #1 off the seat, then asked her if e stated Resident #1 replied at she wanted to stay on the g. AC #2 stated he did not he in the facility at that time. 27/16 at 1:00 PM with the ty when Resident #1 after the bus outing, Nurse impletely unaware the lurse #1 explained the er upon return to the facility 04/21/16 she had fallen and e she was on the outing. st, she thought Resident #1 back into the facility after h, but then learned from the she had fallen when she before it left the facility for stated she immediately d, then called the physician and her assessment ided that she called her son er she notified the stated she called her					
	physician a second tir reported she needed	something stronger than					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345369	B. WING				_ 29/2016
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	1 •	
REX REH	AB & NSG CARE CENTE	R			4420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 157	acetaminophen (Tyler stated the policy for re to report it immediate assessment could tak that the nurse should immediately after ass receive any necessar A review of physician 04/21/16 and 04/22/1 04/21/16: X-ray and left shoulder, con 04/21/16: Norco (hyd milligram, one tablet to needed for pain. 04/22/16: Transfer to knee, right ankle, foot 04/22/16: Schedule a specialist follow/up rig In an interview with th 04/27/16 at 3:29 PM, consulted to see Resi 04/21/16. The orthop Resident #1's x-ray re fracture and a new no malleolar fracture. He need to wear a specia the next 6 weeks to m ankle and that she sh bearing" until that time In an interview with th on 04/27/16 at 4:00 P #1's fall should have I after the fall so that a resident at that time, p physician, and receive and treatment. The D	nol) for her pain. Nurse #1 eporting a resident fall was ly so that a nursing ce place. Nurse #1 added call the physician essing the resident to y orders. 's telephone orders dated 6: right ankle and right knee nplaint of pain lrocodone) 5 milligram/325 by mouth every 6 hours as the [hospital] for x-ray of right t full appointment with orthopedic ght ankle ne orthopedic physician on he confirmed he had been ident #1 status post a fall on bedic physician stated esults revealed an old fibula on-displaced medial e stated Resident #1 would alized boot at all times for naintain alignment of her ould remain "non-weight	F	157	7		

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345369	B. WING				C / 29/2016
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
REX REH	AB & NSG CARE CENTE	R			4420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
F 157 F 309 SS=D	of the fall because the the fall until after the r outing around 5:30 PI In an interview with th 04/28/16 at 5:00 PM, facility had identified t Resident #1's fall as a Administrator stated t the facility grounds with that the facility was re Administrator also sta recreation/activities or provided with in-servin falls/incidents, and that care plan had been up for her to remain in he The Administrator addo outline for a plan of co reporting of fall/accide complete. An interview was com- primary physician on primary physician state expected to receive n fall immediately after have provided orders rather than five or six returned to the facility 483.25 PROVIDE CA HIGHEST WELL BEIN Each resident must re provide the necessary or maintain the higher mental, and psychoso	e activity staff did not report residents returned from the M. e Administrator and DON on the Administrator stated the the staff's failure to report a problem. The he activity bus was still on hen the fall occurred, and esponsible for her care. The ted the two bordinators had been ce education about reporting at Resident #1's nursing pdated with an intervention er wheelchair for all outings. ded that there is a rough borrection to address ents, but that it was not yet ducted with Resident #1's 04/29/16 at 2:10 PM. The ted that he would have otification of Resident #1's her fall so that he could for treatment at that time hours later when she c. RE/SERVICES FOR NG eceive and the facility must y care and services to attain at practicable physical,		309	7		5/27/16

Facility ID: 923427

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FO	RM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,	PLE CONSTRU		(X3) DA	TE SURVEY MPLETED
		345369	B. WING _				C)4/29/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADD	RESS, CITY, STATE, ZIP CODE		
		_		4420 LAKE E	BOONE TRAIL		
KEX KEH	AB & NSG CARE CENTE	R	RALEIGH, NC 27607		NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTION(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOULD BEREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			JLD BE	(X5) COMPLETION DATE	
F 309	Continued From page and plan of care.	2 6	F 3	09			
	by: Based on record revi physician interviews, nursing assessment i one of three residents injury, Resident # 1. A review of the quarte 02/23/2016 revealed intact and had a parti- included anemia, hea chronic obstructive pu- rheumatoid arthritis. assessment also indic complaint of pain and medications. A review of the nursin 02/23/16 revealed Re- interventions in place due to her history of f the care plan was to r falls over the next 90 On 04/26/16 at 4:30 F observed resting in be elevated wearing a bl leg. In an interview with R observation, Residen	plan of care. REQUIREMENT is not met as evidenced sed on record review, resident, staff, and sician interviews, the facility failed to provide a sing assessment immediately after a fall for of three residents reviewed for accidents with y, Resident # 1. Findings included: view of the quarterly assessment dated (3/2016 revealed Resident #1 was cognitively ct and had a partial list of diagnoses which uded anemia, heart failure, hypertension, onic obstructive pulmonary disease, and imatoid arthritis. The same quarterly essment also indicated Resident #1 had no plaint of pain and received no scheduled pain		assess facility. and foll and car 2. All r nursing fall. A have ha conduct by 5/20 assess after th non-co nusing inservio 3. All s Clinical on the includir assess immedi new hir the Clir Preven 4. The the 24 Reports per wea	noted, Nurse #1 immediatel sed Resident #1 upon return The physician was also no low up treatment orders wer rried out. residents will be provided wir g assessment immediately a chart review of all residents ad a fall in the last 30 days of cted by the DON/Clinical Ma D/16 to ensure a nursing sment was provided immedia the fall. Any findings of ompliance will be corrected v assessment being provided ce education. staff will be inserviced by the I Educator/Clinical Manager, facility Fall Prevention Prog ing the requirement that a nu- sment must be provided iately after a fall by 5/27/16. res will be inserviced upon h nical Educator on the facility tion Program. e DON/Clinical Manager will hour report and the facility V is Monday through Friday (5 ek) in the clinical meeting fo to monitor for a nursing sment being provided immedia	to the tified re given th a fter a who will be nager ately ia a l and c /DON ram ursing All nire by Fall review /ariance days r one	

Facility ID: 923427

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DA	<u>NO. 0938-03</u> TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	CO	MPLETED
		345369	B. WING			C)4/29/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		14/29/2010
				4420 LAKE BOONE TRAIL		
REX REH	AB & NSG CARE CENTE	R		RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 309	Continued From page	- 7	F 30	P		
	as she slowly fell on t		1.50	weekends (Saturday and S	unday) for one	
		er right knee and ankle were		month to monitor for a nursi	• •	
		did not report her pain to the		assessment being provided	-	
		s at that time. She explained		after a fall. A chart review v		
		nold up everyone else" who		conducted by the DON/Clin		
		d the outing, so she told the		Manager/RN Team Leader		
		s she was okay. Resident		documentation in the nurse		
		en on 04/25/16 by the who told her she would need		regarding a nursing assess provided immediately after	-	
		er right lower leg and ankle		chart reviews will be done 7		
	for about a month.	5		by the DON/Clinical Manag	•	
	A nurse's progress no	ote dated 04/21/16		Leader for one month. All f		
		sident #1 returned to the		non-compliance will be imm		
	-	ies outing and that Resident		corrected via a nursing asse		
	had twisted her ankle	fallen in the activity bus and		provided and follow up inse education and/or disciplinar		
	documented that two			facility Quality Assurance a		
		ent #1 had fallen on the floor		Performance Improvement		
		ferring her from the bus		(QAPI) will review the falls of		
	chair to her wheelcha	ir. The note also indicated		audit findings in the monthly		
		isted to her bed and was		Committee meetings for 3 n	nonths.	
		e upon return to the facility.				
	-	e nurse's progress note, sing and swelling to Resident				
	#1's right ankle, and f					
	-	ed new orders for x-rays to				
		nee, and right shoulder. The				
		cated an attempt was made				
		daughter at 5:45 PM, and				
		n was notified at 5:49 PM.				
	#1.	note was signed by Nurse				
	A review of physician	orders revealed the				
		rders on 04/21/16 and				
		right ankle and right knee				
	and left shoulder, cor					
		drocodone) 5 milligram/325				
	⊨miiiigram, one tablet l	by mouth every 6 hours as				1

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							. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	、 <i>,</i>	PLE CONSTRUCTION		X3) DATE S COMPL	
			A. BUILDIN		-	С	
		345369	B. WING				, 29/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		04/25/2010	
				4420 LAKE BOONE TR			
REX REH	AB & NSG CARE CENTE	ER		RALEIGH, NC 27607			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
F 309	Continued From page needed for pain. 04/22/16: Transfer to		F 3	09			
	knee, right ankle, foo	t full appointment with orthopedic					
	coordinators (AC) #1 she stated Resident a her wheelchair to the was preparing to go o 04/21/16 at about 11 Resident #1 was sec the bus's lift and was level via the hydraulio AC #1 stated Resident the bus where her wh the bus seat. AC #1 around her body per	acted with one of the activity on 04/27/16 at 11:50 AM, #1 fell during a transfer from activity bus seat when she on an out-of-town outing on :30 AM. AC #1 explained ured in her wheelchair on elevated to the bus door c lift per standard procedure. nt #1 was then wheeled onto neelchair was locked next to stated Resident #1 grasped her instruction, then she (AC					
	her to the bus seat. A Resident #1 start to b body, and that she sl bus as she (AC #1) w stated she immediate the other activities co	I under her arms to transfer AC #1 stated she felt ose her grasp around her id down to the floor of the vas supporting her. AC #1 ely called for assistance from pordinator (AC #2), who dent #1 off the floor and onto					
	any problem with ass method during transfe stated she asked Res after the fall and if sh facility, but Resident preferred to stay on t	stated she had never had sisting Resident #1 using this ers in the past. AC #1 sident #1 if she was okay e wanted to remain at the #1 replied she was okay and he bus to continue on the					
	getting a nurse to ass the facility to go out of she checked on Resi	ned she did not think about sess her before the bus left of town. AC #1 added that ident #1 throughout the trip, never complained of any					

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		ID HUMAN SERVICES MEDICAID SERVICES			FO	ED: 05/16/2016 RM APPROVED NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345369	B. WING			C 4/29/2016
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, 2		
		5	4	420 LAKE BOONE TRAIL		
	AB & NSG CARE CENTE	R	1	RALEIGH, NC 27607		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE DENCY)	(X5) COMPLETION DATE
F 309	Continued From page	9	F 309			
	pain until they returne 5:00 PM and 5:30 PM	d to the facility between I.				
	PM that he observed bus floor when he res help. AC #2 explained resting primarily on th when he saw her, and foot!" AC #2 also state the bus floor and onto she was okay. AC #2 she was okay and that bus to go on the outin notify anyone in the fa	erview on 04/27/16 at 12:12 Resident #1 down on the ponded to AC #1's call for d Resident #1's weight was e heels of her feet while d that she yelled out, "My ed he lifted Resident #1 off the seat, then asked her if e stated Resident #1 replied at she wanted to stay on the ig. AC #2 stated he did not acility of the fall until the m their outing late in the				
	nurse who was on du returned to the facility #1, she stated she wa resident had fallen. N #1 reported to her up about 5:30 PM on 04/ twisted her ankle whil Nurse #1 stated she t fallen on her way bac out-of-town outing, bu activities coordinators was boarding the bus bus was still at the fac immediately assessed the physician to repor assessment findings. her son and daughter physician. Nurse #1 physician a second tim	after the bus outing, Nurse as completely unaware the Jurse #1 explained Resident on return to the facility at 21/16 she had fallen and e she was on the outing. hought Resident #1 had k into the facility after the at then learned from the s she had fallen when she before the outing while the cility. Nurse #1 stated she d Resident #1, then called t the incident and She added that she called right after she notified the stated she called her				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345369	B. WING _				C 29/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
REX REH	AB & NSG CARE CENTE	R			420 LAKE BOONE TRAIL RALEIGH, NC 27607		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	D BE COMPLETIO	
F 309	acetaminophen (Tylei stated the policy for m to report it immediate assessment could tak that the nurse should immediately after ass receive any necessar An orthopedic physici on note) revealed Re- malleolar (inner ankle and that the plan was non-ambulatory and t maintain alignment at In an interview with th 04/27/16 at 3:29 PM, progress note on 04/2 consulted to see Resi The orthopedic physic x-ray results showed new non-displaced m stated Resident #1 w specialized boot at all to maintain alignment should remain "non-w time. In an interview with th on 04/27/16 at 4:00 P assessment should b assigned nurse imme fall per the facility's fa the purpose of the as possible injuries so th assessment findings physician. The DON able to complete an a the fall because the a	nol) for her pain. Nurse #1 eporting a resident fall was ly so that a nursing the place. Nurse #1 added call the physician essing the resident to y orders. an progress note (no date sident #1 had a new medial e) fracture, nondisplaced, for her to be o wear a walking boot to the orthopedic physician on he confirmed he wrote the 25/16 and that he had been ident #1 status post a fall. cian stated Resident #1's an old fibula fracture and a edial malleolar fracture. He ould need to wear a times for the next 6 weeks to f her ankle and that she weight bearing" until that the Director of Nursing (DON) 'M, she stated that an	F	309			

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 05/16/2016 APPROVED D: 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345369	B. WING					C 29/2016
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
REX REH	AB & NSG CARE CENTE	R			420 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)			IX	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
TAG F 309	Continued From page outing around 5:30 Pl In an interview with th 04/28/16 at 5:00 PM, facility had identified to nursing assessment ii #1's fall was due to the lack of reporting the fat the activity bus was s when the fall occurred responsible for her cat stated the two activities provided with in-servit to immediately report assessment could tak Resident #1's nursing updated on 04/22/16 to remain in her whee Administrator added to for a plan of correction and the need for an in assessment, but it had developed. An interview was com- primary physician on primary physician on primary physician stat have been reported b fall in order for a nurs assessment for injurie	e 11 M. The Administrator and DON on the Administrator stated the the failure to obtain a mmediately after Resident the activities coordinators' all. The Administrator stated till on the facility grounds d, and that the facility was are. The Administrator also the activities coordinators had been the added that the facility was are. The Administrator also the added that the added that the added that the added that the added that the are plan had been with an intervention for her elchair for all outings. The that there is a rough outline n related to reporting falls mediate nursing d not yet been fully ducted with Resident #1's 04/29/16 at 2:10 PM. The ted Resident #1's fall should y the staff at the time of the e to provide an immediate es. The primary physician k Resident #1's right ankle d by the delay in	F	309			TE	

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