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 _____	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interviews with the Responsible Party (RP) and staff and record review, the facility failed to provide a shower consistent with the resident's prior routine and current preference for 1 of 1 resident (Resident #327) reviewed for choices in bathing. Findings included: Resident #327 was admitted to the facility on 5/6/16 with diagnoses that included an acute stroke, generalized weakness, Alzheimer's dementia, and hypertension. Review of the 5/18/16 Admission Minimum Data Set (MDS) indicated Resident #327 was assessed with short and long term memory impairment and moderately impaired cognitive skills for daily decision making. Refusal of care was not identified on the MDS for Resident #327. The section of the MDS, titled, customary routine and activities, indicated it was very important for Resident #327 to choose between a tub bath, shower, bed bath or sponge bath and very important to choose the number of times per week he received a bath. The MDS also	F 242	For resident # 327, showers were offered per preference and resident discharged on 6/2/2016 All the current residents who were coded “1” in MDS section F0400, box C, will be identified and interviewed to determine if they are satisfied with their current shower schedule. If the residents are unsatisfied with the current schedule, modification will be made to incorporate their preferences within the established shower schedule. Residents newly coded as a “1” in MDS section F0400, box C, will be reported to the Interdisciplinary Care Team in the morning report meeting. The noted resident(s) will be interviewed by either the Administrator, Director of Nursing, Assistant Director of Nursing, Clinical Educator/Infection Preventionist, or Nursing Team Leader to ensure their preferences are incorporated into the established shower schedule. All nursing staff will be in-serviced by the Director of	6/24/16

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

Electronically Signed | 06/03/2016

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 _____	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 242	Continued From page 1 indicated the resident required extensive assistance of staff for personal hygiene and was totally dependent on staff for a bath. Review of the shower schedule, kept at the nurse's station, revealed Resident #327 was scheduled for showers on Monday and Friday on the 3-11 shift. Review of the activities of daily living book, used for nursing assistant (NA) documentation of care given, revealed since his 5/6/16 admission, the resident had received 3 showers. Documentation failed to indicate the resident had refused any showers. The shower scheduled for Monday, 5/23/16, had not been documented as given. The RP was interviewed on 5/23/16 at 3:50 PM. She stated prior to admission, the resident received showers on a daily basis. Since admission to the facility, no one had requested information about Resident #327's prior schedule or past routine with bathing/showering. She stated staff told her he would receive showers twice weekly; and she was left with the thought that was not negotiable. The RP stated she while the facility may not be able to provide daily showers, she would like for Resident #327 to receive more than 2 showers per week. NA #1 was interviewed on 5/24/16 at 2:45 PM. The NA stated residents received showers twice a week according to the shower schedule found at the nurse's station. She added if a resident refused a shower, the NA was expected to ask again, report the resident refusal to the nurse and document the refusal in the activity of daily living book also kept at the nurse's station. NA #1 stated she was unaware of any residents that had requested more than the 2 showers per week.	F 242	Nursing, Clinical Educator/Infection Preventionist and/or Team Leaders on the importance of correctly documenting refusals or non-compliance with the residents established shower schedule. The identified patients will be audited to ensure established shower schedules are being met by the Administrator, Director of Nursing, Assistant Director of Nursing, Clinical Educator/Infection Preventionist or Nursing Team Leader weekly for four weeks, biweekly for one month and monthly for one month. Findings will be brought to the monthly Quality Assurance and Performance Improvement meeting for further review. Any deviation will be immediately reported to the Administrator, Director of Nursing, Assistant Director of Nursing, Clinical Educator/Infection Preventionist or Nursing Team Leader for further investigation and correction. The current shower policy will be reviewed in the scheduled June 2016 meeting , revisions will be made if needed. The corrective action will be initiated by 6/24/2016. In-servicing will be completed by 7/1/16. Audits will be completed by 8/30/16. The audit book will be kept in the Director of Nursing Office.	

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 _____	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 242	Continued From page 2 She added prior to providing more than two showers per week, she would need the nurse's approval. She added the resident that requested more than two showers per week would receive those showers if the NA schedule permitted. A telephone interview was held with NA #2 on 5/25/16 at 12:10 PM. She acknowledged she had been assigned to care for Resident #327 during the 3-11 shift on Monday, 5/23/16. The NA stated Resident #327 had not refused care; adding if any resident refused care, the refusal was reported to the nurse and documented in the activity of daily living book. She added Monday night was really busy and she had not offered the resident a shower. The NA added she must have overlooked the resident's scheduled shower. The Director of Nursing (DON) was interviewed on 5/25/16 at 12:20 PM. She stated residents were expected to receive a minimum of 2 showers per week. Any refusals of care were expected to be reported to the nurse for further encouragement and both the nurse and the NA were expected to document the refusal. The DON was unaware Resident #327 had not received his scheduled showers.	F 242		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff	F 332	Nurse #1 was immediately in-serviced	6/24/16

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 _____	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 332	Continued From page 3 interviews the facility failed to be free of a medication error rate greater than 5% as evidenced by 2 medication errors out of 25 opportunities, resulting in a medication error rate of 8% for 1 of 5 residents (resident #40) observed during medication pass. The findings included: Resident #40 was admitted to the facility on 11/1/2014 with diagnoses to include dementia, and glaucoma. A review of physician orders dated 5/1/2016 included Alphagan 0.1% (medication for glaucoma) place 1 drop into each eye twice daily, and Dorzolamide Hydrochloride (HCl) (medication for glaucoma) ophthalmic solution place 1 drop into each eye twice daily. On 5/24/2016 at 8:19 AM, Nurse #1 was observed preparing and administering medications for Resident #40. The Nurse administered Alphagan 0.1% 1 drop to each eye at 8:26 AM. She then opened the second eye medication, Dorzolamide HCl and administered 1 drop to each eye at 8:27 AM. On 5/24/2016 at 8:44 AM, an interview with Nurse #1 was conducted following the medication administration. The nurse stated eye drops were supposed to be given a couple of minutes apart, but these drops were probably less than that. She indicated she usually times the drops, but did not do that this time. On 5/25/2016 at 10:51 AM, an interview was conducted with the Director of Nursing (DON). The DON stated she expects eye drops to be given 3 to 5 minutes apart.	F 332	on the day of incident by the Clinical Educator/Infection Preventionist regarding the proper administration of eye drops including the interval necessary between administration of multiple drops to eliminate a reoccurrence to resident # 40. The facility has identified that all residents have the potential to be affected by the deficient practice , therefore all nurses will be in-serviced by the Director of Nursing, Clinical Educator/Infection Preventionist and/or Team Leaders on proper medication administration of eye drops including multiple eye drop administration intervals. Audits will be conducted on multiple eye drop administration by the Director of Nursing, Assistant Director of Nursing, Clinical Educator/Infection Preventionist, Admission Nurses or Team Leader, at intervals of 5 medications per week for four weeks then five medications bi-weekly for one month and then five medications for a month. The results of the audit will be reviewed in the quality assurance performance improvement meeting each month. Any deviation will be immediately reported to the Administrator, Director of Nursing, Assistant Director of Nursing, Clinical Educator/Infection Preventionist or Nursing Team Leader for further investigation and correction. The corrective action will be initiated by 6/24/2016. In-servicing will be completed	

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 _____	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 332	Continued From page 4	F 332	by 7/1/16. Audits will be completed by 8/30/16. The audit book will be kept in the Director of Nursing Office.	
F 372 SS=E	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to keep the dumpster area free from debris for 4 of 4 dumpsters. The findings included: On 5/22/16 at 4:55 PM an observation of the dumpster area was conducted with Food Service Worker (FSW) #1. The observation revealed 4 dumpsters located within a closed in fenced area. On the ground were a minimum of 20 pairs of used blue gloves, a bottle of stool softener and numerous pieces of paper and 3 small cardboard boxes scattered throughout the fenced in area. FSW #1 stated she did not know why the items were there and they appeared to have been there for "a while". On 5/22/16 at 6:10 PM an observation of the dumpster area was conducted with the Food Service Director (FSD) and the Administrator. The same items were present. The FSD stated he had cleaned the area last Wednesday (5/18/16) when the trash removal company had lifted the dumpsters and he had cleaned under and around them. He stated the reason the items appeared to have been there for an extended time was because of the large amount of rain. On 5/22/16 at 6:10 PM the Administrator stated the dumpster area needed to be cleaned and free	F 372	The dumpster area cleaned of garbage and refuse around dumpsters on day of finding. The Food and Nutrition Service department cook on duty will complete an audit of dumpster area inside of fenced in area. Audit will include monitoring area and ensure any garbage and refuse is cleaned up in a timely manor. Audits will be done daily times two weeks then every other day times 2 weeks then 2 times a week times 2 weeks then weekly thereafter. A log book with be created to house the weekly monitoring/clean-up rounds. Audit findings will be brought to the monthly Quality Assurance and Performance Improvement meeting for further review. Any deviation will be reported to the Administrator and/or Food Service Manager for further investigation and correction. All food service staff will be in-serviced on the importance of maintaining a clean and safe work environment by the Food	6/22/16

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 _____	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 372	Continued From page 5 from debris on the ground. On 5/25/16 at 11:45 PM the FSD stated he had not worked since Wednesday so the area may not have been cleaned since that time.	F 372	Service Manager.. The corrective action will be initiated by 6/22/2016. In-servicing will be completed by 7/1/16. The audit will be completed by 7/17/16. The weekly log book will be started 7/18/16 and be kept in the Food and Nutrition Services Managers office.	