DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR						
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB	NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345508	B. WING			05/24/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
	REHAB & NURSING CA	RE CENTER OF APEX		911 SOUTH HUGHES STREET		
				APEX, NC 27502		
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)		F 69	0		6/15/18
	resident who is contir admission receives s maintain continence	cility must ensure that nent of bladder and bowel on ervices and assistance to unless his or her clinical nes such that continence is				
	ensure that- (i) A resident who enti- indwelling catheter is resident's clinical con- catheterization was n (ii) A resident who en- indwelling catheter or is assessed for remo- as possible unless th demonstrates that ca and (iii) A resident who is receives appropriate	on the resident's sement, the facility must ters the facility without an not catheterized unless the idition demonstrates that eccessary; ters the facility with an subsequently receives one val of the catheter as soon e resident's clinical condition theterization is necessary; incontinent of bladder treatment and services to infections and to restore				
	ensure that a residen receives appropriate restore as much norm possible. This REQUIREMENT by:	on the resident's ssment, the facility must t who is incontinent of bowel treatment and services to nal bowel function as is not met as evidenced				
		n, staff interviews, and		The deficiency cited was for R	esident	
		SUPPLIER REPRESENTATIVE'S SIGNATUF	RE	TITLE		(X6) DATE
Electroni	cally Signed					06/06/2018

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.

PRINTED: 06/29/2018

D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/29/2018 FORM APPROVED OMB NO. 0938-0391	
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
345508	B. WING		05/24/2018	
		STREET ADDRESS, CITY, STATE, ZIP CODE	• • • • • •	
RE CENTER OF APEX	911 SOUTH HUGHES STREET APEX, NC 27502			
Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOL	JLD BE COMPLETION	
 X REHAB & NURSING CARE CENTER OF APEX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 record review the facility failed to keep a catheter bag from coming in contact with the floor for 1 of 2 residents reviewed for catheter care (Resident #86). Findings included: Resident #86 was admitted to the facility on 5/21/18. His active diagnoses included a left hip fracture, urinary tract infection, and atrial fibrillation. Review of Resident #86's baseline care plan dated 5/21/18 revealed the resident was care planed for having a catheter. The interventions included catheter care per protocol. During observation on 5/23/18 at 1:12 PM the Physical Therapy Assistant was observed pushing Resident #86 in a wheelchair down the main hall of the facility to his room. The resident's catheter bag was observed to have the bottom of the collection bag in contact with the floor dragging across the floor as she was pushing him. During an interview on 5/23/18 at 1:16 PM the Physical Therapy Assistant stated catheter bags should not touch the ground for infection control concerns. Upon observing the catheter bag she stated one of the catheter bag clips had come off the wheelchair which caused the bag to come in contact with the ground. During an interview on 5/23/18 at 1:35 PM the Infections Control Nurse stated neither catheter bags nor catheter tubing were to come in contact with the floor. She further stated it was her 		 #86, foley catheter bag was touching floor on two separate instances not The first instance described on 5/2 noted the catheter bag touching the from its mounted position on the with chair. The second instance was on 5/24/18 for Resident #86, where the catheter bag was noted to be touch floor hanging from its position on the frame. In both situations for resident #86, height of the bag was adjusted as a come in contact with the floor. Whit the wheel chair the foley catheter bag touch the floor. The plan for correcting this deficient practice is staff education and scheet auditing. Education will be provided. Staff Educator/Infection Prevention employees that are responsible for catheter bag placement. These employees consist of nurses, certifin nurse's aides, and therapists. A cut employee roster was obtained for the groups noted above. Face to face education will consist of proper fole catheter bag placement to prevent foley catheter bag placement to prevent foley catheter bag from touching the An audit will be conducted by the E of Nursing, Assistant Director of Nursing. 	ted. 3/18 e floor heel e ning the ne bed the to not le in bag chair as did not nt eduled d by the nist to fied rrent he leted end in d during s by the the floor. Director ursing, ionist.	
	AEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345508 AE CENTER OF APEX TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 1 1 ity failed to keep a catheter inted to the facility on ignoses included a left hip infection, and atrial 36's baseline care plan d the resident was care theter. The interventions a per protocol. 15/23/18 at 1:12 PM the stant was observed in a wheelchair down the it to his room. The resident's erved to have the bottom of ontact with the floor for as she was pushing 15/23/18 at 1:16 PM the stant stated catheter bags pround for infection control ving the catheter bag she eter bag clips had come officaused the bag to come in d and it should not have he ground. 15/23/18 at 1:35 PM the se stated neither catheter ing were to come in contact	MEDICAID SERVICES (X2) MULTIF (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A. BUILDING 345508 B. WING	AEDICAID SERVICES (X1) PROVIDERSUPPLERCIAN IDENTIFICATION NUMBER: 345508 B. WING 345508 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 911 SOUTH HUGHES STREET APEX, NC 27502 TEMENT OF DEFICIENCIES INUS TE PRECEDED BY FULL SCIDENTIFYING INFORMATION) TAG PREFIX TAG PREFIX TAG PROVIDERS PLAN OF CORRECT TIMUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) TAG PREFIX TAG PREFIX <td< td=""></td<>	

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 960251

If continuation sheet Page 2 of 4

PRINTED: 06/29/2018

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DA	OMB NO. 0938-039 (X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· /	. ,	A. BUILDING		COMPLETED	
		B. WING			05/24/2018		
		STREET ADDRESS, CITY, STATE, ZIP CODE		IP CODE			
UNC REX	REHAB & NURSING CA	RE CENTER OF APEX		911 SOUTH HUGHES STREET APEX, NC 27502			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE	
F 690	Continued From page 2 expectation that the resident's catheter bag not touch the floor during transport. During observation on 5/24/18 at 8:53 AM Resident #86 was observed in bed. The bottom of the catheter bag was observed to be in contact with the floor. During an interview on 5/24/18 at 8:56 AM Nurse #1 stated catheter bags were to be stored off the floor. Upon observation of Resident #86's catheter bag she stated the bag should not have been in contact with the floor and she would adjust it. She stated someone must have lowered the bed and not noticed it was in contact with the floor. During an interview on 5/24/18 at 8:59 AM the Director of Nursing stated catheter bags were not to touch the floor. She further stated it was her expectation that catheter bags be stored high enough that they were not in contact with the ground at any time.		F 690 5/23/18, it was identified that the for was improperly hung on the wheel The foley product was evaluated for quality and integrity of the bag and attachment system. There are two available for foley bag mounting. O hook was noted to be detached fro wheel chair. User error, not product failure, was the reason for the obset deficiency. In the second instance of 5/24/18, it was found that the bed h was not set appropriately to prevent foley catheter bag from touching the again user error, there was no failud the product being used. The procedure for implementing the of correction will be the completion education conducted by the Staff Educator/Infection Preventionist. A will be conducted by the Director of Nursing, Assistant Director of Nursi Staff Educator/Infection Prevention The monitoring procedure to ensur- plan of correction is effective will be conduct a randomized audit of chool		the wheel chair. Evaluated for the bag and the the observed d instance on the bed height by to prevent the touching the floor, was no failure in the staff the Staff the Staff the Staff the Staff the observed the the staff the staff the staff the observed the staff the staff the staff the staff the staff the observed the staff the staff the staff the staff the staff the observed the staff the staff the staff the staff the staff the staff the staff the staff the staff the staff the staff the staff the staff the staff		
				Residents with foley cat bag placement weekly ti bi-weekly times one mont anticipated completion of 2018. The results of the reviewed in the monthly Performance Improveme The Administrator, Direct Assistant Director of Nul Educator/Infection Preve responsible for impleme correction. The correctiv completed by June 15th	heters for proper imes 1 month, nth, and finally th with an date of August 15, audit will be Quality Assurance ent meeting. ctor of Nursing, rsing, or Staff entionist will be nting the plan of <i>y</i> e action will be		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: K1GU11

Facility ID: 960251

If continuation sheet Page 3 of 4

DEPART CENTER	FORM APPROVED OMB NO. 0938-0391					
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345508	B. WING _		05/24/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
UNC REX	UNC REX REHAB & NURSING CARE CENTER OF APEX			911 SOUTH HUGHES STREET APEX, NC 27502		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMI CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 960251

If continuation sheet Page 4 of 4

PRINTED: 06/29/2018