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 _____	08/01/2014

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 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to provide a barrier between ready to eat food and the servers' bare hands for 4 Nursing Assistant's (NA's), (NA #1, NA #2, NA #3 & NA #4), who picked up bread with their bare hands during 4 of 4 observed meals. A dining observation was conducted on 7/29/14 at 12:40 PM in the 200 hall dining room. NA #1 was observed to sanitize her hands and place a tray on the dining table for a resident. She then assisted the resident with putting butter on her biscuit. NA #1 picked the biscuit up with her bare hands, pulled it in half, laid the top down and applied butter with a knife to the bottom portion. She then placed the bottom of the biscuit on the outer circumference of the plate, picked up the top portion of the biscuit with her bare hands and placed it on the bottom portion. Gloves were available in the dining area, deli tissues or other barriers were not observed. A dining observation was conducted on 7/30/14 at 12:23 PM in the 100 hall dining room. NA #2 was	F 371	Corrective Action for residents found to have been affected by the deficient practice: No residents were identified. Immediately upon realization that the deficient practice was occurring, one on one education was started by nursing management with those coworkers identified. How facility will identfy other residents having the potential to be affected by the same deficient practice: Meal service observations are being conducted by DON, ADON, Nurse Educator, or Department Head to identify deficient technique in delivering and setting up resident meals. Meal delivery, set up and feeding procedures are being observed for all 3 meals.	8/15/14

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

Electronically Signed | 08/14/2014

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F 371	Continued From page 1 observed to sanitize her hands and place a tray on the dining table for a resident. She then used a spoon and one bare finger to move the resident's roll to the side of the resident's plate. At 12:25 PM, NA #2 was observed to place a tray at another residents table. She then assisted the resident with putting butter on her roll. NA #2 picked the resident's roll up with her bare hands, pulled it in half, laid the top down and applied butter with a spoon to the bottom portion. She then placed the bottom of the roll on the outer circumference of the plate, picked up the top portion of the roll with her bare hands and placed it on the bottom portion. Gloves were observed in the dining area, other food barrier items such as deli tissue were not observed. A dining observation was conducted on 7/30/14 at 5:20 PM in the 100 hall dining room. NA #3 was observed to sanitize her hands and place a tray on the dining table for a resident. She then assisted the resident with her tray. NA #3 picked up the residents roll from on top of her quiche and set it beside the quiche with her bare hands. The resident then picked up the roll from her plate and set it off the plate onto the tray. A dining observation was conducted on 7/31/14 at 8:30 AM in the 200 hall dining room. NA #1 was observed to sanitize her hands and place a tray on the dining table for a resident. She then assisted the resident with putting butter on his biscuit. NA #1 picked the biscuit up with her bare hands, pulled it in half, laid the top down and applied butter with a knife to the bottom portion. She then placed the bottom of the biscuit on the outer circumference of the plate, picked up the top portion of the biscuit with her bare hands and placed it on the bottom portion.	F 371	Measures put into place/systemic changes made to ensure that the deficient practice will not recur: Meal Service Policy and Procedure was developed to establish clear expectations for safe and sanitary meal service. All facility staff were educated on the Meal Service Policy and Procedure. Education was completed on 8/15/14. New hire direct care staff orientation now includes Meal Service Policy and Procedure education and observed validation of proper technique during the orientation process beginning. This process began 8/11/14. How the facility plans to monitor its performance to make sure that solutions are sustained: Facility DON, ADON, Nurse Educator, or Department Head will monitor compliance with Resident Meal Service Policy and Procedure by observing a minimum of 6 meals per week for the first 4 weeks beginning 8/15/14. After that, a minimum of 6 meals biweekly for 2 months. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly. Any deviation from policy identified in interviews will be immediately reported to the Administrator	

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F 371	Continued From page 2 Continued observation revealed at 8:39 AM NA #4 was observed applying butter and jelly on a resident's slice of toast while holding the toast with her bare hands. Gloves were observed in the dining area, other food barrier items such as deli tissue were not observed. During an interview with NA #2 on 7/31/14 at 9:13 AM she stated "If a biscuit, roll or piece of bread is near gravy or sauce; or if bread is in the way of a meat I have to cut up, then I pick it up and move it with my hands since I sanitize my hands between each resident that I serve." NA #2 indicated that she had not been told by the facility that she could not pick up bread with her bare hands to move it or apply condiments to it. NA #2 stated "We have been told to sanitize our hands with soap and water or hand sanitizer between each resident that we serve." During an interview with NA #4 on 7/31/14 at 9:28 AM she indicated that NA's are expected to assist the resident that cannot assist themselves with applying the condiments that they choose. NA #4 stated "I did put butter and jam on a piece of toast this morning. I picked up the toast with my hands." NA #4 indicated that she had not been told by the facility that she could not pick up bread with her bare hands to apply condiments to it. NA #4 stated "We have been told to sanitize our hands with soap and water or hand sanitizer between each resident that we serve." During an interview with NA #1 on 7/31/14 at 9:30 AM she stated "We are expected to offer condiments to the resident when we serve them their meal and to assist them if the resident	F 371	or designee for further investigation. Facility DON, ADON, Nurse Educator, or Department Head will review the Meal Service Policy in the monthly Nurse and Nursing Assistant meetings for the months of August, September and October.	

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F 371	Continued From page 3	F 371		

cannot assist him/herself. If a resident wants butter or jelly on their biscuit I open the biscuit with my hands to put the butter on it." NA #1 indicated that the facility had never taught her not to touch the food with her bare hands. NA #1 stated "We are expected to sanitize or wash or hands with soap and water between each resident that we serve."

The Dietary Manger (DM) was interviewed on 7/31/14 at 11:05 AM. The DM indicated that the Staff Development Coordinator (SDC) trained NA's regarding safe serving of food. The DM stated "I would expect that anyone serving food would not touch food items, there must be a barrier between the server and the food item such as gloves or utensils. In the kitchen staff have been trained to wear gloves when bagging food items and to use utensils if they have to move anything around on a food tray."

The SDC was interviewed on 7/31/14 at 2:10 PM. The SDC indicated that when NA's are hired they have go through orientation of facility policy and procedures and training that includes sanitation and universal precautions, but not a specific training or observation of
NA's regarding food handling. The SDC indicated that when NA's are in training, they shadow other experienced NA's who show them what to do when serving food to residents.

The Director of Nursing (DON) was interviewed on 7/31/14 at 2:17 PM. The DON indicated that NA meetings occur once a month and include topics of interest, areas of concern, policy and procedure review and best practice review. The DON indicated that the NA's sanitize or wash their hands with soap and water between each

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F 371	Continued From page 4 resident that they serve and handling of food items had been perceived as a problem. The DON indicated that the topic of safe food serving had not been introduced or discussed in the monthly NA meetings, but she did expect the NA's to know better than to touch the residents' food items. The DON stated "The NA's initial training does not specifically include serving residents in the dining rooms. We do not monitor NA's as they serve residents food. Yes, the NA's do touch the bread items, we are going to fix this. "	F 371		