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 _____	05/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNC REX REHAB & NURSING CARE CENTER OF APEX	911 SOUTH HUGHES STREET APEX, NC 27502

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E 000	Initial Comments An unannounced Recertification survey was conducted on 05/28/19 through 05/31/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #ZCKD11	E 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would	F 623		6/28/19

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

Electronically Signed | 06/17/2019

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F 623	Continued From page 1	F 623		

be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental

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F 623	Continued From page 2 disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide written notice of discharge to the resident's representative for a facility-initiated discharge for 1 of 1 residents reviewed for hospitalizations (Resident #22). The findings included: Resident #22 was admitted to the facility on 10/2/17 with diagnoses that included dementia. A nurse's note dated 4/27/19 revealed Resident #22 was sent to the hospital due to being	F 623	Written notice of transfer/discharge for a facility initiated transfer was not provided to resident's representative prior to transfer to hospital for Resident #22 on 4/27/19. Resident returned to the facility without incident on 5/5/19. If resident requires a facility initiated transfer/discharge in the future, a written notice will be provided to the resident and resident representative. Facility did not have a process for utilization of a notice of transfer/discharge	

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F 623	Continued From page 3 nonresponsive. The note indicated the family was notified of the transfer by phone. Resident #22's medical record revealed no information regarding the resident's responsible representative being provided with written notice of the resident's hospital transfer on 4/27/19. A nurse's note dated 5/5/19 revealed Resident #22 was readmitted to the facility from the hospital on 5/5/19. During an interview on 5/30/19 at 4:11 PM with Nurse #3 she stated when a resident was sent to the hospital the paperwork sent included the face sheet, the list of diagnoses, code status, medication administration record and a transfer form. She indicated there was no written notification of the resident's transfer to the hospital that was sent with the resident. During an interview on 5/30/19 at 4:30 PM Social Worker #1 stated she did not send written notice of discharge to the resident or the resident's representative for the resident's hospital transfer on 4/27/19. The Social Worker stated she was not aware a written notice was required to be provided when a resident was transferred to the hospital. During an interview with the Administrator on 5/30/19 at 5:38 PM he indicated he was not aware of the requirement to provide written notification to the resident or the responsible party for emergent hospital transfers.	F 623	for facility initiated discharges. A new transfer/discharge form will be created and a new process implemented to be effective 6/24/19 and residents requiring a facility initiated transfer/discharged starting 6/24/19 will receive a written notice of transfer/discharge with a copy of the notice sent to the Residents Representative if applicable. Staff involved in resident transfer/discharge will be educated by the Clinical Educator on the new system change for notice of facility initiated transfer/discharge by 6/24/19. A chart audit for ongoing monitoring containing 10% of facility initiated transfers/discharges will be completed weekly times 4 weeks, bi-monthly times 1 month, then monthly times 1 month starting 6/24/19 and completing 9/15/19 by MDS nurse #1 and MDS nurse #2. The results of the audits will be reviewed in the Quality Assurance Performance Improvement meeting each month.	
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c)	F 638		6/28/19

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F 638	Continued From page 4 §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a quarterly minimum data set (MDS) assessment for 1 of 7 residents who had quarterly MDS assessments reviewed (Resident #22). The findings included: Resident #22 was admitted to the facility on 10/2/17 with diagnoses that included dementia and hyperlipidemia. Review of Resident #22's quarterly minimum data set (MDS) assessment dated 3/25/19 revealed Section D, questions D0500A-D0500J were not completed. The unanswered questions D0500A-D0500J related to staff 's assessment of the resident's mood. During an interview with Social Worker #1 on 5/30/19 at 4:30 PM she stated she normally codes Section D of MDS assessments. She stated she did not complete Section D of the 3/25/19 assessment for Resident #22. Social Worker #1 indicated she was not sure why questions D0500A-D0500J were not completed on the assessment dated 3/25/19. An interview was conducted with MDS Nurse #1 on 5/30/19 at 5:00 PM who indicated questions D0500A-D0500J were not completed on the assessment dated 3/25/19. She stated she was unsure the reason these questions were not	F 638	The 3/25/19 Quarterly Minimum Data Set (MDS) assessment for resident #22 was found to be incomplete. MDS nurse #1 entered a modification on 5/30/19 for resident #22. MDS nurses #1 and #2 will be educated by the Clinical Educator on the importance of submitting a complete MDS assessment by 6/20/19. An audit of all open assessments between the dates of 5/30/19 (date error was noted)-6/24/19 will be completed by 6/24/19 by the Director of Nursing and/or Clinical Educator to ensure assessment completion. A process change whereby MDS nurse #1 will validate and finalize MDS assessments complete by MDS nurse #2 and MDS nurse #2 will validate and finalize MDS assessments completed by MDS nurse #1. Ongoing monitoring will be completed by auditing a 10% sample of MDS assessments for completeness weekly times 4 weeks, bi-monthly times 1 month, then monthly times 1 month starting 6/24/19 and completing 9/15/19 by Director of Nursing and/or Clinical Educator.	

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F 638	Continued From page 5 completed and felt the computer system should have caught the error. An interview was conducted with the Administrator on 5/30/19 at 5:38 PM who indicated it was his expectation that MDS assessments are reviewed for accuracy prior to submission.	F 638	The results of the audits will be reviewed in the Quality Assurance Performance Improvement meeting each month.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessments in the areas of hospice services (Resident #21) and discharge status (Resident #96) for 2 of 24 residents whose MDS assessments were reviewed. The findings included: 1. Resident # 21 was admitted to the facility on 4/17/18 with diagnoses which included hypothyroidism, deep vein thrombosis, and adult failure to thrive. A review of the quarterly Minimum Data Set (MDS) dated 3/25/19 revealed Resident #21 was severely cognitively impaired and required total assistance with activities of daily living. In Section O, question 0100 item K, the MDS indicated Resident #21 was on hospice services. A review of the medical record revealed the face	F 641	The facility failed to accurately code the assessment areas of hospice services for resident #21 and discharge status for resident #96 of the MDS assessment. MDS nurse entered modifications for resident #21 on 5/31/19 and resident #96 on 5/30/19 with updated information. MDS nurses #1 and #2 will be educated on importance of submitting accurate MDS assessments by 6/20/19 by the Clinical Educator. An audit of all open assessments between the dates of 5/30/19 (date error was noted)-6/24/19 will be completed by 6/24/19 by the Director of Nursing and/or Clinical Educator to ensure accurate completion of hospice services and discharge status sections of the Minimum Data Set (MDS). A process change whereby MDS nurse #1 will validate and	6/28/19

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F 641	Continued From page 6 sheet did not indicate Resident #21 was on hospice services. The record review also revealed there were no physician orders for hospice services nor any records of hospice services being provided. During an interview with MDS nurse #1 on 5/31/19 at 8:37 AM she stated Resident #21 was not receiving hospice services. She stated Section O question 0100 item K was an error on the MDS and she needed to complete a modification to the MDS to correct the error. 2. Resident #96 was admitted to the facility on 2/20/2019 with medical diagnoses which included right femoral fracture and dementia. A review of social worker notes dated 3/1/2019 revealed the social worker met with Resident #96's niece and spouse and discussed the resident's pending discharge. The goal was for her to return home with home health services. Resident #96's physician order dated 3/7/2019 revealed an order to discharge home with home health services. A review of the resident's discharge Minimum Data Set (MDS) dated 3/7/2019 revealed the MDS specified discharge status as to acute hospital. During an interview with the MDS nurse on 05/30/2019 at 10:05 am, she stated Resident #96 had been discharged to the hospital, but she would check the paperwork to make sure. After she checked the paper work, the MDS nurse stated that it looked like Resident #96 was discharged home with home health. She further	F 641	finalize MDS assessments complete by MDS nurse #2 and MDS nurse #2 will validate and finalize MDS assessments completed by MDS nurse #1. Ongoing monitoring will be completed by auditing a 10% sample of MDS assessments for accurate coding of hospice services and discharge status weekly times 4 weeks, bi-monthly times 1 month, then monthly times 1 month starting 6/24/19 and completing 9/15/19 by the Director of Nursing. The results of the audits will be reviewed in the Quality Assurance Performance Improvement meeting each month.	

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F 641	Continued From page 7 stated that it was an error on the MDS and she would modify it right away. An interview with the Director of Nursing on 5/29/2019 at 5:00 pm revealed she was unaware of the incorrect coding and the MDS should have been coded to show that Resident #96 was discharged home.	F 641		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761		6/28/19

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F 761	Continued From page 8 Based on record review and resident and staff interview the facility failed to secure a prescription medication for 1 of 1 resident (resident #68) whose inhaler was left at the bedside. Findings included: Resident #68 was admitted to the facility on 02/08/19 with diagnoses including asthma. Review of resident #68's Minimum Data Set assessment dated 2/20/19 coded as an admission assessment revealed resident #68 was independent with daily decision making. It further revealed he exhibited no behaviors or refusal of care. A review of resident #68's medical record revealed a physician order for Advair HFA 115/21 micrograms (mcg) 2 puffs inhaled twice daily for asthma. There wasn't a physician order for self-administration of the medication in resident #68's record. There wasn't a physician order allowing Advair HFA inhaler to be kept at bedside in resident #68's record. A review of resident #68's care plan revealed no focus area for self-administration of Advair HFA inhaler. On 05/29/19 at 10:21 AM, in an interview, resident #68 indicated the facility had lost his Advair HFA inhaler. He went on to indicate nurse #1 left the inhaler in his room the evening of 05/28/19. He indicated after nurse #1 left his room, he placed the inhaler on his bedside table. He further indicated nurse #2 asked him this morning if he had it. He went on to indicate when his inhaler couldn't be found, a new inhaler was ordered.	F 761	The facility failed to secure a prescription medication (i.e. inhaler was left at the bedside) for Resident #68. An audit was completed on 5/29/19, during survey process, by the Director of Nursing, Nursing Team Leader, and Administrator of resident #68's inhalers to ensure current compliance. All inhalers for Resident #68 were accounted for and secured in locked medication cart and will not be left at bedside. Resident has since discharged from facility without incident on 6/1/19. A list was obtained from the facility pharmacy of all residents with ordered inhalers. An audit was completed 6/19/19 to verify all inhalers are accounted for and secured in locked medication cart by the Director of Nursing. Medication administration nurses will be educated by the Clinical Educator on the importance of ensuring inhalers are in locked medication carts before and after administration of the medication to the resident which will be completed by 6/24/19. Ongoing monitoring will be completed by auditing a sample of 10% of all inhalers ordered to ensure they are accounted for and secured in locked medication carts. Monitoring will be completed weekly times 4 weeks, bi-monthly times 1 month, then monthly times 1 month to start on 6/24/19 and be completed on 9/15/19 by Director of Nursing and/or Clinical Educator and/or Nursing Team Leader and/or Admission	

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F 761	Continued From page 9 In an interview on 05/29/19 at 3:07 PM nurse #1 indicated she had administered medication including Advair HFA 115/21 mcg to resident #68 on 05/28/19 during the 7pm-11pm shift. She went on to indicate she had been busy that evening but not more busy than usual. She went on to say she may have inadvertently left resident #68's inhaler at his bedside rather than securing it in the medication cart after administration. An interview on 5/29/19 at 3:18 PM with nurse #2 revealed a new Advair HFA inhaler had been ordered for resident #68. She further indicated she had been the first to open it that morning. On 05/29/19 at 3:21 PM an interview with nurse Team Leader #1 revealed resident #68's Advair HFA inhaler had been left in his room on 05/28/19 on the 7pm-11pm shift. She further indicated when it could not be found a new inhaler had been ordered. In an interview on 5/30/19 at 2:22 PM nurse #3 indicated it would not be acceptable practice to leave a prescription medication unsecured at the bedside of a resident. She indicated the prescription medication should have been returned to the medication cart and secured after administration. On 05/30/19 at 2:30 PM, in an interview, nurse Team Leader #2 indicated it would not be acceptable practice to leave an Advair HFA inhaler at the bedside of resident #68. She indicated the medication should have been returned to the medication cart and secured after administration.	F 761	Nurse. The results of the audits will be reviewed in the Quality Assurance Performance Improvement meeting each month.	

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F 761	Continued From page 10 In an interview on 05/30/19 at 2:40 PM the facility's Director of Nursing indicated it would not be acceptable practice to leave an Advair HFA inhaler at the bedside resident #68. She went on to say the inhaler should have been returned to the medication cart and secured after administration.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to discard 1 container of diced ham by the use by date and failed to maintain cooked peach cobbler at a temperature above 135 degrees Fahrenheit during 2 of 3 kitchen observations. The findings included:	F 812	Upon notification of an out of date food item on 5/28/19 (diced ham), the diced ham was immediately discarded. Upon notification of the peach cobbler not at appropriate temperature on 5/30/19, the peach cobbler was immediately discarded and a menu substitution of a canned	6/28/19

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F 812	Continued From page 11 1) During an observation of the walk in cooler on 5/28/19 at 10:02 AM a container of left over diced ham was observed to have plastic wrap over the container. A label was on the plastic wrap. The label on the container was dated 5/22/19. During an interview with the Certified Dietary Manager (CDM) on 5/28/19 at 10:02 AM he stated the date on the label was the date the ham was placed inside the cooler. He said the ham should have been discarded yesterday (5/27/19) because the diced ham was only acceptable for use for 5 days from when it was put in the refrigerator. 2) During an observation of the lunch meal service on 5/30/19 from 11:30 AM through 12:30 PM the peach cobbler was observed stored in individual serving bowls on a sheet pan in the temperature regulated holding unit inside the kitchen near the cooking area. One sheet pan was removed and placed in a rack near the servicing line and when that sheet pan was almost empty a new sheet pan was removed from the holding unit and placed on the serving rack. On 5/30/19 at 12:20 PM the temperature of the peach cobbler was taken with a calibrated thermometer. The temperature of the peach cobbler registered 91 degrees Fahrenheit. During an interview with the CDM on 5/30/19 at 12:30 PM he stated the peach cobbler temperature should be maintained above 135 degrees Fahrenheit.	F 812	peaches was provided. An initial audit was completed by Certified Dietary Manager on 5/28/19 of refrigerators to ensure all items were with in date compliance. All residents taking a PO diet could have been affected by consuming out of date food products and cobbler at an inappropriate temperature. Education will be provided to all Food Service staff by Certified Dietary Manager on use by dates and appropriate serving temperatures of food items by 6/24/19. Food service co-worker position 1-Starter, will check refrigerators daily to verify that foods are date marked and that foods exceeding the expiration period are not being used or stored. Daily verification checks will be recorded on a form located outside the refrigerator. The peach cobbler will now be served at the appropriate safe temperature of equal to or less than 41 degrees Fahrenheit or equal to or greater than 135 degrees Fahrenheit. The Certified Dietary Manager or Cook will continually monitor food expiratory verification log weekly times 4 weeks, bi-monthly times 1 month, then monthly times one month to start on 6/24/19 and be completed on 9/15/19. The Cook will record temperatures of the cobbler when served to verify proper holding temperatures. Continued monitoring of the temperature log will be completed by the Certified Dietary Manager weekly times 4 weeks, bi-monthly times 1 month, then	

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 _____	05/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 12	F 812	monthly times one month to start on 6/24/19 and be completed on 9/15/19. The results of the audits will be reviewed in the Quality Assurance Performance Improvement meeting each month.	