

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/26/2023  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345369</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/23/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>REX REHAB &amp; NSG CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4210 LAKE BOONE TRAIL</b> <b>RALEIGH, NC 27607</b>		
(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	
E 000	Initial Comments	E 000			
F 000	An unannounced recertification and complaint investigation survey was conducted on 3/20/23 through 3/23/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # OUUP11.  INITIAL COMMENTS	F 000			
F 685 SS=D	A recertification and complaint investigation survey was conducted from 3/20/23 through 3/23/23. Event ID# OUUP11. The following intakes were investigated: NC00199049, NC00193039, and NC00193008.  7 of the 7 complaint allegations did not result in deficiency.  Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2)  §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident-  §483.25(a)(1) In making appointments, and  §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observations, resident representative and staff interviews, and record review, the facility failed to assist Resident #55 and their representative in locating missing hearing aids,	F 685	Address how corrective active will be accomplished for those residents found to have been affected by the deficient practice	4/14/23	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/29/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345369</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/23/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>REX REHAB &amp; NSG CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4210 LAKE BOONE TRAIL RALEIGH, NC 27607</b>		
(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 685	<p>Continued From page 1</p> <p>as well as in making appointments, and arranging for transportation to replace the lost devices. This occurred for 1 of 1 sampled resident (Resident #55) reviewed for hearing/vision.</p> <p>The findings included:</p> <p>Resident #55 was admitted to the facility on 12/2/21 with diagnoses including confusion, dehydration, and hypertension.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated 3/7/23 for Resident #55 revealed he had adequate hearing with hearing aids. He was coded as moderately cognitively impaired without any rejection of care behaviors.</p> <p>Review of Resident #55's active care plan (dated 12/10/21) revealed he had impaired verbal communication defined by word finding difficulty related to neuromuscular development. Interventions included: use appropriate adaptive equipment and provide tools necessary to communicate.</p> <p>An observation and interview of Resident #55 on 3/20/23 at 10:21 AM revealed he was not wearing his hearing aids. Resident #55 stated he did not know where they were. A sign was posted on the closet doors of Resident #55's room that read: "please ensure patient's hearing aids are taken out at night and charged and then placed back in his ears in the morning."</p> <p>An observation and interview of Resident #55 on 3/21/23 at 8:56 AM revealed he was not wearing his hearing aids. Resident #55 stated he did not know where they were. A sign was posted on the closet doors of Resident #55's room that read:</p>	F 685	<p>Resident #55 hearing aides are being replaced by the facility. On 3/29/23 the facility called and made payment arrangements with hearing aide company to replace missing hearing aides. Currently awaiting invoice and replacement hearing aides.</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice</p> <p>Complete audit conducted of all residents who reside in facility that have hearing aides. Ensured all hearing aides were in place and found no other resident identified missing their hearing aides Audits completed 3/24/23, 3/27/23</p> <p>Anyone identified as missing their hearing aide will be offered to schedule an appointment with audiology service for replacement and offer to have transportation arranged to the appointment.</p> <p>A report will be ran Monday - Friday to identify any new admissions with hearing aides by the Administrator, Director of Nursing, or Clinical Manager. Once identified, will be added to weekly audit.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will no recur</p> <p>Staff educated on the grievance</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345369</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/23/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>REX REHAB &amp; NSG CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4210 LAKE BOONE TRAIL RALEIGH, NC 27607</b>		
(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 685	<p>Continued From page 2</p> <p>"please ensure patient's hearing aids are taken out at night and charged and then placed back in his ears in the morning."</p> <p>An interview with Nurse Aide (NA) #1 on 3/22/23 at 9:06 AM revealed he had not seen Resident #55's hearing aids for a while. He stated he was not sure how long they had been missing, but Resident #55 was supposed to wear them every morning.</p> <p>Nurse #1 was interviewed on 3/22/23 at 10:27 AM, and she revealed the Nurse Aides on Resident #55's hall told her the hearing aids have been lost for quite some time and his family was aware.</p> <p>During an interview with Resident #55's responsible party (RP) on 03/22/23 at 10:47 AM, he revealed the hearing aids had been missing for the last 6 months. He stated he did not know where they were, and the facility had not provided any further information. The RP indicated the facility did not offer him or Resident #55 a hearing appointment/services for new hearing devices.</p> <p>The Director of Nursing (DON) was interviewed on 3/22/23 at 10:58 AM, and she revealed the Clinical Manager told her she had just heard about Resident #55's missing hearing aids. The DON stated she was not aware that the hearing aids were missing. Staff were expected to report the missing hearing aids immediately, so that a search would have been initiated. If the search resulted in nothing found, then the facility would have needed to figure out how to replace the items.</p> <p>During an interview with the Clinical Manager on</p>	F 685	<p>procedure to include completion of grievance for any missing hearing aids or personal belongings Completed by DATE: <u>4/7/23</u></p> <p>Staff educated on ensuring hearing aids are present and accounted for completed by DATE: <u>4/7/23</u>. All new hires will receive education on completing grievances on missing hearing aids or personal belongings and on ensuring hearing aids are present and accounted for during orientation.</p> <p>A weekly audit will be conducted to ensure hearing aids for those residents identified are present for resident use for 6 weeks by the Administrator, Director of Nursing, or Clinical Manager. A report will be ran Monday -Friday by Administrator, Director of Nursing, or Clinical Manager for 6 weeks to identify any new residents admitted with hearing aids to ensure hearing aids are present</p> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained</p> <p>The facility will present the outcomes of the weekly audit and Monday -Friday report to the Quality Assurance Performance Improvement committee (QAPI). The QAPI committee will decide if the audit and reports process needs to be extended based on compliance.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/26/2023  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345369</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/23/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>REX REHAB &amp; NSG CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4210 LAKE BOONE TRAIL</b> <b>RALEIGH, NC 27607</b>		
(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 685	Continued From page 3 3/22/23 at 12:48 PM, she revealed when Resident #55's hearing aids were lost 6 months ago the RP tried to find the warranty for replacement but was unable to locate the paperwork. She stated the RP never got back to her about the warranty details. The Clinical Manager indicated she called the hearing aids company before the interview, and she will be able to reorder the hearing aids without the warranty paperwork.  An interview was conducted with the Administrator on 3/22/23 at 1:39 PM, and she revealed she did not know why Resident #55's missing hearing aids were not filed as a grievance. The Administrator indicated if someone discovered Resident #55's hearing aids were missing, then they should have notified her and she would have filed a grievance. She stated the Clinical Manager should have notified her when it happened to address the issue in a timely manner.	F 685			
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	F 761		4/14/23	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/26/2023  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345369</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/23/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>REX REHAB &amp; NSG CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4210 LAKE BOONE TRAIL</b> <b>RALEIGH, NC 27607</b>		
(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 761	<p>Continued From page 4</p> <p>temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interviews the facility failed to keep medications secured by storing over-the-counter medications in an unoccupied storage room that had the door propped open with boxes for 1 of 6 storage rooms inspected (the main hall storage room).</p> <p>Findings included:</p> <p>On 03/21/23 at 1:30 PM the main hallway storage room door was observed to have the door propped open with boxes. There were 12 unopened bottles of Zinc 50 Milligram tablets and 3 unopened bottles of ResaQuad capsules stored on a shelf. These items were visible from the hallway and the storage room was unoccupied.</p> <p>In an interview with the Central Supply Aide on 03/21/23 at 1:55 PM she stated she understood propping the door open to the storage room could lead to a resident or a staff person taking items out of the room, specifically the over-the-counter medications. She verbalized understanding that all medications were to be stored in a locked room. She stated she usually kept the storage</p>	F 761	<p>Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>No residents were found to be affected by the deficient practice</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice:</p> <p>All residents except two were identified as having potential to be affected. A list of all residents was reviewed on 3/27/23 by Administrator and Director of Nursing. 3/27/23 audit conducted to ensure all storage room locks were in proper working order and none found to be deficient by maintenance.</p> <p>Address what measures will be put into place or systemic changes made to ensure that solutions are sustained;</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/26/2023  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345369</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/23/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>REX REHAB &amp; NSG CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4210 LAKE BOONE TRAIL RALEIGH, NC 27607</b>		
(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 761	Continued From page 5 room door locked but she was busy and it was easier to leave the door open because she was coming back to unpack more boxes and distribute supplies.  In an interview with the Administrator on 03/22/23 at 10:45 AM she stated all medications were stored in the medication room that was locked. She noted that where the Zinc and ResaQuad were left unlocked was a central receiving supply room. The medications would have been distributed to the locked medication room by the Central Supply Aide. She stated the door to the central receiving supply room should not have been propped open because anyone could have accessed the items. She concluded all medications were to be stored in a locked room.	F 761	Staff educated on keeping door to storage room locked and closed when not in use and not to leave the room unattended if unlocked completed by Date: <u>4/7 /23</u> Audit tool to be conducted twice daily by Administrator, Director of Nursing, or Clinical Manager for 6 weeks to monitor compliance with the door being locked and closed when not in use.  Indicate how the facility plans to monitor its performance to make sure that solutions are sustained  Results of daily audit will be submitted to the Quality Assurance Performance Improvement Committee and the committee will decide if further audits are needed beyond the initial 6 week audit  DATE Corrective Action Completed:		
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	F 812		4/14/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345369</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/23/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>REX REHAB &amp; NSG CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4210 LAKE BOONE TRAIL</b> <b>RALEIGH, NC 27607</b>		
(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 812	<p>Continued From page 6</p> <p>safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§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 record review, observation and staff interviews, the facility failed to date food items opened and placed in the walk-in refrigerator and discard expired food items stored for use in 1 of 1 walk-in refrigerator. These practices had the potential to affect food served to residents. The facility also failed to date leftover food items and discard expired food items stored for use in 1 of 3 resident nourishment refrigerators located in the recreation center of the facility.</p> <p>Finding included:</p> <p>1. On 3/20/2023 at 10:04 a.m. during the initial tour of the kitchen with the Dietary Supervisor, the following food items were observed in the walk-in refrigerator: * Small sandwich size ham slices wrapped in clear plastic wrap dated 3/16/2023. The slice of ham on top was observed with a light tan discoloration to one half of the slice while the other half was observed with a pale pink color. The Dietary Supervisor stated the ham was sliced for sandwiches and was good for 3 days once open from the original package and dated 3/16/2023. The Dietary Supervisor discarded the ham slices in the trash. *Opened package of corn beef wrapped in clear plastic wrap. There was no date written on the clear plastic wrap. The original package for</p>	F 812	<p>Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident 300 chicken salad was found to have been placed the night before 3/22/2023 per interview with resident and resident chose to keep her chicken salad and consume it on 3/22/23. Resident discharged on 3/29/23 to home with no adverse event</p> <p>Resident 301 bottle of salad dressing in a bag was thrown away as resident had been discharged from facility.</p> <p>Address how the facility will identify other resident having the potential to be affected by the same deficient practice:</p> <p>All residents had the potential to be affected by the meat in the kitchen not dated per policy</p> <p>Residents who may have ordered a salad had the potential to be affected by the two plates in plastic containers that were not dated per policy in the kitchen. Those are residents on regular consistency diet Audit</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345369</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/23/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>REX REHAB &amp; NSG CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4210 LAKE BOONE TRAIL RALEIGH, NC 27607</b>		
(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 812	<p>Continued From page 7</p> <p>the corn beef read best if froze by 5/27/23. The Dietary Supervisor stated food items were to be dated when placed in the refrigerator and discard the corn beef in the trash.</p> <p>* A meal tray, that was observed not labeled with a date, contained two plastic sectional plates: one with lettuce and chicken salad and one with lettuce and potato salad and a chicken salad sandwich on a small plate wrapped with clear plastic wrap. There was no date written on the two plastic sectional plates, and there was no date written on the chicken salad sandwich. The Dietary Supervisor stated the two sectional plates and the chicken salad sandwich were made during the weekend for dinner, and food items were to be dated when placed in the refrigerator.</p> <p>On 3/22/2023 at 11:41 a.m. in an interview with Dietary Supervisor, he stated dietary cooks were responsible for checking the walk-in refrigerator at the beginning and end of their shift and he also went through the walk-in refrigerator in the morning checking for expired food items. He explained on the morning of 3/20/2023 during the initial tour of the kitchen, he had not checked the walk-in refrigerator for expirations because he was putting up stock (food items) received that morning.</p> <p>On 3/22/2023 at 1:53 p.m. in an interview with the Dietary Manager, he stated Dietary Cooks were responsible for labeling and dating cooked and opened food items placed in the walk-in refrigerator.</p> <p>On 3/22/2023 at 2:06 p.m. in an interview with Dietary Cook #1, she stated all dietary staff placed food items in the walk-in refrigerator, and all food items required a date written on the food</p>	F 812	<p>of all residents on regular consistency diet completed 3/27/23 by Director of Nursing</p> <p>All but two residents had the potential to be affected by the undated food and expired salad dressing in the refrigerator in recreation room at station one.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>Locks were attached to the recreation refrigerator 3/29/23 in order to control access and ensure items placed in refrigerator are labeled with name and date per policy. Updated Signage posted to make residents and families aware of new process 3/29/23. The team leader, clinical manager, Director of Nursing, and Administrator will have the key and will ensure items placed in refrigerator are labeled and dated per policy.</p> <p>A daily audit of the recreation refrigerator will be completed for 6 weeks by the Administrator, Clinical Manager, Director of Nursing, or team leader.</p> <p>Dietary Staff educated on labeling, dating, and storage of food in the kitchen completed by DATE: <u>4/7/23</u></p> <p>Signage placed in kitchen to remind dietary staff to label and date food per policy completed 3/29/23.</p> <p>Audit will be completed daily by the dietary team lead or designee of the freezer,</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345369</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/23/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>REX REHAB &amp; NSG CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4210 LAKE BOONE TRAIL RALEIGH, NC 27607</b>		
(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 812	<p>Continued From page 8</p> <p>item when placed in the walk-in refrigerator. She explained she checked food items for dates and expiration dates when removing food items from the walk-in refrigerator to cook. She stated if a date was not written on the food item, the food item did not look right and was not used within 3 days of the written date on the food item, food items were discarded from the walk-in refrigerator.</p> <p>2. On 3/22/2023 at 8:03 a.m., a resident nourishment refrigerator was observed located in the recreation center with old brown dried liquid stains on the shelves in the refrigerator. A sign on the freezer door read, "All prepared food must be labeled with name, date, time and room number. The refrigerator was cleaned nightly and if food was not labeled as stated, the items would be thrown away. Prepared food was only good for 24 hours." The following items were observed in the resident nourishment refrigerator:</p> <ul style="list-style-type: none"> <li>* A container of chicken salad labeled with room number 123 and Resident #300's last name. There was no expiration date or date when placed in the refrigerator written on the container of chicken salad.</li> <li>* A bottle of salad dressing with an expiration date 3/2/2023 in a plastic bag with Resident #301's room number 123 and her first and middle name and last initial written on the outside of the plastic bag.</li> </ul> <p>On 3/22/2023 at 8:08 a.m. in an interview with Nurse #2, she explained the resident nourishment refrigerator located in the recreation center was used to store resident's foods. She stated family members placed food items in the refrigerator and have been shown and asked to label items placed in the refrigerator. She explained when</p>	F 812	<p>fridge, and cooler to ensure items are stored, labeled, and dated correctly for 6 weeks</p> <p>Staff educated on policy that all resident food items placed in station one recreation room must be labeled with name and date and that the team leader and managers will have a key to access locks on refrigerator to place resident food items with name and date per policy. Staff Educated that prepared food items must be disposed after 24 hours. Completed by DATE: <u>4/7</u> /23</p> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:</p> <p>All audit results will be presented to the Quality Assurance Performance Improvement committee and will determine compliance and continuation of the audits.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345369</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/23/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>REX REHAB &amp; NSG CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4210 LAKE BOONE TRAIL</b> <b>RALEIGH, NC 27607</b>		
(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 812	<p>Continued From page 9</p> <p>she checked the resident nourishment refrigerator that morning, she requested housekeeping to clean the refrigerator. She stated the night shift staff were responsible for checking the resident nourishment refrigerators each night and discarding food items not labeled, dated and used in 24 hours. She stated Resident #301 had been discharge from the facility and discarded the expired bottle of salad dressing in the trash. Nurse #2 stated she would check with Resident #300 on the date for the chicken salad.</p> <p>On 3/23/2023 at 5:30 a.m. in an interview with Nurse #3, he explained the resident nourishment refrigerator located in the recreation center was checked by the 11 p.m. to 7 a.m. nurse assigned the A and B wing, and on the 11 p.m. to 7 a.m. shift on 3/21/2023, he was assigned to the F-wing hall. He stated as the team leader for the 11 p.m. to 7 a.m. shift, he was responsible for ensuring the resident nourishment refrigerator in the recreation center was checked nightly, and on the 11 p.m. to 7 a.m. shift 3/21/2023, the resident nourishment refrigerator was not checked. He said foods items were to be labeled with date and name, and food items were to be discard if not used within 24 hours.</p> <p>On 3/23/2023 at 5:33 a.m. in an interview with the Director of Nursing, she stated food items were to be dated and labeled with resident's name when placed in the resident nourishment refrigerator, and the 11 p.m. to 7 a.m. nursing staff were responsible in checking the resident nourishment refrigerators nightly and removing any food items not used within 24 hours.</p>	F 812			