JAN 1 4 2014

PRINTED 01/06/2014
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345369	A. BUILDING _____ B. WING _____	C 12/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REX REHAB & NSG CARE CENTER	4420 LAKE BOONE TRAIL RALEIGH, NC 27607

(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 000	INITIAL COMMENTS On 12/23/13, the Division of Health Service Regulation, Nursing Home Licensure and Certification Section conducted an onsite revisit on a recertification survey and a complaint investigation survey. The survey team exited on 12/23/13. However, on 12/30/13, the facility provided additional information and a physician interview was conducted. Therefore, the survey exit date was 12/30/13.	F 000	This plan of correction is not an admission that any deficiency existed at the time of the survey in question, or of the accuracy of any of the allegations contained in the CMS 2567 survey report. This plan of correction is the facility's allegation of compliance with all applicable state and federal requirements and is being submitted to meet requirements of state and federal law for skilled nursing facilities.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of	F 157	F157 During the 12/23/13 complaint survey, the surveyor alleged that the facility didn't notify the physician that a psychiatric consult was not provided and that behaviors continued after trazodone was started for 1 of 1 resident reviewed for a traumatic experience. The facility discharged the resident on 12/18/13 to Arkansas per family request prior to the surveyor presenting these findings. [12/18/13]	01/09/14

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

PT, NHA, MHA ROY TEMPLE ON BEHALF OF D. HELEN GRAND, ADMINISTRATOR — 1/14/2014

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.

FORM CMS-2567(02-99) Previous Versions Obsolete YW2L11 Facility ID: 923427 If continuation sheet Page 1 of 12

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F 157	Continued From page 1 this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and physician interviews, the facility failed to notify the physician that a psychiatric consult was not provided and that behaviors continued after trazodone was started for 1 of 1 sampled resident reviewed for a traumatic experience (Resident #485). The findings included: Resident #485 was admitted into the facility on 11/18/13 from the hospital. Diagnoses included Dementia. The admission minimum data set completed on 12/3/13 indicated Resident #485 cognitive status was moderately impaired. Inattention and disorganized thinking was listed as present/fluctuated. Trouble falling asleep or staying asleep or sleeping too much and delusions, was indicated as occurred. Extensive assistance of one personal physical assist was required with dressing and toilet use. Urinary and bowel was listed as frequently incontinent. Psychological therapy was not indicated as received. The care plan dated 12/4/13 listed altered thought process related to age and change in environment as a problem concern. As an approach, the care plan read "refer to physician orders for update of interventions." A review of the physician telephone order dated 12/2/13 revealed an order was obtained for trazodone 25 milligram (mg) to be administered	F 157	To determine whether any other residents were affected by the alleged deficient practice, the facility audited all records of all residents for physician orders for psychiatric consults and/or medications designed to address psychiatric/mental behaviors to determine if ordered referrals were timely made and the consults provided, and whether the behaviors at issue continued notwithstanding ordered medications and whether the residents' physicians were notified as appropriate. [1/9/14] Preventive measures implemented include the following: The Clinical Nursing Managers have provided training to all nurses regarding when and how to notify the MD/PA/NP of episodic events. This training specifically included the duty to notify the physician of missed referrals for psychiatric	

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F 157	Continued From page 2 by mouth at bed time for insomnia. A review of the physician telephone order dated 12/4/13 revealed an order that read "pysch consult - status post traumatic cath in emergency room, patient crying out in the night and refusing care." A review of the psychiatry referral dated 12/4/13 listed Resident #485 to be evaluated for "traumatic cath in the emergency room, patient crying out at night and refusing care." A review of the physician assistant assessment and plan of care co-signed by the physician on 12/9/13 revealed the purpose of the psychological consult ordered on 12/4/13 was to address "trauma and why patient will not allow herself to be touched." A review of the nurse's note revealed on 12/9/13 at 4:00 am, Resident #485 reported that someone was "molesting her, and touching her private parts." A review of the medication administration record revealed trazodone 25 mg was administered by mouth at 9:00 pm on 12/2, 12/3, 12/4, 12/5, 12/6, 12/7, 12/8 (not signed as administered), 12/9, 12/10, 12/11, 12/12, 12/13, 12/14, 12/15, 12/16 and 12/17/13 with improved sleep pattern. In an interview on 12/23/13 at 11:37 am, the administrator when questioned regarding the psychiatric consult that was ordered on 12/4/13 stated that per her review of the clinical record from 12/4/13 to 12/18/13 (date of discharge to another facility) she did not see where services were provided. The administrator stated that she	F 157	or other specialty consultations and ongoing psychiatric/mental behaviors that persist after initiation of ordered medications designed to address those behaviors. This training will be completed by 1/9/14 for all staff on duty. Any staff nurse not educated on this process on or before 1/8/14 will be educated on an individual basis prior to returning to work. [1/9/14] A review of resident changes in condition, as communicated within the 24-hour nurses' report, will be conducted daily by the supervising nurse-on-duty to ensure that appropriate and timely notifications were made for all residents who have had significant changes. "Timely" notification means as soon as staff become aware of the change through the processes described herein. In addition, a review of resident charts will be completed to identify any failures to make	

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F 157	Continued From page 3 expected the resident to have been evaluated as ordered. In an interview on 12/23/13 at 12:00 noon, the social worker when questioned regarding Resident #485 stated that she was the primary social worker for the resident. The social worker acknowledged that she was aware that there was a pending psychiatric consult; however, she was not aware that the consult service was not provided. During a telephone interview on 12/30/13 at 9:23 am, the physician when questioned regarding Resident #485 stated that she was not aware that after trazodone was started on 12/2/13, that continued statements were made by the resident to the facility staff on 12/9/13, of thoughts that someone touched her private parts and molested her. She indicated that she was under the impression that after trazodone was started the resident's behavior improved. The physician acknowledged that she was aware that the initial psychiatric consult was ordered as a result of a traumatic urine catheterization completed in the emergency room, followed by the resident crying out in the night and refusing care while she resided in the nursing facility.	F 157	appropriate notifications for significant changes in resident condition per the following schedule: 100% of resident charts each day for five days; then a 20% random sample each month, to continue until no incidents of failure to notify of significant changes are identified. Additionally a weekly audit will be completed by the Clinical Manager comparing the team leader report to the physician communication log. If anything on the team leader report is missed on the physician communication report, the Clinical Manager will re-educate the nurse completing the team leader report and notify the physician of the patient change/episodic event. The Director of Nursing will be monitoring the weekly reports on a monthly basis. [1/9/14 & Ongoing]	
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.	F 319		

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F 319	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews, the facility failed to obtain a psychiatric evaluation for a resident who presented with signs and symptoms of a traumatic encounter for 1 of 1 sampled resident reviewed for a traumatic experience (Resident #485). The findings included: Resident #485 was admitted into the facility on 11/18/13 from the hospital. Diagnoses included Dementia. The admission minimum data set completed on 12/3/13 indicated Resident #485 cognitive status was moderately impaired. Inattention and disorganized thinking was listed as present/fluctuated. Trouble falling asleep or staying asleep or sleeping too much and delusions, was indicated as occurred. Extensive assistance of one personal physical assist was required with dressing and toilet use. Urinary and bowel was listed as frequently incontinent. Psychological therapy was not indicated as received. The care plan dated 12/4/13 listed altered thought process related to age and change in environment as a problem concern. As an approach, the care plan read "refer to physician orders for update of interventions." A review of the nurses' notes revealed on 11/28/13 at 7:00 pm, Resident #485 was observed "screaming and talking loud" and stated there was a man under her blanket who "touched her private parts." The resident was indicated as "reassured and a staff member sat with the resident." On 11/28/13 at 10:45 pm, Resident #485 was observed screaming and yelled out "they were touching her (her private parts) a man." When the resident was observed by the	F 319	Any discrepancies from the monthly monitoring of the audits will be reviewed at the monthly QAPI Meeting for 3 months and quarterly thereafter, until there have been two consecutive quarters with no discrepancies. [1/9/14 & Ongoing] F319 During the complaint survey on 12/23/13 the surveyor alleged that the facility failed to obtain a psychiatric evaluation for a resident who presented with signs and symptoms of a traumatic encounter for 1 of 1 resident reviewed for a traumatic experience. The facility discharged the resident on 12/18/13 to Arkansas per family request prior to the surveyor presenting these findings. [12/18/13] To determine whether any other residents were affected by the alleged deficient practice, the facility audited all records of all	01/09/14

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F 319	Continued From page 5 facility staff she was indicated as "agitated and grabbed her genital area under the covers with her hands." After much reassurance the resident was indicated as "finally calmed down." It was noted that a friend who came to the facility informed the facility that the resident had a traumatic catheterization completed in the emergency room by a male nurse. It was further noted that the resident was very private, never married, nor had any male relationship. Upon further assessment by the nursing staff it was assessed that the resident "firmly believed that a man was hurting her", even when left alone and no one was with her the resident would "suddenly and spontaneous" start yelling that "she is being attacked." Recommendation was for no male nursing assistants to provide personal care. On 11/29/13 at 5:00 am, when care was attempted Resident #485 stated repeatedly "you should be ashamed of yourselves what you have done to me" and yelled out "get away from me." The resident refused to allow the nursing staff to wash her or blood to be drawn. Continue to monitor the resident was indicated. On 11/29/13 at 11:20 am, it was noted that Resident #485 was "agitated, unable to be redirected, yelling out, having delusions of men in her room trying to touch her private parts, covering her groin area, even though there had been no men around or in her room." It was indicated that the resident stated "I am so ashamed, this will kill me, I'll never get over this." It was further documented that the resident "had been awake for the majority of the 3 pm - 11 pm shift with this delusion, vital signs and morning needs not obtained, administration get order to allow resident to sleep, physician assistant aware " On 12/1/13 at 6:30 pm, the resident yelled out "get these men out my room; they're trying to touch my privates." It was further	F 319	residents for physician orders for psychiatric consults and/or medications designed to address psychiatric/mental behaviors to determine if ordered referrals were timely made and the consults provided, and whether the behaviors at issue continued notwithstanding ordered medications and whether the residents' physicians were notified as appropriate. [1/9/14] Preventive measures implemented include the following: Under her existing contract with Rex, the facility engaged Elena Matthews, MD to provide routine and consultant psychiatric services. Dr. Matthews made her first visit to the facility on December 27, 2013. [12/27/13] In addition to Dr. Matthews' services, we also re-instated our previous contract with Dr.	

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F 319	Continued From page 6 noted that the resident was redirected and reassured that there were no men in her room and that the resident refused to eat. The nurse's note dated 12/2/13 (time not specified) stated that "Resident #485 had not slept all night." A review of the physician telephone order dated 12/2/13 revealed an order was obtained for trazodone 25 milligram (mg) to be administered by mouth at bed time for insomnia. A review of the physician telephone order dated 12/4/13 revealed an order that read "pysch consult - status post traumatic cath in emergency room, patient crying out in the night and refusing care." A review of the psychiatry referral dated 12/4/13 listed Resident #485 to be evaluated for "traumatic cath in the emergency room, patient crying out at night and refusing care." A review of the physician assistant assessment and plan of care co-signed by the physician on 12/9/13 revealed the purpose of the psychological consult ordered on 12/4/13 was to address "trauma and why patient will not allow herself to be touched." A review of the nurse's note revealed on 12/9/13 at 4:00 am, the resident reported that someone was "molesting her, and touching her private parts." The resident requested that the facility call a friend, who was indicated as spoke with the resident, and informed her that she would come and stay all night with her, and that no acute concerns were observed while the friend was present at the bedside of the resident.	F 319	Kamdar effective 12/31/13. [12/31/13] The Clinical Nurse Managers immediately faxed any outstanding psychiatric consult orders to the psychiatrist for referral. [12/27/13] Nursing already conducts chart reviews on a daily basis, including a review of orders for psychiatric consults ensuring referrals have been made. Discrepancies identified will be communicated via the 24-hour report and during the M-F AM stand-up meetings. Additionally, a new process has been implemented for retrieval of psych orders. Upon receipt of an order for psych services, the nurse will log the order in	

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F 319	Continued From page 7 A review of the physician assistant assessment and plan of care co-signed by the physician on 12/11/13 indicated "patient refusing to be touched." A review of the medication administration record revealed trazodone 25 mg was administered by mouth at 9:00 pm on 12/2, 12/3, 12/4, 12/5, 12/6, 12/7, 12/8 (not signed as administered), 12/9, 12/10, 12/11, 12/12, 12/13, 12/14, 12/15, 12/16 and 12/17/13 with improved sleep pattern. A review of the social worker progress notes completed on 11/29, 12/2, 12/5, 12/9, 12/10, 12/11, 12/16, and 12/18/13 (date of discharge) revealed no specific approaches that addressed Resident #485's needs for effective coping, per behaviors indicated in the nurses notes from 11/28/13 to 12/9/13, nor a follow up on the ordered psychiatric consult. A review of the physician statement dated 12/27/13 in part read "acute events of 12/2/13 with delirium, patient refusing contact, cleared. Baseline dementia history. We added trazodone at night which lead to much improved sleep and improved behavior reported - acute psychiatric evaluation not necessary with improvements - though we never canceled consult (oversight)." In an interview on 12/23/13 at 11:11 am NA (nursing assistant) #1 when questioned regarding Resident #485 stated "I overheard that Resident #485 was resistant to care in the morning, would not allow the NAs to wash between her legs and would fight the NAs when care was attempted." NA #1 stated she recalled once when the resident had a bowel movement she was resistant to allow her to provide care to clean her. She added that	F 319	the psych referral binder and notify the social worker. The social worker will initiate the referral to psych by faxing the order to the psychiatrist and will document the date the referral was sent. When the psychiatrist visits the patient he/she will sign and date the psych communication binder as well as complete any necessary documentation/physician orders. [1/9/14] The Clinical Nursing Managers have provided training to all nurses and social workers regarding the process change. This training will be completed by 1/9/14 for all staff on duty. Any staff nurse or social worker not educated on this process on or before 1/9/14 will be educated on an individual basis prior to returning to work. [1/9/14] The social work office will conduct weekly audits of the psych communication binder. The social work office will re-fax to the psychiatrist any	

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F 319	Continued From page 8 the resident required lots of reassurance regarding what type of care was going to be provided to her. NA #1 stated that when she touched the resident to provide care, the resident jumped and was startled. NA #1 added that she had to constantly explain and reassure the resident the type of care that she was going to provide to her, and the resident would allow her to clean her quickly. NA #1 concluded that the nursing staff was aware of the resident behavior and her resistant to allow care to be provided. In an interview on 12/23/13 at 11:25 am Nurse #1 when questioned regarding Resident #485 statements that her private parts were touched in a manner in which she was uncomfortable, resistant to allow care to be provided, stated that she recalled the resident screamed and yelled when care was attempted by the nursing staff to her private area "genital area". She added that she recalled a particular incident in which a male NA assisted the resident while she ambulated to the toilet and the male nursing assistant assisted with snapping the brief around the resident and she screamed that the male nursing assistant touched her private parts. Nurse #1 added upon becoming aware of the statement made by the resident, she questioned the resident regarding where the man was and the resident indicated he was under the covers. She added that as a solution she assigned a female NA to provide care to the resident. Nurse #1 acknowledged that she was aware that the resident screamed and yelled whenever care was attempted to her genital area, was resistant to care, and that the resident required increased reassurance and encouragement by the nursing staff, before care could be provided. Nurse #1 did not acknowledge that she was aware of the ordered psychiatric	F 319	orders for consults that are more than one week old and not yet completed. The social work office will notify the resident's attending physician, and the DON or Administrator, of any delays in service greater than ten business days and will document such notification in the psych communication binder. [1/9/14 & Ongoing] Any discrepancies from the monthly review of the audits will be assessed at the monthly QAPI Meeting for 3 months and quarterly thereafter, until there have been two consecutive quarters with no discrepancies. [1/9/14 & Ongoing]	

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F 319	Continued From page 9 consult. In an interview on 12/23/13 at 11:31 pm, NA #2 when questioned regarding Resident #485 indicated "It was a challenge to provide care to her due to the resident screamed, yelled, and fought, when attempting to provide care to her." NA #2 stated "even if you touched her hand she screamed loudly." NA #2 concluded the nurses were aware of this behavior. In an interview on 12/23/13 at 11:37 am, the administrator when questioned regarding the psychiatric consult that was ordered on 12/4/13 stated that per her review of the clinical record from 12/4/13 to 12/18/13 (date of discharge to another facility) she did not see where services were provided. She added that the process for a resident to be seen is that once a physician order was written for needed services, the resident name is written in the psychiatric referral book and the resident is evaluated when the clinician is onsite. The administrator indicated that she identified there was a problem with the contracted psychiatric provider services on November 3, 2013, which has continued to date with delayed visits, which contributed to Resident #485 not being evaluated during her stay. She elaborated that she expected the resident to have been evaluated as ordered. The administrator concluded that if residents presented with acute psychiatric concerns in which the facility was unable to manage, residents would be expected to be transported to the hospital to be evaluated. In an interview on 12/23/13 at 12:00 noon, the social worker when questioned regarding Resident #485 stated that she was the primary social worker for the resident. The social worker	F 319		

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(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 319	Continued From page 10 indicated typically when a psychiatric consult was ordered, if nursing obtained the order for needed consultation, the nursing department was responsible for ensuring that the ordered services was completed. She added that if a consult order was physically presented to her, then she would write the resident's name in the psychiatric referral book. The social worker acknowledged that she was aware that there was a pending psychiatric consult; however, she was not aware that the consult service was not provided. During a telephone interview on 12/30/13 at 9:23 am, the physician when questioned regarding Resident #485 stated that she was not aware that after trazodone was started on 12/2/13, that continued statements were made by the resident to the facility staff on 12/9/13, of thoughts that someone touched her private parts and molested her. She indicated that she was under the impression that after trazodone was started the resident's behavior improved. The physician added that it was not uncommon for residents with delirium to become agitated, and the goal would be to provide directional guidance and reassurance. When further questioned regarding the psychiatric consult that was ordered, the physician stated that if the resident physical condition could not be managed by the staff, the resident could have been sent to the emergency room, however, she felt the resident condition did not warrant such an action, being the resident behaviors improved, after the trazodone was started. She further added that it was hard to say if the psychiatric consult should have been carried out, considering the resident condition improved during her stay. The physician concluded that she was aware that the initial psychiatric consult was ordered as a result of a	F 319		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345369	A. BUILDING _____ B. WING _____	C 12/30/2013

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F 319	Continued From page 11 traumatic urine catheterization completed in the emergency room, followed by the resident crying out in the night and refusing care while she resided in the nursing facility.	F 319		