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 08/20/2014

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 No deficiencies were cited as a result of the complaint investigation survey of 8/20/14. Event ID# QEHU11.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a comprehensive dialysis care plan for one of one resident (Resident #340) reviewed for dialysis care. Findings included: Resident #340 was admitted to the facility on 8/8/14 for short-term rehabilitation with multiple	F 279	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, the submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet	9/12/14

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

Electronically Signed | 09/12/2014

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F 279	Continued From page 1 diagnoses including end stage renal disease (ESRD), coronary artery disease (CAD), diabetes mellitus, and hypertension (HTN). The annual Minimum Data Set (MDS) assessment, dated 8/15/14, indicated that Resident #340 was cognitively intact, was independent with personal hygiene, but required limited to extensive assistance with bed mobility, transfers, dressing and toilet use, and was receiving dialysis care prior to being admitted to the facility. The resident's care plan, dated 8/15/14, was reviewed. There was no care plan developed which included goals and approaches to address the resident's needs as a recipient of hemodialysis in an outpatient dialysis facility. On 8/20/2014, at 11:18 AM, the interim administrator stated that the facility did not have a dialysis contract or policy and had not been care planning residents for out of facility dialysis because they were viewed the same as other doctor's appointments. He stated that after reading the federal guidelines, the facility realized that they should have a care plan and policy for dialysis residents in place and were taking the steps to implement a policy as of the morning of 8/20/2014. He reported that Resident #340 was the only resident in the facility receiving dialysis at the time and staff had spoken to the dialysis center about his dialysis treatments since his admission to the facility and had placed it on the resident's chart. The administrator also reported that nursing staff was not checking the resident's fistula and vitals before and after dialysis, but would be starting to do so on the resident's next dialysis day.	F 279	requirements established by state and federal law. For Tag 0279- How Corrective action will be accomplished for those patients/residents found to have been affected by the deficient practice: A comprehensive care plan was developed for Resident #340 on 8/21/14. This care plan includes goals and approaches to address the resident's needs as a recipient of outpatient hemodialysis. How the facility identified other residents having the potential to be affected by this same deficient practice: An audit was completed on 8/20/14 revealing that there were no other residents receiving outpatient hemodialysis. Protocol has been developed to identify the hemodialysis dependent resident's needs upon admission. Hemodialysis dependent residents will be assessed per protocol. Hemodialysis dependent residents will have a comprehensive care plan developed at the time of admission or upon starting hemodialysis. Protocol has been established to ensure that the care plan is implemented as written.	

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F 279	Continued From page 2 On 8/20/2014 at 3:00 PM, the MDS nurse stated the comprehensive care plan for Resident #340 had been completed, but the facility had not been care planning dialysis residents. She reported that effective 8/20/2014, per discussion in the facility's daily stand up meeting, they would be developing a dialysis protocol that will include care planning for residents receiving dialysis.	F 279	Measures that the facility will put into place or systemic changes made to ensure that the deficient practice will not recur: In-servicing was provided to all nurses on the requirement for a comprehensive care plan that includes the resident goals and approaches for the hemodialysis resident at the time of admission. In-servicing was provided for all nurses on the newly developed hemodialysis resident management protocol. Documentation, resident assessment and treatment training was provided. Plan for monitoring the facility's performance to make sure the solutions are sustained, correction is achieved, evaluated for effectiveness, and intergrated into the quality assurance program: The Plan of Correction will be reviewed monthly at the facility's all staff meetings x 2 months to ensure continued understanding and compliance. Monitoring by the DON or designee of compliance with established protocol and care planning requirements will be completed weekly x 4 weeks for all residents receiving hemodialysis. Monitoring will decrease to biweekly x 4 weeks then monthly x 2 months as long as the first 4 weeks of monitoring reveal	

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F 279	Continued From page 3	F 279	compliance and understanding of the Plan of Correction. Results of the monitoring will be presented and facility performance will be reviewed monthly at the Quality Assurance Performance Improvement meeting. Any deviation from the established Plan of Correction will be brought to the Administrator for further follow up and action necessary to address the deviation.	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews, the facility failed to implement a medication change related to a pharmacy recommendation for 1 (Resident #203) of 5 residents reviewed for unnecessary medications. The findings included: Resident #203 was admitted to the facility on 2/10/14 with medical diagnoses including atrial fibrillation. The most recent quarterly Minimum Data Set (MDS) dated 8/6/14 documented the resident was severely cognitively impaired. Review of the medical record for Resident #203 revealed a pharmacy recommendation dated	F 333	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. For tag 0333: How corrective action was accomplished for the resident found to be affected by the deficient practice:	9/12/14

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F 333	Continued From page 4 8/3/14 signed by the physician that read in part "She has atrial fibrillation so it would be a viable option to further reduce the Metoprolol to 6.25 milligrams (mg) by mouth twice a day (bid) as her heart rate has been ranging in the 60's." Review of the August 2014 physician orders revealed an order for Metoprolol 25 mg one half of tablet (12.5mg) by mouth twice daily. Further review of the August 2014 Medication Administration Record (MAR) revealed an order for Metoprolol 12.5 mg by mouth twice a day. The same MAR documented the pulse rate for Resident #203 was 62 beats per minute on 8/5/14. The MAR also documented the pulse rate was 55 beats per minute on 8/12/14. On 8/20/14 at11:35 am during an interview, the attending physician stated it was his expectation for the facility nurses to transcribe the order and implement the medication change. In an interview on 8/20/14 at10:43 am, the Director of Nursing stated it was her expectation for the nurses to transcribe the order and adjust the medication as ordered.	F 333	For resident #203, the attending physician was notified of delay in order implementation. A variance was completed and the medication dose was reduced per order on 8/20/14. How the facility identified other residents having the potential to be affected by this same deficient practice: An audit was completed on 9/11/14 to ensure all other pharmacy recommendations were processed as written. The audit revealed that there were no other unprocessed orders. Measures put into place or systemic changes made to ensure that the deficient practice will not recur: Pharmacy Recommendation Procedure was developed to ensure that all monthly pharmacy recommendations are processed timely. In-servicing was provided to all nurses on the Pharmacy Recommendation Procedure. The procedure outlines that all original pharmacy recommendations will be given to the provider to be addressed, returned and any new orders written within 14 days. How the facility will monitor it's	

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F 333	Continued From page 5	F 333	performance to make sure the solutions are sustained, correction is achieved, evaluated for effectiveness, and integrated into the quality assurance program: The Plan of Correction will be reviewed monthly at the facility's nurse's meeting to ensure continued understanding and compliance. Monitoring by the DON or designee of compliance with established procedure will be completed monthly x 3 months. Results of the monitoring and performance will be reviewed monthly in the Quality Assurance Performance Improvement Committee meeting monthly for a minimum of 3 months. Any deviation from the established Plan of Correction will be brought to the Administrator for further follow up and action necessary to address the deviation.	