STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345369	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rex Rehab & Nursing Care Center	**4210 Lake Boone Trail , Raleigh, North Carolina, 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
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted from 8/18/25 through 8/21/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1D393E-H1.	E0000		09/02/2025
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 8/18/25 through 8/21/25. Event ID# 1D393E-H1 The following intakes were investigated: 884106, 884105, and 884104. 12 of the 12 complaint allegations did not result in deficiency.	F0000		09/02/2025
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the	F0578	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On Monday, August 18th, nursing leadership corrected the code status discrepancy by clarifying resident #25's wishes to be DNR (do not resuscitate). The code status was corrected throughout the medical record, and the electronic medical record (EMR) and Medical Orders for Scope of Treatment (MOST) form both reflect the correct advanced directive. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents in the facility have the potential to be affected by the same deficient practice as all residents have the right to formulate an advanced directive. By Tuesday, August 19th, a full audit of all residents' code statuses was conducted by the nursing and case management teams. No other discrepancies were noted.	09/05/2025

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 reverse for further 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.

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

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F0578 SS = D	Continued from page 1 facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, facility failed to have accurate advanced directive documentation throughout the medical record for 1 of 5 residents reviewed for advanced directives (Residents #25). The findings included: Resident #25 was admitted to the facility on 7/3/25 with diagnoses that included chronic kidney disease and hypertension. Her admission Minimum Data Set assessment dated 7/25/25 revealed Resident #25 was cognitively intact. The electronic medical record profile indicated Resident #25's code status as “do not resuscitate.” Review of the advanced care planning notes, which are progress notes, in Resident #25's medical record indicated she did not have an advanced directive. A Medical Orders for Scope of Treatment (MOST) form dated 7/24/25 for Resident #25 stated attempt CPR (cardio-pulmonary resuscitation) and full scope of treatment. Review of Resident #25's physician's orders revealed there was no order addressing code status.	F0578	Continued from page 1 Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur. Audits of the residents' advanced directives, specifically comparing the code status listed in the EMR and the MOST form, will be conducted by the Minimum Data Set (MDS) Coordinators and Health Information Technology (HIM) Assistant upon admission and quarterly. During the audit, the team will identify any discrepancy between the two pieces of documentation and escalate concerns to nursing leadership. Nursing leadership will collaborate with the Medical Director and providers to speak with the resident and/or power of attorney (POA) to clarify their wishes regarding code status and make necessary updates to the medical record. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The MDS Coordinators and HIM Assistant will routinely audit all residents' documentation regarding code status and advanced directives upon admission and at least quarterly to ensure accuracy. The results of the audits will be reviewed by the Clinical Educator and presented in the Quality Assurance Performance Improvement (QAPI) meeting with the Interdisciplinary Team on a quarterly basis. Include dates when corrective action will be completed. Nursing leadership and the case managers completed an audit of the code statuses of all residents in the facility on August 18th. The HIM Assistant will complete another audit of all code status documentation by September 5th. These audits will be completed every three months for the next year, ending in September of 2026. At that time, the MDS Coordinators will continue to audit code status with each resident's quarterly MDS assessment.	

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F0578 SS = D	Continued from page 2 An interview was conducted on 8/18/25 at 3:34 PM with the Social Worker (SW) who stated Resident #25's code status was "do not resuscitate." The SW could not explain why the electronic record profile stated a code status of do not resuscitate while the MOST form stated attempt CPR and full scope of treatment. An interview was conducted on 8/18/25 at 4:00 PM with the resident and she stated she wished to have a code status of do not resuscitate. An interview was conducted on 8/18/25 at 3:45 PM with the Director of Nursing (DON). The DON could not explain why Resident #25's medical record showed a discrepancy regarding her code status with the electronic medical record profile and the MOST form in the chart. She reported in an emergency she believed staff would follow the electronic medical record profile which indicated "do not resuscitate." The DON stated she would ensure the code status was corrected throughout the medical record which would be a do not resuscitate.	F0578		