

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(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 Rex Rehab & Nursing Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4210 Lake Boone Trail Raleigh, NC 27607	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] with diagnoses that included chronic kidney disease and hypertension. Her admission Minimum Data Set assessment dated [DATE] 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 [DATE] 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. An interview was conducted on [DATE] 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 [DATE] 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 [DATE] 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.</p>

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.

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