STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 01/06/2017

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CARY HEALTH AND REHABILITATION	6590 TRYON ROAD CARY, NC 27518

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F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and observations, the facility failed to accurately code	F 278	Resident #81: A review of Resident #81□s medical record and the Admission	1/26/17

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

Electronically Signed | 01/25/2017

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F 278	Continued From page 1 the Minimum Data Set for 2 of 19 sampled residents regarding active diagnoses (Resident #81), and behaviors (Resident #67). Findings included: 1) Resident #81 was admitted to the facility 11/28/16 with admission diagnoses which included acute and chronic respiratory failure with hypoxia (low oxygen levels), muscle weakness, major depressive disorder, chronic respiratory failure, assistance with personal care, and chronic bronchitis A review of the admission Minimum Data Set (MDS) dated 12/5/16 revealed none of the above marked in Section I of the MDS (the active diagnoses section of the MDS). The MDS further revealed Resident #81 had received antianxiety and antidepressant medications 3 out of 7 days, and received oxygen therapy, occupational therapy, and physical therapy during the look back period. An interview was conducted on 1/5/17 at 12:08 PM with MDS nurse #2. She stated, "I completed this (Resident #81) MDS and signed off on it to indicate it was complete and accurate. (Resident #81) has active diagnoses which included- I don't see any listed. None of the above is checked which means she doesn't have any active diagnoses within the past 7 days. I would consider this MDS partially accurate, but not the active diagnoses section (Section I). Information to accurately complete an MDS is retrieved from hospital discharge summaries, the patient, the history and physical from the facility doctor, family, face to face assessment of the resident, progress notes, nursing notes, treatment records, consults, and physician orders. " MDS nurse #2 added, " I guess I missed this one." An interview was conducted on 1/5/17 at 12:30PM with the Executive Director. She stated,	F 278	MDS dated 12/5/ 2016 were completed by the RN MDS Coordinator. The Admission MDS Section I dated 12/5/2016 was corrected by the RN MDS Coordinator with a Modification completion to Section I (Active Diagnosis) of the Admission MDS on 1/6/2017 to reflect accurate admission diagnoses to include: Arthritis, Anxiety Disorder, Depression, Manic Depression, Muscle Weakness, Chronic Kidney Disease, Need for Assistance with Personal Care, Asthma, Respiratory Failure, and Constipation. Resident #67: A review of Resident #67□s medical record and Discharge MDS dated 8/25/2016 was completed by the RN MDS Coordinator. On 1/5/2017 the Discharge MDS Section E (Behaviors) was corrected by the RN MDS Coordinator with a modification to Section E to accurately reflect the resident□s behaviors as documented in the resident□s medical record. Section I - Admission Diagnosis: A review was completed on 1/5/2017 by the RN MDS Coordinator of residents who were identified as having potential to be affected by the same deficient practice. The review included Admission MDS of residents admitted to the facility 11/1/2016-12/31/2016. 3 of 33 (included Resident #81) were identified to not have diagnosis codes entered into Section I. The other 2 residents were discharged from the facility. Modifications were made as appropriate. Section E-Behaviors: A review was completed on 1/23/2017 by the RN MDS	

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F 278	Continued From page 2 "Technically the MDS nurses fall under my supervision. My expectation is to code the MDS accurately to reflect the clinical and functional status of all residents. I would expect a resident admitted to a long term care facility to have at least 1 active diagnoses. " 2) Resident #67 was admitted to the facility on 6/14/16 with diagnoses which included anxiety disorder, and depression. Review of a progress note dated 8/25/16 stated Resident #67 had yelled out all day long. The note further revealed other residents complained about Resident #67 yelling and cursing at the nurse aids trying to help her. Review of Resident #67 ' s discharge MDS dated 8/26/16 revealed the resident was assessed on Section E (Behaviors) of the MDS as exhibiting no verbal behavioral symptoms directed toward others. During an interview on 01/05/2017 at 3:20 PM MDS Coordinator #1 stated the MDS dated 8/26/16 was incorrect. During an interview on 1/5/16 at 4:40 PM the Administrator stated that Resident #67 had yelled and cursed at staff. She further stated it was her expectation that the MDS dated 8/25/16 would reflect these behaviors. She further stated the MDS dated 8/25/16 was incorrect. Based on record review and staff interviews, the facility failed to code a resident as having verbal behavioral symptoms directed towards other on a Minimum Data Set (MDS) for 1 of ? sampled residents, (Resident # 67). Findings included: Resident #67 was admitted to the facility on 6/14/16 with diagnoses including hypertension, pneumonia, diabetes mellitus, anxiety disorder,	F 278	Coordinator of residents who were identified as having potential to be affected by the same deficient practice. The review included those residents identified with behaviors to assure Section E on the MDS was coded accurately to reflect those behaviors. The RN MDS Coordinator and MDS Nurse were re-educated by the RN Regional MDS Coordinator on 1/16/2017, regarding accurate coding to include Section I and on 1/23/2017 Section E on the MDS (behaviors) was started for SW and MDS this will be completed by 1/26/2017. The Executive Director and RN MDS Coordinator/ Designee will monitor the MDS coding of Section I on Admission MDS of 2 residents and Section E on 2 discharged residents using the Quality Improvement tool two times a week for 12 weeks and then monthly. The results of the monitoring will be reviewed in the Quality Assurance Performance Improvement Meetings every month for 12 months and any areas identified for improvement will be reviewed at that time and adjustments made to the QI monitoring as appropriate. Expected date of completion January 26, 2017.	

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F 278	Continued From page 3 depression, asthma, and respiratory failure. Review of a progress note dated 8/25/16 stated Resident #67 had been yelling all day long. The note further revealed other residents had complained about Resident #67 yelling and cursing at the nurse aids trying to help her. Review of Resident #67's discharge MDS dated 8/26/16 revealed the resident was assessed on section E of the MDS as exhibiting no verbal behavioral symptoms directed toward others. During a staff interview on 01/05/2017 at 3:20 PM Debbie Craig MDS coordinator stated the minimum data set dated 8/26/16 was incorrect. During an interview on 1/5/16 at 4:40 PM the Administrator stated that Resident #67 was manipulative and would yell and curse at staff. She further stated it was her expectation that the minimum data set dated 8/25/16 would reflect these behaviors. She further stated the minimum data set dated 8/25/16 was incorrect.	F 278		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care.	F 328		1/26/17

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The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.

(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.

(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.

(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.

(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.

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F 328	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, and observation, the facility failed to respond to an alarming oxygen concentrator, which resulted in a low oxygen saturation rate for 1 of 2 sampled residents (Resident #81) who received respiratory care. Findings included: Resident #81 was admitted to the facility on 11/28/16 with admitting diagnoses which included acute and chronic respiratory failure with hypoxia (low oxygen levels), and chronic bronchitis. A review of the admission Minimum Data Set (MDS) revealed Resident #81 was cognitively intact, required supervision for all activities of daily living, was not steady but was able to stabilize herself without human intervention, had no limb impairments, and used no mobility devices. Resident #81 received oxygen therapy, and BIPAP (Bi-level Positive Airway Pressure) and or CPAP (Continuous Positive Airway Pressure). A review of the care plans dated 11/28/16 included a care plan for ineffective breathing patterns. The goals were realistic and interventions included Oxygen as ordered. A review of a physician order dated 12/29/16 revealed an order which read, " Titrate O2 (oxygen). 2-4 liters to keep O2 sats (saturation) greater than 91% (percent). An alarm was observed sounding on the 200 Hall at 12:10 PM on 1/4/17.	F 328	Resident #81 was identified on 1/4/2017 as having her oxygen concentrator audible alarm sounding. The resident was placed on a portable oxygen tank which was on the resident□s wheelchair at her bedside and her oxygen saturations immediately improved to 98% and a new oxygen concentrator was bought to the room. The resident□s former concentrator was removed from the room. Resident #81 was assessed by the DCS, RT and the PA (Physician□s assistant) due to her respiratory status and a low grade fever. The RT checked the concentrator after removal from the resident□s room to assure in proper working order. Orders were written by the PA to include a Chest X-ray, antibiotics (resident had a low grade fever that morning), and Prednisone for COPD exacerbation. The Nurse #4 identified as not responding timely to the alarming oxygen concentrator was removed from caring from the residents until an investigation could be completed and immediately re-educated by DCS. Nurse #3 was also immediately re-educated by the DCS. On 1/4/2017 the RT completed an audit of all residents (13) using oxygen and checked each concentrator to assure proper functioning. Interviews were conducted by the DCS and SW with alert and oriented residents who indicated that their needs were met timely regarding oxygen alarms. There were no concerns expressed by residents from these interviews.	

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F 328	Continued From page 6 A continuous observation was made on 1/4/17 from 12:10 PM through 12:25 PM of the 200 Hall directly outside the room where Resident #81 resided. Nurse #3 was observed at a medication cart directly across the hall from Resident #81 ' s doorway. The alarm was heard coming from Resident #81 ' s room. Nurse #3 stated, " Yes. I hear the alarm also. " She then called down the hall to Nurse #4. There was no response to Nurse #3 ' s call for help, so she called a second time. Nurse #4 responded to Resident #81 ' s room after the third call for help was made by Nurse #3. Nurse #4 entered Resident #81 ' s room. From the foot of the bed, Resident #81 was observed with nasal flaring, hyperventilation, accessory muscle usage, and a dusky, pale color (all symptoms of respiratory distress). A nasal cannula (oxygen tubing) was in place and connected to an oxygen concentrator, which was alarming, beside the bed. There was no portable oxygen cylinder observed at the bedside. Nurse #4 left the bedside and returned 2 minutes later with a portable oxygen cylinder and assessed the vital signs of Resident #81. Nurse #4 stated, " I guess the concentrator ran out of oxygen. " Per Nurse #4 ' s assessment, Resident #81 had an oxygen saturation rate of 84% before she was placed on portable oxygen. Resident #81 had an oxygen saturation of 98% after being placed on portable oxygen. It was 12:20 PM when Nurse #4 placed Resident #81 on portable oxygen. An interview was conducted with Nurse #4 on 1/4/17 at 12:26 PM. She was asked about Resident #81 ' s oxygen supply. She stated, " I guess I misspoke when I told you she (Resident #81) was out of oxygen. I should have said the oxygen concentrator malfunctioned. "	F 328	On 1/4/2017 & 1/5/2017 the RT in-serviced staff on oxygen malfunctions and proper functioning of oxygen concentrators and the importance of timely response to oxygen alarms. The staff was also in-serviced by DCS and ADCS regarding the neglect policy and procedure which was completed by 1/6/2017. The DCS /Designee will use the Quality Improvement monitor tool to monitor response to oxygen concentrator alarms though drills weekly for 12 weeks and then monthly for 10 months to assure timely response to oxygen alarms date of completion to be January 26, 2017. The results of this monitoring will be reported monthly in the Quality Assurance meeting and any areas identified for improvement will be addressed as appropriate. The RT will continue to come to the facility at least 1-2 times per week and check maintenance/ function of oxygen concentrators.	

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An interview was conducted on 1/4/17 at 12:30 PM with Nurse #2. She stated respiratory therapy (RT) comes to the facility every week and checks all the RT equipment, including the concentrators. The hall nurses were responsible to check the concentrators every shift. The concentrators created oxygen and if there was a malfunction which included if it became unplugged, or the water reservoir was empty an alarm would go off. She also stated, " Everyone is responsible to answer alarms. If an oxygen dependent resident goes without oxygen for 5 minutes or more they can develop hypoxia or worse-die."

A nursing note dated 1/4/17 at 2:30 PM read, " Pt (Resident #81) (with) an episode of SOB (shortness of breath) this AM (morning) when facility owned O2 concentrator went dead. While I (Nurse #4) was at the nurse ' s station, (Nurse #3) notified me that the O2 concentrator (alarm) in room was going off. Upon entering room the concentrator was beeping. Pt was immediately hooked up to portable O2 that was at pts' bedside as per facility protocol. O2 sat was 86% before apply portable. It then went up to 98% after application of O2. Nurse Practitioner notified of pt's earlier c/o (complaints of) not feeling well. Also of temp (temperature) 99.6. A new concentrator was brought into room and was hooked up by Nurse #2. "

An interview was conducted on 1/6/17 at 3:30 PM with Nurse #3. She stated, "I heard the alarm going off in (Resident #81 ' s room), but it wasn't my resident. I saw the nurse at the nurse ' s station (Nurse #4) so I called her. " Nurse #3 added Nurse #4 responded after the 3rd time called. Nurse #3 also stated, " All staff are responsible to respond to alarms, but I had

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medications in my hands for another resident. I saw the nurse for that room so I thought she would respond. I know (Resident #81) is oxygen dependent. " She also stated, " An oxygen dependent resident can become hypoxic without oxygen. Hypoxia can lead to, at the worst, death. We check concentrators before we put them in to use. " When asked who maintained respiratory equipment, Nurse #3 stated respiratory therapy came to the facility about 3 times per week to check residents and equipment. If a concentrator malfunctioned residents were placed on portable oxygen, assessed, and if ordered, given a breathing treatment. The malfunctioning equipment got tagged and sent out for maintenance.

An interview was conducted on 1/6/17 at 3:45 PM with Resident #81. She stated, "My oxygen concentrator keeps messing up. The alarm keeps going off. It was fine until today. I know the machine was changed out, but I don't know why. I don't remember what happened that other morning. I just know I haven't felt well all day. When the alarm goes off, the oxygen stops. I have my own personal portable tank here that I use to go to the bathroom. I have to wear oxygen 24/7 (24 hours per day. 7 days per week). If I don't get oxygen I can't breathe."

An interview was conducted 1/6/17 at 3:55 PM with the Director of Clinical Services. She stated, "All staff are responsible to answer equipment alarms when they sound. Staff are exposed to respiratory care equipment during orientation and hands on preceptorship so they should be familiar with the equipment. My expectation is for nurses to get up and go to the room to assess the situation whether or not it is their assignment.

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F 328	Continued From page 9 This resident should have been put on portable oxygen right away. Respiratory therapy comes out to the facility at least 2-3 times per week. They do function checks on concentrators and assess residents. If there's a malfunctioning piece of equipment they send it out to be fixed. It is my expectation that staff respond to alarms in a timely manner."	F 328		