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 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARY HEALTH AND REHABILITATION	6590 TRYON ROAD CARY, NC 27518

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigatin conducted during the recertification survey. Event #KCLK11. Intake #NC00134377, NC00134843, NC00135178, NC00134211. A follow up visit event #TSYP12 was conducted during recertification and compliant investion.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit.	F 636		3/13/18

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

Electronically Signed | 02/22/2018

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F 636	Continued From page 1 (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to complete a comprehensive Admission Minimum Data Set (MDS) assessment for 1 of 22 residents reviewed (Resident #75). Findings included:	F 636	Preparation and/or execution of this plan does not constitute agreement or admission by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by	

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F 636	Continued From page 2 Resident #75 had been admitted on 12/13/2017 from an acute hospital. Her comprehensive Admission Minimum Data Set (MDS) assessment was dated 12/20/2017. A physician order dated 12/26/2017 indicated "patient to discharge to home 12/26/2017." Resident #75 was discharged, return not anticipated to home on 12/26/2017. An entry tracker dated 12/29/2017 for Resident #75 indicated this was an admission from an acute hospital. No comprehensive Admission MDS assessments were observed completed for Resident #75 since her admission on 12/29/2017. An interview with Resident #75 was conducted on 2/07/2018 at 5:20 PM. The resident stated she had been discharged to home. While at home, she fell, hit her head and had been taken to the hospital. She stated the hospital then sent her to Cary Rehab again. An interview with MDS nurse #1 was conducted on 2/07/2018 at 5:24 PM. The nurse stated Resident #75 had been discharged return not anticipated on 12/26/2017. When the resident returned on 12/29/2017 and an Admission MDS assessment should have been completed. An interview with the Administrator (AD) was conducted on 2/08/2018 at 11:37 AM. The AD stated the MDS nurses report directly to him. He also stated it was his expectation that assessments were completed according to the	F 636	the provisions of federal and state law. F636 483.20 (b)(1)(2)(i)(iii) Comprehensive Assessment and Timing A root cause analysis completed on the processes leading to the deficiency Comprehensive Assessments and Timing cited including adherence to RAI manual guidance. 1. A comprehensive Admission Minimum Data Set (MDS) was completed and submitted on 2/8/18. MDS Nurse #1 educated on 2-8-18 by the Administrator on timeliness and accuracy of MDS assessments. 2. Quality Review of current residents admitted to the facility in the past 30 days was performed on 2-7-2018 to ensure initial assessments were performed accurately and timely. Follow up based on findings. 3. Regional MDS Coordinator provided re-education on 2-22-2018 to facility MDS department on timeliness and accuracy of MDS assessments. 4. Director of Nursing to complete Quality Monitoring of new admissions to ensure proper MDS assessment types are performed according to RAI Manual weekly x 12 weeks then monthly & PRN utilizing quality improvement monitoring tool. Findings to be reviewed at monthly Quality Assurance and Performance	

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F 636	Continued From page 3 Resident Assessment Instrument (RAI) manual.	F 636	Improvement Committee (QAPI) meeting. Quality monitoring schedule modified based on findings.	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to secure 2 of 6 medications carts (unit two split cart and 400 hall cart) and failed to discard loose medications in 2 of 3 medication carts reviewed for medication storage (unit one	F 761	F761 483.45(g) Label/Store Drugs and Biologicals A root cause analysis completed leading	3/13/18

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F 761	Continued From page 4 split cart and 200 hall cart) . Findings included: 1. On 2/05/18 at 6:10 AM an observation was made of a medication cart parked at the unit 2 nurses' desk. The lock mechanism was observed in the unlocked position, no staff were observed in the hall or at the desk. A few moments later, Nurse #3 was observed walking in the hall toward the desk. An interview with Nurse #3 was conducted on 2/05/2018 at 6:11 AM. The nurse stated this cart was the unit two split cart and that she should have locked the cart when she left to answer a call bell. The nurse demonstrated the cart was unlocked by opening the top left drawer. The nurse then locked the cart by activating the lock mechanism. An interview with the Director of Nurses (DON) was conducted on 2/08/2018 at 8:43 AM. The DON stated medication carts should be secured when unattended. 2. On 2/05/18 at 09:06 AM an observation was made of a medication cart parked between rooms 403 and 405. The lock mechanism was observed in the unlocked position and no staff were observed in the hall. An interview with Nurse #2 was conducted on 2/05/18 09:13 AM. The nurse stated this was the 400 hall cart and demonstrated the cart was unlocked by opening the top left drawer. The nurse stated he should have locked the medication cart before leaving the area and the cart should be locked when it was out of the line of sight.	F 761	to the deficiency include keeping medication carts locked and ensuring loose medications are removed from medication carts timely was completed. 1. Unit 2 split cart and 400 hall medication carts observed by Director of Nursing as locked and having no loose pills within on 2-8-18. Nurse #2 and Nurse #3 educated on properly securing and storing medications 2-5-2018. 2. Quality Observation of Medication carts conducted by Director of Nursing/Designee to ensure remain locked appropriately. Quality Observation of Medication carts conducted by Director of Nursing/Designee to ensure continue to have no loose pills identified within. Follow up based on findings. 3. Current licensed staff re-educated by Director of Nursing on properly securing, storing medications and maintaining medication carts free of loose medications. 4. Director of Nursing or Assistant Director of Nursing to complete Quality Monitoring of medication carts weekly x 12 weeks then monthly and PRN utilizing quality improvement monitoring tool to ensure medication carts are properly locked and that loose pills are not identified within medication carts. Findings to be reviewed at monthly Quality Assurance and Performance Improvement Committee (QAPI) meeting. Quality Monitoring schedule modified based on findings.	

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F 761	Continued From page 5 An interview with the Director of Nurses (DON) was conducted on 2/08/2018 at 8:43 AM. The DON stated medication carts should be secured when unattended. 3. On 2/08/2018 at 2:58 PM the unit one split cart was reviewed for medication storage. The Director of Nursing (DON) was present during the review. The top left drawer was observed with 15 loose tablets on the bottom of the drawer. The second left drawer was observed with 6 loose tablets on the bottom of the drawer. An interview with the DON was conducted on 2/08/2018 at 3:10 PM. The DON stated it was her expectation that medication carts be kept clean and loose medications should be discarded. 4. On 2/08/18 at 3:06 PM the 200 hall cart was reviewed for medication storage. The Director of Nursing (DON) was present during the review. The second left drawer was observed with 12 loose tablets on the bottom of the drawer. An interview with DON was conducted on 2/08/2018 at 3:10 PM. The DON stated it was her expectation that medication carts be kept clean and loose medications should be discarded.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 812		3/13/18

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F 812	Continued From page 6 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interviews the facility failed to maintain the temperature of the tossed salad at 41 degrees or below during 1 of 1 tray line observations. The findings included: On 2/7/2018 at 11:40 AM the temperature of the tossed salad was checked. The temperature registered 51 degrees on the calibrated digital thermometer. The tossed lettuce salad which was topped with shredded cheese was inside an insulated bowl with a lid on it. On 2/7/18 at 11:45 AM the dietary aid stated she made the salad in a stainless steel bowl and placed it back into the walk-in cooler prior to putting the salad into the individual insulated bowels with lids and storing them in the walk-in cooler. She stated she was unsure why the salad was not colder because she had followed the procedure as the corporate food service manager had instructed. On 2/7/18 at 12:30 PM the Dietary Manager stated the temperature of the salad should be 40	F 812	F812 483.60(i)(1)(2) Food Procurement Store/Prepare/Serve/Sanitary A Root Cause Analysis completed on the processes that lead to the deficiency cited including serving food at proper temperatures. 1. Temperature of tossed salad tested prior to serving noted as less than 41 degrees as required. Dietary Manager received individualized re-education by Regional Dietary Manager on 2-20-2018 on required food temperature service/storage ranges. 2. Quality Review of food temperatures conducted by Regional Dietary Manager/Designee on 2/22/2018 to ensure food stored/served at temperatures within required range. Follow up based on findings. 3. Dietary staff re-educated by Regional	

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F 812	Continued From page 7 degrees or less. The corporate food service manager was interviewed on 2/8/18 at 9:30 AM. She stated the correct temperature for cold items should be less than 41 degrees. She added she had instructed the dietary aid to put the salad into a metal bowel and put it in the walk in cooler so that it would be cold enough. She said she did not monitor the salad temperature during the preparation.	F 812	Dietary Manager on 2-22-2018 required food service/storage temperature ranges. 4. Dietary Manager / designee to complete Quality Monitoring of food temperatures weekly x 12 weeks then monthly and PRN using the quality improvement monitoring tool to ensure food products are stored, prepared and served at proper temperatures. Findings to be reviewed at monthly Quality Assurance and Performance Improvement Committee (QAPI) Meeting. Quality Monitoring schedule modified based on findings.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		3/13/18

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F 842	Continued From page 8 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and	F 842		

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F 842	Continued From page 9 determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to assure accurate documentation of blood sugars and administration of insulin for 1 of 3 residents (resident # 77) reviewed for accurate documentation. The findings included: Resident #77 was admitted to the facility on 10/13/17. She was discharged on 1/1/18 and readmitted on 1/11/18 from an acute care hospital. The diagnoses included respiratory failure, urinary tract infection, diabetes, cerebrovascular disease and hemiplegia. The quarterly Minimum Data Set (MDS) dated 1/14/18 revealed Resident #77 was severely cognitively impaired and required total assistance with all activities of daily living. She had limited range of motion on both upper and lower extremities on both sides. She had a urinary catheter and was always incontinent of bowel. She received insulin. During a record review the January 2018 physician ' s orders included orders for blood sugar to be checked every 6 hours and Novolog insulin to be given based on the results of the blood sugar. The order dated 1/26/18 stated the resident was to receive 16 units of NPH insulin every 6 hours. A review of the January 2018 Medication Administration Record (MAR) revealed the orders	F 842	F842 483.20(f)(5), 483.70(i)(1)-(5) Resident Records A root cause analysis completed on the processes that lead to the deficiency involving documentation of medication administration. 1. Nurse #4 wrote a nurse□s note on 2-8-18 to explain the omission of documentation in the medication administration record. Nurse #4 received individualized re-education on 2-8-2018 on documentation of Medication Administration Record. 2. Quality Review of the Medication Administration Record for prior 30 days performed by the Director of Nursing/Designee for omitted entries. Follow up based on findings. 3. Nurses re-educated by Assistant Director of Nursing on 2-8-2018 on accurate and timely documentation of the Medication Administration Record. 4. Director of Nursing /Designee to complete Quality Monitoring of Medication Administration Records for omitted entries	

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F 842	Continued From page 10 for the sliding scale insulin were rewritten on 1/26/18 prior to 6:00 PM. There was no documentation of the blood sugar level or the dose of insulin given on 1/31/18 at 6:00 PM or at Midnight. In addition the scheduled 16 units of NPH insulin were not documented as given on 1/31/18 at 6:00 AM, at 6:00 PM or at midnight. A review of the February 2018 MAR revealed the 16 units of Novolin N insulin was scheduled every 6 hours at 6:00 AM, 12:00 PM, 6:00 PM and midnight. The MAR revealed the order was rewritten on 2/3/18. There was no documentation the insulin was given at midnight on 2/3/18 on the MAR. There was also no documentation the insulin was given on 2/7/18 at 6:00 AM or at midnight. During a telephone interview on 2/8/18 at 6:10 PM with Nurse #4, who worked the 11:00 PM to 7:00 AM shift who worked on 2/3/18 stated he did document the insulin administration but he had documented it in the previous order before it was rewritten. An additional review of the MAR revealed there was no documentation on 2/3/18 at midnight on the old order or the rewritten order. During an interview with the Director of nursing on 2/8/18 at 6:15 PM she stated they had discussed the missing documentation with nurse #4 and he came in today to write an explanation in the nursing notes because he told her the midnight dose documented on the next day. She had no explanation as to why the documentation for the 2 undocumented 6:00 AM doses or the missed documentation for the January doses of insulin. She stated she had completed random record	F 842	weekly x 12 weeks then monthly and PRN using the quality improvement monitoring tool. Findings to be reviewed at month Quality Assurance and Performance Improvement Committee (QAPI) meeting. Quality monitoring schedule modified based on findings	

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F 842	Continued From page 11 reviews based on the plan of correction and had previously reviewed this record but had not picked this particular record on her last record review because she was completing random record reviews.	F 842		