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 07/14/2022

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

(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
E 000	Initial Comments A recertification and complaint investigation survey was conducted from 7/11/22 through 7/14/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #XUNC11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 07/11/2022 through 07/14/2022. Event ID# XUNC11. 2 of the 15 complaint allegations were substantiated but did not result in a deficiency. The following intakes were investigated: NC00189430, NC00189462, NC00189582, NC00189799, NC00189937, NC00190067, and NC19097.	F 000		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623		8/20/22

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

Electronically Signed | 08/05/2022

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F 623	Continued From page 1 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;	F 623		

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F 623	Continued From page 2	F 623		

(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:

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F 623	Continued From page 3 Based on record review and staff interviews the facility failed to provide written notification to the resident representative and the ombudsman when a resident was transferred to the hospital. This was evident for 1 of 1 resident that was reviewed for hospitalizations (Resident #59). Findings Included: Resident #59 was admitted to the facility on 05/30/2022. The quarterly Minimum Data Set (MDS) for Resident #59 dated 06/04/2022 identified the resident had severely cognitive impaired cognition. Review of the medical record for Resident #59 revealed she was discharged to the hospital on 05/24/2022 and re-admitted to the facility on 05/30/2022. An interview with the Social Worker (SW) on 07/14/2022 at 2:06 pm revealed she was not aware whose responsibility it was to provide the written notification of a resident's discharge to the resident representative and ombudsman. She stated there had been no written notification provided to either the resident representative or ombudsman when Resident #59 was hospitalized. SW indicated she had not provided written notification to the resident/RP or the ombudsman for any residents transferred. The SW indicated she had been employed at the facility for the last 1 year. An interview with the Administrator on 07/14/2022 at 3:30 pm revealed it was the SW's responsibility to provide written notification of a resident's	F 623	1.Resident # 59 family was sent a letter of discharge to hospital on 8/4/22. 2.The facility Social Service Director will review residents identified went a transferred to the hospital in last thirty days to ensure that the resident representative and the ombudsman were notified in written of the resident□s transfer to the hospital. These letters were sent out to the responsible parties on 8/4/22. 3.The Regional Director of Clinical Services will provided education to the facility Social Service Director, Executive Director and Director of Nursing in regarding of written notification to the resident representative and ombudsman of resident□s transfer to the hospital. 4.The Executive Director /designee will complete Quality Monitoring Review on two sampled residents identified as being transferred to the hospital to ensure that resident representative and ombudsman when provided written notification of the transfer weekly times four weeks and bi □ monthly times two. The results of Quality Monitoring reviews will be reported to the Quality Assurance Performance Committee monthly for two months. The Committee will review the findings and determine if further action is needed.	

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F 623	Continued From page 4 discharge to the resident representative and the ombudsman. He stated that the SW was not aware of this and going forward the SW would complete the notification per the regulation.	F 623		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, the facility failed to develop a comprehensive care	F 657	1.On 7/18/22 Resident # 247 was discharged from the facility.	8/20/22

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F 657	Continued From page 5 plan that addressed the use of an indwelling urinary catheter within 7 days of completion of the comprehensive assessment for 1 of 1 resident (Resident #247) reviewed for urinary catheters. Findings included: Resident #247 was admitted to the facility on 6/28/22 with diagnoses that included a sacral ulcer requiring urinary catheter. Her admission Minimum Data Set (MDS) dated 7/3/22 indicated a severe cognitive impairment. She had an indwelling catheter. Review of Resident #247's comprehensive care plan revealed it did not address the resident's indwelling urinary catheter. During an interview on 7/14/22 at 3:20 PM, the MDS nurse indicated the indwelling urinary catheter should be addressed in the comprehensive care plan. She indicated she believed the facility had until 7/18/22 to complete the comprehensive care plan and that was why the catheter had not been care planned at that time. She was unaware the comprehensive care plan should be completed within 7 days of the comprehensive assessment (admission MDS dated 7/3/22). During an interview on 7/14/22 at 3:45 PM, the Director of Nursing confirmed Resident #247 did not have a care plan that addressed the use of an indwelling urinary catheter. She revealed the catheter should be included on the comprehensive care plan.	F 657	2.The Regional MDS nurse completed Quality Monitoring Review of current resident□s identified with indwelling catheter to ensure comprehensive care plan was developed that addresses the use of indwelling catheter within seven days of completion of comprehensive assessment. 3.On 8/3/22 The Regional Clinical Director nurse provided re-education to the facility MDS nurses in regard to the requirement of developing comprehensive care plan with resident requiring indwelling catheter within seven days of completion of resident assessment. 4.The Regional MDS nurse or designee with complete Quality Monitoring Review of two sampled residents identified with indwelling catheter to ensure care plan developed that addresses the use of indwelling catheter within seven days of completion of comprehensive assessment weekly times four weeks and bi- monthly times two. The results of Quality Monitoring reviews will be reported to the Quality Assurance Performance Committee monthly for two months. The Committee will review the findings and determine if further action is needed.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		8/20/22

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F 677	Continued From page 6 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to provide assistance with eating for a resident with visual impairment who required limited assistance for one of five residents (Resident #91) reviewed for dining. Findings included: Resident #91 was admitted to the facility 9/22/21 with diagnoses that included blindness and a stroke. A care plan dated 3/27/22 focused on Activities of Daily Living (ADLs) indicated Resident #91 required tray set up and assistance with eating that ranged from supervision to extensive assistance due to blindness. Resident#91's quarterly Minimum Data Set (MDS) dated 6/23/22 indicated severe cognitive impairment. He required limited assistance with eating. An observation was made on 7/11/22 at 1:30 PM of Resident #91 eating lunch near the nurse's station. The lid of Resident #91's plate was not removed. The lid was not removed from an ice cream cup and Resident #91 was attempting to drink from the ice cream cup. The nurse assisted with opening the ice cream cup and put the spoon in the cup then walked away. Resident #91 was attempting to use the spoon as a straw, was unsuccessful, then ate the ice cream directly from	F 677	1.On 8/2/22 Resident#91 was evaluated by therapy services to determine the appropriate assistance, set up and equipment needed for the resident. The resident Activity Daily Living care plan was review by MDS nurse and updated to include the amount assistants the resident required with eating. 2.On 8/4/22 the Director of Nursing /designee reviewed current residents to ensure resident requiring assistances with eating were being provided appropriate assistances. 3.The Staff Development Coordinator /designee will provide education in regarding to reviewing resident care plan/kardex 4.The Director of Nursing or designee with complete Quality Monitoring review of five sampled residents to ensure that appropriate assistance is being provided with eating weekly time four weeks, bi monthly times two. The results of Quality Monitoring reviews will be reported to the Quality Assurance Performance Committee monthly for two months. The Committee will review the findings and determine if further action is needed.	

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F 677	Continued From page 7 the cup with his mouth. An observation was made on 7/13/22 at 8:50 AM of Resident #91 in bed sleeping with his breakfast tray in front of him. His orange juice and cereal were not opened, and his toast was unbuttered. Resident #91 woke easily and stated he would like to eat his breakfast but needed help. During an interview on 7/13/22 at 9:05 AM, Nurse Aid #1 indicated that when she brought the breakfast tray that morning, Resident #91 said he did not want it and she was going to come back and check in later. Staff assisted Resident #91 by setting up his meal and telling him the locations of the items on his tray. Staff were to check in with Resident #91 throughout the meal period. During an interview on 7/14/22 at 3:00 PM, the Director of Nursing (DON) revealed Resident #91 required set up assistance and at times required one person assistance with meals. Staff should be setting up his tray and assisting as needed. During an interview on 7/14/22 at 4:00 PM, the Administrator revealed staff should provide cueing and set-up assistance for Resident #91.	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary	F 690		8/20/22

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F 690	Continued From page 8 incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide catheter care by allowing the urine collection bag to rest on the floor for 1 of 1 resident (Resident #247) reviewed for urinary catheters. Findings included: Resident #247 was admitted to the facility on 6/28/22 with diagnoses that included a sacral ulcer requiring a urinary catheter. Her admission Minimum Data Set indicated a severe cognitive	F 690	1.On 7/14/22 Resident #247 charge nurse immediately reposition the catheter urine collection bag to allow space between collection bag and floor. 2.On 7/15/22 Director of Nursing/designee completed Quality Monitoring Review of current residents identified with use of urine collection bag to ensure collection bag was position to allow space between bag and floor.	

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F 690	Continued From page 9 impairment. She had a urinary catheter. An observation was made on 7/13/22 at 1:50 PM of Resident #247 sleeping in her bed with her catheter urine collection bag hooked to the side of the bed. The bed was in low position and the urine collection bag rested on the floor. An observation was made on 7/14/22 at 12:45 PM of Resident #247 sleeping in her bed with her urine collection bag hooked to the side of the bed. The bed was in low position and the urine collection bag rested on the floor. During an interview on 7/14/22 at 12:45 PM, Nurse #1 indicated that if the tubing was not touching the floor, it was acceptable for the urinary collection bag to touch the floor. During an interview on 7/14/22 at 12:50 PM, the Staff Development Coordinator revealed the urinary collection bag should not touch the floor. If the bed was in low position, staff should ensure the bag was not touching the floor. During an interview on 7/14/22 at 12:50 PM, the Regional Clinical Director indicated the urinary collection bag should not touch the floor. During an interview on 7/14/22 at 4:00 PM, the Administrator revealed nursing should be monitoring catheters and urinary collection bags.	F 690	3.The Director of Nursing /designee will provided education to the direct care staff (licensed nurses and nursing assistants) regarding care of resident with urine collection bag that included allowing space between bag and floor. Direct Care staff that has not completed the education by 8/20/22 will completed the education prior to working next scheduled shift. 4.The Director of Nursing or designee will conduct Quality Monitoring Review of two sampled residents identified with catheter urine collection bag , weekly times four, bi monthly times two. The finding of the audits will be reported to Quality Assurance Performance Committee monthly and updated as indicated. The Quality Monitoring Schedule will be modified based on findings.	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		8/20/22

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F 880	Continued From page 10	F 880		

designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the

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F 880	Continued From page 11 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and vendor interviews, the facility failed to implement a Legionella prevention program and ensure 2 of 2 vendors entering the facility were screened prior to entry and were wearing masks. This had the potential to effect 103 residents. Findings included: 1. Review of the Emergency Preparedness and Infection Control Programs revealed the facility did not have a procedure or program for water safety management for Legionella. During an interview on 7/14/22 at 10:45 AM, the	F 880	1. On 7/14/22 the Administrator and Maintenance Director were re-educated on Infection Control as it relates to the Water Management Program, specifically Legionella, by the Divisional Director of Safety. The Administrator, Director of Nursing and Staff Development Coordinator was re-educated on 7/14/22 by the Regional Director of Clinical Services on visitor, staff and vendor Covid screening prior to entry facility and wearing of N95 mask and/or well-fitting face mask in areas of the facility they may encounter residents. On 7/15/22 facility posted signs on exterior doors that	

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(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 880	Continued From page 12 Maintenance Supervisor revealed the facility did not test the water for Legionella. He indicated he was new to the position and was not aware of requirements for water testing. During an interview on 7/14/22 at 10:50 AM, the Administrator revealed the facility did not have a program for testing the water for Legionella. He believed testing was optional unless there was an outbreak of Legionella. The facility had not conducted a Legionella risk assessment. The Administrator confirmed he was involved with development of the Emergency Preparedness program last reviewed 3/28/22. 2. Information obtained from the Center for Disease Control website revision date 2/2/22 indicates that all visitors and vendors should wear a N95 face mask or well-fitting face mask in all areas of the facility they may encounter residents. An observation was made on 7/13/22 at 11:20 AM of two plumbers entering the residents' dining room without wearing masks. Residents were present in the dining room for an activity within 6 feet of where the plumbers were working. During an interview on 7/13/22 at 12:17 PM, Plumber #1 indicated he was not screened prior to entry, and no one informed him he needed to wear a mask. He revealed he entered through the kitchen door, and no one directed him to get screened for COVID-19 at the front entrance or to wear a mask. He indicated he has been to the facility in the past but had entered through the kitchen as staff said it was an emergency repair. During an interview on 7/13/22 at 1:20 PM, the Administrator revealed all vendors should be screened at the front and provided with a mask	F 880	individuals must enter through the Lobby and be screened. 2. On 7/14/22 The Divisional Director of Safety reviewed the facility□s Emergency Preparedness Plan related to water management related to Legionella. The Administrator and Maintenance Director completed a quality review by re-establishing the water management program with the guidance of the CDC Toolkit on Water Management. This program includes a detailed outline of the water system in the facility, including where the water enters, exits, and any potential sites for Legionella to grow. The water management program also has measurable and visual inspections to include water temperature checks. A quality review was completed by observation by the Director of Nursing to ensure staff, visitors and vender were wearing mask on _7/14/22_. On _7/15/22_The Director of Nursing /designee were the Covid screening forms to ensure that staff, visitors and vendors had completed Covid screening tool prior to entry facility. The Root Cause Analysis was completed by the Regional Director of Clinical Services, Executive Director, and the Director of Nursing on 8/3/22. An ADHOC Quality Assurance Performance Improvement Committee was held on 8/4/22 to formulate and approve a plan of correction for the deficient practice. On 8-5 Administrator reviewed doors and ensured that all door has the screening signs.	

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 07/14/2022

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F 880	Continued From page 13 prior to entry. He was unaware vendors were entering through the kitchen door.	F 880	3.The facility has an established water program to reduce the risk of growth and spread of Legionella in the building□s water system. On 7/15/22__the Executive Director and Maintenance Director were re-educated by the Divisional Director of Safety on the Emergency Preparedness Plan as it relates to the facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility water system. On 7/15/22 the Director of Nursing, Administrator, and Staff Development Coordinator were re-educated by the Regional Clinical Director on visitor/vendor screening prior to entry, and wearing of N95 face mask as well- fitting face mask in all areas of the facility they may encounter residents. The staff Development coordinator will provide re-education to the facility staff. The Divisional Director of Safety also reviewed the water management program that considers the ASHRAE industry standard and the CDC toolkit, and includes control measures such as: physical controls, temperature management, and visual inspections. Facility Staff to include licensed nurses, certified nursing assistants, temporary nursing staff, and medication aides, housekeeping, therapy services, social worker, human resources, activities, dietary and Maintenance were re- educated by the Director of Nursing/designee that they must entry the facility through the front door and complete screening tool prior to entry resident areas of the facility. The re-education will also include vendors who	

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F 880	Continued From page 14	F 880	must enter through front doors and complete Covid screening tool before entry to resident areas of the facility. Director of Nursing / Designee will provide education to any contracted services prior to the start of their first shift to facility and all new employees will be educated during new hire orientation. The education will be completed by 8/20/22. 4.The Administrator/ Designee will conduct quality reviews of water safety management monitoring to include control measures such as: physical controls, temperature management, and visual inspections once a week for 12 weeks. The administrator /designee will complete Quality Review by observation weekly of 15 staff, visitor and vendors to ensure they have completed Covid screening form prior to entry the facility and are wearing appropriate mask in resident areas. These monitor tools will be completed weekly x 12 weeks, then as needed to ensure compliance. The Executive Director and Director of Nursing will report the results of the quality monitoring (audit) and report to the Quality Assurance Improvement committee three monthly times. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	