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 12/15/2022

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
F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 12/14/2022 through 12/15/2022. Event ID #LKTF11. 6 of the 16 complaint allegations were substantiated resulting in deficiencies. The following intakes were investigated NC00195113 and NC00195819.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-	F 580		1/12/23

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

Electronically Signed | 01/11/2023

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 12/15/2022

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
F 580	Continued From page 1 (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the resident, staff, and physician, the facility failed to notify the physician after an unwitnessed fall for 1 of 1 resident (Resident #1) reviewed for hospice. The findings included: Resident #1 was admitted to the facility on 6/23/22. A review of the quarterly Minimum Data Set (MDS) dated 9/29/22 and indicated Resident #1 was cognitively intact. Review of the medical record did not reveal any notes or nursing assessment from Resident #1 ' s fall on 12/3/22.	F 580	F580 Resident #1 Hospice/Provider/Responsible Party was notified of fall on 12/4/22. The Director of Nursing on 1/10/2023 completed review of 24hr reports from previous 30 days for all residents identified to assure Physician, Hospice provider and Responsible Party were notified of change in condition timely. On 1/9/23 the Director of Nursing or designee provided education regarding timely notification to Hospice/Provider/Responsible Party of any change in condition with resident in a timely manner. The Director of Nursing or designee will complete Quality Review, three times a	

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 12/15/2022

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
F 580	Continued From page 2 There was no documentation in the record that the physician was notified. An interview was conducted with Resident #1 on 12/14/22 at 11:10 AM. Resident #1 stated he was in the bathroom on 12/3/22. He stated he fell as he was getting off the toilet, he became dizzy, lightheaded, fell, and hit his head on the wall. An interview was conducted with Nurse #1 on 12/14/22 at 1:38 PM. Nurse #2 stated Resident #1 had a fall the night of 12/3/22. Nurse #2 stated Resident #1 did not appear to be injured. The nurse denied completing a head-to-toe assessment. Nurse #2 stated she was unable to document in the electronic health record due to the system being down. Nurse #2 stated that she did not report the fall to the physician. An interview was conducted with the On Call Nurse #1 (Wound Care Nurse) on 12/14/22 at 2:42 PM. The nurse stated when she entered Resident #1 ' s room to assist, he reported that he had fallen the previous night. The On Call Nurse stated she notified the Hospice on Call Nurse, took vital signs, and completed a head-to-toe assessment An interview was conducted with the Medical Director on 12/14/22 at 4:50 PM. The Medical Director stated that he was not notified directly but the Hospice group was alerted about Resident #1 ' s fall. The Medical Director stated Resident #1 declined to have an Xray when he was first approached but agreed the next day because he was having more discomfort. An interview was conducted with the Director of Nursing on 12/15/22 at 1:20 PM. The DON stated	F 580	week for four weeks, once a week times four weeks and bi- monthly times one to ensure that resident are thoroughly assessed after fall. The results of the review will be reviewed in the Quality Improvement Committee monthly times three months. The committee will review the results to determine if further action is needed. Alleged compliance on 1/12/2023	

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 12/15/2022

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
F 580	Continued From page 3 the physician should have been notified of Resident #1 ' s fall. An interview with the Administrator on 12/14/22 revealed he had been made aware thar Resident #1 had fallen on night shift of 12/3/22. The Administrator stated he expected that Nurse #1 would have notified the physician of Resident #1 ' s fall.	F 580		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, staff and physician interview the facility failed to thoroughly assess a resident for injury after a fall for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #1). The findings included: Resident #1 was admitted to the facility on 6/23/22. A review of the quarterly Minimum Data Set (MDS) dated 9/29/22 and was cognitively intact. He required limited assistance with one-person physical assist for transfers and toileting due to	F 684	F684 Resident #1 was assessed on 12/4/22 by the charge nurse and attending physician was notified. The attending physician orders x ray of hip and shoulder on 12/4/22, resident refused. On 12/6/22 resident agreed to the x ray previous ordered, results were negative for fracture or acute injury. The Director of Nursing on 1/10/23 completed Quality Review of resident identified with falls in the last thirty days to ensure that each were thoroughly assess for injuries post fall.	1/12/23

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 12/15/2022

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
F 684	Continued From page 4 his unsteady gait. The care plan last updated 9/22/22 revealed Resident #1 had an actual fall related to poor balance, use of psychoactive medication, and unsteady gait. The goal was for Resident #1 to resume usual activities and minimize the risk of further falls though the next review date. Interventions included keep wheelchair and walker within resident ' s reach and reeducate Resident #1 to use call bell for assistance. A review of an interdisciplinary note dated 12/4/22 at 11:00 AM revealed that Resident #1 reported to the On Call Nurse that he was using the call bell for assistance because he had fallen in the bathroom the previous night and staff told him to call for assistance. The On Call Nurse documented she had not received any information regarding Resident #1 falling. The On Call Nurse notified the Hospice nurse and the weekend on call physician was made aware of the fall. The On Call Nurse documented that Resident #1 ' s vital signs were taken and read within normal limits, a complete head to toe assessment was conducted and no issues were noted. The On Call Nurse notified the Administrator of the unwitnessed fall on the previous shift. Review of an interdisciplinary noted dated 12/4/22 at 3:00 PM revealed Resident #1 denied any pain at that time and his resident representative was notified. An interview was conducted with Resident #1 on 12/14/22 at 11:10 AM. Resident #1 stated he was in the bathroom on Sunday night. He stated that as he was getting off the toilet, he became dizzy,	F 684	On 1/9/23 the Director of Nursing or designee provided education to license nurses regarding thoroughly assessing resident after fall. License nurses that do not receive the education will be provided the education prior to working next scheduled shift. The Director of Nursing or designee will complete Quality Review, three times per week times four weeks, one time per week times four weeks and bi- monthly times one to ensure that resident are thoroughly assessed after fall. The results of the review will be reviewed in the Quality Improvement Committee monthly times three. The committee will review the results to determine if further action is needed. Alleged compliance on 1/12/2023	

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 12/15/2022

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
F 684	Continued From page 5	F 684		

lightheaded, fell and his head on the wall. Resident #1 stated it took staff 45 minutes to get him up off the floor using the lift for assistance. Resident #1 stated he was moaning in pain. Resident #1 stated that Nurse #1 came to the room and asked him if he was hurting. Resident #1 stated that Nurse #1 did not ask him if he needed to go to the hospital.

An interview was conducted with NA #3 on 12/14/22 at 1:02 PM. NA #3 stated that Resident #1 had put his bathroom light on. When she arrived Resident #1 was laying on the floor. NA #3 stated that she called out for Nurse #2, and she did not come to Resident #1 ' s room. NA #3 stated that NA #6 came in to assist and left to go get Nurse #2. Resident #1 stated he had bumped his head and was in pain. NA #3 stated that Resident #1 had expressed to her and NA #6 he wanted to go to the hospital. NA #3 stated Nurse #2 did not check Resident #1 she just asked him a few questions. NA #3 stated that she and the other nurse aide assisted Resident #1 up with the lift.

Nurse Aide #6 was unavailable for interview.

An interview was conducted with Nurse #2 on 12/14/22 at 1:38 PM. Nurse #2 stated she had completed her medication pass when NA #3 reported that she needed some help to get Resident #1 up. Nurse #2 stated Resident #1 laying on the floor in the doorway of the bathroom. Nurse #2 stated Resident #1 was trying to transfer from the toilet to the wheelchair and slipped. Nurse #2 stated Resident #1 did not report he had hit his head but complained of being stiff and moaned while being transferred with the lift. Nurse #2 stated she checked

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 12/15/2022

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
F 684	Continued From page 6	F 684		

Resident #1 for injury. She stated once Resident #1 was transferred to bed he was given Morphine for pain. Nurse #2 stated she was unable to document in the electronic health record due to the system being down. Nurse #2 stated that she was unable to locate the paper progress notes and did not place the fall on the 24-hour nursing report. Nurse #2 stated that she did not report the fall to Hospice or the oncoming nurse the next morning. Nurse #2 stated she did not attempt to contact the on-call nurse or Director of Nursing (DON) because she did not know who the on-call nurse or DON was.

An interview was conducted with Nurse #1 on 12/14/22 at 12:17 PM. Nurse #1 stated she was aware that Resident #1 had fallen within the past couple of weeks. Nurse #1 stated that the electronic record documentation system was down, and staff had to document on nursing notes in the resident ' s hard chart. Nurse #1 stated when a resident had an unwitnessed fall, the nurse was responsible for notifying the physician, Director of Nursing, and resident representative. Nurse #1 further stated that the nurse was to initiate neurological checks and write a progress note on the resident ' s status.

An interview was conducted with the On Call Nurse on 12/14/22 at 2:42 PM. The On Call Nurse stated she was the Administrative Staff on Call the weekend of 12/2/22 to 12/4/22. The nurse stated Resident # 1 had placed his call light on to go to the bathroom. The On Call Nurse stated she was unsure of whether Resident #1 required one- or two-person assistance, so she went to check. The nurse stated when she entered Resident #1 ' s room to assist, he reported that he had fallen the previous night.

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 12/15/2022

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
F 684	Continued From page 7	F 684		

The On Call Nurse stated she notified the Administrator, Hospice on Call Nurse, took vital signs and completed a head-to-toe assessment. The nurse stated Resident #1 reported he had fallen some time between 11 PM and 1 AM and she notified his son. The On Call Nurse stated Nurse #2 did not report that Resident #1 had fallen, and the fall was not documented on the 24-hour shift report sheet. The nurse further stated Resident #1 did not ask her to go to the hospital but did complain of pain.

A telephone interview was conducted with Hospice Nurse #2 on 12/14/22 at 4:07 PM. Hospice Nurse #2 stated that she received a call on 12/4/22 at 3:35 PM. Hospice Nurse #2 stated she arrived at the facility on 12/4/22 at 3:50 PM, Resident #1 was sitting in his wheelchair on the computer. Hospice Nurse #2 stated she did offer to send Resident #1 to the hospital twice and he declined both times. She stated Resident #1 complained of hurting all over to include his head, neck, back and shoulders. Hospice Nurse #2 stated Resident #1 had recently received his pain medication. She offered Resident #1 his as needed pain medication and he refused. Hospice nurse #2 stated she expected Nurse #2 would have notified hospice of the fall when it happened.

An interview was conducted with the Medical Director on 12/14/22 at 4:50 PM. The Medical Director stated that he was not notified directly but the Hospice group was alerted about Resident #1 ' s fall. The Medical Director stated Resident #1 declined to have an Xray when he was first approached but agreed the next day because he was having more discomfort. The Medical Director stated that he could not say that

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 12/15/2022

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
F 684	Continued From page 8 the facility ' s failure to assess the resident would have caused additional injury due to Resident #1 already being very sick. The Medical Director stated Resident #1 was evaluated by the Physician Assistant (PA) on 12/6/22. An attempt to reach the PA on 12/14/22 was unsuccessful. An interview was conducted with the Administrator on 12/14/22 at 5:15 PM. The Administrator stated he was made aware that Resident #1 had a fall on 12/4/22 and it had happened on the night shift. The Administrator stated he expected that Nurse #1 would have notified the On Call Nurse and DON about the fall.	F 684		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff interview, and pharmacist interview the facility failed to acquire a scheduled medication for administration. This failure resulted in 8 doses of this medication being missed for 1 of 3 sampled residents (Resident #1) reviewed for the provision of pharmaceutical services to meet resident ' s needs. The findings included: Resident #1 was admitted to the facility on 6/23/22 with diagnoses that included congestive	F 760	F760 Resident #1 attending physician and responsible party were notified of missed eight missed doses of scheduled Oxycodone 5 mg that include two doses on 9/20/22, three doses on 9/23/22 and three doses on 11/18/22. The Director of Nursing on 1/10/23 completed Quality Review of Medication Records for last thirty days of residents identified with scheduled narcotics to ensure that narcotics were available and	1/12/23

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 12/15/2022

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
F 760	Continued From page 9 heart failure and cancer. Resident #1 was receiving Hospice Services. A review of the quarterly Minimum Data Set (MDS) dated 6/29/22 revealed Resident #1 was cognitively intact. Resident #1 was assessed as rarely having pain which he rated 2 of 10 and received scheduled pain medication. Review of a physician ' s order dated 9/1/22 revealed Resident #1 was to receive Oxycodone Hydrochloride (HCl) 5 milligrams- Give 2 tablets by mouth four times a day for Pain Review of a physician ' s order dated 9/23/22 revealed Resident #1 was to receive Oxycodone Hydrochloride 5 milligrams -Give 3 tablets by mouth 4 times a day for pain. A review of Resident #1 ' s September 2022 Medication Administration Record (MAR) and Controlled Medication Utilization Record revealed on 9/20/22 the resident ' s Oxycodone HCl 5 mg was no longer available. The September MAR revealed Resident #1 was not provided any pain medication on 9/20/22 at 5:00 PM, 9/20/22 at 9:00 PM. There was no documentation for the missed doses. The September MAR further revealed Resident #1 was not provided any pain medication on 9/23/22 at 1:00 PM, 9/23/22 at 5:00 PM, and 9/23/22 at 9:00 PM. Further review of the MAR revealed that the medication was not available for administration. A review of Resident #1 ' s November 2022 MAR revealed the resident ' s Oxycodone HCl 5mg was not available as of 11/17/22. The November MAR revealed Resident #1 was not provided any pain medication on 11/18/22 at 9:38 AM, 11/18/22	F 760	administrated per physician orders. On 1/9/23 the Director of Nursing or designee provided education to license nurses regarding administration of scheduled narcotics per physician orders. The education included the action to be taken if the license nurse unable to administrator scheduled narcotic due to unavailable. License nurses that do not receive the education will be provided the education prior to working next scheduled shift. The Director of Nursing or designee will complete Quality Review, three times per week for four weeks, one time a week times four weeks and bi- monthly times one to ensure scheduled narcotic medication are available and being administrator per physician orders. The results of the review will be reviewed in the Quality Improvement Committee monthly times three. The committee will review the results to determine if further action is needed. Alleged compliance on 1/12/2023	

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 12/15/2022

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
F 760	Continued From page 10	F 760		

at 1:33 PM, 11/18/22 at 5:00 PM. The MAR revealed that the medication was no available due to awaiting supply from pharmacy.

During an interview with Resident #1 on 12/14/22 at 11:10 AM, the resident stated he had not received his scheduled pain medication 4 times a day on several occasions. He explained the facility was out of his pain medication two days in September and two days in November. Resident #1 further stated he was having pain in his neck, back and hips when he missed his medications. Resident #1 stated he was given an alternative pain medication on 11/17/22 and 11/18/22 at bedtime.

An interview conducted with Nurse #4 on 12/14/22 at 1:00 PM revealed she was aware a prescription for Oxycodone HCl 5 milligrams had been sent to the pharmacy on 9/23/22 Nurse #3 stated she was awaiting the medication ' s delivery on the night shift of 9/23/22, but medication did not arrive with 10:00 PM medication delivery. The nurse stated the medication is signed in and placed in the medication cart. Nurse #4 stated that she reported to the oncoming nurse that the medication was not available and to follow up with the pharmacy. Nurse #4 stated that she did not give Resident #1 any pain medication. Nurse #4 stated she offered Resident #1 his alternative pain medication and he refused. Nurse #4 stated Resident #1 did not appear to be in pain during her observations.

On 12/14/22 an attempt to contact Nurse #5, who was the nurse that documented he was awaiting medication supply from pharmacy in November, was unsuccessful.

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 12/15/2022

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
F 760	Continued From page 11 A telephone interview was conducted with the dispensing pharmacist from the facility ' s contracted pharmacy on 12/15/22 at 2:06 PM. During the interview the pharmacist reported the pharmacy dispensed 30 Oxycodone HCl on 9/24/22 at 1:00 PM. The pharmacist stated pharmacy received the prescription for Oxycodone HCL 5 milligrams on 9/23/22 but Hospice needed prior approval. The medication was dispensed as soon as the pharmacy received the approval from Hospice. On 11/17/22 the pharmacist stated the pharmacy received a refill request for the medication after the 1:00 PM cutoff time. The pharmacist stated that Oxycodone HCl 5 milligrams was dispensed on 11/18/22 to arrive to the facility at 10:00 PM. An interview was conducted with the Director of Nursing on 12/15/22 at 1:20 PM. The DON stated that she expected the nurse to contact the pharmacy to reorder the medication when the dose pack was down to the last 10 pills. The DON stated at that time the pharmacy would be able to communicate with the nurse whether a new prescription was needed. The DON stated staff would not know if a prior authorization would be needed for a resident under Hospice care. The DON further stated staff had access to pharmacy cut off times which was placed at the nurse ' s station. An interview was conducted with the Administrator on 12/15/22 at 3:34 PM. The Administrator stated he expected that medications would be ordered and available for residents as ordered.	F 760		
F 806 SS=D	Resident Allergies, Preferences, Substitutes	F 806		1/12/23

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 12/15/2022

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
F 806	Continued From page 12 CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interviews, and staff interviews the facility failed to provide food according to likes and dislikes for 1 of 1 resident reviewed for food preference (Resident #1). Resident #1 was admitted to the facility on 6/23/22. Record review of the Minimum Data Set (MDS) Quarterly Assessment dated 9/29/22 revealed Resident #1 was cognitively intact. Record review of Resident #1's Food Preference List dated 11/30/22 revealed green peas was listed on his dislikes list and the Food Preference List dated 12/8/22 revealed turkey sandwiches were to be added to his lunch and dinner tray. During an interview on 12/14/22 at 9:56 am Resident #1 revealed that he received food items on his meal trays that he is not able to eat and that he has listed as a dislike. Resident #1 stated he has spoken to the dietary department on multiple occasions, but it has not resolved the problem. He stated the Dietary Manager had met	F 806	F806 On 12/14/22 Resident #1 was interviewed by the Dietary Manager and preferences/likes and dislikes were updated to include adding turkey sandwich to his lunch and dinner tray. His dislikes were updated to include green peas. On 1/11/2023 the Dietary Manager completed Quality Review of facility residents to ensure that each resident preferences/likes/dislikes were correct and reflected on the meal tray card. On 12/21/2022 the Executive Director provided education to the Dietary Staff regarding validation of likes/dislikes and preference on the tray card when preparing the resident meal tray. Dietary Staff that do not receive the education will be provided the education prior to working next scheduled shift. The Executive Director or designee will	

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 12/15/2022

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
F 806	Continued From page 13 with him several times and he provided a list of his likes and dislikes to her. An observation of Resident #1's lunch tray on 12/14/22 at 2:00 pm revealed he was served green peas for lunch and did not have a turkey sandwich. Resident #1 stated he did not eat peas and had notified the facility of this information and that he was to have a turkey sandwich on his tray. Review of Resident #1's meal ticket did not list green peas as a dislike and did not have a turkey sandwich listed on ticket. During an interview on 12/14/22 at 2:15 pm the Dietary Manager revealed resident food preferences were entered into the meal ticket system and the system automatically removed dislikes from the meal tickets, but she was unable to state why Resident #1's meal ticket was not updated with his preference to not have green peas. The Dietary Manager stated she would review his meal ticket information and ensure his lists were updated. She stated the facility was unable to provide a turkey sandwich at this time because they did not have any turkey. The Dietary Manager stated the food delivery arrived today, but the turkey was not available from the supplier. An interview was conducted on 12/15/22 at 1:12 pm the Administrator revealed the expectation was that Resident #1 would receive the appropriate meals.	F 806	observe various meals to ensure tray card is validated when preparing resident meal tray, three times a week times four weeks, two times week times four week and one time a week times four weeks and twice a month for 1 month. The results of the review will be reviewed in the Quality Improvement Committee monthly times three. The committee will review the results to determine if further action is needed. Alleged compliance on 1/12/2023	
F 809 SS=F	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the	F 809		1/12/23

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 12/15/2022

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
F 809	Continued From page 14 facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interviews, and staff interviews the facility failed to serve meals on time to residents for 1 of 1 meal observation. This failure had the potential to impact all residents who received food from the kitchen. The findings included: Review of the Meal Delivery Sheet, updated on 7/11/22, revealed meal delivery times were as follows: Breakfast: 7:40 am 400 Hall, 7:50 am 200 Hall, 8:10 am 300 Hall, and 8:30 am 100 Hall. Lunch: 11:45 am 400 Hall, 12:00 pm 200 Hall, 12:20 pm 300 Hall, and 12:40 pm 100 Hall. Dinner: 5:40 pm 400 Hall, 5:50 pm 200 Hall, 6:10 pm 300 Hall, and 6:30 pm 100 Hall.	F 809	F809 On 12/15/2022 the Executive Director validated with the Dietary Manager the scheduled meal times and the expectation that meals are to be served to the residents units per the schedule. On 12/16/2022 the Executive Director observed Breakfast, Lunch and Dinner to ensure that the meals trays were served to the resident units per the schedule times. The Dietary Manager provided education to the Dietary staff regarding the schedule meal times on 12/21/2022. Dietary Staff that do not receive the education will be provided the education prior to working next scheduled shift.	

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 12/15/2022

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
F 809	Continued From page 15 a. Resident #1 was admitted to the facility on 6/23/22 and was cognitively intact on the Minimum Data Set (MDS) Quarterly Assessment dated 9/29/22. During an interview on 12/14/22 at 9:56 am Resident #1 revealed that meals were not provided at a consistent time. Resident #1 stated the breakfast arrived between 9:00-11:00 am, lunch arrived between 1:00-4:00 pm, and dinner arrived as late at 8:00 pm. He stated he never knew when his meals would be delivered. b. Resident #5 was admitted to the facility 8/30/18 and was cognitively intact on the MDS Annual Assessment dated 9/12/22. During an interview on 12/14/22 at 11:15 am Resident #5 stated all meals were late. She stated she has snacks from home that she eats while waiting for lunch because she was hungry. c. Resident #4 was admitted to the facility 3/14/16 and was cognitively intact on the MDS Quarterly Assessment dated 10/27/22. An interview on 12/14/22 at 11:35 am Resident #4 revealed the meals were delivered to the residents late for most meals and on most days. Resident #8 stated she just waits for the meal tray because they are not consistent with the time the food comes. During an interview on 12/14/22 at 11:43 am Nurse Aide (NA) #5 revealed meal trays were not delivered at a set time. She stated she did not recall a time when lunch was not delivered before the end of her shift at 3:00 pm but the lunch trays have been delivered around 2:00-2:30 pm on several occasions.	F 809	The Executive Director or designee will complete Quality Review of meals at different times of the day to ensure that the meals are delivered per scheduled meal times, three times per week times four weeks, one time week times four weeks and bi- monthly times one month. The results of the review will be reviewed in the Quality Improvement Committee monthly times three. The committee will review the results to determine if further action is needed. Alleged compliance on 1/12/2023	

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 12/15/2022

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
F 809	Continued From page 16	F 809		

During an interview on 12/14/22 at 11:51 am the Cook revealed the late meal delivery was because they were short staffed. He stated there was normally 4 staff members during the morning/lunch meals but today there was only 3. The Cook stated the lunch line was to start at 11:45 but he would not be able to start on time today because he had a food delivery and he needed to check the order and put it away. He stated he would not be ready to start the tray line until 12:20 pm.

An interview on 12/14/22 at 11:57 am NA #4 revealed the breakfast and lunch meals were consistently delivered late. She stated she has gone to kitchen to check on food trays for the resident because they need to assist with feeding and be able to complete their work by the end of their shift and the late delivery of lunch makes it hard to get done by 3:00 pm.

An observation on 12/14/22 at 12:21 pm of the kitchen revealed the tray line was not prepared to start. The potatoes and peas were in the tray line steam table, but no other food was in place for meal service.

An interview with the Cook on 12/14/22 at 12:23 pm revealed that the lunch tray line was not ready to start, and he stated he would need more time to prepare the line for lunch service due to the earlier delivery.

During an interview on 12/14/22 at 12:27 pm the Dietary Aide #1 revealed it was difficult to get the meal trays done in time because they don't have much staff, but they try to get them done and out to the residents as quickly as they can.

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 12/15/2022

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
F 809	Continued From page 17 An interview with Dietary Aide #2 on 12/14/22 at 12:29 pm revealed meals were often late but was unable to state how late. An observation of the lunch meal tray delivery was completed on 12/14/22. The lunch tray line began at 12:34 pm and the lunch carts left the kitchen at the following times: Hall 400 at 12:41 pm, Hall 200 at 12:47 pm, Hall 300 at 1:00 pm, and Hall 100 at 1:46 pm. During an interview on 12/14/22 at 1:45 pm the Dietary Manager revealed the tray line was expected to be started on time, so the residents received their meals as scheduled. The Dietary Manager stated she was new to the facility but was aware the kitchen had staffing challenges and was working on hiring additional staff and completing the training process. An interview was conducted on 12/15/22 at 1:12 pm the Administrator revealed the expectation was that tray line was started and meals were delivered to the residents as scheduled.	F 809		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services	F 849		1/12/23

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 12/15/2022

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
F 849	Continued From page 18	F 849		

when a resident requests a transfer.

§483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes

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 12/15/2022

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
F 849	Continued From page 19	F 849		

responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.

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 12/15/2022

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
F 849	Continued From page 20 (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient.	F 849		

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 12/15/2022

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
F 849	Continued From page 21 (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the resident, facility staff, and hospice staff, the facility failed to notify the hospice provider after an unwitnessed fall for 1 of 1 resident (Resident #1) reviewed for hospice. The findings included: Resident #1 was admitted to the facility on 6/23/22.	F 849	F849 Resident #1 hospice nurse was notified on 12/4/22 of unwitnessed fall that occurred on 12/3/22 by treatment nurse. On 1/10/23 the Director of Nursing completed Quality Review of last thirty days for resident identified with Hospice Services to ensure that the Hospice Provider where notified of falls.	

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 12/15/2022

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
F 849	Continued From page 22 A review of the quarterly Minimum Data Set (MDS) dated 9/29/22 indicated Resident #1 was cognitively intact. The MDS assessment indicated Resident #1 was on Hospice services. The active care plan revealed Resident #1 was staying at the facility for long term care and had hospice services. An interview was conducted with Resident #1 on 12/14/22 at 11:10 AM. Resident #1 stated he was in the bathroom the night of 12/3/22. He stated that as he was getting off the toilet, he became dizzy, lightheaded, fell and his head on the wall. Resident #1 stated that his hospice provider was not notified of the fall until the following day (12/4/22). He explained the On Call Nurse (Wound Care Nurse) indicated she had to notify the hospice nurse when she assessed him on the morning after the fall (12/4/22). An interview was conducted with Nurse #2 on 12/14/22 at 1:38 PM. Nurse #2 stated Resident #1 had a fall the night of 12/3/22. Nurse #2 stated she was unable to document in the electronic health record due to the system being down. Nurse #2 stated that she did not report the fall to Hospice. An interview was conducted with the On Call Nurse (Wound Care Nurse) on 12/14/22 at 2:42 PM. The nurse stated when she entered Resident #1 ' s room to assist on 12/4/22, he reported that he had fallen the previous night. The On Call Nurse stated she notified the Hospice On Call Nurse, took vital signs, and completed a head-to-toe assessment. She stated the Hospice On Call Nurse stated she would be coming to the facility to further look at Resident #1.	F 849	The Director of Nursing provided education on 1/9/23 to licensed nurses regarding notification to hospice provider when hospice resident has change of condition to include fall. License nurses that do not receive the education will be provided the education prior to working next scheduled shift. The Director of Nursing or designee will complete Quality Review, three times a week four weeks, one time week for four week and bi- monthly times one to ensure that Hospice providers are notified of incidences related to fall timely. The results of the review will be reviewed in the Quality Improvement Committee monthly times three. The committee will review the results to determine if further action is needed. Alleged compliance on 1/12/2023	

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 12/15/2022

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
F 849	Continued From page 23 A telephone interview was conducted with Hospice Nurse #2 on 12/14/22 at 4:07 PM. Hospice Nurse #2 stated that she received a call on 12/4/22 at 3:35 PM indicating Resident #1 had a fall during the previous night. Hospice Nurse #2 stated she arrived at the facility on 12/4/22 at 3:50 PM, Resident #1 was sitting in his wheelchair on the computer. Hospice Nurse #2 stated she did offer to send Resident #1 to the hospital twice and he declined both times. Hospice nurse #2 stated she expected Nurse #1 would have notified hospice of the fall when it happened. An interview was conducted with the Director of Nursing on 12/15/22 at 1:20 PM. The DON stated she expected that Nurse #2 would have notified the hospice provider of Resident #1's fall. An interview with the Administrator on 12/14/22 revealed he had been made aware thar Resident #1 had fallen on night shift of 12/3/22. The Administrator stated he expected that Nurse #2 would have notified the hospice provider of the resident's fall.	F 849		