JUN 22 2012

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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	06/06/2012

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 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, 1. the facility failed to maintain sanitary conditions in the kitchen by not ensuring opened and resealed food items were dated and labeled in 1 of 1 dry storage area; 2. the facility failed to remove dented cans from ready to use food items and 3. the facility failed to keep produce/poultry food wholesome, labeled and dated in 1of 1 walk in refrigerator and freezer. Findings included: 1. During an observation in the dry storage area on 6/5/12 at 9:07AM, several items were located on shelves, sandwich bags and storage bins opened undated or labeled. The items included bread crumbs opened in sandwich bag unlabeled or dated, vanilla pudding,opened in sandwich bag unlabeled or dated, light brown sugar opened in a box, loose and opened macaroni, spaghetti and other noodles in a large clear bin unlabeled or dated and a quarter pound of butter wrapped in seran wrap unlabeled or dated.	F 371 F371	Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and or executed because it is required by provision of Federal and State regulations. 1. Opened and resealed food items were dated and labeled in the dry storage area on 6/5/2012. Dented cans have been removed from the ready to use storage area on 6/5/2012. Produce/Poultry have been labeled and dated in the walk in refrigerator and freezer on 6/5/2012. 2. Current residents are at risk. The dietary manager and dietary staff have been re-educated on proper storage, labeling of opened/resealed produce/poultry, removal of dented cans from the ready to use are, dating and labeling of food items in the dry storage area by the Regional Dietician by 7/3/2012 3. Education regarding proper storage and labeling of food items and removal of dented cans from the ready to use area will be part of orientation for new hires in dietary department. The dietary manager and /or cook will complete a QA tool for proper storage, labeling, and removal of dented cans daily x 7 days/wk x 2 weeks, then daily 5 x week x 2 weeks, then 3 x week x 4 weeks, then wkly x 4 weeks, then monthly x 9 months. 4. Results of the QA tool will be presented at QA committee monthly x 12 months to identify trends and need for further education and or monitoring.	7-3-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sharla Vaughn CNHA, BSN — TITLE — (X6) DATE: 6/22/2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 371	Continued From page 1 2. During an observation in the dry storage area on 6/5/12 at 9:07AM, there were 2 dented cans of apples were stored with other ready to be served cans of food. 3. During an observation in the walk in refrigerator on 6/5/12 at 9:30AM, the following items were found opened, undated or labeled, 1 green bag of pastries(dumplings0, 2 bags of opened French fries in a brown bag dated 4/25/12, opened ice cream, crab cakes in white bag unlabeled or dated. 4. During an observation on 6/5/12 at 9:43AM, the following items were found on the shelves, in black crates or on the floor in the walk in freezer opened, undated or labeled. The items included 1 package of open waffles, 2 bags of crab cakes, 3 green bags of pastries(dumplings), 3 bags of opened French fries, 1 bag of onion rings, 1 box of opened freezer burned chicken, opened ice cream on shelves and on floor under meats. Additional, trash and wrappers, spoons etc were also found on the floor of the freezer. During an interview on 6/5/12 at 9:43AM, the dietary manager (DM) and registered dietician (RD) were present and DM identified all the items that were undated or unlabeled in the dry storage area, refrigerator and freezer. The DM indicated that the condition of the freezer with opened food and trash on the floor was unacceptable. DM further stated that the expectation was for the kitchen staff to stock all products in accordance with the policy which would include name of product, date opened, dented cans should be returned to vendor, and dry products should be	F 371		

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F 371	Continued From page 2 sealed in approved containers and leftover foods used within 3 days or discarded. The kitchen staff was also expected to clean the food storage areas weekly when food was delivered.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. 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.	F 431	1. The vials of Tuberculin diagnostic agent have been removed from 2 med rooms and destroyed on 6-5-2012. Medication refrigerator temperatures are between 36 degrees and 46 degrees in 2 medication rooms. 2. Current residents are at risk. Licensed nursing staff have been re-educated on labeling of multi-dose vials of medication upon opening, following manufacturers guidelines regarding destruction after opening, recording refrigerator temperatures daily, and steps to take if temperatures are out of acceptable range by the Director of Clinical Services, or unit manager by 7/3/2012. 3. The Director of Clinical Services, Unit Manager and or weekend supervisor will complete a QA tool daily, 7 days week x 2 weeks, 5 x 1wk x 2 wks, 3x wk x 4 wks, wkly x 4 wks then monthly for 9 months. 4. results of the QA tool will be presented at QA committee monthly for 12 months to identify trends and need for further education and monitoring.	7-3-12

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F 431	Continued From page 3	F 431		

This REQUIREMENT is not met as evidenced by:
Based on observations and staff interviews, the facility failed to remove opened, undated multi-dose vials of tuberculin diagnostic agent from two (2) of two (2) medication rooms and failed to maintain the medication refrigerator temperatures between 36 degrees Fahrenheit and 46 degrees Fahrenheit for two (2) of two (2) medication refrigerators. Findings include:

1.An inspection of the hall 100/200 medication room refrigerator at 9:45AM on 6/6/12 revealed two opened, undated multi-dose vial of Tuberculin Purified Protein Derivative (PPD). PPD is a diagnostic agent used as a skin test for tuberculosis. The manufacturer's product information for storage requirements read in part: "A vial of PPD which has been entered and in use for 30 days must be discarded." The manufacturer's label on the PPD vial read "Discard opened product after 30 days." Oxidation and degradation may occur after 30 days resulting in reduced potency and possible inaccurate test results. The medication refrigerator temperature was observed to be 30 degrees Fahrenheit and there was approximately 2 " of ice built up on the freezer section, which was located inside the top half of the refrigerator. A second observation of the refrigerator on 6/6/12 at 10:30AM the refrigerator temperature was observed to be 34 degrees Fahrenheit.

In an interview on 6/6/12 at 9:47AM, the Nurse Manager confirmed the vial of PPD had not been

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CARY HEALTH AND REHABILITATION	6690 TRYON ROAD CARY, NC 27518

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F 431	Continued From page 4	F 431		

dated when opened. The nurse manager stated the vial should have been dated when it was opened. The unit manager discarded the opened vials of PPD. The Nurse Manager was uncertain as to who was responsible for defrosting the freezer since recent changes had been made in the Administrative staff.

In an interview on 6/6/12 at 10:30AM, the Director of Nursing (DON) stated the staff was supposed to date all injections when opened. The DON stated she expected the staff to check medications routinely. The DON also stated if the refrigerator temperatures are not within the correct range then the maintenance supervisor should be made aware. She stated that there was no set schedule to defrost the freezers but that she would institute one.

2.An inspection of the 300 Hall medication room refrigerator at 9:50AM on 6/6/12 revealed one opened, undated multi-dose vial of Tuberculin Purified Protein Derivative (PPD). PPD is a diagnostic agent used as a skin test for tuberculosis. The manufacturer's product information for storage requirements read in part: "A vial of PPD which has been entered and in use for 30 days must be discarded." The manufacturer's label on the PPD vial read "Discard opened product after 30 days." Oxidation and degradation may occur after 30 days resulting in reduced potency and possible inaccurate test results. The medication refrigerator temperature was observed to be 34 degrees Fahrenheit.

In an interview on 6/6/12 at 9:47AM, the Nurse Manager confirmed the vial of PPD had not been

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F 431	Continued From page 5 dated when opened. The nurse manager stated the vial should have been dated when it was opened. The unit manager discarded the opened vials of PPD. The Nurse Manager was uncertain as to who was responsible for defrosting the freezer since recent changes had been made in the Administrative staff. In an interview on 6/6/12 at 10:30AM, the Director of Nursing (DON) stated the staff was supposed to date all injections when opened. The DON stated she expected the staff to check medications routinely. The DON also stated if the refrigerator temperatures are not within the correct range then the maintenance supervisor should be made aware. She stated that there was no set schedule to defrost the freezers but that she would institute one. During an interview with the Maintenance Supervisor on 6/6/12 at 11:00AM he stated that in these types of refrigerators the freezer section acts like a cooling mechanism. He stated that he was in the process of defrosting the freezer in the medication room on hall 100/200.	F 431		

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K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: A. Based on observation on 06/20/2012 there were penetrations in the riser room ceiling that were not properly sealed. 42 CFr 483.70 (a)	K 012	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. K12	
K 061 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 06/20/2012 the valves on the the accelerator of the dry sprinkler system were not supervised. 42 CFR 483.70 (a)	K 061	1. The penetrations in the riser room ceiling have been properly sealed. 2. No resident was listed in this citation. A facility audit was conducted to ensure that the facility ceilings had proper sealing in place in areas if penetrated. The Maintenance Director in serviced the maintenance staff in regards to appropriately assuring that the facility ceiling was free from any penetrations and how to properly seal if needed. 3. The Maintenance Director will add to the preventative Maintenance program a monthly routine audit of facility ceilings to assure no evidence of penetrations and to assure areas of concern are properly sealed or repaired. 4. Maintenance Director will Discuss findings, concerns at QA for the next 3 months.	8-4-12
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sharla Haugh — TITLE: LNHA, BSW — (X6) DATE: 7/6/12

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K 062	Continued From page 1 This STANDARD is not met as evidenced by: A. Based on observation on 06/20/2012 there was no high and low air pressure alarm on the dry side of the sprinkler system. B. Based on observation on 06/20/2012 the facility had not had the five (5) year obstruction test nor the three (3) year flow test. C. Based on observation on 06/20/2012 the sprinkler heads on the back dock need to be inspected for corrosion. 42 CFR 483.70 (a)	K 062	K61 1. The valves on the accelerator of the dry sprinkler system are now supervised. 2. No resident was named in this citation. Maintenance Director will in service maintenance staff on monitoring panel function and items that are to be supervised by panel. 3. Maintenance Director will add to monthly preventative maintenance rounds the testing of the alarm panel to assure the accelerator of the dry sprinkler system is supervised and functioning properly. 4. Maintenance Director will discuss findings, concerns at QA for the next 3 months.	8.4.12
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	K 072		
K 076 SS=D	This STANDARD is not met as evidenced by: A. Based on observation on 06/20/2012 there were items stored in the egress corridor near the laundry. 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.	K 076	K62 1. The dry side of the sprinkler system now has a high low pressure alarm. The (3) year obstruction test was completed on 8/22/2011 by Jernigans Fire and Sprinkler Co. The (5) year obstruction test was completed on 7/2/2012 by Homeland Fire and Safety, Inc. Homeland Fire and Safety inspected the sprinkler heads on the back dock and throughout facility and will replace sprinkler heads as appropriate due to corrosion by 8/4/2012.	8.4.12

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K 076	Continued From page 2 (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: A. Based on 06/20/2012 there was an unsecured 02 cylinder in the room between room 209 and 207. 42 CFR 483.70 (a)	K 076	2. No specific resident was named in this citation. Maintenance Director will include in quarterly sprinkler inspection the inspection of sprinkler heads to assure they are free from corrosion. They will be replaced as appropriate. 3. Maintenance Director will add sprinkler inspection rounds to monthly preventative maintenance rounds to assure sprinkler heads are free from corrosion. 4. Maintenance Director will discuss findings, concerns at QA for the next 3 months. K72 1. Items located in the egress corridor near the laundry were removed on 6/20/2012. 2. No specific resident was named in this citation. Facility audit was completed by the Maintenance Director on 6/20/2012 to assure all areas of egress are maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. Staff will be in serviced by the Maintenance Director on the importance of keeping means of egress free and clear for safety by 8-4-2012. 3. Department Heads will continue to identify areas of concern daily during facility rounds and remove and report as appropriate. 4. Maintenance Director will discuss findings, concerns at QA for the next 3 months.	8.4.12

CONT.

Completion date:
8-4-2012

K76

1. The O2 cylinder in the full O2 storage room between room 207 and 209 was secured and placed in the appropriate holding rack immediately when identified on 6/20/2012 by Maintenance Director.
2. No resident was named in this citation. Maintenance Director audited facility to assure all storage of O2 was properly maintained and appropriate. Facility staff to be educated on proper storage of O2 cylinders for safety by 8/4/2012 by Maintenance Director.
3. Maintenance Director will add to daily rounds the inspection of O2 storage areas to assure proper storage is maintained for safety. Department Heads will continue to monitor and correct proper O2 storage during facility daily rounds.
4. Maintenance Director will discuss findings, concerns at QA for the next 3 months