STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/18/2016

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 There were no deficiencies cited as a result of the complaint investigation survey ending 2/18/16. . Event ID #.861Q11.	F 000	This Plan of Correction does not constitute an admission or agreement by provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and federal law.	
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services,	F 156	**F156** 1. Resident #132 and #53 are no longer residents of the facility. 2. All residents on a skilled Medicare stay have the potential to be affected by this citation. All residents currently on a Medicare stay were reviewed by the Interdisciplinary Team to determine their discharge date and the Social Worker was informed in order to complete the notice of Medicare non-covered letter in compliance with F156. 3. The social worker was re-educated by the Executive Director on the facility's policy on issuing Medicare non-covered letters on 3/8/2016. 4. The Executive Director will conduct Quality Improvement monitoring of the proper issuance of the Medicare Non-covered letter by auditing residents who discharged from a Medicare stay weekly times 2 month and then monthly for 1 month, and monitoring may continue if the Quality Assurance and Improvement Committee determines additional monitoring is need to maintain compliance. The results will be documented on a Quality Assurance and Improvement Monitor Form. The Executive Director will report the results of the monitoring to the Quality Assurance Performance Improvement Committee Monthly for 3 months.	3/8/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elizabeth H Hallenbeck — TITLE: Executive Director — (X6) DATE: 3/11/2016

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 156	Continued From page 1	F 156		

including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility

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F 156	Continued From page 2 written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff the facility failed to provide a notice of Medicare non-coverage to 2 of 3 residents who received skilled services and required a notice of Medicare non-coverage. (Resident #132 and Resident #53) Findings included: 1. Resident #132 was admitted to the facility on 11/15/15 for skilled physical therapy and occupational therapy. Record review revealed the last covered day for Medicare was 12/22/15 and there was no non- coverage letter. 2. Resident #53 was admitted to the facility on 8/19/15 for skilled physical therapy and skilled nursing services occupational therapy. Record review revealed the last covered day for Medicare was 9/4/15 and there was no non - coverage letter. Interview on 02/18/2016 at 9:46 AM with the administrator, business office manager, MDS coordinator, and corporate representative was conducted. The MDS coordinator indicated the previous Social Workers #1 and #2 were responsible for non-coverage notices and that they were no longer employed at the facility. Further interview with the MDS coordinator	F 156		

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F 156	Continued From page 3 revealed Residents #132 and #53 should have been provided a notice of non-coverage. Interview on 02/18/2016 at 10:00 AM with the administrator revealed her expectations were the non-coverage letters be provided by the social worker in the designated time frame.	F 156		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews and record reviews, the facility failed to honor preferences related to smoking for 1 of 1 residents reviewed who was assessed to be a safe smoker (Residents #88). The findings included: A review of the facility's policy on Smoking (Revised 1/22/15) included the following procedures, in part: "1. Residents will be evaluated for eligibility regarding smoking privileges upon admission, quarterly, and in change of condition. 2. The facility will maintain a list of smokers who have been assessed and granted smoking privileges.	F 242	**F242** 1. Resident #88 is designated as a safe smoker and may make choices regarding their smoking to include that they may smoke whenever they like and that they may smoke unsupervised. The previous smoking policy was revised to allow safe smokers to smoke whenever they liked and without supervision. 2. All additional smokers residing in the facility will we assessed for safety of smoking by 3-8-16 by the social worker. All safe smokers may smoke unsupervised and whenever they want. 3. The Director of Clinical Services will re-educate all nursing staff and administrative staff by 3/17/2016 on the right to make choices concerning safe smoking to include that residents who are deemed safe smokers may smoke whenever they like and that they may do so unsupervised. Residents deemed unsafe shall be supervised by a staff member at designated smoking times. All staff was informed that all smokers were currently deemed	3/8/16 3/17/16

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F 242	Continued From page 4 3. The facility shall establish and post designated resident smoking times. 4. Resident smoking times will be clearly posted in assigned areas within the facility. The designated smoking areas will be determined by the facility. 5. Smoking materials will be retained, and stored by the nursing staff for all residents who have been granted smoking privileges. 6. No fire igniting materials (matches/lighters) will be in the resident's possession at any time and is strictly prohibited. 7. Designated staff will supervise residents during assigned smoking times." Resident #88 was admitted to the Skilled Nursing Facility on 7/21/15. A review of Resident #88's Care Area Assessment for Activities of Daily Living dated 7/30/15 revealed the resident was alert, oriented, and able to make her needs known. Her Care Plan initiated on 7/30/15 included a Focus Area on Safety, which noted the resident was a smoker. The Care Plan interventions included, in part: safe smoking assessment on admission and quarterly; instruct resident on smoking protocol; provide designated smoking area for residents; monitor for continued safe smoking; and provide scheduled staff supervised smoking times. Resident #88's most recent quarterly Minimum Data Set (MDS) assessment dated 12/13/15 revealed she had intact cognitive skills for daily decision making, scoring a 15 out of 15 on the Brief Interview for Mental Status. The MDS assessment indicated Resident #88 required supervision only for her Activities of Daily Living	F 242	to be safe smokers. All residents will be assessed by the admitting nurse within 24 hours of admission to determine if the resident smokes and if the resident is deemed as a safe or unsafe smoker. Residents will be re-assessed quarterly or as the condition of the resident changes by the charge nurse/and or social worker. The Director of Clinical Services/and or designee will monitor all smokers to ensure re-assessments are completed quarterly or at the change of condition of a resident. 4. The Executive Director, Director of Clinical Services, or Nurse Manager will complete Quality Improvement monitoring of each smoker residing in the facility to ensure that they are able to smoke whenever they want and they may do so unsupervised as long as they are deemed a safe smoker. This monitoring will be performed by interviewing all smokers to ensure that they can smoke whenever they want and without supervision. The Director of Clinical Services/and or designee will also monitor all smokers to ensure re-assessments are completed quarterly or at the change of condition of a resident. Monitoring will be done 3 times a week for 1 months, then 2 times weekly for 1 month, then 1 time weekly for 1 month and may continue if the Quality Assurance and Performance Improvement Committee determines additional monitoring is needed to maintain	

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F 242	Continued From page 5 (ADLs), with the exception of being independent for locomotion on/off the unit, toileting, and bathing. A review of the facility's Resident Council meeting minutes dated 1/12/16 included an Addendum to the minutes, which read in part: "Smoking Residents were asked to stay briefly after the monthly Resident Council Meeting to discuss the re-implementation of the smoking policy. Due to the safety of all residents, attendees were informed that the smoking policy would be re-implemented starting next month. (Name of Facility Administrator and staff member) explained that Residents would no longer be able to freely smoke on the porch without the supervision of a staff member. During the meeting, Residents were able to come up with appropriate smoking times. Smoking times will be set in place and all smoking materials will no longer be allowed to be kept on person. (Name of Administrator) explained that any Resident who was noncompliant would be issued a 30 day discharge. Letters will be sent out to all family members outlining the smoking policy." A review of a letter sent out and signed by the facility's Administrator on 1/18/16 read, in part: " ...I would like to provide a gentle reminder regarding our smoking policy. It seems that we have a number of residents who are not abiding by the terms of our policy so I wanted to outline it below and ask for your support on continued compliance: · All cigarettes and lighters are to be kept	F 242	compliance. The results will be documented on a Quality Assurance and Performance Improvement Monitor form. The Director of Clinical Services will report the results of the monitoring to the Quality Assurance Performance Improvement Committee monthly for 3 months.	

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F 242	Continued From page 6 locked by nursing personnel. · All residents who wish to smoke may do so during Supervised Smoking Times: 6am, 9:30am, 1pm, 3:30pm, 7pm, 10pm, and 2am. · Any non-compliance may lead to discharge from the facility." A review of the Safe Smoking Evaluation completed on 1/29/16 by the facility's Social Worker revealed Resident #88 was determined to be a "Safe Smoker." The evaluation indicated Resident #88 was able to communicate the risks associated with smoking; to light a cigarette safely with a lighter; smoke safely; utilize ashtray safely and properly; and, able to extinguish cigarette safely and completely when finished smoking. Review of a signed Smoking Contract between the facility and Resident #88 was dated 2/9/16 and read as follows: "I understand that as a resident of (Facility Name), there are certain guidelines and policies I must adhere to, during my stay. As someone who smokes regularly, I agree to comply with the rules and regulations, set forth by this facility, to prevent any catastrophic, or detrimental incidents from occurring. I (Resident's Name), agree to only smoke during the designated times set forth by this facility. I also agree to not have any smoking items (ie, lighters, cigarettes, e-cigarettes, matches, etc.) in my possession at any time, outside of the smoking area. I understand that I am responsible for funding my own cigarette supply. Should I have a family member or friend provide my cigarettes, I understand that they are to give them to a staff member, to be placed with resident cigarette supply.	F 242		

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F 242	Continued From page 7 I understand that failure to comply with these rules, could result in discharge from this facility. I understand that should I have any questions or concerns regarding the smoking policy, I must consult the facility social worker or administrator. My signature below acknowledges my acceptance of this agreement, and can be reviewed upon my request." An interview was conducted on 2/16/16 at 4:00 PM with Resident #88. During the interview, the resident discussed the smoking policy and pointed to the facility letter (dated 1/18/16) she received and posted next to her bed. Resident #88 reported she typically went out to smoke at each designated smoking time. The resident reported that at the designated smoking times, residents would obtain his/her cigarettes from staff; have cigarettes lit by staff; and be supervised by a staff member while he/she smoked. When asked what would happen if she wanted to smoke at a time not designated for smoking, the resident stated, "Then you get written up." Upon inquiry, the resident reported she wasn't certain what would happen after being written up but stated she thought three write-ups may result in losing the smoking privileges. During the discussion of the smoking policy, Resident #88 stated multiple times, "It makes you feel like you're in kindergarten." On 2/17/16 at 9:55 AM, an observation was made of Resident #88 smoking a cigarette while being supervised by a staff member in the designated smoking area. An interview was conducted on 2/17/16 at 4:10 PM with the facility's Social Worker and	F 242		

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Admissions Director. During the interview, the facility's Smoking Policy was discussed. The Admissions Director reported the Smoking Policy was discussed at a Resident Council meeting last month. At that time, the residents were told effective 2/1/16, all smoking would be supervised within the designated smoking area at designated times. He noted the residents felt this would be a difficult change, but realized they would need to comply with the new policy if they wanted to stay at the facility. The Social Worker acknowledged she assumed responsibility for completing a smoking assessment for all residents who smoke. She reported the assessment consisted of verbal questions and a demonstration of the residents ' ability to safely hold a cigarette. The Admission Director and Social Worker confirmed Resident #88 was assessed to be a safe smoker. When asked how the facility's current policy honored the resident's right to make choices, the Admission Director stated this right was observed because residents still had the right to smoke.

An interview was conducted on 2/17/16 at 4:43 PM with the facility's Administrator. During the interview, the Administrator recalled she asked to speak with the smokers after the Resident Council meeting in January. She reported resident input was obtained in designating the smoking times. Afterwards, a facility letter was sent out to residents/families as a reminder of the bullet points of the smoking policy that had been in existence in the past, but had not been followed. The letter informed residents and their families that if the resident did not abide by the smoking policy, the facility had a right to discharge him/her from the facility. The Administrator reported they have had, "some noncompliant people...and have discharged one

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F 242	Continued From page 9 person based on the noncompliance." She indicated this one discharge was mutual because the resident couldn't smoke when he/she wanted to. Upon inquiry, the Administrator confirmed each resident was assessed for safe smoking. She stated the residents deemed to be a safe smoker were technically a safe smoker even if not supervised. But, she added, "Our policy is we will supervise while smoking." A follow-up interview was conducted on 2/18/16 at 9:00 AM with the facility's Administrator. At that time, the Administrator stated she had two primary concerns regarding the issue of those smokers assessed as safe being allowed to smoke without supervision. First of all, she felt she had a responsibility to protect all residents in the facility. And second, she reported a few weeks ago there had been a gas leak at the facility and if the resident(s) in the vicinity had smoked without supervision, there may have been severe consequences. The Administrator indicated the current smoking policy was not only a facility policy, but a corporate policy as well.	F 242		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with facility staff, the facility failed to	F 248		

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F 248	Continued From page 10 encourage the resident to participate in activities or provide activities for 1 of 3 sampled residents reviewed for activities. (Resident #118) The findings included: Review of the Policies and Procedures for Activity Program dated 11/30/14 and revised 11/1/15 revealed: " Policy: An ongoing wide range of therapeutic programs, interventions and techniques designed and offered to residents, endeavoring to meet the spiritual, intellectual, emotional, psychosocial, physical and leisure needs of each resident. " Therapeutic recreational programming consisted of individual, small and large group activities, presented regularly, to meet the needs and interests of each resident, and included but are not limited to: Individualized activities. Resident #118 was admitted to the facility on 10/19/15 and readmitted 1/5/16. The diagnoses included Parkinson's disease.. The most recent admission Minimum Data Set dated 1/12/15 revealed: The resident was coded as having minimal short and long term memory problems with the BIMS score of 11. He was coded as having no behaviors or mood problems. His interview for Customary Routines and Activities revealed that it was very important for Resident #118 to have books, newspapers and magazines to read. He enjoyed listening to music he liked. He enjoyed being around animals such as pets, to keep up with the news and do favorite activities. Resident #118 indicated it was somewhat important to do things with groups of people and	F 248	**F248** 1. The Activity Director addressed this issue immediately by interviewing Resident #118 to determine interests and identify scheduled activities in which the Resident wished to participate. A Care plan was put in place for Resident #118 on 2/19/16. Resident #118 expired on 2/27/16. 2. All Residents in the facility have the potential to be affected. On 3/7/16, the Activity Director conducted an audit on all Residents to determine those Residents who are at risk for decreased activity participation. 3. The Executive Director will re-educate the Activities Director and activities staff on the importance of inviting all Residents to scheduled activities of interest and proper documentation by 3-17-16. Individualized activity care plans will also be put in place for all Residents in the facility by 3-17-16. Care plans will address the needs, strengths, and preferences for each Resident. All activity assessments and care plans will be completed by or under the supervision of the Activity Director.	2/18/16 2/27/16 3/7/16 3/17/16 3/17/16

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F 248	Continued From page 11 participate in religious services or practices. Activities of Daily Living was coded as requiring extensive assistance with one to two plus persons physical assist. Resident did not walk in room or corridor. Bathing was coded as total dependence with two plus persons physical assist. Range of motion was coded with impairment on both sides of his body. Mobility device was wheelchair. Resident #118 coding revealed that he was frequently incontinent of bowel and bladder. Observations on 02/16/2016 at 03:05 PM revealed the resident was observed lying in bed only (no activity involvement) Interview on 02/18/2016 at 9:39 AM with the Activities Director revealed he did not come out for activities. Last week came for haircut and yesterday was shaved. They were on the activity log. She continued that she had 1 to 1 visits with him. The Activity Director indicated that she did not know why he was in bed all of the time. The Activity Director went to retrieve the activity log. Observation of the Activity Log and Interview with the Activity Director on 02/18/2016 at 9:55 AM revealed there was no visits for Resident #118 " due to an oversight " . The Activity Director continued that the resident had no activity visits since his admission. Resident #118 was admitted originally on 10/9/15. Observation on 02/18/2016 at 10:43 AM of Resident #118 revealed that he was in bed with head of the bed up with his eyes closed and his mouth open..	F 248	4. The Activity Director or Activities Assistant will complete the Quality Improvement Monitoring daily by documenting activity attendance and refusals in the activity participation log. The Activity participation log will be reviewed weekly by the Activities Director for 6 months to identify Residents at risk for low activity participation. The results will be recorded on the QI Monitoring tool and will be reported to the Quality Assurance Committee monthly by the Activity Director for 3 months.	

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F 248	Continued From page 12 Interview on 02/18/2016 at 11:00 AM with the Administrator revealed her expectation was that each resident received individual, personalized activities.	F 248		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to develop a comprehensive care plan that addressed the left ventricular device for 1 of 1 resident residing in the facility with the device. (Resident # 62). The facility failed to develop a comprehensive careplan addressing an activity program for 1 of 3 residents reviewed for	F 279	**F279** 1. Resident #62 is no longer a resident at this facility. An activity care plan was initiated by the MDS coordinator on 2/18/2016 for resident #118. 2. All residents have the potential to be affected by this citation. The MDS Director audited all residents to ensure residents' with left ventricular assisted device are care planned to include system checks, emergencies, monitor of the setting, power sources and overall care. The MDS Director also audited all care plans to ensure each resident had an activity care plan by 3-17-16. The Activity Director audited all residents to assess for low activity participation on 3/7/2016. 3. The MDS Director and Activity Director was re-educated by the Executive Director on 3/8/2016 of the facility's Care Planning Policy. 4 The MDS Director will conduct Quality Improvement monitoring of 5 resident's care plans to ensure that the care plan is reflective of the care needs of that resident weekly for two months then review 5 resident's care plans one time a month for three months, and monitoring may continue if the Quality Assurance and Improvement Committee determines additional monitoring is need to maintain compliance. The results will be documented on a	2/18/16 3/8/16

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F 279	Continued From page 13 participation in activities. (Resident #118). The findings included: 1. Resident #62 was admitted to the facility on 1/6/16 from a hospital stay with cumulative diagnoses which included advanced congestive heart failure (CHF). Record review revealed Resident #65 had a left ventricular assisted device (LVAD) reinserted on 11/27/ 12 to manage the diagnosis of CHF. A LVAD is an electromechanical circulatory device with a drive line site (that usually exits through the right upper quadrant of the abdomen) that is used to partially or completely replace the function of a failing heart. This device must have a power source at all times. Review of the medical record revealed there was no written care plan that addressed the LVAD system checks, emergencies, monitoring of the setting, power sources, overall care associated with the unit, complications or risks. Interview on 02/18/2016 5:53 PM with the administrator revealed her expectation was to have staff develop individualized and specific care plans for each residents. 2. Resident #118 was admitted to the facility on 10/19/15 and readmitted 1/5/16. The diagnoses included Parkinson's disease, muscle weakness, difficulty in walking, symbolic dysfunctions, voice and resonance disorder, cellulitis, hyperlipidemia, sepsis, pneumonia, protein calorie malnutrition and hypertension. The most recent admission Minimum Data Set dated 1/12/15 revealed: The resident was coded as having minimal short and long term memory problems with the BIMS score of 11. He was coded as having no behaviors or mood	F 279	Quality Assurance and Improvement Monitor Form. The MDS Director will report the results of the monitoring to the Quality Assurance Performance Improvement Committee Monthly for 3 months.	

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F 279	Continued From page 14 problems. His interview for Customary Routines and Activities revealed that it was very important for Resident #118 to have books, newspapers and magazines to read. He enjoyed listening to music he liked. He enjoyed being around animals such as pets, to keep up with the news and do favorite activities. Resident #118 indicated it was somewhat important to do things with groups of people and participate in religious services or practices. Activities of Daily Living was coded as requiring extensive assistance with one to two plus persons physical assist. Resident did not walk in room or corridor. Range of motion was coded with impairment on both sides of his body. Mobility device was wheelchair. There was no care plan for activities due to the Activity Director ' s oversight. Observation on 02/16/2016 at 03:05 PM revealed the resident was observed lying in bed only (no activity involvement) Interview on 02/18/2016 at 9:39 AM with the Activities Director revealed he did not come out for activities. She continued that she had 1 to 1 visits with him. The Activity Director indicated that she did not know why he is was in bed all of the time. The Activity Director went to retrieve the activity log. Observation of the Activity Log and Interview with the Activity Director on 02/18/2016 at 9:55 AM revealed there was no visits for Resident #118 due to an oversight. The Activity Director continued that the resident had no activity visits	F 279		

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F 279	Continued From page 15 since his admission. Observation on 02/18/2016 at 10:43 AM of Resident #118 revealed that he was in bed with head of the bed up with his eyes closed. Interview on 02/18/2016 at 11:00 AM the Administrator revealed her expectation was that each resident received individual, personalized activities with care plan..	F 279		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 observations, record review and staff interviews, the facility failed to provide thorough incontinent and perineal care to promote cleanliness and prevention of urinary tract infections for 1 of 2 residents in the sample reviewed for incontinent care. (Resident #142) Findings included: Resident #142 was admitted to the facility on 6/2/15 with cumulative diagnoses which included anemia and diabetes mellitus. Review of the Quarterly Minimum Data Set (MDS) Assessment dated1/20/16 revealed the resident had impaired cognition, required extensive assistance from staff for toileting and	F 312	**F312** 1. Resident # 142 routinely receives Personal hygiene care per the facility's Hygiene policy and procedure guidelines and in accordance with the resident's care plan. CNAs # 10, 11, 14, and 15 received re-education along with a skills competency check off for ADL Perineal care, and resident care plans by Director of Clinical Services on 2/23/2016. 2. All residents who are care planned for assistance with Perineal care are at risk thus an audit will be conducted by 3/17/2016 by the Director of Clinical Services and/of Assistant Director of Clinical Services to ensure all Perineal care needs are being met. 3. All licensed and certified nursing staff will be re-educated by the DCS and ADCS regarding the facility's policy and procedure	2/23/16 3/17/16 2/23/16 2/17/16

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F 312	Continued From page 16 was always incontinent of bowel and bladder. Review of Resident #142 ' s care plan revised on 10/27/15 revealed the resident was incontinent of bladder and required approaches that included " Check for incontinence. Wash, rinse and dry soiled areas. " Observation on 02/16/2016 at 04:16:06 PM revealed Resident #142 had a strong offensive urine odor. By 4:24 PM nursing assistant #10 (NA) and NA #11 were observed during incontinence care. Resident #142 was transferred from the wheelchair. The resident ' s soiled brief was removed. The resident had experienced a urinary incontinent episode. The brief was wet, smelled of urine that was brown in color. NA #11used disposable personal cleaning wipes to cleanse the resident ' s groin areas but did not cleanse the external genitalia (referring to the vulva and perineal area). On 02/16/2016 at 4:45 PM, an inquiry about the brown colored urine noted in the brief was conducted. NA #10 indicated she also noticed the brown colored urine in the wet brief when she removed the brief. Additionally, NA #10 indicated she usually performed the incontinent care as observed. Observation on 02/17/2016 at 2:14 PM during incontinence care for Resident #142 performed by NA #14 and NA #15 was conducted. Resident #142 had experienced a urinary incontinent episode and disposable wipes were used to cleanse the groin area. The resident ' s genitalia was not cleansed. Interview on 02/17/2016 at 2:20:05 PM with NA	F 312	regarding Perineal Care by 2/23/2016. Return Demonstrations will be conducted by the DCS and/or designee by 2/17/16. All new Licensed /Certified staff will receive this education during the orientation process. 4. Skill competency check off audit for perineal care will be completed by DCS, ADCS, and or Unit managers weekly for three months and one time a month for three months, and monitoring may continue if the Quality Assurance and Improvement Committee determine additional monitoring is need to maintain compliance. The results will be documented on a Quality Assurance and Improvement Monitor Form. The DCS will report the results of the monitoring to the Quality Assurance Performance Improvement Committee Monthly for 3 months.	

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F 312	Continued From page 17 #14 revealed this was her usual routine in providing perineal care. NA #15 indicated that she usually cleansed the external genitals during a shower because it was easier to cleanse. Continued interview revealed an inquiry about the observation of the external genitals not being cleansed. After the inquiry Resident #142 ' s external genitals were cleansed with the personal disposable wipes by NA #14. Interview on 02/18/2016 at 5:50 PM with the administrator revealed her expectations were for staff to clean the resident.	F 312	**F356** 1. Staff posting was corrected on 2-17-16 by the Executive Director. 2. All residents residing in the facility have the potential to be affected. 3. The Executive Director re-educated the Director of Clinical Services, Assistant Director of Clinical Services, Unit Managers, Scheduler, 11-7 charge nurses, receptionist, and weekend supervisor on facility staff posting. The Nursing staffing scheduler and or Unit Manager will check the posting in the morning and is responsible for entering and posting the Staffing. The Charge Nurse on 11-7 on the 200 hall nurse is responsible for entering and ensuring the accuracy of the information as well as posting the correct number of staff for the over night shift. The Unit Manager and or RN Supervisor will ensure accuracy of the posting daily. The Director of Clinical services will ensure that staff posting information is retained for 18 months to include all weekends and holidays. 4.The Executive Director or Human resources Manager will complete Quality improvement monitoring 3 times a weekly for 2 months, then 3 times weekly for 1 month utilizing the QI Tool for Staff Posting. The monitoring will include the posting and retention of the nurse staffing information and may continue if the quality Assurance committee determines there needs to be additional monitoring to maintain compliance. The Executive Director will report the results of the monitoring to the Quality Assurance and Improvement Committee Monthly for 3 months.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request,	F 356		2/17/16 2/16/16

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F 356	Continued From page 18 make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to post nurse staffing information on a daily basis for 3 of the past 7 days; and failed to retain staff postings for 4 of the past 30 days. The findings included: An observation made on 2/15/16 at 6:15 PM revealed daily nurse staffing information posted at the front desk of the main lobby was dated 2/12/16. The initial facility tour conducted on 2/15/16 at 6:20 PM confirmed a current posting of the 2/15/16 nurse staffing information was not displayed within the facility. An observation made on 2/16/16 at 2:59 PM revealed the posting had been updated with the 2/16/16 daily nurse staffing information. An interview was conducted with the facility's Scheduler on 2/17/16 at 11:57 AM. During this interview, the Scheduler reported that she herself was responsible to post the 1st and 2nd shift staffing information each weekday, Monday through Friday. She reported she would leave the next day's staff posting (which started with the 11PM to 7AM shift) on the 200 Hall Medication Cart each evening before she left for the day.	F 356	the nursing staff posting information will be retained for 18 months. 4.The Executive Director or Human resources Manager will complete Quality improvement monitoring (to include posting is present, correct , and filed for retention) daily utilizing the QI Tool for Staff Posting Monday through Friday and the receptionist will complete the quality Assurance and Improvement on Saturday and Sunday. The monitoring may continue if the quality Assurance committee determines there needs to be additional monitoring to maintain compliance. The Human resource Manager will report the results of the monitoring to the Quality Assurance and Improvement Committee Monthly.	

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F 356	Continued From page 19	F 356		

The Scheduler stated the 3rd shift hall nurse was responsible to complete and post the 3rd shift nurse staffing information. The Scheduler reported she was off on the weekend. Therefore, before leaving on Friday, she would leave two additional posting forms to be completed each day on the weekend. She stated that the weekend supervisor was responsible to be sure the postings were completed for each shift on the weekend. Upon inquiry, the Scheduler reported she was off work on Monday, 2/15/16. When she came in on Tuesday, 2/16/16, she discovered the staff postings from the weekend were not available. At that time, the Scheduler collected the information needed and completed the postings for 2/13/16, 2/14/16, and 2/15/16.

A review of previous nursing staff postings was conducted on 2/17/16 at 12:05 PM with the facility's Scheduler. The review revealed staff postings for 4 of the past 30 days were missing (1/28/16, 1/31/16, 2/6/16, and 2/7/16). Upon inquiry, the Scheduler stated she was not aware these postings were missing. She reported nurse staff postings were supposed to be retained for 18 months. The Scheduler indicated she had taken some time off this past month and felt this may have been part of the reason some of the postings had been missed.

An interview was conducted with the Administrator on 2/17/16 at 4:50 PM. The Administrator stated her expectation was, "That we have current staff postings." She indicated the Scheduler was supposed to set out the weekend postings and the weekend supervisor was supposed to fill them out. The Administrator reported the facility would provide in-service education on completing the postings in a timely

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F 356	Continued From page 20 manner and would work on a back-up plan for when the facility's Scheduler was off.	F 356		
F 431 SS=E	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	**F431** 1. The Director of Clinical Services removed and destroyed resident # 11 and #1's 0.2% brimonidine ophthalmic solution from the refrigerator on 2/18/2016. Resident # 127's 0.5% Timolol ophthalmic solution was removed and destroyed by the DCS on 2/18/2016. The house stock tuberculin ppd was removed and destroyed on 2/18/2016. Resident #1's 0.004% Travatan Z ophthalmic solution was removed and destroyed by the DCS on 2/18/2016. All affected medication was re-ordered from the pharmacy by the Director of Clinical Services on 2/18/2016. 2 .All residents have the potential to be affected by this citation. An audit was conducted by the Assistant Director of Clinical Services of all medication rooms and med carts on 3/14/2016 to ensure all medications were stored and labeled according to manufacturer instructions. 3. In-service education regarding medication storage and labeling by the Assistant Director of Clinical Services on 3/2/2016 to all licensed nursing personnel. Additional in-service education will be provided to all new nurses during orientation by the Assistant Director of Clinical Services.	2/18/16 3/14/16 3/2/16

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F 431	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to store medications as specified by the manufacturer in 2 of 2 medication store rooms (100-200 Hall Med Room and 300 Hall Med Room); failed to label medications with an shortened expiration date as specified by the manufacturer in 2 of 2 medication store rooms (100-200 Hall Med Room and 300 Hall Med Room); and, failed to remove an expired medication from 1 of 2 medication store rooms (100-200 Hall Med Room). The findings included: 1a) An observation of the 300 Hall Medication Store Room on 2/18/16 at 4:20 PM revealed two unopened bottles of 0.2% brimonidine ophthalmic (eye) solution labeled for Resident #11 were stored in the refrigerator. The refrigerator temperature at the time of the observation was 40o Fahrenheit (F). The manufacturer's product information indicated 0.2% brimonidine ophthalmic solution should be stored at room temperature between 59o F - 77o F. Brimonidine ophthalmic solution is a medication used to treat glaucoma. A review of Resident #11's February 2016 Physician Orders revealed there was a current order for 0.2% brimonidine ophthalmic solution to be instilled as 1 drop into both eyes every 8 hours. An interview was conducted on 2/18/16 at 4:53 PM with the facility's Director of Nursing (DON). Upon inquiry, the DON indicated he would expect all medications to be stored as recommended by	F 431	4.The Director of clinical services or Assistant Director of Clinical Services will monitor the proper medication storage and labeling in all medication rooms by utilizing the Quality Improvement tool three times a week for one month and then weekly thereafter for 2 months and monitoring may continue if the Quality Assurance and Improvement Committee determines additional monitoring is need to maintain compliance. The Director of Clinical Services will report the results of the monitoring to the Quality Assurance and Improvement Committee Monthly for 3 months.	

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F 431	Continued From page 22 the manufacturer. 1b) An observation of the 300 Hall Medication Store Room on 2/18/16 at 4:20 PM revealed two unopened bottles of 2% - 0.5% dorzolamide-timolol ophthalmic (eye) solution labeled for Resident #1 were stored in the refrigerator. The refrigerator temperature at the time of the observation was 40o Fahrenheit (F). The manufacturer's product information indicated 2% - 0.5% dorzolamide-timolol ophthalmic solution should be stored at room temperature between 68o F - 77o F. Dorzolamide-timolol ophthalmic solution is a combination medication used to treat glaucoma. A review of Resident #1's February 2016 Physician Orders revealed there was a current order for 2% - 0.5% dorzolamide-timolol ophthalmic solution to be instilled as 1 drop into both eyes twice daily. An interview was conducted on 2/18/16 at 4:53 PM with the facility's Director of Nursing (DON). Upon inquiry, the DON indicated he would expect all medications to be stored as recommended by the manufacturer. 1c) An observation of the 100-200 Hall Medication Store Room on 2/18/16 at 4:35 PM revealed one unopened bottle of 2% - 0.5% dorzolamide-timolol ophthalmic (eye) solution labeled for Resident #23 was stored in the refrigerator. The refrigerator temperature at the time of the observation was 39o Fahrenheit (F). The manufacturer's product information indicated 2% - 0.5% dorzolamide-timolol ophthalmic solution should be stored at room temperature between 68o F - 77o F.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/18/2016

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

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F 431	Continued From page 23 Dorzolamide-timolol ophthalmic solution is a combination medication used to treat glaucoma. A review of Resident #23's February 2016 Physician Orders revealed there was a current order for 2% - 0.5% dorzolamide-timolol ophthalmic solution to be instilled as 1 drop into both eyes daily. An interview was conducted on 2/18/16 at 4:53 PM with the facility's Director of Nursing (DON). Upon inquiry, the DON indicated he would expect all medications to be stored as recommended by the manufacturer. 1d) An observation of the 100-200 Hall Medication Store Room on 2/18/16 at 4:35 PM revealed one unopened bottle of 0.5% timolol ophthalmic (eye) solution labeled for Resident #127 was stored in the refrigerator. The refrigerator temperature at the time of the observation was 39o Fahrenheit (F). Manufacturer product labeling on the ophthalmic solution stated, in part: "Store at room temperature 15-30o Celsius (59 - 86o F)." Additionally, the manufacturer's product information indicated 0.5% timolol ophthalmic solution should be stored at room temperature between 59 - 86o F. Timolol ophthalmic solution is a medication used to treat glaucoma. A review of Resident #127 ' s February 2016 Physician Orders revealed there was a current order for 0.5% timolol ophthalmic solution to be instilled as 1 drop into both eyes twice daily. An interview was conducted on 2/18/16 at 4:53 PM with the facility ' s Director of Nursing (DON).	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/18/2016

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CARY HEALTH AND REHABILITATION	6590 TRYON ROAD CARY, NC 27518

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F 431	Continued From page 24 Upon inquiry, the DON indicated he would expect all medications to be stored as recommended by the manufacturer. 2a) An observation of the 300 Hall Medication Store Room on 2/18/16 at 4:20 PM revealed an open, undated vial of Tuberculin PPD injectable medication (used for skin test in the diagnosis of tuberculosis) was stored in the refrigerator. The manufacturer's product information indicated opened vials should be discarded after 30 days. An interview was conducted on 2/18/16 at 4:53 PM with the facility ' s Director of Nursing (DON). Upon inquiry, the DON indicated he would have expected the Tuberculin PPD injectable medication to have been dated when opened and discarded as recommended by the manufacturer. 2b) An observation of the 100 - 200 Hall Medication Store Room on 2/18/16 at 4:35 PM revealed an open, undated vial of Tuberculin PPD injectable medication (used for skin test in the diagnosis of tuberculosis) was stored in the refrigerator. The manufacturer's product information indicated opened vials should be discarded after 30 days. An interview was conducted on 2/18/16 at 4:53 PM with the facility's Director of Nursing (DON). Upon inquiry, the DON indicated he would have expected the Tuberculin PPD injectable medication to have been dated when opened and discarded as recommended by the manufacturer. 3) An observation of the 300 Hall Medication Store Room on 2/18/16 at 4:20 PM revealed one unopened bottle of 0.004% Travatan Z ophthalmic (eye) solution labeled for Resident #1	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 25 was stored in the refrigerator. The Travatan Z ophthalmic solution was past the manufacturer's labeled expiration date of January 2016. Travatan Z ophthalmic solution is a medication used to treat glaucoma. A review of Resident #1's February 2016 Physician Orders revealed there was not a current order for 0.004% Travatan Z ophthalmic solution. An interview was conducted on 2/18/16 at 4:53 PM with the facility's Director of Nursing (DON). Upon inquiry, the DON indicated he would expect all expired medications to be removed/discarded from the medication store rooms.	F 431		