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 04/27/2016

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 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff and resident interviews, the facility failed to ensure hand rails were secured to the wall to prevent a fall for one of three resident ' s reviewed for falls (Resident #1). Findings included: Resident #1 was admitted on 10/10/2015 with the current diagnoses of anxiety, bipolar disorder, chronic pain, and chronic obstructive pulmonary disease. Resident #1 Quarterly Minimum Data Set (MDS) dated 4/8/16 revealed the resident was cognitively intact. Resident had no behaviors. The resident was independent with bed mobility, transfers, locomotion, dressing, eating and toilet use. The resident required supervision with personal hygiene. Resident ' s #1 balance was steady. Resident #1 was on a pain medication regimen. Pain was present occasionally for moderate pain. The resident was on an antibiotic, antipsychotic, and antianxiety medications. The resident participated in assessments and goal settings. Family or significant other did not participate and resident had no guardian or legal representative. Resident #1 had the following care plans in place	F 323	F323 The handrail which caused the issue for this particular resident (#1) was corrected on April 18, 2016. All of the handrails in the facility were checked for correct operation and repairs made where deemed necessary on May 6th, 2016. The maintenance manager was inserviced on May 6th on looking for handrails not attached correctly and repairing them when found to be lacking integrity. The online preventative maintenance program had "inspecting handrails" added to the monthly task list which the maintenance director completes. This monthly check will permanently. Any time this situation arises it will be repaired and this information will be brought to the quality assurance committee which meets monthly.	5/11/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/11/2016

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for antipsychotic medications updated 4/22/16, Skin/Wound updated 4/22/16, Activities of daily living updated 4/22/16, Safety with history of falls updated 4/22/16, Pain updated 4/22/16. The fall care plan included that the resident follows fall protocol, investigate the root cause of the fall, maintain a clear pathway, call light in reach, and educate the resident, occupational therapy to evaluate, appropriate footwear, anticipate needs of resident, and perform skin checks weekly.
Resident #1 was interviewed on 4/26/16 at 2:55 PM. She stated that two weeks ago, she had a fall from the brown booster railing near the dining room, which was attached to the wall. She stated she put her hand on the railing and the railing gave way and she fell hitting her left knee on the floor. She could not recall the date but X-rays were taken of her left knee. She also stated that she received a shot in the knee and ice was applied to her knee and had been getting extra pain medication. The extra pain medication was stopped yesterday. She still thought the right side of her left knee was slightly swollen and was painful.
A note from the physician dated 4/14/16 stated resident #1 stated she fell while walking in the hall and landed on the left knee. The resident ' s left knee was tender. The plan was for an X-ray to be completed and a message was left with the resident ' s family.
A nursing note dated 4/14/16 at 6:00 PM stated resident #1 had an x-ray to the left knee ordered from the physician due to pain. The resident told the physician she fell on her left knee on 4/13/16.
A nursing note dated 4/14/16 at 7:30 PM stated X-ray results were faxed to the physician. There was no fracture. There was an order to follow up with orthopedics.
The Fall Root Cause investigation report dated

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4/15/16 revealed the fall was reported to the nurse on 4/14/16. The trip of fall hazard identified was the rail by the smoking deck was loose. Environmental concerns identified was the hand rail was loose and was reported to maintenance manager. The resident had chronic knee pain. The summary stated the resident walked to the handrail by the smoking area and stated that she was there " I just went down on my knee a few days ago. I have had knee problems before. " The homework sheet for railing was added, the physician was notified and X-rays were ordered. The vitals sign section was not completed. The fall root cause investigation report on 4/15/16 was completed by the DON.
A nursing note dated 4/17/16 stated resident #1 requested for an increase in pain medication. The physician was called and orders were given.
The resident ' s Medication Administration Record (MAR) was reviewed from 4/1/16 through 4/27/16. It revealed the resident ' s pain medication was changed from 1 tablet of Oxycodone (a medication used to reduce pain) as needed three times a day to 1 tablet of Oxycodone as needed every four hours for one week 4/17/16 through 4/24/16. The resident received the increased dose fifteen times during the week. On 4/15/16, 4/17/16 4/20/16, 4/21/16, 4/23/16 it was documented on the back of the MAR the resident received pain medication for " knee pain. "
An orthopedics discharge summary dated 4/19/16 revealed the reason for visit was left knee after a fall and the resident had osteoarthritis of left knee. The orthopedics note dated 4/19/16 stated the resident fell today onto left knee. It was slightly swollen with no fracture from X- rays ' results. The plan was a steroid shot was given, apply ice two to three times a day to knee for 48

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hours and compression.
A nursing note dated 4/24/16 stated the resident ' s family was spoken with and " let her know nurse #1 reported to the physician that the resident reported a fall and left knee pain. Orders were given. "
An observation of the resident ' s left knee was made on 4/26/16 at 2:58 PM. The resident stood, pulled her pants down independently. The resident ' s knee did not appear to be grossly swollen and was approximately the same size as the right knee. All skin on her left knee was intact. No bruises or skin tears were noted.
On 4/27/16 at 3:00 PM, the brown wall railing was observed missing from the wall off of hall 100 near the dining room. No other railing observed appeared to be missing.
The Director of Nursing (DON) was interviewed on 4/27/16 at 1:51 PM. She stated the resident reported a fall on 4/14/16 and stated the fall occurred on 4/13/16. The physician was aware. The fall was not witnessed or reported until 4/14/16. The resident reported that it was the railing that caused the fall and the maintenance man had now removed the railing. The resident reported there was a piece of railing that fell off when the resident grabbed onto it. The nurse working on 4/14/16 did not notify her the day that it happened but she found out the day after via the X-ray order from the physician.
The Maintenance Supervisor was interviewed on 4/27/16 at 2:25 PM. He stated he had taken the rail apart the hand rail near the dining room on Friday 4/15/16 before and had noticed it was loose. He had put the railing back on the wall and tightened it. On Monday 4/18/16, he received a text message from the administrator stating the resident grabbed the hand rail and it turned. When he observed it, the rail was positioned

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horizontal so he took off the railing completely from the wall. He did not order a new part for it and did not have a record of it. The maintenance Supervisor provided the text message the administrator had sent him in regards to the hand rail. The test message was dated 4/18 at 11:02 AM.

Nurse #1 was interviewed on 4/27/16 at 3:30 PM. He stated that if a resident had a fall he would do an assessment for injuries, call the resident ' s family, and notify the physician and DON. Neurological checks would be started and a Situation, Background, Assessment and Recommendation (SBAR) incident report would be completed and placed in chart. He stated resident #1 had chronic knee pain. The resident told the physician on 4/14/16 that she had fell on 4/13/16 and the physician had an order that stated the resident fell. He saw the physician order on 4/14/16 and that is how he knew the resident had reported a fall. X-rays were ordered and completed. He stated he did not report it to the DON. He stated he told the resident the x-ray results were negative.

The DON provided documentation of the maintenance log. It revealed that on 4/15/16, the handrail by dining was reattached and on 4/18/16. The DON was interviewed 4/27/16 at 4:10 PM. She stated the maintenance man reattached the railing on 4/15/16. Then the wall railing was removed on 4/18/16. Resident #1 was alert and oriented times four.

The physician was interviewed on 4/27/16 at 4:21 PM. He stated resident #1 reported a fall to him and he ordered an X-ray and increased the resident pain medication. He stated he also told the nurse that the resident had a fall. The resident embellishes her pain and he couldn ' t say if she had increased pain after the fall but he did

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F 323	Continued From page 5 increase her pain medications after the reported fall. He stated the resident reported she was holding on to the wall railing and she went down on her knee.	F 323		
F 468 SS=D	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff and resident interviews, the facility failed to provide secure hand rails on the wall to prevent accidents for one of three residents reviewed for falls causing Resident #1 to fall and sustain a knee injury. Findings included: Resident #1 was admitted on 10/10/2015 with the current diagnoses of anxiety, bipolar disorder, chronic pain, and chronic obstructive pulmonary disease. Resident #1 ' s Quarterly Minimum Data Set (MDS) dated 4/8/16 revealed the resident was cognitively intact, had no behaviors, and was independent with bed mobility, transfers, and locomotion. Resident ' s #1 balance was steady. On 4/27/16 at 3:00 PM, the brown wall hand railing was observed missing from the wall off of hall 100 near the dining room. The space where the missing rail was measured 16 inches by 8 inches. No other hand railings observed appeared to be missing. A note from the physician dated 4/14/16 stated Resident #1 stated she fell while walking in the hall and landed on the left knee. The resident ' s	F 468	F468 The handrail which caused the issue for this particular resident (#1) was corrected on April 18, 2016. All of the handrails in the facility were checked for correct operation and repairs made where deemed necessary on May 6th, 2016. The maintenance manager was inserviced on May 6th on looking for handrails not attached correctly and repairing them when found to be lacking integrity. The online preventative maintenance program had "inspecting handrails" added to the monthly task list which the maintenance director completes. This monthly check will permanently. Any time this situation arises it will be repaired and this information will be brought to the quality assurance committee which meets monthly.	5/11/16

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left knee was tender. The physician ordered an X-ray of the resident ' s left knee.
A nursing note dated 4/14/16 at 7:30 PM stated X-ray results were faxed to the physician. There was no fracture. There was an order to follow up with orthopedics.
A review of the facility fall investigation report dated 4/15/16 revealed Resident #1 ' s fall was reported to the nurse on 4/14/16. The fall hazard identified was the rail between the smoking deck and the dining hall was loose. The report identified the hand rail was loose and was reported to maintenance manager. The summary stated the resident walked to the handrail by the smoking area and stated that she was there and " I just went down on my knee a few days ago. I have had knee problems before. " The maintenance log for the railing was added, the physician was notified and X-rays were ordered. The fall root cause investigation report on 4/15/16 was completed by the DON.
An orthopedics discharge summary dated 4/19/16 revealed the reason for visit was left knee after a fall and the resident had osteoarthritis of left knee. The orthopedics note dated 4/19/16 stated the resident fell today onto left knee. It was slightly swollen with no fracture from X- rays ' results. The plan was a steroid shot was given, apply ice two to three times a day to knee for 48 hours and compression.
A nursing note dated 4/17/16 stated Resident #1 requested for an increase in pain medication. The physician was called and orders were given.
Resident #1 was interviewed on 4/26/16 at 2:55 PM. She stated that two weeks ago she had a fall in the hallway near the dining room. She explained she put her hand on the railing that was attached to the wall and the railing gave way and she fell hitting her left knee on the floor. She

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could not recall the date but X-rays were taken of her left knee. She also stated that she received a shot in the knee and ice was applied and she had been getting extra pain medication. The extra pain medication was stopped yesterday. She still thought the right side of her left knee was slightly swollen and was painful.
The Director of Nursing (DON) was interviewed on 4/27/16 at 1:51 PM. She stated the resident reported a fall on 4/14/16 and stated the fall occurred on 4/13/16. The physician was aware. The fall was not witnessed or reported until 4/14/16. The resident reported that it was the railing that caused the fall and the maintenance man had now removed the railing. The resident reported there was a piece of railing that fell off when the resident grabbed onto it.
On 4/27/16 at 1:51 PM, the DON showed which hand railing had been removed by maintenance. It was located off of 100 hall between the dining room and smoking area.
The Maintenance Supervisor was interviewed on 4/27/16 at 2:25 PM. He stated he had taken the rail apart the hand rail near the dining room on Friday 4/15/16 before and had noticed it was loose. He had put the railing back on the wall and tightened it. On Monday 4/18/16, he received a text message from the administrator stating the resident grabbed the hand rail and it turned. When he observed it, the rail was positioned horizontal so he took off the railing completely from the wall. He did not order a new part for it and did not have a record of it. The maintenance Supervisor provided the text message the administrator had sent him in regards to the hand rail. The test message was dated 4/18 at 11:02 AM.
The DON provided documentation of the maintenance log. It included on 4/15/16, the

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F 468	Continued From page 8 handrail in the hallway by dining room (hall 100) was reattached and on 4/18/16. The DON was interviewed 4/27/16 at 4:10 PM. She stated the maintenance man reattached the railing on 4/15/16. Then the wall railing was removed on 4/18/16. The physician was interviewed on 4/27/16 at 4:21 PM. He stated Resident #1 reported a fall to him and he ordered an X-ray and increased the resident ' s pain medication. He stated he also told the nurse that the resident had a fall. He stated the resident reported she was holding on to the wall railing and she went down on her knee.	F 468		