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 08/08/2017

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 281 SS=B	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately document that wound treatments were not provided for 1 of 3 residents reviewed for wound care (Resident #2). Findings included: Resident #2 was admitted to the facility on 7/26/16. His diagnoses included acute kidney failure, diabetes mellitus, and muscle weakness. Review of Resident #2's most recent comprehensive minimum data set assessment dated 6/29/17 revealed the resident was assessed as severely cognitively impaired and had a diabetic foot ulcer. Review of a wound care sheet dated 6/6/17 revealed the resident had a diabetic ulcer on his right heel, and a shearing wound on his left hip. Review of Resident #2's physician orders revealed on 6/6/17 he was ordered to have his right heel diabetic ulcer cleansed and have a pre-moistened dressing applied every day and as needed. On 6/6/17 he was also ordered to have his left hip wound cleansed and a dressing applied every three days and as needed.	F 281	1.Nurse who entered inaccurate record no longer employed by facility. 2.Quality monitoring was performed to ensure only current residents' Treatment Administration Records (TARs) are noted in Treatment Record Book. All TARs of discharged residents were removed from the Treatment Record Book by the Director of Nursing on 8-9-17. Review of TARs by the Director of Clinical Services for discharged residents in last 30 days confirmed no documentation completed after resident was discharge from the facility. 3.Nurses will be re-educated on ensuring discharged residents' TARs are removed from Treatment Record Book and proper documentation completed on ordered treatments by 8-18-17. The Director of Clinical Services or Assistant Director of Clinical Services to complete quality monitoring on 3 discharged residents weekly for 4 weeks then monthly to ensure TARs removed from treatment book when resident is discharged. The	8/18/17

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

Electronically Signed | 08/18/2017

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F 281	Continued From page 1 Review of a nursing home to hospital transfer form revealed Resident #2 was transferred to the hospital for a change in condition on 6/13/17. Resident #2 did not return to the facility until 6/20/17. Review of Resident #2's June treatment record revealed the right heal treatment was initialed, indicating treatment had been done, on 6/14/17, 6/15/17, 6/16/17, 6/17/17, 6/18/17, and 6/19/17. Resident #2's hip wound treatment was initialed, indicating treatment had been done, on 6/15/17, and 6/18/17. During an interview on 8/8/17 at 9:25 AM Treatment Nurse #1 stated that when the treatment record was initialed by a nurse, it meant that the care was performed on that day. After reviewing the June treatment record for Resident #2, she stated that it appeared Resident #2 had received wound treatments during the days he was not in the facility. Treatment Nurse #1 stated that she was not working at the facility during the time in question and that Treatment Nurse #2 had initialed the records. She further stated she did not know why Treatment Nurse #2 indicated she had done treatment during those days. She further stated Treatment Nurse #2 no longer worked at the facility. During a phone interview on 8/8/17 at 9:46 AM Treatment Nurse #2 stated that if the treatment record was initialed, she performed the treatment. She stated if the resident was not in the facility the treatment record was turned around in the chart and left blank on those days. She stated that it could not have been her initials on the treatment record because she would not have	F 281	Director of Clinical Services or Assistant Director of Clinical Services to complete quality monitoring on 3 residents weekly for 4 weeks then monthly to ensure documentation completed accurately on treatment records per physician's order. 4.The results of the quality monitoring will be submitted to the QAPI Committee by the Director of Clinical Services for review by IDT members each month. The QAPI Committee will evaluate the effectiveness and amend as needed.	

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F 281	Continued From page 2 signed them if the resident was out of the facility. She further stated she did not remember those days specifically. During an interview on 8/8/17 at 9:50 AM the Director of Nursing stated that the initials on the treatment record for June 13th through June 20th were Treatment Nurse #2's initials. She further stated that the record had been documented inaccurately several days in a row which was not professional. The Director of Nursing stated she would have expected the record to be completed to reflect accurate information that the wound treatments were not provided.	F 281		
F 514 SS=B	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;	F 514		8/18/17

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F 514	Continued From page 3 (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain an accurate treatment record for 1 of 3 residents reviewed for wound care (Resident #2). Findings included: Resident #2 was admitted to the facility on 7/26/16. His diagnoses included acute kidney failure, diabetes mellitus, and muscle weakness. Review of Resident #2's most recent comprehensive minimum data set assessment dated 6/29/17 revealed the resident was assessed as severely cognitively impaired and had a diabetic foot ulcer. Review of a wound care sheet dated 6/6/17 revealed the resident had a diabetic ulcer on his right heel, and a shearing wound on his left hip. Review of Resident #2's physician orders revealed on 6/6/17 he was ordered to have his right heel diabetic ulcer cleansed and have a pre-moistened dressing applied every day and as	F 514	1.Resident #2 no longer resides in the facility. 2.Quality monitoring was performed to ensure only current residents' Treatment Administration Records (TARs) are noted in Treatment Record Book. All TARs of discharged residents were removed from the treatment book by the Director of Nursing on 8-9-17. Review of TARs by the Director of Clinical Services for discharged residents in last 30 days confirmed no documentation completed after resident was discharge from the facility. 3.Nurses will be re-educated on ensuring discharged residents' TARs are removed from Treatment Record Book and proper documentation completed on ordered treatments by 8-18-17. The Director of Clinical Services or Assistant Director of Clinical Services to complete quality monitoring on 3 discharged residents	

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F 514	Continued From page 4 needed. On 6/6/17 he was also ordered to have his left hip wound cleansed and a dressing applied every three days and as needed. Review of a nursing home to hospital transfer form revealed Resident #2 was transferred to the hospital for a change in condition on 6/13/17. Resident #2 did not return to the facility until 6/20/17. Review of Resident #2's June treatment record revealed the right heal treatment was initialed, indicating treatment had been done, on 6/14/17, 6/15/17, 6/16/17, 6/17/17, 6/18/17, and 6/19/17. Resident #2's hip wound treatment was initialed, indicating treatment had been done, on 6/15/17, and 6/18/17. During an interview on 8/8/17 at 9:25 AM Treatment Nurse #1 stated that when the treatment record was initialed by a nurse, it meant that the care was performed on that day. After reviewing the June treatment record for Resident #2, she stated that it appeared Resident #2 had received wound treatments during the days he was not in the facility. Treatment Nurse #1 stated that she was not working at the facility during the time in question and that Treatment Nurse #2 had initialed the records. She further stated she did not know why Treatment Nurse #2 indicated she had done treatment during those days. She further stated Treatment Nurse #2 no longer worked at the facility. During an interview on 8/8/17 at 9:44 AM the Director of Nursing stated agreement that the medical records were inaccurate because the resident was not in the facility. She further stated it was her expectation that the medical records	F 514	weekly for 4 weeks and monthly for 3 months to ensure TARs removed from treatment book when resident is discharged. The Director of Clinical Services or Assistant Director of Clinical Services to complete quality monitoring on 3 residents weekly for 4 weeks then monthly for three months to ensure documentation completed accurately on treatment records per physician's order. 4.The results of the quality monitoring will be submitted to the QAPI Committee by the Director of Clinical Services for review by IDT members each month. The QAPI Committee will evaluate the effectiveness and amend as needed.	

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F 514	Continued From page 5 would be accurate. During a phone interview on 8/8/17 at 9:46 AM Treatment Nurse #2 stated that if the treatment record was initialed, she performed the treatment. She stated if the resident was not in the facility the treatment record was turned around in the chart and left blank on those days. She stated that it could not have been her initials on the treatment record because she would not have signed them if the resident was out of the facility. She further stated she did not remember those days specifically. During an interview on 8/8/17 at 9:50 AM the Director of Nursing stated that the initials on the treatment record for June 13th through June 20th were Treatment Nurse #2's initials.	F 514		