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 09/23/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation (event ID 6QSI11) and revisit survey (event ID 0L2K12) survey were conducted from 09/21/18 through 09/23/18. Immediate jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity (J). The deficiency constituted substandard quality of care. Immediate Jeopardy began on 09/04/2018 and was removed on 09/23/2018. A partial extended survey was conducted.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems.	F 636		10/30/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 10/11/2018

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 636	Continued From page 1 (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete the initial	F 636	F636 1. Ad Hoc QAPI Committee Meeting	

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F 636	Continued From page 2 comprehensive assessment for 1 of 10 sampled residents required comprehensive assessments (Resident #11). Findings included: Resident #11 was admitted to the facility on 8/31/18. Review of Resident #11's medical record revealed staff had not completed a 14 day comprehensive Minimum Data Set (MDS) assessment as of 9/23/18. Nurse #5 was interviewed on 9/23/18 at 8:26 AM. She said her duties usually included working on MDS assessments. She said this resident's MDS was not completed on time because three of the Care Area Assessments (CAAs) were not done. The three areas were in activities of daily living, falls and pressure ulcers. Further interview at 11:12 AM on the same day revealed she and Nurse #3 were responsible for MDS tracking. Nurse #5 stated, "We were not able to keep up." Nurse #5 added when she came back from vacation leave, we were late in completing some resident MDS assessments. Nurse #5 further stated that since her return to work she has been working on floor and resident MDS assessments are not being completed as scheduled. Nurse #3, the MDS Coordinator, was interviewed on 9/23/18 at 10:16 AM. She said she was new in the MDS role. She said Nurse #5 was on vacation leave from 9/6-18/18. Regarding MDS timely completions, she said, there were a lot of admissions and she did what she was able on assessments. She said she got the MDS role on 7/31/18. Prior to that, she was the RN Supervisor on 3-11 shift. Nurse #3 said she was on leave for two months and when she came back the	F 636	conducted (9/27/18). Root Cause Analysis (RCA) completed (10/4/18). Resident #11s comprehensive Minimum Data Set (MDS) Assessment has been amended 10/2/18. 2. Regional MDS Coordinator/Facility MDS Coordinator conducted a Quality Review of current facility residents on (10/2/18) to ensure comprehensive MDS Assessment has been completed as required. Follow up based on findings. 3. Regional MDS Coordinator provided re-education for facility MDS Department on (9/28/18) regarding RAI requirements including completion of comprehensive assessments. 4. MDS Coordinator/Designee to complete Quality Improvement Monitoring of current residents to ensure comprehensive MDS Assessments completed timely as required 5x/week x 4 weeks, 3x/week x 4 weeks, weekly x 4 weeks, then monthly and as needed. Regional MDS Coordinator to validate findings weekly x4, monthly x2, then as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	

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F 636	Continued From page 3 previous MDS Coordinator was no longer working. She said an as needed MDS nurse would come a few days a week. She said the issue is staffing. We struggle every day. She stated she gets pulled from her job working as a MDS Coordinator to do patient care. Staffing has gotten worse since the administrator, Director of Nurses and Assistant Administrator left. The Unit Managers also stepped down. On 9/23/18 at 1:30 PM, the Regional Vice President of Operations referenced the services of the as needed MDS nurses to help the nursing home get back on track with timely assessments.	F 636		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.	F 655		10/30/18

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F 655	Continued From page 4 §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop a baseline care plan within 48 hours of admission to the facility for 1 of 1 residents reviewed for baseline care plan (Resident #11). Findings included: Resident #11 was admitted to the facility on 8/31/18 and readmitted on 9/1/18. He had diagnoses including chronic pain, infection and hypertension. A blank baseline care plan was observed in the chart. Nurse #5 was interviewed on 9/23/18 at 8:26 AM. She said her duties usually included working on Minimum Data Sets (MDS) assessments. She looked for the baseline care plan and couldn't find	F 655	F655 1. Ad Hoc QAPI Committee Meeting conducted (9/27/18). Root Cause Analysis (RCA) completed (10/4/18). Resident # 11s discharged from the facility. 2. Regional MDS Coordinator/Facility MDS Coordinator conducted a Quality Review on (9/27/18) of current facility residents admitted for the last 30 days to ensure baseline care plan completed as required. Follow up based on findings. 3. Regional MDS Coordinator/Divisional Director of Clinical Services /Regional Director of Clinical Services have provided re-education on (9/25/18) for MDS	

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F 655	Continued From page 5 one for Resident #11. She said that it was possible the record was pulled when he was discharged back to the emergency room on 9/1/2018. Nurse #3, the MDS Coordinator, was interviewed on 9/23/18 at 10:16 AM. She said she was new in the MDS role. Regarding baseline care plans, she said the register nurse is supposed to develop the baseline care plan. She said the former Director of Nurses used to help with it. She said the as needed MDS nurses would come a few days a week. They were going to train her how to do the baseline care plan. She said the issue is staffing. We struggle every day. She explained she got pulled from doing her MDS and care planning duties to do patient care. On 9/23/18 at 1:30 PM, the Regional Vice President of Operations referenced the services of the as needed MDS nurses to help the nursing home get back on track with timely assessments and care planning.	F 655	Department and Licensed Nurses regarding completion of Baseline Care Plan per facility guideline/regulation. 4. MDS Coordinator/Designee to conduct Quality Improvement monitoring of newly admitted residents 5x/week x 4 weeks, weekly x 4, and then monthly and as needed. Regional MDS Coordinator to validate Quality Improvement Monitoring weekly x 4, monthly x 2, then quarterly and as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 656		10/30/18

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F 656	Continued From page 6 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to develop a person centered care plan for 1 of 1 residents (Resident #13) who received Peritoneal Dialysis. Findings included: Resident #13 was originally admitted to the facility on 8/9/17 and re-admitted 11/27/17. Review of a	F 656	F656 1. Ad Hoc QAPI Committee Meeting conducted (9/27/18). Root Cause Analysis (RCA) completed (10/4/18). Resident #13□s comprehensive care plans amended on (9/23/18) to reflect peritoneal dialysis. 2. Regional MDS Coordinator/Facility MDS Coordinator have conducted a	

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F 656 Continued From page 7

quarterly MDS (Minimum Data Set-a tool used for resident assessment) dated 8/31/18 revealed Resident #13 had no cognitive impairments and had not rejected care. Toileting and bed mobility required extensive assistance, but all other activities of daily living (ADLs) required minimum to no assistance. Active diagnoses included end stage renal disease, peripheral vascular disease, and peritoneal dialysis.

Review of a physician order dated 11/27/17 read, in part, "Start peritoneal dialysis at 10:00 PM. Off at 9:00 AM."

A review of the care plans for Resident #13 revealed no care planning for peritoneal dialysis.

An interview was conducted on 9/21/18 at 4:55 PM with Nurse #11 who was typically assigned to care for Resident #13. She stated she disconnected his peritoneal dialysis (PD) every morning at 9:00 AM.

An observation and resident interview with Resident #13 was conducted on 9/22/18 at 1:30 PM. He stated PD was never missed by the staff. He stated there had been no issues related to his PD since his arrival in the facility.

An interview was conducted on 9/23/18 at 1:40 PM with Nurse #5. She stated care plans were formulated by the MDS Coordinator. She stated she was responsible to update the care plans, but was not responsible for developing them. The former MDS Coordinator would have formulated the peritoneal dialysis care plan, but had not. She also stated a care plan should have been done on peritoneal dialysis when the resident was admitted but was not.

F 656

Quality Review on (10/9/18) of current facility residents who receive peritoneal dialysis services to ensure comprehensive care plans reflective of service. Follow up based on findings.

3. Regional MDS Coordinator provided re-education on (10/4/18) for facility MDS department regarding comprehensive care plan process.

4. MDS Coordinator/Designee to complete Quality Improvement Monitoring of resident with peritoneal dialysis services to ensure comprehensive care plan implemented weekly x 4, monthly x 2, and then quarterly and as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.

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F 656	Continued From page 8 An interview was attempted with the former MDS Coordinator on 9/23/18 at 2:10 PM. An interview was conducted on 9/23/18 at 1:45 PM with the Interim Director of Nursing. She stated it was her expectation there would be a care plan for a resident on peritoneal dialysis.	F 656		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, staff and family interview, physician and Physician Assistant (PA) interviews the facility failed to supervise and provide limited assistance to Resident #5 after toileting and redressing while the resident performed hand hygiene in the bathroom. While unsupervised, the resident fell in the bathroom and hit her head. She was sent to the emergency room and diagnosed with a closed head injury and subdural hematoma. The deficient practice affected 1 of 4 residents who were sampled for supervision to prevent accidents (Resident #5). Immediate jeopardy began on 9/4/18 when Resident #5 was left in the bathroom to wash her hands after toileting. She fell and hit her head. She was sent to the emergency room for	F 689	F689 1. Ad Hoc QAPI Committee Meeting conducted (9/27/18). Root Cause Analysis (RCA) completed (10/4/18). Identified employee suspended pending investigation. Investigation conducted. Four Step Plan of Correction initiated. Resident #5 no longer resides in facility. 2. Divisional Director of Clinical Services/Regional Director of Clinical Services conducted a Quality Review on (9/22/18) of facility processes for effective communication/identification of resident level of assist, employee understanding of identified level of assist as it relates to provision of care and services. Divisional Director of Clinical Services/Regional	10/30/18

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F 689 Continued From page 9

evaluation. Immediate jeopardy was removed on 9/23/18 when the facility provided a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of level of D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems in place are effective.

Findings included:

According to the hospital discharge summary dated 8/9/18, Resident #5 was admitted to the hospital for weakness and falls. She was subsequently admitted to the nursing home on 8/9/18.

A baseline care plan dated 8/9/18 was established for Falls/Safety/Elopement with a goal that said, Will remain free of injury. Interventions included evaluate cognitive status and gait steadiness and maintain safe environment.
A physical therapy (PT) evaluation dated 8/16/18 identified fall predictors for Resident #5 : These included: Age greater than 80, female gender, gait impairment, history of falls, impaired activities of daily living (ADL), impaired cognition, impaired strength, visual impairment and five or more medications. She had more than two falls in the last year without injury and had, no fear of falling. Contact guard was noted. Her prior level of function was independent. She used a rolling walker 16 -20 feet. Cues were required for walker body orientation and distances were limited due to fatigue.

A care plan dated 8/22/18 for ADLs indicated limited assist of one for transfer, dressing, toilet

F 689

Director of Clinical Services conducted a Quality Review of resident Kardex on (9/22/18) to ensure required level of assistance listed. Divisional Director of Clinical Services/Regional Director of Clinical Services conducted a Quality Review on (9/22/18) of certified nursing assistance for utilization of identified level of assist during provision of resident care and services. Divisional Director of Clinical Services/Regional Director of clinical Services conducted a Quality Review on (10/10/18) of resident fall events for the last 60 days to ensure investigation/follow up completed per facility guidelines/regulation. Follow up based on findings.

3. Divisional Director of Clinical Services/Regional Director of Clinical Services completed re-education of Licensed Nurses on (9/22/18) related to communication/identification of resident level of assist i.e. updating Kardex and completion of Event Report, investigation, notification per facility guidelines/regulation. Divisional Director of Clinical Services completed re-education on (9/22/18) with Certified Nursing Assistants including observation regarding utilization of identified level of assist; utilization of Kardex for reference.

4. Divisional Director of Clinical Services/Designee to complete Quality Improvement Monitoring of fall event investigation follow up ensuring completion per facility guideline/regulation 5x/week x 8 weeks, weekly x 4 weeks, monthly x 3, then quarterly and as needed. Divisional Director of Clinical

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F 689

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use and personal hygiene.

The resident was assessed using the Minimum Data Set with assessment reference date of 8/23/18. The assessment indicated she understood and could understand. She had moderate impairment in cognition. She required limited assistance from one staff person for transfer, personal hygiene and walking in the room. She required extensive assistance for dressing and toilet use. Her balance was assessed as not steady. She was occasionally incontinent of bowel and bladder. Her diagnoses included anemia, atrial fibrillation, heart failure, hypertension, urinary tract infection, hyponatremia, hyperlipidemia and thyroid disorder. She had a history of falls, but none in the nursing home. She received an anticoagulant and diuretic.

According to PT Treatment Encounter Notes, Physical Therapy Assistant (PTA) #1 had worked with Resident #5 throughout the course of her stay. PTA #1 was interviewed on 9/22/18 at 10:40 AM. He said the need for assistance typically varied with Resident #5 . It would depend on what activity she had prior to therapy. She had a rolling walker. She required supervision. He said supervising meant eyeballs on person. She would walk to the bathroom. They practiced pivoting and foot position. They would ambulate from her room to the gym. He usually provided stand by assistance (SBA) to supervision. SBA meant being really close. If she lost balance he would be close enough to prevent a fall. He was not sure if she had therapy on the day of the incident. He stated 8/31/18 was the last day he saw her. She needed supervision and verbal cues for ADLs.

F 689

Services to complete Quality Improvement Monitoring of Kardexes to ensure transfer status current as well as random observation of 2 Certified Nursing Assistants for implementation of identified level of assistance weekly x 4 weeks, monthly x 3 months, then quarterly and as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.

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(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 689	Continued From page 11 September 2018 Physician Monthly Orders included the following medications: Atorvastin, cholesterol lowering mediation, digoxin, an antiarrhythmic medication, Lasix, a diuretic, synthroid, a medication to treat hypothyroidism, Lopressor, blood pressure medication, Certavite Senior, a vitamin, Potassium chloride, for low potassium levels, Senokot for constipation and warfarin, a blood thinner, also known by the brand name Coumadin. Nurse #2 was interviewed on 9/22/18 at 9:51AM regarding the level of ADL assistance Resident #5 needed prior to her fall on 9/4/18. He said she was steady on feet. She was taught how to use the call bell and would use it. She required minimal assistance with most ADLs, but for walking she was strictly supervision. He clarified supervision meant watching. He said she had been discharged from therapy and was preparing to move to an assisted living facility. Nurse #1 was interviewed on9/21/18 at 3:27 PM about the day of the incident. She said she had worked with Resident #5 on 9/4/18. She said a family member was in the room at the time of the fall and was present often during the resident's stay. She said Nurse Aide (NA) #9 had just provided Resident #5 with incontinence care. NA#9 then left work for the day. She said Resident #5 wanted to go to the bathroom again. Nurse #1 said she was not sure if the family member put Resident #5 on the toilet or if she (Nurse #1) put her on the toilet. Nurse #1 said the resident's toileting was taking a long time and when she was finished, NA #1 came in the bathroom and cleaned the resident. Nurse #1 said a short time later she heard a thump. Nurse #1 said four to five staff ran into the resident's	F 689		

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F 689	Continued From page 12 room. Nurse #1 saw the resident's walker at the sink. The resident's family member was up against wall, but standing. Resident #5's head was up against bathroom door and there was blood. Nurse #1 said she assessed the resident. Resident #5 said her head hurt. Nurse #1 found a small laceration on the resident's head. Resident #5 was sent to the emergency room. Nurse #1 notified the supervisor and the nurse practitioner and called the power of attorney. She said no staff was in the room at the time of the fall. NA #1 was interviewed on 9/21/18 at 3:48 PM about the period of time immediately before the resident's fall. She said on 9/4/18 at 2:00 PM she relieved NA#9. She said she made a round. She asked Nurse #1 what to do. The nurse said Resident #5 was on the toilet. She said, "Go in and clean her up." NA #1 said she cleaned her up. She said the family member was sitting on edge of bed. NA #1 stated, "I asked [family member] if she needed assistance and [family member] said No, I can help her." NA #1 said we use a Kardex to know resident needs. NA #1 specified that Resident #5 was stand and pivot with transfers and could feed herself. She said she went to the toilet, but wore diapers for protection. She said, "I was in the bathroom. {Family member] said Mama needs to wash her hands. She said, I have it. When she got to door, I walked out. I got half way down the hall and I heard boom. Everyone ran. She was on the floor. She had gash and was bleeding. They evaluated her. We got her into chair and then bed. Emergency Medical services got her." A telephone interview was conducted on 9/21/18 at 5:43 PM with the family member who was in	F 689		

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F 689	Continued From page 13 the room at the time of the incident and was the sole witness. The family member said, "I was in the room. The door to the bathroom was open. She went into the bathroom." She said two Senokots had been given. Someone took her to the bathroom. They stood her up. Pulled her pants up and walked out. She had her walker. Put walker along wall by paper towel holder. She washed her hands. Put paper towels in trash can. She turned right instead of turning left toward her walker. Her legs tangled up and she hit her head on other door which was closed. Her head was toward door. I was on the bed. I jumped up and screamed. I looked in the hall and saw no one. I ran back. I stepped over her. Blood was under her head. Three to five people appeared. The Physician's Assistant came in for brief second. One of the responders said, "Let's pick her up" and they got a towel under her head. The pulled diaper and pants up. They told me she was on falls protocol. They were supposed to help her. I did not tell the aide she could go. She was on Coumadin. They could have guided her fall. A nurse's note recorded after the incident was dated 9/4/18 at 3:45PM. It said, "Resident had large bowel movement and had been cleaned, dried and barrier cream applied. [Family member] was in room as well. CNA asked [Family member] if further assistance was needed to help resident wash hands. [Family member] stated "I got it". CNA left room. Staff heard loud noise and "help". Resident found on bathroom floor with head resting up against bathroom door with [Family member] standing over resident. [Family member] stated "she was washing her hands and she fell". Resident had a small laceration on the back of her head.	F 689		

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Followed by profuse bleeding. Cleaned site with sterile water, cleaned area and applied gentile pressure. Bleeding stopped. NP and manager notified and present in room as well. Sent resident out via EMT (emergency medical transport), Fall at 2:45 PM. Notified [responsible party (RP)] of fall. Had been notified by [family member] of fall. [RP] asked if she was alone. Notified {RP] that [family member] was in the bathroom at the time and no staff witnessed the fall. [RP] made staff aware that resident will be headed to [hospital].

A Situation Background Assessment Report dated 9/4/18 indicated "Fall with head injury. Rehab, weakness, status post stroke, congestive heart failure, small laceration on back of head. Pain yes, 3/10, Found resident on bathroom floor. Family present. New pain, 9/4/18 at 2:25 PM Send to ER.

Excerpts from the hospital emergency room (ER) record dated 9/4/18 indicated Resident #5 arrived at 2:54PM. Her diagnoses were closed head injury, fall, subdural hematoma, hyponatremia, and a supratherapeutic International normalized ratio (INR) (blood thinning/thickness measurement). The chief complaint was patient had a witnessed lost balance and fall hitting head prior to admission. Patient (Pt) was assisted to wheelchair then to bed by skilled nursing facility staff. "Emergency Medical Services (EMS) states that the bystander reported she was walking backwards, slipped, fell and hit the right side of her head." She complained of headache. Upon arrival to the ED, a small laceration of the patient's occipital region was noted. Bleeding was controlled when they arrived. Of note, the patient's warfarin was recently increased. Pt's

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F 689	Continued From page 15 medications were listed including warfarin. At 4:19 PM the INR was 4.39. At 5:36 PM Kcentra, (a product used for the urgent reversal of acquired coagulation factor deficiency induced by a medication like Warfarin) was ordered. Resident #5 expired on 9/9/18. The Regional Director of Clinical Services entered an incident report on 9/21/18. It included the following information. Event Date 9/4/18 at 2:24PM. Upon entering the resident's bathroom she was sitting on the floor with her head up against the bathroom door her [family member] was standing with her back up against the wall that the toilet rail sits on and her walker was at the bathroom sink. Fall to floor unwitnessed. Was the resident who fell attended by an employee? No. Location Restroom: Resident. Was the resident found on the floor? Yes. Prior to using the bathroom the resident was sitting in her wheelchair in her room. What footwear was in use at the time of the event? Shoes. Resident's history of Condition: cardiovascular disease and falls. Was the resident assessed for fall prior to event? No. Did the resident's plan of care include fall prevention? Yes. Were safety measures to prevent a fall in place prior to event? Yes. Preventive measures: Assistive devices: Instructed resident on and end encouraged use of; call light, encouraged and taught use of, grab bar in bath room, therapy, call light within reach. Room well lit, Toileted at least every two hours. What assistive devices ...? Walker. Was the resident injured? Yes. What was the level of injury? Minor injury. 1 laceration. Current medications? Diuretics, laxatives, anti-hypertensives, cardiovascular meds, anticoagulant. Initial disposition. ER. The resident's disposition was documented in the	F 689		

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medical record. Possible causative factors - other Unknown all safety measures were in place.

During interview on 9/22/18 at 11:44 AM the Regional Director of Clinical Services said I was there that day, but just in the executive director's office. She said there was no investigation of the accident found.

On 9/22/18 at 10:10 AM the physician assistant was interviewed. She said Resident #5 was our rehab patient. She was very medically complex. She had an extensive hospital stay prior to entry. Hyponatremia continued to be an issue. We followed Resident #5 closely with several medication adjustments. She was followed by nephrology. She was doing well in rehab. She was planned to discharge to and assisted living facility later that week. She said she had spoken to the family member that day about discharge paperwork. She said she had not assessed her ADLs, but said Resident #5 was able to get up probably with standby and minimal assist. She could do some ADLs. We always had someone by her. She said the family member was in the room. After the fall she said the family member was in the room. She repeated NA #1's account of leaving the room and why she left. She said she understood the family member was in the resident's room, but not in the bathroom. She said the aide was not in room because the family member was there. She said the resident was in the bathroom by herself. She fell. She hit back of head. The family member called in hallway. Staff came to assess. Small laceration was found and it was no longer actively bleeding. She arranged to send her to the emergency room. The PA said the subdural hematoma was likely result of the fall.

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On 9/22/18 at 9:58 AM the resident's physician was interviewed. He said Resident #5 was quite sick. She had bad congestive heart failure (CHF) and hyponatremia. He said Resident #5 was on warfarin that was difficult to adjust and on high end meds. He said she was followed by nephrology. He was asked if it was possible she had a brain bleed before the fall or if the fall resulted in the bleed. He said it would be difficult to know if the fall came before or after the bleed. He said with CHF and low sodium, balance is a problem. He mentioned she had two to three complicating factors that could contribute to falls and was on warfarin. He said four to five people responded. He said his expectation would be everything the nursing home staff did. He added there was an attempt to provide assistance and the implementation of the care plan was sort of a gray area.

On 9/22/18 at 12:00 PM, the Regional Director of Clinical Services stated her expectation is to provide the assistance the resident needs. At 12:03 PM, the Administrator stated the same expectation.

On 9/22/18 at 3:11 PM the Interim Director of Nurse said she started last Monday, September 17, 2018. She said, "Typically there is a root cause analysis done after a fall. There is an intervention put in place. It's talked about in stand up. We make sure everything is in place and functioning. We meet for three days and monitor for three days."

On 9/22/18 at 11:43 AM the administrator was notified of immediate jeopardy.

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F 689	Continued From page 18 An acceptable credible allegation of immediate jeopardy removal was received on 9/23/18 at 12:20 PM. It included the following. 1. Root Cause Analysis was completed regarding care and services provided to Resident #5 on 9-22-18: Root Cause determined to be the CNA assumed her responsibility ended and she left the resident unsupervised. Resident #5 ambulates using a rolling walker and on 9-4-18, was assisted times 1 with transfer to toilet by licensed nurse at approximately 2:15pm. Resident is care planned for 1 staff assistance with transfer. According to the Certified Nursing Assistant (CNA) statement and interview, CNA completed peri-care, and assisted resident to be seated on rolling walker in resident room bathroom. Family member reminded resident to wash her hands. After resident completed toileting, CNA assumed that her responsibility ended and she left the resident unsupervised. According to CNA statement from her interview, when CNA left resident room resident and family member were in bathroom, at sink washing hands and resident was seated on rolling walker. At approximately 2:25pm nurse and CNA's heard loud noise and responded to room and noted resident on floor in bathroom up against bathroom door. Resident #5 assessed by nurse and physician assistant and sent to ER for evaluation. The Center is unable to locate evidence of a thorough investigation. Director of Nursing (DON) and Unit Manager who were employed during the time of the event are no longer employed at center. CNA involved was suspended 9/22/18, pending investigation of event regarding Resident #5 to ensure CNA receives appropriate re-education and training to prevent future incidents. 2. On 9-22-18, 2:55pm Center Administration	F 689		

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including Regional Director of Clinical Services (DCS), Interim DON, Interim Divisional Executive Director (ED), Consulate sister center ED's and Regional Vice President of Operations (RVPO) immediately began education to licensed nurses and CNAs on:
" Staff to provide the supervision and or assistance as indicated per plan of care (Kardex) for transfers and ambulation for all residents. Staff aware location of plan of care (Kardex).
" Staff are responsible for transfers and ambulation regardless of who else may be present.
" All current Licensed Nurses and Certified Nursing Assistants educated on 9-22-18 or prior to working next scheduled shift. Temporary staff will be educated via telephone and/or in person prior to their next scheduled shift.
3. Center Executive Director convened an Ad Hoc Quality Assurance Performance Improvement Meeting 9-22-18 6:00PM regarding Plan of Removal of Immediacy. Director of Nursing and Regional Director of Clinical Services to conduct random quality improvement monitoring using a sample size of 5 residents 3 times weekly X 4 weeks, 2 times weekly X 4 weeks, then weekly X 4 weeks then monthly as needed. Results of the quality monitoring to be brought to the monthly Quality Assurance Process Improvement. Quality Improvement Monitoring schedule modified based on findings of monitoring.
4. Center Divisional Interim Executive Director alleges abatement of Immediate Jeopardy on 09/23/18 at 11:00 a.m.

The immediate jeopardy was removed on 9/23/18 at 1:04 PM. Staff had been trained on following

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F 689	Continued From page 20 the care plan, the responsibility of the staff to deliver care as it is determined on the care plan and how to respond to family members who insist on providing assistance.	F 689		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, the facility failed to have prescribed medications available on the day of admission to manage the pain of 1 of 1 residents reviewed for pain. The resident returned to the emergency room to be treated for symptoms of medication withdrawal the day after admission to the nursing home and had suffered pain as described by the resident and witnessed by caregivers (Resident #11). Findings included: Review Resident #11's medical record revealed he was admitted to the nursing home on 8/31/18 at 5:35 PM from the hospital. According to the admission physician's orders, Resident #11 had diagnoses including a past medical history of arthritis, chronic pain lumbar herniated disc, ulnar nerve compression and current diagnoses including paraspinal abscess, spondylosis of lumbar region, chronic pain syndrome, spinal cord stimulator implant and more.	F 697	F697 1. Ad Hoc QAPI Committee Meeting conducted (9/27/18). Root Cause Analysis (RCA) completed (10/4/18). Resident # 11 has had pain reassessed. Intervention/Medication is available and given as ordered. 2. Divisional Director of Clinical Services/Regional Director of Clinical Services/Designee has conducted a Quality Review on (10/10/18) of current residents with orders for pain medication to ensure available for use. Follow up based on findings. 3. Divisional Director of Clinical Services /Designee provided re-education for Licensed Nurses on (9/24/18) regarding process for obtaining pain medication upon resident admission. 4. Divisional Director of Clinical Services to complete Quality Improvement Monitoring of newly admitted residents for prompt availability of pain medication	10/30/18

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F 697	Continued From page 21 Resident #11 had several medications ordered upon admission to the facility on 8/31/18 including methadone 10 milligrams per oral two times a day at 8:00 AM and 8:00 PM. A telephone order dated 8/31/18 was obtained for oxycodone APAP 5/325 1 tab by mouth every 6 hours as needed for pain. Review of Resident #11's medical record revealed the monthly August 2018 Medication Administration Record (MAR) was not in the chart. Nurse #2 confirmed it was not on the record on 9/22/18 at 3:56 PM. Nurse #5 confirmed on 9/23/18 at 8:26 AM that she never found the August MAR. According to the admission nursing note dated 8/31/18 and written by Nurse #4, Resident #11 arrived at the facility at 5:35 PM from the hospital. He was alert, oriented and anxious. Resident #11 was increasingly agitated and reported pain. He refused to allow the nurse to assess him due to pain. The physician assistant was notified that his antibiotic and methadone were not available because the medications had not been delivered from the pharmacy and were not available in the facility's emergency medications box. The 8/31/18 nursing note indicated that oxycodone - APAP 5/325mg 1 every 6 hours was ordered until medications arrived from pharmacy. Resident #11 was medicated, but remained agitated. Resident #11 refused a body assessment a second time, stating "if you come back in an hour with another pill then we can do it." Nurse #4 explained to Resident #11 that oxycodone /APAP was available until other medications were delivered from pharmacy.	F 697	5x/week x 4weeks, weekly x 4, then monthly x 2 and as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring Schedule modified based on findings.	

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F 697	Continued From page 22 Resident #11 expressed dissatisfaction with that answer. An attempt to interview Nurse #4 was made on 9/22/18 at 3:29 PM. The voice mail box was full. Interview with Nurse #2 on 9/22/18 at 2:45 PM revealed he was assigned to care for Resident #11 after Nurse #4 on 9/1/2018. He said Nurse #4 had not had a lot of experience with admissions in the evening and she had two to three admissions that day. He said the resident's intravenous antibiotic and the methadone did not come from the pharmacy that night. He said the antibiotic was not a concern because the next dose was not due until the morning. He said Resident #11 received oxycodone /APAP in between, but his pain was "through the roof." The pharmacy was called and said they were unable to deliver the medications to the facility that night. Nurse #2 called again and the pharmacy was unable to give him an estimated time of arrival for the delivery and the resident was declining. He said Resident #11 was at the facility for fourteen hours before he obtained orders to send him back to the hospital. On 9/1/18 a physician's order was written to send Resident #11 to send to the emergency room related to Methadone withdrawal. Resident #11 was admitted to the emergency room on 9/1/18 at 11:12 AM for complaint of pain. The emergency triage note indicated "patient has chronic pain and is seen at [__] pain clinic for L4-5 pain and abscess on spine. Patient states pain is 12/10." Resident #11 was administered Fentanyl intravenously. The final impression was L 5 -S1 paraspinal abscess, back pain, chronic back pain, spinal cord stimulator and recent abscess. Resident #11 was discharged from the	F 697		

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F 697	Continued From page 23	F 697		

emergency room and readmitted to the nursing home on 9/1/2018.

An interview was conducted on 9/23/18 at 9:44 AM with a pharmacy technician at the facility's pharmacy. She pulled communications the pharmacy received from the nursing home on 8/31/18. She said the nursing home sent a fax for Methadone on 8/31/18 at 11:30 PM. She said the pharmacy closed at midnight. On 9/1/18 at 3:34 AM a hand written MAR was faxed. The nursing home called at 8:19 AM indicating they needed methadone stat. She said the pharmacy has a helpline the nursing home can call to get meds after hours.

Resident#11 was interviewed on 9/23/18 at 8:15 AM regarding his recollection of his admission at the nursing home on 8/31/18. He said on the night of admission, the nursing home did not have all medications on arrival. He said he had to go back to hospital. He said it was a late discharge from the hospital. He said they brought him to the room and put him in bed. He said he got his medications at the hospital at 4:00 PM and the next dose of pain medication was scheduled at 8:00 PM. He was told the medications were on order. He asked again around 9:00 PM. Still not there. Around 11:00 PM, he received oxycodone /APAP. He said he had whole body pain. Around 11:00 - 11:30 PM, he said, "I went into cold turkey. I didn't sleep. I was in pain." Nurse #2 saw what was going on and gave me medications he had available. He called the pharmacy. "I was hurting to high heaven." He told Nurse #2 to call 911.

On 9/23/18 at 10:06 AM NA #3 was interviewed. She said Resident #11 rings for pain pills. She

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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 697	Continued From page 24 recalled his admission, "I remember the first or second night he was here. His meds did not come. I observed him being in pain. That night he didn't get pain meds."	F 697		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interviews and observations, the facility failed to	F 725	F725 1. Ad Hoc QAPI Committee Meeting	10/30/18

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F 725 Continued From page 25

provide sufficient nursing staff for 3 of 13 sampled residents (#11, #12, #13): 1) provide sufficient licensed nursing staff to perform timely assessments and care planning. Nurses whose routine responsibilities included assessments and care planning were reassigned to provide direct care to residents. This resulted in assessments and care plans not being completed timely for Resident #11 and #13; 2) provide support, oversight and as needed education from nursing leadership to licensed nurses to prevent a significant medication error for 1 of 6 sampled residents (Resident #12) and to assist a nurse with acquiring a medication during a new admission process (Resident #11).

Findings included:

1. The facility had insufficient staff to complete an assessment and care planning. Cross refer to the following citations: F636 Based on record review and staff interview, the facility failed to complete the initial comprehensive assessment for 1 of 10 sampled residents required comprehensive assessments (Resident #11); F655 Based on record review and staff interview, the facility failed to develop a baseline care plan within 48 hours of admission to the facility for 1 of 1 residents reviewed for baseline care plan (Resident #11), and; F 656 Based on record review, resident and staff interviews, the facility failed to develop a person centered care plan for 1 of 1 resident (Resident #13) who received peritoneal dialysis.

Observation on 9/21/18 at 4:12 PM revealed Nurse #3 working on the Hall 2 medication cart. She said, "We've had a shortage of nurses last week. I was pulled on Friday (9/14/18)." Nurse

F 725

conducted (9/27/18). Root Cause Analysis (RCA) completed (10/4/18). Residents #11, 12, & 13 care planning and assessments completed timely. Resident # 12 receives medications as ordered/without error. Resident #11 medications have been acquired.

2. Administrator and Divisional Director or Clinical Services completed a Quality Review on (10/10/18) of current facility residents for acuity/staffing needs as well as current facility employed Licensed Nurses for appropriate quantity and skill level. Follow up based on findings.
3. Regional Vice President of Operations provided re-education on (10/10/18) for facility leadership team regarding regulation standards for sufficient staff.
4. Administrator/Designee to complete Quality Improvement Monitoring of Licensed Nurse Staffing to ensure sufficient nursing staff in place to enable timely completion of assessments/care plans, resident medications are acquired timely upon admission and resident medications are administered without significant medication error daily x 8 weeks, 3x/week x 4 weeks, weekly x 4, then monthly and as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.

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F 725	Continued From page 26 #3 was the Minimum Data Set nurse (MDS). She was responsible for performing MDS Assessments, baseline care plans and comprehensive care plans. She was given assignments on a hall administering medications to residents when there was no other staff to perform the duty. An interview was conducted with Nurse #3 on 9/22/18 at 10:50 AM. She stated there were usually 5 nurses in the building, but there had only been 4 lately so she had been re-assigned from MDS (Minimum Data Set) to resident care. She stated, "It's been a struggle with staffing since September 14th, the day before the hurricane. We're struggling with staffing and it's difficult to meet the needs of the residents. I can only speak for myself about why I have trouble meeting the resident needs, but for me we do not have enough staff. I'm the MDS nurse, but they've pulled me to the floor to help with staffing." Interview with the Interim Divisional Executive Director, the Regional Director of Clinical Services (DCS) and the Regional Vice President of Operations (RVPO) was conducted on 9/23/18 at 1:30 PM. The RVPO explained that the Director of Nurses (DON) had been on leave. He said she returned from leave for about three days prior to Hurricane Florence. (According to the NC Emergency Management Meteorologist's tropical weather update dated 9/14/18, Hurricane Florence made landfall in North Carolina.) He said several essential nursing staff had not reported to work during the Hurricane and included the DON and Assistant DON. A unit manager also resigned without notice on the day of or day before the hurricane. The interim DON	F 725		

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F 725	Continued From page 27 started work on 9/17/18. He said the Regional DCS had spent significant time in the facility since late August, mentoring the DON and assuming nursing leadership responsibilities. 2. The facility had insufficient staff to provide support and instruction from nursing leadership. Cross refer to the following citations: F726. Based on record review, staff interviews, and observations, the facility failed to demonstrate nursing competency related to calculating the infusion rate for intravenous Vancomycin (an antibiotic used to treat severe infections) administration for 1 of 1 sampled residents (Resident #12); F760. Based on record review, staff and resident interviews, and observations, the facility failed to administer intravenous (IV) antibiotics as ordered for one of one residents (Resident #12) reviewed for IV antibiotic administration; F 755 Based on record review, pharmacy interview, staff and resident interview, the facility failed to acquire a prescribed pain medication to treat 1 of 1 resident's pain. The resident had to be returned to the emergency room to be treated for symptoms of medication withdrawal the day after admission (Resident #11). An interview was conducted with Nurse #10 on 9/22/18 at 10:45 AM. She stated another resident had developed chest pain at 9:04 AM and she had to send the resident to the emergency department. She also stated Resident #12 had not received his antibiotic yet because she had medicated another resident for pain, and was not very familiar with IV medications. She stated she had arrived late this morning and there was a discrepancy with the narcotic count so her medication pass start time was delayed. She	F 725		

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F 725	Continued From page 28 stated, "We usually have a unit manager to help us, but we don't have one anymore." An interview was conducted on 9/23/18 at 1:25 PM with the Interim Director of Nursing. She stated the former Director of Nursing (DON) was no longer employed as of 9/17/18 and a unit manager walked out with the former DON. She also stated 5 nurses had not followed the facility Adverse Weather Policy during the hurricane and were terminated or resigned without notice. An interview was conducted with the Regional Director of Clinical Services on 9/21/18 at 5:05 PM. She stated she had been at the facility consistently for the last 3 weeks and, "It's a mess." She stated, "Multiple nurses and other staff members were terminated or resigned without notice because they did not show up during the hurricane." She also stated staff from their 'sister' facility had been assigned to this facility to assist with insufficient staffing.	F 725		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 726		10/30/18

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F 726	Continued From page 29 §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and observations, the facility failed to demonstrate nursing competency related to calculating the infusion rate for intravenous Vancomycin (an antibiotic used to treat severe infections) administration for 1 of 1 sampled residents (Resident #12). Findings included: Resident #12 was admitted to the facility 9/7/2018. A review of the admission MDS (Minimum Data Set- a tool used for resident assessment) dated 9/14/18 revealed Resident #12 was cognitively intact and displayed no behaviors or rejection of care. Active diagnoses included osteomyelitis (an infection of the bone), infection and inflammation due to left hip prosthesis (artificial hip), and left hip pain.	F 726	F726 1. Ad Hoc QAPI Committee Meeting conducted (9/27/18). Root Cause Analysis (RCA) completed (10/4/18). Physician notified of dosage miscalculation on (9/22/18), follow up completed as indicated. Resident #12 received Vancomycin at infused at the correct rate. 2. Divisional Director of Clinical Services/Regional Director of Clinical Services have conducted a Quality Review on (10/11/18) of current residents receiving intravenous medication for infusion completed by licensed nurse demonstrating competency. Follow up based on findings. 3. Divisional Director of Clinical Services/Regional Director of Clinical Services have provided Licensed Nurses	

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F 726	Continued From page 30 Review of a physician (MD) order dated 9/14/18 read, "Vancomycin 2gm (grams) in NS (Normal Saline) 0.9% (percent). 500 ml (milliliters) over 120 minutes QD (daily)." Review of the Medication Administration Record (MAR) revealed Vancomycin was started at 11:20 AM on 9/22/18. An observation of the Vancomycin infusing by an electronic medication pump was made on 9/22/18 at 3:00 PM. A review of the medication label revealed the label, placed by the consulting pharmacy, read, "Infuse entire contents (520ml) over 180 minutes (3 hours). The rate set on the pump read 66.7 ml/ (per) hour. An interview with Nurse #10 was conducted on 9/22/18 at 3:05 PM. She stated the Vancomycin was hung around 11:38AM by another nurse because she was not familiar with intravenous medication administration. She stated she thought it was to run over 4 hours, and was unable to perform a drip rate calculation. She stated it was a 500mL bag so the rate should be 60mL/hour. She also stated she was not familiar with intravenous (IV) medication administration or calculating IV medication drip rates. She stated there was no Staff Development Coordinator or nurse educator to conduct in services or education, but if there was she would have received the needed education to figure out drip rates. An interview was conducted on 9/23/18 at 9:50AM with Nurse #8. She stated the IV drip rate is located on the order, medication administration record, and medication label that pharmacy puts on the medication. We are in serviced on medication administration at hire and annually,	F 726	re-education on (10/12/18) including competency demonstration IV infusion including but not limited to calculating drip rate. 4. Divisional Director of Clinical Services/Designee to complete random Quality Improvement Monitoring of Licensed Nurses to ensure IV medication administration infused utilizing the correct drip rate using a sample size of 5 weekly x 6 weeks, bi-weekly x 6, then monthly x 3 and as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	

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F 726	Continued From page 31 but do not take a medication administration test. There is no nurse educator here to my knowledge." An interview was conducted on 9/23/18 at 1:25PM with the Interim Director of Nursing. She stated, "It is my expectation that nurses know how to perform drug calculations. To my knowledge, there is no medication test given to nurses at the time of hire. They go through basic orientation and get sent out to the floor."	F 726		
F 755 SS=G	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of	F 755		10/30/18

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F 755 Continued From page 32
receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on record review, pharmacy interview, staff and resident interview, the facility failed to acquire a prescribed pain medication to treat 1 of 1 resident's pain. The resident returned to the emergency room to be treated for symptoms of medication withdrawal the day after admission to the nursing home (Resident #11).

Findings included:

Review Resident #11's medical record revealed he was admitted to the nursing home on 8/31/18 at 5:35 PM from the hospital. According to the admission physician's orders, Resident #11 had diagnoses including a past medical history of arthritis, chronic pain lumbar herniated disc, ulnar nerve compression and current diagnoses including paraspinal abscess, spondylosis of lumbar region, chronic pain syndrome, spinal cord stimulator implant and more.

Resident #11 had several medications ordered upon admission to the facility on 8/31/18 including methadone 10 milligrams per oral two times a day at 8:00 AM and 8:00 PM. A telephone order dated 8/31/18 was obtained for oxycodone APAP 5/325 1 tab by mouth every 6 hours as needed for pain.

Review of Resident #11's medical record

F 755

F755
1. Ad Hoc QAPI Committee Meeting conducted (9/27/18). Root Cause Analysis (RCA) completed (10/10/18). Resident #11□s pain medication received on (9/03/18) from pharmacy and available for administration.
2. Divisional Director of Clinical Services/Regional Director of Clinical Services/Designee has conducted a Quality Review on (10/10/18) of current residents with orders for pain medication to ensure available for use. Follow up based on findings.
3. Divisional Director of Clinical Services /Designee provided re-education on (9/24/18) for Licensed Nurses regarding process for obtaining pain medication upon resident admission.
4. Divisional Director of Clinical Services to complete Quality Improvement Monitoring of newly admitted residents for prompt availability of pain medication 5x/week x 4weeks, weekly x 4, then monthly x 2 and as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring Schedule modified based on findings.

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F 755	Continued From page 33 revealed the monthly August 2018 Medication Administration Record (MAR) was not in the chart. Nurse #2 confirmed it was not on the record on 9/22/18 at 3:56 PM. Nurse #5 confirmed on 9/23/18 at 8:26 AM that she never found the August MAR. According to the admission nursing note dated 8/31/18 and written by Nurse #4, Resident #11 arrived at the facility at 5:35 PM from the hospital. He was alert, oriented and anxious. Resident #11 was increasingly agitated and reported pain. He refused to allow the nurse to assess him due to pain. The physician assistant was notified that his antibiotic and methadone were not available because the medications had not been delivered from the pharmacy and were not available in the facility's emergency medications box. The note indicated that oxycodone - APAP 5/325mg 1 every 6 hours was ordered until medications arrived from pharmacy. Resident #11 was medicated, but remained agitated. Resident #11 refused a body assessment a second time, stating "if you come back in an hour with another pill then we can do it." Nurse #4 explained to Resident #11 that oxycodone /APAP was available until other medications were delivered from pharmacy. Resident #11 expressed dissatisfaction with that answer. An attempt to interview Nurse #4 was made on 9/22/18 at 3:29 PM. The voice mail box was full. Interview with Nurse #2 on 9/22/18 at 2:45 PM revealed he was assigned to care for Resident #11 after Nurse #4 on 9/1/2018. He said Nurse #4 had not had a lot of experience with admissions in the evening and she had two to three admissions that day. He said the resident's intravenous antibiotic and the methadone did not	F 755		

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F 755	Continued From page 34 come from the pharmacy that night. He said the antibiotic was not a concern because the next dose was not due until the morning. He said Resident #11 received oxycodone /APAP in between, but his pain was "through the roof." The pharmacy was called and said they were unable to deliver the medications to the facility that night. Nurse #2 called again and the pharmacy was unable to give him an estimated time of arrival for the delivery and the resident was declining. He said Resident #11 was at the facility for fourteen hours before he obtained orders to send him back to the hospital. On 9/1/18 a physician's order was written to send Resident #11 to send to the emergency room related to Methadone withdrawal. Resident #11 was admitted to the emergency room on 9/1/18 at 11:12 AM for complaint of pain. The emergency triage note indicated "patient has chronic pain and is seen at [__] pain clinic for L4-5 pain and abscess on spine. Patient states pain is 12/10." Resident #11 was administered Fentanyl intravenously. The final impression was L 5 -S1 paraspinal abscess, back pain, chronic back pain, spinal cord stimulator and recent abscess. Resident #11 was discharged from the emergency room and readmitted to the nursing home on 9/1/2018. An interview was conducted on 9/23/18 at 9:44 AM with a pharmacy technician at the facility's pharmacy. She pulled communications the pharmacy received from the nursing home on 8/31/18. She said the nursing home sent a fax for Methadone on 8/31/18 at 11:30 PM. She said the pharmacy closed at midnight. On 9/1/18 at 3:34 AM a hand written MAR was faxed. The nursing home called at 8:19 AM indicating they	F 755		

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F 755	Continued From page 35 needed methadone stat. She said the pharmacy has a helpline the nursing home can call to get meds after hours. Resident#11 was interviewed on 9/23/18 at 8:15 AM regarding his recollection of his admission at the nursing home on 8/31/18. He said on the night of admission, the nursing home did not have all medications on arrival. He said he had to go back to hospital. He said it was a late discharge from the hospital. He said they brought him to the room and put him in bed. He said he got his medications at the hospital at 4:00 PM and the next dose of pain medication was scheduled at 8:00 PM. He was told the medications were on order. He asked again around 9:00 PM. Still not there. Around 11:00 PM, he received oxycodone /APAP. He said he had whole body pain. Around 11:00 - 11:30 PM, he said, "I went into cold turkey. I didn't sleep. I was in pain." Nurse #2 saw what was going on and gave me medications he had available. He called the pharmacy. "I was hurting to high heaven." He told Nurse #2 to call 911. On 9/23/18 at 10:06 AM NA #3 was interviewed. She said Resident #11 rings for pain pills. She recalled his admission, "I remember the first or second night he was here. His meds did not come. I observed him being in pain. That night he didn't get pain meds."	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced	F 760		10/30/18

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	345403	A. BUILDING ______ B. WING ______	C 09/23/2018

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F 760

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by:
Based on record review, staff and resident interviews, and observations, the facility failed to administer intravenous (IV) antibiotics as ordered for one of one resident (Resident #12) reviewed for IV antibiotic administration.

Findings included:

Resident #12 was admitted to the facility 9/7/2018. A review of the admission MDS (Minimum Data Set- a tool used for resident assessment) dated 9/14/18 revealed Resident #12 was cognitively intact and displayed no behaviors or rejection of care. Active diagnoses included osteomyelitis (an infection of the bone), infection and inflammation due to left hip prosthesis (artificial hip), and left hip pain.

Review of the physician (MD) orders dated 9/7/18 read, in part, "Vancomycin in 0.9% (percent) sodium chloride. 2 grams 500 ml (milliliter) soln (solution) IVPB (IV piggyback). Inject 500 ml into the vein daily." The scheduled time read 9:00 AM (morning). The stop date (the date the medication would be completed) was 10/9/18.

Review of a physician progress note dated 9/19/18 read, in part, "Had labs (trough-a test used to accurately measure medication efficacy and peak-a test used to measure the highest concentration of medication in the blood) drawn yesterday with Vanc (Vancomycin) trough remaining slightly elevated. Patient very anxious and upset this morning because he says his abx (antibiotic) did not go in last night-order reviewed with nurse on cart today-a few days ago order was changed to give IV abx at 9:30 PM instead of daily in morning. Reviewed with nurse today

F 760

F760
1. Ad Hoc QAPI Committee Meeting conducted on (9/27/18). Root Cause Analysis (RCA) completed on (10/10/18). Resident #12s intravenous antibiotics administered as ordered.
2. Divisional Director of Clinical Services/Regional Director of Clinical Services/Designee has conducted a Quality Review on (10/11/18) of current facility residents receiving intravenous (IV) antibiotics as ordered per physician. Follow up based on findings.
3. Divisional Director of Clinical Services/Designee provided re-education on (9/24/18) for Licensed Nurses regarding timely administration of IV antibiotics.
4. Divisional Director of Clinical Services/Designee to complete Quality Improvement Monitoring of current residents receiving IV antibiotic therapy for timely administration 5x/week x 4 weeks, weekly x 4 weeks, monthly x 2, and as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.

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(outside hospital) ID (infectious disease) needs to be informed of timing of abx and Vanc troughs as these values are not true indicators due to timing errors." The MD progress note also read, in part, "Reviewed with nurse this AM IV Vancomycin will be adjusted today to be given at 9:00 AM." The note concluded the outside hospital would clarify any new or additional orders.

An additional MD order dated 9/19/18 read, "Change administration time of IV Vancomycin to 9AM (do not change to evening labs due to need for accurate trough levels)."

An additional MD order dated 9/21/18 read, "Please restart Vanco (Vancomycin) q (every) 9 AM 9/22 to get back on schedule."

An additional MD order dated 9/22/18 at 11:05 AM read, in part, "Give Vancomycin now."

Review of the Medication Administration Record (MAR) revealed Vancomycin was started at 11:20 AM on 9/22/18.

An observation and interview was conducted with Resident #12 on 9/22/18 at 10:40 AM. He stated his IV antibiotic was supposed to be up by 8:00 AM every day and was not hung yet. He stated he was concerned because his IV antibiotic was frequently late.

An observation of the Vancomycin infusing by an electronic medication pump was made on 9/22/18 at 3:00 PM. A review of the medication label revealed the label, placed by the consulting pharmacy, read, "Infuse entire contents (520ml) over 180 minutes (3 hours). The rate set on the pump read 66.7 ml/ (per) hour.

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F 760 Continued From page 38 F 760

An interview was conducted with Nurse #10 on 9/22/18 at 10:45 AM. She stated another resident had developed chest pain at 9:04 AM and she had to send the resident to the emergency department. She also stated Resident #12 had not received his antibiotic yet because she had medicated another resident for pain, and was not very familiar with IV medications. She stated she had arrived late this morning and there was a discrepancy with the narcotic count so her medication pass start time was delayed. She stated, "We usually have a unit manager to help us, but we don't have one anymore."

An interview was conducted with Nurse #3 on 9/22/18 at 10:50 AM. She stated she usually completed MDS assessments for residents, but had been pulled to staff the floor recently. She agreed the antibiotic for Resident #12 was over 2 hours late. She also stated it was extremely important to hang this particular antibiotic (Vancomycin) at the ordered time because doses were calculated based on laboratory results. She stated if the medication was given late it would impact the test results and could affect the dose of antibiotic.

Observations were made on 9/23/18 at 10:05 AM and 10:40 AM of Resident #12. No Vancomycin was observed being administered until 11:00 AM.

An interview was conducted on 9/23/18 at 9:50AM with Nurse #8. She stated medications were given 1 hour before or 1 hour after the scheduled time, but Vancomycin was given at a specific time because peak & trough lab levels needed to be resulted for appropriate dosage of medication. She stated, "If a medication is late we

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F 760	Continued From page 39 call the MD. The IV rate is located on the order, MAR and medication label." An interview was conducted on 9/23/18 at 10:30 AM with Nurse #3. She stated, "Telephone orders are transcribed onto the MAR from the Physician Order Sheets. Vancomycin is hung at the same time every day related to labs needing to be drawn to determine drug levels. If Vancomycin is late is will affect the drug level." An interview was conducted on 9/23/18 at 10:40 AM with Nurse #10. She stated, "(The weekend supervisor) told me to hang the Vancomycin at 10:00 AM since it was 3 1/2 hours late getting hung yesterday. She wrote to give the medication every 24 hours on the MAR and I was doing what she told me. I don't check MD orders because I assume the MAR is correctly transcribed from the physician orders." She stated she relied on other nurses to complete her IV medications. An interview was conducted with Nurse #9 on 9/23/18 at 2:10 PM. She stated, "(Nurse #10) came to me and said she had to give Vancomycin at 9:00 AM according to the order. She told me she was late giving it yesterday and wanted to know the best time to give it today. I told her she could give it an hour before or after the ordered time but it had to be 10:00 AM exactly so it didn't affect the peak and trough lab. I didn't look at the order, I went by what she had told me." She also stated standard practice was to give a medication 1 hour before or after the ordered time, but 2 hours past the ordered time was considered a medication error, and could affect the peak and trough levels of the antibiotic.	F 760		
F 835	Administration	F 835		10/30/18

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F 835 SS=F	Continued From page 40 CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interviews, the facility failed to have sufficient department heads to administer and oversee operations. Findings included: 1. Interview with the Interim Divisional Executive Director, the Regional Director of Clinical Services (DCS) and the Regional Vice President of Operations (RVPO) was conducted on 9/23/18 at 1:30 PM. The RVPO said the facility had "the perfect storm of events." a. He said the former administrator resigned effective 9/30/18, but ended up leaving earlier on 9/5/18. He added that the Interim Divisional Executive Director's initial role was to mentor the former administrator. The Interim Divisional Executive Director became the interim administrator on 9/5/18. b. He said the former Director of Nurses (DON) was on a leave prior to Hurricane Florence (According to the NC Emergency Management Meteorologist's tropical weather update dated 9/14/18, Hurricane Florence made landfall in North Carolina.) He said she returned to work for three days prior to Florence. He said she was designated as essential staff during the storm.	F 835	F835 1. Regional Vice President of Operations (RVPO) authorized contracting with personnel agencies on 09/23/18 to provide temporary department head staff to administer and oversee operations. 2. RVPO/Human Resources Director conducted a Quality Review on (9/23/18) of facility administration (department head) needs. Follow up based on findings. 3. RVPO/Divisional Executive Director conducted a Town Hall meeting on (10/10/18) with current facility staff to provide information regarding implementation of new facility leadership (department heads) as well as answer questions and offer support. 4. RVPO to conduct Quality Improvement Monitoring of facility progress/success with implementation of new leadership (department heads) to ensure sufficient; able to administer and oversee operations weekly x 4, monthly x2 , quarterly x 1 and as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	

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F 835	Continued From page 41	F 835		

He said she did not work during the storm and was no longer working post the storm. The RVPO said the Interim DON started on 9/17/18. The RVPO said the Regional DCS had spent significant time in the nursing home since the last week in August. At that time she was mentoring the DON.

c. He said the Assistant Director of Nurses did not report to work during Florence and was no longer working post the storm.

d. He said the Activities Director did not report to work during Florence and was no longer working post the storm.

e. He said a Unit Manager resigned without notice either the day before or the day of the storm. The RVPO said they decided to retain two unit managers from a staffing agency on 9/20/18 and 9/21/18.

f. He said the Social Services Director (SSD) separated employment on 9/4/18. Interview with the Social Services Assistant on 9/21/18 at 2:58 PM revealed, the SSD had been gone since 8/28/18. She said the nursing home had 120 beds and the census was 112, but was usually around 106 residents. She said the SSD used to participate in the care plan meetings, handle discharge issues, family meetings and set up home health, but she said they shared the responsibility. She ended the interview with "I just want to make sure we have enough people here to handle concerns."

The RVPO stated staff were aware of what was going on at the facility related to leadership change and their commitment to them. He

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F 835	Continued From page 42 added, "We have brought administrators from other nursing homes to this building to support and communicate. " Administrators from two different facilities were present on 9/23/18 assisting with requests for the partial extended survey and assisting the administrator and Interim DON.	F 835		