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 11/06/2018

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 The survey team entered the facility 11/1/18 to conduct a complaint investigation and revisit survey and exited on 11/3/18. Additional information was obtained on 11/5/18 and 11/6/18. Therefore, the exit date was changed to 11/6/18. Tags F636, F 655, F 656, F689, F 725, F 726, F755, F 760, and F 835 were corrected as of 11/6/18. A repeat tag was cited. New tags were also cited as a result of the complaint investigation survey that was conducted at the same time as the revisit. The facility is still out of compliance.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interviews, family interviews, and staff interviews the facility failed to complete comprehensive weekly skin assessments for 2 of 2 sampled residents reviewed with documented skin impairment (Resident #1 and Resident #2). The facility also failed to apply the physician prescribed cream to Resident #2's sacrum/buttocks and refer Resident #1 to the wound Nurse Practitioner for evaluation of an	F 684	F 684 1. A weekly skin assessment was completed for Residents #1 on 11/15/18. Resident #1 noted with no skin impairment and an order was obtained to discontinue wound NP consult due to skin intact. Resident # 2 no longer resides in the facility. Nurse #3 and #4 re-educated on skin management to include completion of weekly skin assessments,	12/4/18

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

Electronically Signed | 11/19/2018

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 11/06/2018

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 684	Continued From page 1 abscess as ordered by the Physician Assistant. The findings included: 1. Resident # 2 was admitted to the facility on 10/17/18 following a right transmetatarsal amputation (part of his foot was removed). Additionally the resident had severe peripheral artery disease, history of left leg amputation, end stage renal disease, coronary artery disease, diabetes, chronic anemia, and hypertension. Review of the resident's Minimum Data Set assessment, dated 10/24/18, revealed the resident was cognitively intact. The resident needed extensive assistance with bed mobility and bathing. The resident was coded as being occasionally incontinent of bladder and frequently incontinent of bowel. The resident was assessed to have an application of ointments/ medications other than to his feet. Review of the resident's care plan, dated 10/22/18, revealed the resident had impaired skin integrity problems. The care plan included directions to perform weekly skin checks and notify the physician if there was a change in condition. Review of Resident # 2's skin evaluation form, initiated on his admission date of 10/17/18, revealed instructions at the top of the form which read, "Licensed nurses will complete skin evaluation weekly and prior to discharge or transfer." The skin form included an anterior and posterior picture of a human body. Nurses were directed on the form to indicate with an "x" on the picture of the body regarding any skin problems. Record review revealed the admission 10/17/18	F 684	receiving orders for all identified wounds, ensuring orders obtained for wounds on day of admission or on day of identification and follow-up completion for wound NP consults. 2. The Director of Nursing/ Assistant Director of Nursing/Unit Manager conducted a quality review of current residents skin assessment with completion of weekly skin evaluation to include residents with wounds identified were reviewed to ensure treatment ordered and initiated on 11/15/18. Follow-up based on findings. 3. Director of Nursing, Assistant Director of Nursing and Unit Managers provided Nurses re-education on skin management to include completion of weekly skin assessments, receiving orders for all identified wounds, ensuring orders obtained for wounds on day of admission or on day of identification and follow-up completed for wound NP consults. 4. Director of Nursing, ADON and Unit Manager to conduct random Quality Improvement Monitoring using a sample size of 5 residents with wounds 3 times weekly for 12 weeks then monthly to ensure weekly skin evaluation completed and any identified wound order received and treatment complete as ordered. Quality Improvement Monitoring will be completed on all new admissions weekly for 12 weeks then monthly to ensure residents with wounds have treatment orders completed and initiated upon admission. Findings of monitoring to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified	

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 11/06/2018

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 684	Continued From page 2	F 684		

assessment had been completed by the facility wound nurse. The wound nurse had drawn a mark on the human body picture in the sacral area but did not describe the area on the form. The wound nurse had noted the resident had some bruises, a rash, was a left leg amputee, and had a right transmetatarsal amputation.

There was no assessment on the skin evaluation form for the week of 10/21/18 to 10/27/18.

Review of physician orders revealed on 10/28/18 an order was written for the resident to have Zinc Oxide to his sacrum and buttocks every shift and PRN (as needed).

On the 11/1/18 skin assessment form, Nurse # 3 signed as completing the skin assessment. Nurse # 3 made the note, "foot previously identified." There was no mention of any other skin problems on the 11/1/18 skin assessment, and there was nothing depicted on the picture of the human body to show the resident had any skin problems other than his amputated foot.

Review of the resident's November, 2018 TAR (treatment administration record) revealed there were no nurse's initials on 11/1/18 to signify the Zinc Oxide had been applied on the 7:00 AM to 3:00 PM shift or the 3:00 PM to 11:00 PM shift.

On 11/2/18 at 10:40 AM, Resident # 2 was interviewed with his responsible party (RP), who was also present in the room. The resident reported that his amputated foot was not his biggest concern. The resident reported his bottom was more of a concern. The resident stated it bothered him more than his foot, and it had been bothering him for several days. The

based on findings.

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 11/06/2018

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 684	Continued From page 3	F 684		

resident's RP stated she had been placing a barrier cream on the resident's bottom, but it had been red for many days.

The resident's sacrum/ buttocks were observed with the facility's wound care nurse on 11/2/18 at 1:10 PM. The resident's skin on his buttocks and sacrum appeared a very deep purplish and inflamed color of red.

The wound care nurse was interviewed on 11/2/18 at 1:50 PM and reported the following. She provided care to his foot daily, but the resident's sacrum/buttocks were not under her daily care. She had looked at his bottom on Tuesday (10/30/18) when the wound nurse practitioner had been present and they were looking at his surgical foot wound. The wound nurse was aware the resident had some redness to his bottom on 10/30/18, and the nurses were supposed to be applying Zinc Oxide to the resident's bottom every day. The wound nurse reported the resident's bottom had changed since 10/30/18, and when she had last seen the redness, it had not appeared the deep dark purple reddish color she saw on 11/2/18.

Nurse # 4 was interviewed on 11/2/18 at 2:55 PM and reported the following. She had cared for the resident on the day shift of 11/1/18. She had not looked at the resident's sacrum/ buttocks on 11/1/18 or applied the Zinc Oxide. According to the nurse, she had been busy until 10:00 AM, and at 10:00 AM the resident went to dialysis and did not return on her shift.

Nurse # 3 was interviewed on 11/2/18 at 3:50 PM. Resident #2's skin assessment completed on 11/01/18 was reviewed and Nurse #3 confirmed

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 11/06/2018

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 684	Continued From page 4	F 684		

she had completed it. The nurse reported she had looked at the resident's skin from head to toe on 11/1/18, and she had not seen any redness on the resident's bottom. The nurse reported she had not applied Zinc Oxide to the resident's bottom. According to the nurse, she was an agency nurse, and she had not known she was to apply the Zinc Oxide to the resident's bottom.

Interview with the Divisional Clinical Services (DCS) employee on 11/3/18 at 2:35 PM revealed the following. It was her expectation that licensed nurses should have been assessing the buttocks and sacrum every shift when they applied the ordered cream and if there was no improvement then they should have informed the unit manager, wound nurse, and physician assistant. It was also her expectation that weekly skin audits be done and documented on the skin assessment form, and if any skin conditions were noted then a detailed description of the skin problem would be documented to indicate the extent of the skin problem.

2. Record review revealed Resident # 1 was last admitted to the facility on 1/17/18 with a diagnosis of End Stage Renal Disease (ESRD), diabetes, hypertension, and chronic obstructive pulmonary disease.

Review of the resident's quarterly Minimum Data Set assessment, dated 8/15/18, revealed the resident was cognitively intact.

Review of the resident's care plan, last reviewed on 10/1/18, revealed the resident had a history of skin abscess formation in May, 2018. One of the listed interventions on the care plan was to perform weekly skin checks.

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 11/06/2018

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 684	Continued From page 5 Review of the resident's skin evaluation forms from 8/1/18 to 9/16/18 revealed skin checks were documented as performed on the following dates with the following notations. There was no documented skin assessment for the week of 8/5/18 to 8/11/18. 8/12/18-"Abscess" was noted with no further explanation. 8/19/18-Abscess R (right) abdomen was noted with no further explanation. There was no documented skin assessment for the week of 8/26/18 to 9/1/18. 9/2/18-"Abscess on side of R (right) abdomen" was noted with no further explanation. 9/9/18-"Abscerss on side of R side abdomen" was noted with no further explanation. 9/16/18-"Abscess R side abdomen" was noted with no further explanation. Review of progress notes revealed the PA (Physician Assistant) had seen Resident # 1 on 8/9/18 and noted she had a new boil that had appeared in the last two days. The PA noted this was the second boil the resident had recently had, and it was likely due to resistant Staphylococcus. The PA ordered the resident be placed on Doxycycline 100 mg for 10 days. On 8/13/18 the PA ordered a change in the resident's antibiotic to Bactrim DS one pill for 9 days. On 8/13/18 the PA also ordered "wound NP (nurse practitioner) to see abscess." There was no documentation showing the resident was seen by the wound nurse practitioner.	F 684		

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 11/06/2018

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 684	Continued From page 6	F 684		

Record review revealed the resident was seen by a geriatric physician on 8/15/18 at his office, and the abscess was drained at that time. The geriatric physician noted to continue the resident's antibiotic.

Interview with the resident's responsible party (RP) on 11/1/18 at 11:05 AM revealed she had been concerned about the abscess. The RP stated she did not feel the nurses were assessing the resident's skin, and she had decided to take the resident to a geriatric physician in August and had set up the appointment herself. According to the daughter, the geriatric physician felt the abscess needed to be drained, and he did so at his office. The resident's RP also had concerns that the facility was not monitoring the healing of the abscess following its drainage.

Interview with the resident on 11/2/18 at 4:25 PM revealed the abscess had started small, and she thought she recalled she had been the one to bring it to the nurse's attention.

The wound nurse was interviewed on 11/2/18 at 12:20 PM and again on 11/3/18 at 9:00 AM. The wound nurse reported the following. She was newly hired to the facility near the end of August, and began working with Resident #1 sometime after the first of September. At the time she began working with the resident, the abscess was mostly healed. She had found no documentation prior to her care showing when the abscess had initially formed and how it initially presented when found. She also had found no documentation how the wound progressed with treatment. She also had found that the wound nurse practitioner never saw the resident as ordered. The wound nurse

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 11/06/2018

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 684	Continued From page 7 stated the wound nurse practitioner usually visited on Tuesdays to review wounds, and although Resident # 1 was at dialysis on Tuesdays, the wound NP was generally in the building throughout part of the afternoon. Interview with the wound nurse practitioner on 11/6/18 at 9:00 AM revealed she was routinely in the facility on Tuesdays, and had no record of the consult ordered for Resident #1 written on 8/13/18. Interview with the DCS employee on 11/3/18 at 9:45 AM revealed it was her professional nursing standard expectation that any type of skin condition be assessed and the assessment documented in the clinical record. According to the DCS employee, she had not been present in the facility during the time Resident # 1 was being treated in August for her abscess. The DCS employee was not aware why the wound nurse practitioner had never been consulted as ordered regarding the management of Resident # 1's abscess care.	F 684		
F 697 SS=D	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 interview, and family interview the facility failed to assure one (Resident # 7) of three sampled residents, who	F 697	F697 1. Resident #7 no longer resides at the facility. Nurse #1 and #2 were re-educated	12/4/18

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 11/06/2018

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 697	Continued From page 8 were reviewed for pain management, received prescribed pain medication as ordered. The findings included: Record review revealed Resident # 7 was a ninety-one year old resident who was initially admitted to the facility on 10/16/18. The resident was hospitalized from 10/17/18 to 10/18/18, and was readmitted to the facility on 10/18/18. The resident resided in the facility until the date of 11/2/18 when she was again transferred to the hospital at 2 PM. The resident had the following diagnoses: history of colon cancer, arthritis, respiratory failure, chronic pulmonary edema, heart failure, coronary artery disease, hypertension, hypothyroidism, and dementia. Review of imaging studies, which had been completed on 10/17/18 at the hospital and which were located on the resident's facility record, revealed the resident also had muscle and bone issues. According to the studies, the resident had severe degenerative disc disease throughout the lumbar spine with anterolisthesis of L5 on S1 (the upper spinal vertebra had slipped in front of the lower vertebra). The resident had significant multilevel degenerative changes throughout the cervical spine with stair step anterolisthesis of multiple cervical vertebra. The resident had chronic degenerative changes of the right shoulder, and the imaging study showed the resident appeared to have a chronic rotator cuff injury based on the appearance of her humerus bone. (The rotator cuff is a group of muscles and tendons that surround the shoulder joint). Review of the resident's admission Minimum	F 697	on assessing resident for pain and administering pain medication as ordered. NA #1, NA #2, PTA #1, PTA #2 and PT #1 were re-educated on reporting complaints of pain to nurse for follow-up to include evaluation of resident, administering pain medication as ordered and notification of MD as indicated. 2. The Director of Nursing/Assistant Director of Nursing/Unit Manager conducted a quality review of current resident's plan of care for pain management; including but not limited to current pain assessment, pain medication administered per physicians order and documented on medication administration record on 11/16/18. Director of Nursing/Director of Rehab/Designee conducted a quality review of residents during receipt of physical and occupational therapy treatment to ensure pain reported/managed per standard. Follow up based on findings. 3. Director of Nursing, ADON and UM provided re-education to nurses on assessing resident for pain and administering pain medication as ordered on 11/14/18. DON, ADON and UM provided re-education to nurses, certified nursing assistants and therapy staff on reporting of resident's pain to assigned nurse for follow-up to include assessing of resident, administering pain medication as ordered and notification of MD if necessary on 11/14/18. 4. Director of Nursing, ADON or UM to complete Quality Improvement Monitoring on 10 residents' medication record weekly for 12 weeks then monthly to ensure	

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 11/06/2018

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 697	Continued From page 9 Data Set Assessment, dated 10/25/18, revealed the resident was cognitively impaired. The resident had a Brief Interview for Mental Status Score of 5 on a scale of 1 to 15. The resident was also coded as having mild pain at times. Review of the resident's care plan, dated 10/31/18, revealed the resident had pain. The care plan included directions that the resident's pain medications be given per orders. Record review revealed the resident had an order, which originated on 10/18/18, for Tylenol 650 mg (milligrams) every four hours as needed (PRN) for pain. The resident also had an order, which originated on 10/19/18, for Tylenol 650 mg (milligrams) to be given on a scheduled basis three times per day. This was in addition to the PRN order. According to the record, this order was never discontinued by the physician/ PA (Physician Assistant) and was to be in effect through the resident's last residency date of 11/2/18. Review of the Resident's October, 2018 MAR revealed the resident was not documented as receiving the scheduled doses of Tylenol on 10/30/18 and 10/31/18. There had been no designated times for the administration of the scheduled Tylenol on the MAR, and therefore the MAR was entirely blank beside the order. Review of the Resident's November, 2018 MAR revealed the scheduled Tylenol order was not included on the MAR at all. Therefore, there was no evidence the resident received the Tylenol on a scheduled basis on 11/1/18 and 11/2/18.	F 697	resident is receiving pain medication as ordered. Director of Nursing/Director of Rehab to complete Quality Improvement Monitoring of residents during receipt of physical and occupational therapy treatment to ensure pain reported/managed per standard using a random sample of 3 residents 2x/week x 4 weeks, weekly x 4 weeks, then monthly x 3 and as needed. Findings of quality monitoring to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	

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 11/06/2018

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 697	Continued From page 10	F 697		

According to the October, 2018 MAR and November, 2018 MAR the resident received four doses of her PRN Tylenol between the dates of 10/30/18 to 11/2/18. If given according to a TID (three times per day) schedule as ordered, the resident should have had ten doses of Tylenol between the dates of 10/30/18 and 11/2/18 prior to her hospital transfer on 11/2/18.

Record review revealed the resident also had an order, which was dated 10/19/18, for a SalonPas-Lidocaine 4% patch to be applied daily to the resident's right knee for 12 hours. According to the record, this order was never discontinued by the physician/PA and was to be in effect through the resident's last residency date of 11/2/18.

Review of the Resident's October, 2018 and November, 2018 MAR revealed the resident did not receive the SalonPas-Lidocaine 4% patch on the dates of 10/30/18 to 11/2/18. The order had not been transcribed to the resident's new October, 2018 MAR, which was started on 10/18/18 following her readmission date of 10/18/18. The SalonPas-Lidocaine 4% patch also did not appear on the November, 2018 MAR.

For the dates of 10/30/18 to 11/2/18, the resident had no further medication pain orders other than the scheduled Tylenol, the PRN Tylenol, and the SalonPas-Lidocaine 4% patch.

Review of Resident # 7's October, 2018 MAR revealed between the dates of 10/30/18 to 11/2/18, the resident received two doses of Norco 5 mg/325 mg at bedtime. This was on 10/30/18 and 10/31/18.

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 11/06/2018

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 697	Continued From page 11	F 697		

The resident's record was reviewed with the facility's Divisional of Clinical Services (DCS) employee on 11/3/18 at 9:45 AM. The DCS employee was interviewed at this time and again on 11/3/18 at 2:35 PM. The DCS reported the following. The DCS verified the resident had not received the scheduled Tylenol as ordered in October and November, 2018 nor the SalonPas-Lidocaine 4% pain patches. This was due to transcription errors on the resident's MARs which had gone undetected by facility staff. According to the DCS employee, administration times should have been written onto the October MAR so that the nurses would have known when they were to be responsible for giving the scheduled Tylenol. According to the DCS employee, this had not occurred in October, 2018 and therefore led to the nurses not administering it on 10/30/18 and 10/31/18. The scheduled Tylenol order should have appeared on the November, 2018 MAR, but the order had not been included and this led to the Tylenol not being administered on 11/1/18 and 11/2/18 on a scheduled basis. The facility did have SalonPas-Lidocaine 4% patches available at the facility, but the DCS employee verified the resident had never received any. The DCS employee also attributed this to transcription problems. The DCS employee did not know why the nurses had given the resident Norco on 10/30/18 and 10/31/18. The DCS employee provided the resident's controlled medication utilization records, which showed the nurses had taken the Norco from the resident's old supply of Norco filled on 10/16/18. According to the chart review with the DCS, the Norco had been discontinued following the date of 10/18/18 and was never reordered. According to the DCS the discontinued order had been placed back on the

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 11/06/2018

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 697	Continued From page 12	F 697		

2018 October, MAR without a written order to start the Norco again, and she had not been able to determine how this had occurred or why it had occurred. The DCS employee stated it was her expectation that the resident would have received her pain medications as ordered. According to the DCS employee, all errors should have been caught at the end of October, 2018 when the old MARs and orders were checked prior to changing to the new November, 2018 MAR. According to the DCS employee, Resident # 7's MARs and orders were checked, but the scheduled Tylenol and SalonPas-Lidocaine 4% pain patch errors had not been caught at the end of the month.

The following interviews were conducted regarding the resident's pain symptoms.

Nurse # 2 was interviewed on 11/3/18 at 12:30 PM and reported the following during the interview. She worked week-ends with the resident, and did not recall the resident complaining of pain. She was not aware of any pain patch the resident was to receive.

Nurse # 1 was interviewed on 11/5/18 at 6:52 AM. Nurse # 1 reported the following. She had cared for the resident approximately three or four times on night shift. On occasion the resident would have pain. According to Nurse, # 1, she thought the resident was receiving Norco around 9 PM every night to help with pain. On the occasions during which she had cared for the resident, the nurse felt the resident had rested okay. She did recall Resident # 7 had been on the 24 hour nursing report due to right knee pain and breakthrough pain at some point.

NA # 1 was interviewed on 11/5/18 at 2:50 PM,

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 11/06/2018

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 697	Continued From page 13	F 697		

and reported the following during the interview. She generally took care of Resident # 7 five days per week during the day shift. The NA referred to Resident # 7 having some "old age aching." The NA reported when the resident would first get up from bed the resident would say, "Oh, my knee hurts," or "My body is aching." After the resident would "get going" she tended not to complain and seemed to do okay unless she had to stand and go to the bathroom. When she would go to the bathroom, the resident would comment, "Oh that knee gives me trouble."

NA # 2 was interviewed on 11/5/18 at 3:33 PM and reported the following. She had worked with Resident # 7 approximately three times on the 3:00 PM to 11:00 PM shift. The resident generally did not complain of pain during the first of the shift, but would do so near the end of the shift. The NA stated the resident would say she was in pain around bedtime. The NA would tell the nurses.

PTA # 1 (physical therapy assistant) was interviewed on 11/5/18 at 12:14 PM and reported the following. The resident had chronic type pain and a "very bad knee." The PTA did not feel the resident's pain was an "overriding issue" for the resident, and it had not limited her ability to participate in therapy.

PTA # 2 was interviewed on 11/5/18 at 3 PM and reported the following. The resident complained of pain sporadically. When the PTA would encourage the resident to stand, the resident would say, "Oh, my knee is going to hurt." According to PTA # 2, the resident had told her she had the knee pain for years. Also PTA # 2 reported that although the resident had knee

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 11/06/2018

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 697	Continued From page 14 pain, it had not limited the resident's ability to participate in therapy. PT (Physical Therapist) # 1 was interviewed on 11/5/18 at 12:40 PM and reported the following. She had just begun to work with Resident # 7 near the end of the resident's residency. PT # 1 stated the resident would say she "ached all over" when she worked with her. The resident's responsible party (RP) was interviewed on 11/3/18 at 1:00 PM. The RP reported the following. She visited the resident daily, and she felt the resident was in pain every time she visited. The RP reported that the resident "hurt all over," and especially had pain in her shoulder and her right knee. The RP had never seen a pain patch on the resident. The RP stated the resident had taken Norco for 1.5 years at bedtime before residing at the facility, and it worked to help control her pain at night in order that she rest.	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive 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 observation, record review, resident interview, family interview, and staff interview the facility failed to assure professional standards of communication occurred between the facility and the dialysis center which resulted in a phosphate	F 698	F698 1. Dialysis communication book sent with Resident #1 to dialysis along with resident's medication Renvela 2.4 gm to be given with meals. Nurse #4 and #5	12/4/18

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 11/06/2018

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 698	Continued From page 15 binding medication not being administered as ordered at meals for one (Resident # 1) of three sampled dialysis residents. The findings included: Record review revealed Resident # 1 was last admitted to the facility on 1/17/18 with a diagnosis of End Stage Renal Disease (ESRD). Review of the resident's quarterly Minimum Data Set assessment, dated 8/15/18, revealed the resident was cognitively intact. Review of the resident's care plan, dated 10/1/18, revealed the resident received hemodialysis for her ESRD. One of the care plan interventions was to "communicate with dialysis facility as needed." Record review revealed the resident attended dialysis three days per week on Tuesday, Thursday, and Saturday. Record review revealed the resident had an order for a packet of Renvela 2.4 gram to be given three times per day with the resident's meals. (Renvela is a phosphate binder medication used to lower phosphorus in the blood of residents with kidney disease). Interview with Resident # 1's responsible party (RP) on 11/1/18 at 11:05 AM revealed the RP had a concern about the facility's system of communicating with the dialysis center. The RP stated the facility used a communication book to send and receive information on dialysis days. The RP stated she visited often, and the communication book was usually in the back of the resident's wheelchair within a pocket. The RP was concerned the staff were not reviewing the	F 698	were re-educated on ensuring dialysis residents medications are sent with resident if ordered during time of dialysis along with dialysis communication book with dialysis communication form. Upon return the post dialysis assessment should be completed and documented on the dialysis communication form. Education was completed on 11/08/18. 2. The Director of Nursing/Assistant Director of Nursing/Unit Managers conducted a quality review on all current Dialysis residents to ensure all medications scheduled during dialysis time medications are sent with resident and each resident has a dialysis communication book with dialysis communication forms sent to dialysis, completed and returned as required. Education was completed on 11/08/18. 3. Director of Nursing, Assistant Director of Nursing and Unit Manager re-educated nurses on ensuring dialysis residents medications are sent with resident if scheduled during the time of dialysis along with dialysis communication book with dialysis communication form. Upon return the post dialysis assessment should be completed and documented on the dialysis communication form. Education was completed on 11/14/18. 4. Director of Nursing, ADON or UM to complete Quality Improvement Monitoring on Dialysis residents 2 times weekly for 12 weeks then monthly to ensure medications given per MD order and documented appropriately and dialysis communication book sent with resident with post dialysis assessment form	

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 11/06/2018

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 698	Continued From page 16 information in it. On 11/2/18 at 10:20 AM the resident was observed in her room in bed. The date of 11/2/18 corresponded to a Friday, and the resident had been to dialysis the previous day. The resident was aware that there was a book used for communication with the dialysis center. On 11/2/18 at 10:20 AM, the dialysis book was observed to be in a pocket in the back of the resident's wheelchair within her room. The resident did not know if anyone had reviewed it. Within the book were forms entitled, "Dialysis Communication Records." At the top of the forms, there was a space for the facility nurses to make notations about the resident's medications before the resident left for dialysis. For the forms in the book, dated 10/30/18 and 11/1/18, there were no notations about any of the resident's medications. Interview with the facility's Divisional of Clinical Services (DCS) employee on 11/2/18 at 11:00 AM revealed the facility used the book to communicate with dialysis staff. Staff were to document information they needed to convey in the communication book before the resident went to dialysis. The book was supposed to be removed by the facility's transport staff member from her wheelchair following the resident's return to the facility from dialysis each day. The transport staff member was to directly give the book to the unit manager, and the unit manager was to look at the book to see if the dialysis center had noted any information. According to the facility's Divisional of Clinical Services (DCS) employee, the book should have been removed from the resident's wheelchair on 11/1/18, and should not have still been in the resident's room on 11/2/18.	F 698	completed. Findings of monitoring to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	

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 11/06/2018

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 698	Continued From page 17	F 698		

The dialysis manager, who worked at Resident # 1's dialysis center, was interviewed via phone on 11/2/18 at 2:30 PM regarding communication between the facility and the dialysis center. The manger reported there had been an issue with the Renvela 2.4 gram packet not being sent with the resident from the facility. According to the manager, the Renvela order had originated with the nephrologist on 6/26/18 and was to be taken with every meal. According to the manager, the resident's supply of Renvela was at the facility, and the dialysis center had no supply. The manager stated a packet was not being sent with the resident to dialysis. The resident ate her lunch while at the dialysis center, and according to the manager, the nephrologist wanted the resident to have it also during her dialysis lunches. The dialysis staff members had not been giving it to the resident because they did not have it. They had recently talked to the facility about the Renvela. According to the manager, it was still not being sent. The dialysis manager stated they did look at the communication book that was sent to them from the facility.

On 11/2/18 at 2:50 PM, Nurse # 5 was interviewed. Nurse # 5 reported she sent the Renvela with the resident's lunch to the dialysis center, and the dialysis center would send it back without administering it.

On 11/2/18 at 3:20 PM, Nurse # 4 was interviewed and reported the following. She worked with the resident on the week-ends at times, and she was not aware of any medication or packets which were to be sent with the resident. According to the nurse, she did not send any packet or medication with the resident to

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 11/06/2018

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 698	Continued From page 18 dialysis. On 11/2/18 at 4:25 PM, the resident was interviewed again. The resident did not know if the Renvela binder was being sent with her or not. She did know that she did not take it while at dialysis. On 11/2/18 at 5:10 PM a follow up interview was conducted with the (DCS) employee. The DCS employee had confirmed that the transport staff member had never removed the resident's communication book from the wheelchair on 11/1/8 and given it to the unit manager. Therefore, it had remained in her room without being reviewed from 11/1/8 to 11/2/18. It was her expectation that the nurses use the communication book to work with the dialysis center to coordinate care. It was also her expectation that there should have been communication with the dialysis center about the Renvela and that documentation of it being sent would be included within the communication book so the dialysis center would know to administer it.	F 698		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records.	F 842		12/4/18

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 11/06/2018

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 842	Continued From page 19	F 842		

§483.70(i)(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

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches

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 11/06/2018

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 842	Continued From page 20 legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (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 interviews the facility failed to assure the medication administration records (MARs) were complete and accurate for two (Resident # 2 and # 7) of four sampled residents whose MARs were reviewed. The findings included. 1a. Record review revealed Resident # 7 was initially admitted to the facility on 10/16/18. The resident was hospitalized from 10/17/18 to 10/18/18, and was readmitted to the facility on 10/18/18. The resident resided in the facility until the date of 11/2/18 when she was again transferred to the hospital at 2 PM. The resident had an order, dated 10/19/18, for Tylenol 650 mg (milligrams) to be given on a scheduled basis three times per day. According to the record, this order was never discontinued by the physician/ PA (Physician Assistant) and was to be in effect through the resident's last residency date of 11/2/18.	F 842	F842 1. Resident #2 and Resident #7 no longer reside in the facility. 2. Director of Nursing, Assistant Director of Nursing and Unit Manager has conducted a Quality Review on 11/14/18 of current resident's physician orders to ensure medications are transcribed as ordered. Follow up based on findings. 3. Director of Nursing, Assistant Director of Nursing and Unit Manager re-educated nurses on proper process for medication transcription and verification of medications to assure accuracy and prevention of medication errors to include 2nd nurse will validate physician orders for transcription accuracy and completeness on medication administration record/treatment administration record after noted by nurse receiving order. Education was completed on 11/14/18. 4. Director of Nursing, ADON or UM to	

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 11/06/2018

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 842	Continued From page 21 Review of the Resident's October, 2018 MAR revealed the resident was not documented as receiving the scheduled doses of Tylenol as ordered. There had been no designated times for the administration of the scheduled Tylenol, and therefore the MAR was blank beside the order. Review of the Resident's November, 2018 MAR revealed the scheduled Tylenol order was not included on the MAR at all. There was no evidence the resident received the Tylenol on a scheduled basis on 11/1/18 and 11/2/18. The resident's record was reviewed with the facility's Divisional of Clinical Services (DCS) employee on 11/3/18 at 9:45 AM. The DCS employee was interviewed at this time and again on 11/3/18 at 2:35 PM. The DCS reported the following. The resident had not received the scheduled Tylenol as ordered in October and November, due to the MARs not being complete. According to the DCS employee, the MAR should have included designated times in October, 2018 for the scheduled Tylenol to be given, and the facility staff had failed to transcribe the times to the MAR. The November, 2018 MAR should have included the scheduled Tylenol order, but the November 2018 had not been complete. According to the DCS employee the error should have been caught at the end of October, 2018 when the old MARs and orders were checked prior to the use of the new November, 2018 MAR. According to the DCS employee the errors on the MARs had gone undetected. 1b.Resident # 7 had an order, which was dated 10/19/18, for a SalonPas-Lidocaine 4% patch to be applied daily to the resident's right knee for 12 hours. According to the record, this order was	F 842	complete Quality Improvement Monitoring on 10 residents' physicians' orders and medication administration record/treatment administration record 3 times weekly for 12 weeks then monthly to ensure medication transcribed to MAR/TAR accurately and administered as ordered. Findings of quality monitoring to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	

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 11/06/2018

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 842	Continued From page 22	F 842		

never discontinued by the physician/PA and was to be in effect through the resident's last residency date of 11/2/18.

Review of the Resident's October, 2018 and November, 2018 MAR revealed the resident did not receive the SalonPas-Lidocaine 4% patch in October, 2018 and November, 2018. The order had not been transcribed to the resident's new MAR which was started on 10/18/18 following her readmission date. The SalonPas-Lidocaine 4% patch also did not appear on the November, 2018 MAR.
The resident's record was reviewed with the facility's Divisional of Clinical Services (DCS) employee on 11/3/18 at 9:45 AM. The DCS employee verified the MARs had been incomplete and the errors had gone undetected by staff. According to the DCS employee the error should have been caught at the end of October, 2018 when the old MARs and orders were checked prior to the use of the new November, 2018 MAR.

1c. Record review revealed Resident # 7 had an order, dated 10/16/18, for Norco 5-325 mg to be given at bedtime. While in the hospital from 10/17/18 to 10/18/18, the resident's Norco was discontinued. Upon the facility readmission date of 10/18/18, the Norco was not ordered to be continued. Following 10/18/18, there were no orders to restart the Norco.

Review of Resident # 7's October, 2018 MAR revealed the Norco order was transcribed back onto the resident's October, 2018 MAR on the date of 10/28/18. An order date was written beside it for 10/16/18. The nurses signed as giving four doses from 10/28/18 to 10/31/18. The order did not appear on the November, 2018

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 11/06/2018

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 842	Continued From page 23	F 842		

MAR.

The resident's record was reviewed with the facility's Divisional of Clinical Services (DCS) employee on 11/3/18 at 9:45 AM. The DCS employee was interviewed at this time and again on 11/3/18 at 2:35 PM. The DCS reported the following. The DCS employee did not know why the discontinued order had been placed back on the MAR on 10/28/18. The DCS employee provided the resident's controlled medication utilization records, which showed the nurses had taken the four doses of Norco from the resident's old supply of Norco filled on 10/16/18. The DCS employee confirmed she could not find any order to restart the Norco on 10/28/18, and that the MAR was not an accurate reflection of the resident's October, 2018 orders.

2a. Resident # 2 was admitted to the facility on 10/17/18.

Review of physician's orders revealed an order on 10/31/18 at 12:30 PM for the resident to have a Dulcolax 10 mg (milligrams) suppository every other day.

Review of Resident # 2's November, 2018 MAR revealed the order had been erroneously transcribed to the November, 2018 MAR as a PRN order and not a scheduled medication.

The record was reviewed with the Divisional of Clinical Services (DCS) employee on 11/2/18 at 3:15 PM. According to the DCS employee, the order had been transcribed wrong to the November, 2018 MAR. According to the DCS employee the error should have been caught at the end of October, 2018 when the old MARs and

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 11/06/2018

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 842	Continued From page 24	F 842		

orders were checked prior to the use of the new November, 2018 MAR. According to the DCS employee the transcription error had gone undetected.

2b. Record review revealed the Resident had an order, dated 10/17/18, for Levaquin 500 mg to be administered every other day for 17 doses.

A review of the November, 2018 MAR on 11/1/18 at 2:10 PM with the resident's Nurse (Nurse # 4) revealed the date of 11/2/18 was documented on the MAR to be the resident's 4th of his 17 doses. Nurse # 4 was not aware why the MAR was reflecting the 4th of 17 doses was next due since he had been at the facility for 16 days.

The Divisional of Clinical Services (DCS) employee was interviewed on 11/2/18 at 7:35 AM and reported the following. She had reviewed what had occurred with the MAR, and there had been a transcription error. The DCS employee stated the nurse, who initially transcribed the order on 11/17/18, should have placed an "X" on the days on which the resident was not to receive the antibiotic. According to the DCS employee, this had not been done when the resident was initially admitted. Therefore, on 10/26/18 the order was rewritten on the MAR to depict the days on which the resident was not receive it. When the order was rewritten on 10/26/18, the nurse erroneously started 10/27/18 as "day # 1" on the MAR. The nurse should have written 10/26/18 as "day # 5" given that the resident was documented as receiving it on 10/24/18. The DCS verified the order, which was rewritten on 10/26/18 and appeared on the November, 2018, was not an accurate reflection of the resident's Levaquin order.

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 11/06/2018

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 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record reviews, family interview, and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in September, 2018. This was for one recited deficiency which was originally cited on a complaint investigation completed on 9/23/18 and was recited on a survey completed on 11/6/18. The deficiency was in the area of pain management. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: 1a. F 697: Based on record review, staff interview, and family interview the facility failed to assure one (Resident # 7) of three sampled residents, who were reviewed for pain management, received prescribed pain medication as ordered. The findings included: The facility was originally cited on 9/23/18 for failure to have a pain medication available for administration. On the complaint and follow up	F 867	F867 1. The Executive Director held a Quality Assurance Performance Improvement meeting on 11/19/18 with the Interdisciplinary Team including the Director of Nursing, Assistant Director of Nursing, Unit Managers, Social Services, Dietary Manager, Admissions Director, Activities Director, MDS Coordinator, Medical Records and Business office Manager focusing on the citation of F697 pain management. The facility quality assurance reviewed the new plan of correction for maintaining compliance in this area. Committee reviewed the initial quality review of F697 resident's pain assessment and ensuring resident receiving pain medication. Plan of correction was reviewed and approved by the Quality Assurance Committee. 2. During the Quality Assurance Performance Improvement on 11/19/18 the Executive Director re-educated the attendees on the Quality Assurance process to include identifying, correcting, and monitoring of any identified deficiency to ensure compliance and quality are maintained. 3. The Quality Assurance Performance	12/4/18

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 11/06/2018

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 867	Continued From page 26 survey, dated 11/1/18 to 11/6/18, the facility failed to administer prescribed pain medication to a cognitively impaired resident. The facility's Divisional Clinical Services (DCS) employee and administrator were interviewed via phone on 11/6/18 at 1:50 PM. According to these employees, the facility did implement changes in September, 2018 to address pain management in their quality assurance program. According to the employees, the original pain management deficiency dealt with pain medications not being available, and they had gone through all of the residents' medication orders to assure pain medications were available and being administered to residents. According to the employees, Resident # 7 was not receiving her prescribed pain medications due to transcription errors on the resident's Medication Administration Records and not due to the medications being unavailable. The facility failed to show they had a quality assurance program which allowed them to identify and work to resolve all problems with pain management, regardless of the root cause of the problem.	F 867	Improvement Committee will continue to meet on at least a monthly basis identifying new concerns as well as reviewing past identified concerns with updated interventions as required. The Regional Vice President of Operations and or the Regional Director of Clinical Services will attend the Quality Assurance Performance Improvement meeting for 3 months then quarterly for 2 quarters for validation. Opportunities will be corrected as identified by the Executive Director. 4. The Results of these reviews will be submitted to the Quality Assurance Performance committee by the Executive Director for review by Interdisciplinary members each month for 6 months then quarterly for 2 quarters. The Quality Assurance Performance Committee will evaluate the effectiveness and amend as needed.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		12/4/18

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 11/06/2018

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 880	Continued From page 27 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F 880		

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 11/06/2018

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 880	Continued From page 28 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure screening for Tuberculosis infection was performed for 3 of 3 sampled residents (Residents #2, #7 and #8) and 3 of 3 sampled staff (Nurse Aide #3 and #4 and Nurse #6). Finding included: The facility's policy for Screening Resident for Tuberculosis had a review date of 9/1/2017. Screening New Admissions or Readmissions: 1. The facility will screen referrals for admission and readmission for information regarding exposure to, or symptoms of. TB and will check results of recent (within 12 months) tuberculin skin tests (TST), blood assay for Mycobacterium tuberculosis (BAMT) or chest X-rays (CXR). 2. Any resident without documented negative TST, BAMT or CXR within the previous 12 months will receive baseline (two-step) or (one-step) BAMT or CXR within 12 months will receive a baseline	F 880	F880 1. Residents #2, #7 and #8 no longer reside in the facility. Nurse Aides #3, #4 and Nurse #6 received two step Tuberculosis screening on 11/20/18. 2. Director of Nursing, Assistant Director of Nursing and Unit Managers conducted a Quality Review of residents to ensure 2 step PPD (purified protein derivative) test administered to residents admitted in past 30 days and annual Tuberculosis screening completed on all current residents on 11/20/18. Director of Nursing/Assistant Director of Nursing/Human Resources conducted a quality review on all current employees to ensure employees hired in past 30 days had evidence of Tuberculosis screening noted in file and annual Tuberculosis Screening completed on current employees. Follow up based on findings. 3. Director of Nursing/Assistant Director	

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 11/06/2018

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 880	Continued From page 29 two-step TST or one-step BAMT upon admission. If the TST is negative, a follow-up TST will be administered 1 to 3 weeks after the initial test is read. The BAMT is a one-step test. The facility's policy for Screening Resident for Tuberculosis had a review date of 9/1/2017. New employee screening: Each newly hired employee will be screening for TB infection and disease after an employment offer been made but prior to the employee's duty assignment. The Employee Health Coordinator (or designee) will accept documented verification of two-step TST or BAMT results with the preceding twelve months. If the TST or BAMT result was negative, the employee will not be given another skin test prior to beginning employment. If the previous skin test was positive or unavailable, the employee must have additional verification of absence of active TB. Interview with the Interim Director of Nurses (DON) on 11/3/18 at 1:33 PM revealed she was the facility's designated infection preventionist. The DON stated, "I have been trained and went through SPICE (Statewide Program for Infection Control and Epidemiology)." She said the TB testing protocol used at the nursing home was a two-step process for residents on admission. The first step was done on the day of admission and the second step was done two weeks later. She said the medication or charge nurse administered the test. She said staff receive a TB test after they are hired. She said it was a two-step process and a screen for signs and symptoms. She said the first step was usually done the day of orientation. 1. Resident #7 had a Minimum Data Set with an assessment reference date of 10/25/18. It	F 880	of Nursing/Unit Manager provided re-education on 11/14/18 for Licensed Nurses regarding tuberculosis screening to include two-step PPD on admission and annual screening to include signs and symptoms of tuberculosis. The Regional Human Resources re-educated the Human Resource Director on policy of tuberculosis screening upon hire on 11/20/18. 4. Director of Nursing/Assistant Director of Nursing/Unit Manager to complete Quality Improvement Monitoring of new admissions residents and new employees 2 times weekly for 12 weeks then monthly to ensure 2 step PPD completed. Director of Nursing/Assistant Director will complete quality improvement monitoring on 5 residents and 5 employees two times weekly for 12 weeks then monthly to ensure annual tuberculosis screening is complete. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	

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 11/06/2018

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 880	Continued From page 30	F 880		

indicated she was admitted on 10/16/18 from an acute care setting. The October Medication Administration Record (MAR) included an entry for PPD (purified protein derivative) Skin Test on admit and two weeks later. PPD annually on October 30. An entry was made on 10/16/18. It said, "Give R (right) arm". On 10/19/18, a notation was made that the test was read and (-) negative. The step two date was boxed off on the MAR with the word, "Give," but the entry was blank. On 11/3/18 at 1:33 PM, the DON indicated the blank meant step 2 was not given. Record review revealed there was no documentation to indicate Resident #7 had ever had a 2-step test or if the person had a single skin test in the last twelve months.

2. Resident #8 had a Minimum Data Set with an assessment reference date of 10/23/18. It indicated she was admitted on 10/16/18 from an acute care setting. The October Medication Administration Record (MAR) included an entry for PPD (purified protein derivative) Skin Test on admit and two weeks later. PPD annually. An entry was made on 10/16/18. It said, "Give L (Left) arm". On 10/19/18, a notation was made that the test was read and (-) negative. The step two date was boxed off on the MAR with the word, "Give Stage 2," but the entry was blank. On 11/3/18 at 1:33 PM, the DON indicated the blank meant step 2 was not given. Record review revealed there was no documentation to indicate Resident #8 had ever had a 2-step test or if the person had a single skin test in the last twelve months.

3. Resident #2 had a Minimum Data Set with an assessment reference date of 10/24/18. It indicated she was admitted on 10/17/18 from an

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 11/06/2018

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 880	Continued From page 31	F 880		

acute care setting. The October Medication Administration Record (MAR) included an entry for PPD (purified protein derivative) Skin Test on admit and two weeks later. PPD annually. An entry was made on 10/17/18. It said, "Give R (Right) arm". On 10/20/18, a notation was made that the test was read and (-) negative. The step two date was boxed off on the MAR with the word, "Give Stage 2," but the entry was blank. On 11/3/18 at 1:33 PM, the DON indicated the blank meant step 2 was not given. Record review revealed there was no documentation to indicate Resident #2 had ever had a 2-step test or if the person had a single skin test in the last twelve months.

4. Nurse Aide #3 was employed on 10/16/18. A review of her employee file included a TB screening document. A question on the document was "Have you ever had a PPD or chest x-ray?" The answer was "Yes" and negative for both. There was no documentation in Nurse Aide #3's employee file that indicated she had been tested for TB since being employed at the facility or within the preceding 12 months. Interview with the Director of Nurses (DON) on 11/3/18 at 3:18 PM indicated the two step TB testing had not been done for NA#3 since she was employed by the facility.

5. Nurse Aide #4 was employed on 10/12/18. A review of her employee file included a document that indicated Quantiferon TB Gold (a test for diagnosing TB) with a final result of "Negative". There was no date on the record. Interview with the facility's Human Services Coordinator on 11/3/2018 at 2:08 PM confirmed the employee's TB record did not include a date for the lab result. Interview with the Director of Nurses (DON) on

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 11/06/2018

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 880	Continued From page 32 11/3/18 at 3:18 PM, indicated two step testing had not been done for NA#4 since she was employed by the facility. 6. Nurse #6 was employed on 10/22/18. A review of her employee file included a document that indicated a TB test had been given on 8/8/18. The location was in the forearm and the results were negative. On 11/3/18 at 3:12 PM, the Director of Nurses (DON) indicated two step testing had not been done for Nurse #6 since she was employed by the facility. The DON said they can accept TB documentation that the TB test was administered at another location, if it was done within the past six months and then the nursing home gives step two. The DON said there was no evidence step two had been administered for Nurse #6.	F 880		