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 06/25/2019

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 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		7/23/19

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

Electronically Signed | 07/11/2019

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F 580	Continued From page 1 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, family interview, and staff interviews, the facility failed to notify the responsible party when there was an accident which resulted in injury and a change in medication orders for one (Resident # 1) out of three residents who were reviewed for notification of family. The findings included. 1a. Record review revealed Resident # 1 was admitted to the facility on 6/22/16. The resident had diagnoses of dementia, muscle weakness, abnormal posture, and heart disease. Review of Resident # 1's quarterly MDS (Minimum Data Set) assessment, dated 4/26/19, revealed the resident was cognitively impaired. The resident was coded as having a BIMS (Brief Interview for Mental Status) of three. Review of the resident's care plan, dated 5/9/19, revealed the resident was receiving hospice services due to dementia with degeneration in her status. Record review Resident # 1 was seen by a psychiatric nurse practitioner (NP) on 5/22/19. The NP noted facility staff reported the resident	F 580	F580 Notification of Change 1. The family was notified by the hospice nurse at the time of the incident. Resident #1 suffered no harm as a result of the family not being notified by the facility. An Ad Hoc QAPI was held on 7/10/2019. 2. DON/designee will complete a quality review by 7/15/19 of all residents with falls and medication changes in the last 30 days to ensure families or POA□s were notified. Follow up based on findings. 3. DON/designee will provide education to all licensed nurses by 7/15/19 in regard to F580 with emphasis on notification of any changes in condition and medication changes. 4. DON/designee will complete Quality Monitoring 3 times weekly for 1 month, then monthly for 3 months. Findings to be reported to QAPI Committee, by DON, monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of compliance: 7/23/19	

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F 580	Continued From page 2	F 580		

had been wandering into other resident's rooms and taking such things as sweet items and a pair of dentures, and that Resident # 1's roommate had moved out of the room because of Resident # 1's disruptive behaviors. The recommendation was made by the psychiatric NP to place Resident # 1 on Namenda (a drug used to treat moderate to severe dementia). On 5/22/19 an order was obtained from the resident's primary physician/ PA (physician assistant) to start Namenda 5 mg (milligrams) daily for 7 days, and then to increase the dosage to 5 mg twice per day after the seven days.

Review of the record revealed Family Member # 1 was listed as the resident's RP (responsible party). There was no documentation the RP was notified regarding the new medication order when it originated on 5/22/19.

Family member # 1 and Family member # 2 were interviewed on 6/24/19 at 12:40 PM. Family member # 1 confirmed she lived locally and was very involved in Resident # 1's care. According to Family Member # 1 she had not been notified when the new medication was ordered. According to Family Member # 2, he had health care power of attorney for Resident # 1, and he had not been informed when the new order originated for Namenda.

Nurse # 2, who manages Resident # 1's unit, was interviewed on 6/25/19 at 3:20 PM. Nurse # 2 stated she thought the psychiatric nurse practitioner would have discussed the new medication with the family when the NP suggested it's use, and therefore Nurse # 2 had not called them. Nurse # 2 stated although the Namenda was ordered the resident had often

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F 580	Continued From page 3	F 580		

refused it. Nurse # 2 obtained Resident # 1's MARs (medication administration records). After reviewing the MAR with Nurse # 2, Nurse # 2 stated the documentation showed the resident received five doses of Namenda prior to the discontinuation of the Namenda on 6/11/19.

Interview with Resident # 1's physician on 6/24/19 at 12:40 PM revealed he felt the Namenda was a medication with few side effects, and that a trial of the drug had been appropriate for Resident # 1. According to the physician there was no evidence Resident # 1 had suffered any negative outcome from a trial of the medication. The physician did state the family should have been notified regarding the new order to try the medication.

1b. Review of nursing notes and a facility's accident investigation report revealed Resident # 1 was found on the floor on 6/9/19 at 4:30 PM. The resident was documented to have a bruise to her left forehead. The nurse documented that hospice was informed, attended to the resident, and that family was notified.

Review of hospice notes revealed an entry by a hospice nurse on 6/9/19 documenting that Resident # 1 had fallen out of her chair and sustained a large hematoma to the left forehead over the eye with mild abrasions and bleeding. The hospice nurse noted the resident had a "goose egg" approximately 3 inches by 2 inches from her hairline to her eyebrow and the length of her eyebrow.

Family member # 1 (the resident's listed responsible party according to the facility record) and Family member # 2 were interviewed on 6/24/19 at 12:40 PM. The RP (responsible party)

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F 580	Continued From page 4 stated she had not been called the evening of the fall and did not know Resident # 1 was injured until she arrived at the facility the following day for a routine visit. At that time, she found Resident # 1 to be badly bruised. She questioned Nurse # 2, who was Resident # 1's nurse unit manager. The unit manager had not been aware that the RP had not been called. According to the RP and Family Member # 2, none of Resident # 1's emergency contacts on the facility record had been called by the facility when Resident # 1 fell and injured herself on 6/9/19. Interview with the Administrator and DON on 6/24/19 at 2:30 PM revealed the nurse, who had been present at the time of the fall on 6/9/19, was not available for interview and was out of the country. The Administrator stated the hospice nurse had arrived on 6/9/19 following the fall and had also assessed the resident in addition to the facility nurse, and it had been the facility's understanding that the family was notified by the hospice nurse regarding the fall. The Administrator stated that the hospice nurse had informed the facility staff that she would talk to the family, and they thought the correct person had been notified in a timely manner by the hospice nurse. The Administrator stated hospice's communication should not have relieved the responsibility of the facility's nurse to communicate with the responsible party.	F 580		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 658		7/23/19

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F 658	Continued From page 5 (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, resident and family interviews, and staff interviews the facility failed to provide surgical wound dressing changes per nursing professional standards for one (Resident # 6) of three sampled residents with surgical wounds. The findings included. Record review revealed Resident # 6 was admitted to the facility on 6/14/19 following a hospitalization from 5/22/19 to 6/14/19. According to the hospital discharge summary, dated 6/14/19, the resident had end stage renal disease and diabetes, and had been initially hospitalized on 5/22/19 for worsening foot wounds. During hospitalization, the resident was identified to have osteomyelitis (infection of the bone) in his right lateral foot. During the hospitalization, the resident underwent a left below the knee amputation and a right great toe amputation and right partial fifth metatarsal (long foot bone) excision. Review of hospital records revealed at the time of discharge, the resident was wearing a stump protector on his left stump, and physical therapy had been providing wound care to his right foot surgical wounds. According to the hospital discharge summary, the resident was to continue antibiotic treatment for the osteomyelitis of his right foot at the facility. According to hospital records, Physical Therapy last provided Resident # 6 wound care on the date of his hospital discharge, 6/14/19. The physical therapist noted the following in their 6/14/19 note. The resident's right lateral foot wound had increasing granulation but still had a moderate amount of exposed bone. The	F 658	F658 Services Provided Meet Professional Standards 1. Resident #6 was evaluated by the PA on (06-17-19). Resident #6 suffered no harm from the surgical wound dressing not being changed. An Ad Hoc QAPI meeting was held on 7/10/2019 in regard to wound management. 2. DON/designee will conduct a Quality Review on (07-12-19) of all residents with surgical wound dressing changes to ensure dressings are being changed per MD order. Follow up based on findings. 3. DON/designee provided re-education to all licensed nurses on (07-15-19 in regard to F658 with emphasis on following Physicians orders to ensure surgical wound dressing changes are being done per MD orders. 4. DON/designee to complete Quality Improvement monitoring of surgical wound dressing changes to ensure dressings are beings changed as ordered. Monitoring will be conducted 3 x weekly for 1 month, then monthly for 3 months. Findings will be reported to QAPI Committee, by DON, monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of compliance:7/23/19	

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resident's right great toe was noted to be stable with the incisional flap noted to be dry and intact. The physical therapist noted physical therapy was using a wound vac to the resident's right foot, and the wound vac would be continued until his discharge to the skilled nursing facility. The physical therapist noted the resident would benefit from continued wound care.

Review of the hospital discharge summary did not reveal any wound instructions for the facility to follow for the resident's right foot wounds when he was transferred on 6/14/19.

Review of the resident's initial care plan, dated 6/14/19, revealed the facility identified the resident had altered skin integrity and documented the goal was to heal any skin issues. The facility also identified the resident had an infection, and that treatments would be applied.

Review of facility orders revealed Resident # 6's first wound treatment orders were obtained three days following admission. On 6/17/19 an order was obtained to cleanse the resident's right foot wounds with saline, apply a wet to dry dressing to the resident's right lateral foot wound, and apply a quaze dressing to the right great toe wound. The resident's foot was then to be wrapped in Kurlex.

Review of the resident's June, 2019 TAR (Treatment Administration Record) revealed no order had been transcribed to the TAR prior to 6/17/19. The TAR was blank for the dates of 6/15/19 and 6/16/19.

Review of Resident # 6's admission MDS (Minimum Data Set) assessment, dated 6/21/19 revealed the resident was cognitively intact.

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Resident # 6 was interviewed on 6/23/19 at 4:31 PM simultaneously with his family member. During the interview, the resident and his family member stated the resident's right foot dressings had not been changed for the first few days he was at the facility. According to the resident and his family, the resident's left stump had healed, but his right foot wounds had needed care which had not been rendered. According to the resident there had been some confusion regarding to whether he needed a wound vac, and the dressings had not been done.

The Director of Nursing was interviewed on 6/25/19 at 4:55 PM and reported the following. The resident was admitted on 6/14/19, which corresponded to a Friday. At the time of admission, the hospital had not sent specific instructions regarding wound care, but the facility was aware the hospital had been using a wound vac to the resident's right foot up until day of transfer to the facility. On the day of admission, the admitting nurse had pulled back the bandages to look at the right foot wounds but had not changed them since they had been changed that day at the hospital. The DON stated an attempt was made to clarify with the hospital the wound orders which needed to be continued at the facility, and if the resident needed a wound vac to the right foot. The admitting nurse did not hear back on 6/14/19. On Saturday, 6/15/19, Resident # 6 went to dialysis and the right foot wound bandages were not changed by the day shift nurse on 6/15/19, and clarification of the orders had not occurred. The DON stated that Nurse # 1 had cared for Resident # 6 on the evening shift of 6/15/19 (Saturday) and on both day shift and evening shift of 6/16/19 (Sunday).

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F 658	Continued From page 8 The DON stated the week-end nurses should have sought clarification from the medical physician about what dressing needed to be applied when no clarification had been obtained from the hospital, and it was his expectation as a standard of practice that the clarification would have occurred, and dressings done on 6/15/19 and 6/16/19. Nurse # 1 was interviewed on 6/25/19 at 5:10 PM and reported the following. She did not often work on Resident # 6's unit. On the week-end of 6/15/19 and 6/16/19, it was her understanding that there was a treatment nurse that was responsible for dressing changes and obtaining any clarification orders that needed to be done. The nurse stated no one mentioned to her a clarification needed to be obtained and the dressings done, or she would have taken care of it if she had known. Interview with the DON on 6/25/19 at 7:00 PM revealed there was a consistent treatment nurse on Monday through Friday, but there was not always a treatment nurse on the week-ends. On the week-end of 6/15/19 and 6/16/19, there had not been a treatment nurse, and the floor nurses should have taken care of the clarification orders and dressing changes for Resident # 6. According to the DON, he had looked at Resident # 6's right foot wound on 6/19/19 with the Administrator and there was no sign of drainage or deterioration in the wound bed.	F 658		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency	F 755		7/23/19

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F 755	Continued From page 9 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 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, resident interview, and staff interviews the facility failed to administer medications as ordered on the day of admission to 1 of 3 sampled residents reviewed for receipt of medications on admission date (Resident #4). The findings included: Record review revealed Resident # 4 was	F 755	F755 Pharmacy Services/Procedures/Pharmacist/Records 1. Resident #4 was evaluated by the PA on (06-10-19). Resident #4 is receiving his medications as ordered. An Ad-Hoc QAPI meeting was held on 7/10/2019. 2. DON/designee will conduct a Quality Review on Physician orders on admission	

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F 755	Continued From page 10 admitted to the facility on 6/8/19 following orthopedic surgery for a tallus (ankle) fracture. The resident also had a diagnosis of seizure disorder. A review of Resident # 4's admission orders dated 6/8/19 revealed he was prescribed medications which included: Levetiracetam 750 mg (milligrams) was ordered twice per day and scheduled at 8:00 AM and 8:00 PM on the physician order sheets. (This medication is used for seizures). Gabapentin 300 mg was ordered three times per day and scheduled at 8:00 AM, 2:00 PM, and 8:00 PM on the physician orders sheets. (This medication is used for both pain and seizures.) Lovenox 40 mg subcutaneously every twelve hours and was scheduled at 8:00 AM and 8:00 PM on the physician orders sheets. (This medication is used to prevent blood clots following surgery). Review of Resident # 4's admission MDS (Minimum Data Set) assessment, dated 6/15/19, revealed the resident was cognitively intact. Resident # 4 was interviewed on 6/23/19 at 3:45 PM. Resident # 4 stated he arrived shortly after 1:00 PM on the day of his admission, and he was not given all of his night time medications. The resident could not recall all the medications he missed, but stated he knew one of them was his seizure medication. A review of Resident # 4's June 2019 MAR (Medication Administration Record) revealed the following. There were no nurse's initials by Levetiracetam 750 mg (milligrams) scheduled for 6/8/19 at 8:00	F 755	for the last 30 days to ensure of all medications to ensure an adequate supply was available. Follow up based on findings. 3. DON/designee will provide re-education to all licensed nurses, to include agency nurses by 7/15/19 in regards to F755 with emphasis on order transcription and verifying adequate supplies of medications are available. Licensed nurses and agency nurses will also be re-educated on accessing and utilization of the stat medication supply by 7/15/19. Licensed nurses and agency nurses will be provided individual access codes to obtain medications from the stat medication supply (Omnicell). 4. DON/designee to complete Quality Improvement monitoring on all medications by 07-15-19 to ensure there is an adequate supply. Monitoring will be conducted 3 x weekly for 1 month, then monthly for 3 months. Findings to be reported to QAPI Committee, by DON, monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of compliance: 7/23/19	

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F 755	Continued From page 11	F 755		

PM.
There were no nurse's initials by Gabapentin 300 mg scheduled for 6/8/19 at 8:00 PM.
There were no nurse's initials by Lovenox 40 mg subcutaneously scheduled for 6/8/19 at 8:00 PM.

The Director of Nursing and Administrator were interviewed together on 6/24/19 at 2:30 PM. The Administrator reported the following. Medication orders were to be sent to the pharmacy to be filled on the day of a resident's admission. There was a cut off time, which was 7:00 PM on week-days and 12:00 PM on week-ends, by which time the orders needed to be faxed to the pharmacy in order that they be filled on the day of admission. The medications were then sent by the pharmacy that admission evening or night following admission date. If the nurse's needed medications before they arrived then they were to obtain the medications from their back up supply, which was located in the facility. Levetiracetam, Gabapentin, and Lovenox were all medications which were stored in the facility's supply of back up medications.

During the 6/24/19 interview at 2:30 PM, the Administrator further stated Resident # 4 arrived sometime between 1:00 and 2:30 PM on 6/8/19. The nurse, who had been assigned to care for Resident # 4 on the evening of 6/8/19, had been an agency nurse. There was no record the three medications had been removed from the facility's back up supply on 6/8/19 and administered to Resident # 4 at any time on the evening or night of his admission. In addition, there was no record Resident # 4's medications had been delivered by their pharmacy on 6/8/19 in time to be given on the evening or night of 6/8/19.

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 06/25/2019

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 755	Continued From page 12 According to the Administrator's interview of 6/24/19 at 2:30 PM, the agency nurse did not have access to the facility's back up medication supply because it contained narcotics, and this could have contributed to the nurse not removing the medications from the back up supply and administering them. The Administrator stated the agency nurse should have gone to another facility nurse and obtained help in acquiring the three medications from their back up supply and then administered them to Resident # 4 on the evening of the admission. A follow up interview, conducted with the DON on 6/25/19 at 4:55 PM, revealed he had tried to reach the agency nurse on 6/24/19 and 6/25/19, and the agency nurse could not be reached for comment. The DON validated the three medications had not been given on the evening of Resident # 4's admission. The DON stated if the nurse had not signed that the medications were removed from the back up supply and signed on the MAR that they were administered, then they had not been administered. The DON also stated Resident # 4 was alert and oriented, and the DON validated the resident was credible in his statement regarding missed medications.	F 755		