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 07/09/2021

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

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E 000	Initial Comments An unannounced recertificationand complaint survey was conducted on 06/28/2021 through 07/02/2021. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #WPOR11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted 06/28/2021 through 07/02/2021. Event ID# WPOR11 1 of the 9 complaint allegations were substantiated resulting in deficiencies. 9/8/21 IDR panel met and decided to delete F 641. 2567 re-posted on 9/10/21 to reflect IDR decision.	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible	F 644		7/23/21

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

Electronically Signed | 07/21/2021

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F 644	Continued From page 1 serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to obtain a Level II Preadmission Screening and Resident Review (PASRR) for a resident with an active diagnosis of a serious mental illness for 2 of 2 residents reviewed for PASRR (Resident #87 and Resident #63). The findings included: Resident #87 was admitted to the facility on 05/07/2014 and was readmitted to the facility on 12/18/2017 after hospitalization. Review of the PASRR Level I Determination Notification letter dated 05/05/2014 revealed that "A PASRR number already exists for the above-named individual. You may use the existing PASRR number until it expires." Review of Resident #87's quarterly Minimum Data Set (MDS) dated 04/28/2021 revealed Resident #87 current diagnoses included, in part, Depression (other than bipolar), Bipolar Disorder, and Anxiety disorder. An interview on 06/30/2021 at 9:52 AM with the Social Worker (SW), the SW stated Resident #87 was diagnoses with Depression, Bipolar Disorder, and Anxiety Disorder after the determination letter's date and she should have been re-evaluated for a Level II PASRR. The SW also stated the determination letter is the only documentation that was available because she just started working in the facility four (4) days	F 644	1. Level II PASSR will be requested for both residents by 7/20/21. 2. 100% audit will be done for all resident to ensure that every resident with new psychiatric diagnosis has a level II PASSR requested. 3. New order for psychotropic medications will be sent by psychiatric nurse to Executive Director, Director of Nursing and Social Worker for evaluation as to whether a Level II PASSR should be requested due to new psychiatric diagnosis. Social Worker will conduct an audit of 5 records weekly x 4 weeks, bi-monthly for two more weeks to ensure that all residents meeting criteria for Level II PASSR have a current assessment. 4. Results of audit will be reported to QAPI quarterly for the next two quarters.	

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F 644	Continued From page 2	F 644		

ago and was not in the current position when the evaluation should have been completed.

An interview with the Director of Nursing (DON) on 06/30/2021 at 12:48 PM, The DON stated a PASRR level II should have been completed with the new mental health diagnosis.

An interview with the facility's Administrator on 06/30/2021 at 03:13 PM, the Administrator stated PASRR information is expected to be completed when there is a new mental health diagnosis.

2. Resident #63 was admitted to the facility on 03/12/20 with diagnoses which included, in part, encounter for other orthopedic aftercare, hypertension and chronic respiratory failure.

Review of Resident #63's annual Minimum Data Set, dated 03/05/21, indicated Resident #63 had diagnoses which included, in part, anxiety, depression, psychotic disorder and adjustment disorder with mixed anxiety and depressed mood.

Review of Resident #63's medical record indicated his psychiatric diagnoses were diagnosed and added after his admission date as follows:
--04/03/20: anxiety disorder due to known physiological condition, adjustment disorder with mixed anxiety and depressed mood
--01/22/21: brief psychotic disorder
--02/18/21: delusional disorder

During an interview with the Social Worker (SW) on 06/30/21 at 10:00 a.m., the SW explained she had only been working at the facility for four days. She further explained Resident #63's medical

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F 644	Continued From page 3 record revealed a Level I Preadmission Screen and Resident Review (PASRR) with no expiration date. The SW stated she could find no documentation Resident #63 had been evaluated for a Level II PASRR after new psychiatric diagnoses were added to his diagnoses list. During an interview with the Administrator on 07/02/21 at 12:40 p.m., the Administrator explained it had been the responsibility of the former SW to complete the application for Level II PASRR evaluations. The Administrator stated a Level II PASRR application had not been completed for Resident #63. The Administrator stated a training for the PASRR process will be completed next week to ensure PASRR Level II applications will be done as needed.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		7/23/21

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F 656	Continued From page 4 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a comprehensive care plan to address dialysis treatment for 1 of 1 resident reviewed for dialysis. (Resident #298) Findings Included: Resident #298 was admitted 05/06/2021 with a diagnosis of End Stage Renal Disease (ESRD). The admissions Minimum Data Set (MDS) dated 05/11/21 had Resident #298 coded as severely cognitively impaired and as having Dialysis. The care plan dated 05/30/2021 had a focus of	F 656	1. The care plan was updated 7/15/21. 2. A 100% audit of care plans of residents with a diagnosis of ESRD was completed on 7/15/21. 3. An in-service regarding comprehensive care plans was done by the Director of Nursing on 7/15/21. All residents with a diagnosis of ESRD will have their chart reviewed by the MDS coordinator monthly for six months to ensure accurate care plans in place. 4. Results of the monthly review will be reported by the MDS coordinator to the QAPI committee for 6 months.	

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F 656	Continued From page 5 dependency on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits, disease process (Dementia), and physical limitations. The care plan did not include Resident #298's dialysis treatment. The May 2021 Medication Administration Record (MAR) included dialysis treatment as a Physicians' order. On 07/02/2021 at 4:39 PM in an interview with the MDS Nurse, she stated Resident #298's dialysis treatment was supposed to be care planned and it must have been oversighted. On 07/02/2021 at 4:55 PM in an interview with the Director of Nursing (DON), she stated a care plan should have been developed to address Resident #298's dialysis treatment. On 07/02/2021 at 4:58 PM the Administrator, she stated it was expected for staff to have included dialysis in the care plan for Resident #298.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F 657		7/23/21

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F 657	Continued From page 6 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to update the care plan in the areas of wandering for 1 of 1 sampled resident reviewed for wandering.(Resident # 150) The findings included: Resident # 150 was admitted to the facility on 07/21/2018 and readmitted on 06/17/2021 with multiple diagnoses that included hypertension, renal failure, dementia, anxiety and depression. The Admission Minimum Data Set (MDS) dated 06/23/2021 indicated the resident's cognition as moderately impaired. She requires extensive assistance with bed mobility, transfer, dressing and is independent with eating. Review of the psych report dated 05/13/2021 indicated Resident #150 frequently wanders into other residents' rooms, steals belonging, and brings the belonging back to her room.	F 657	1. The care plan was updated to reflect resident behaviors 7/21/21. 2. A 100% audit of timeliness of care plans was completed on 7/15. 3. An in-service regarding updating care plans timely was done by the Director of Nursing on 7/15/21. An audit of residents identified with behaviors will be conducted by the MDS coordinator on four sampled residents, weekly x 4, bi-monthly x 2 to ensure that care plans are updated timely. 4. Results of the monthly audit will be report to the QAPI committee for two quarters.	

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F 657	Continued From page 7 Review of the care plan dated 06/24/2021 did not indicate an update of the Resident # 24 wandering into other resident's rooms and did not indicate updated interventions for wandering behaviors for Resident # 24. An interview was conducted with Resident # 24 on 06/29/2021 at 10:40AM, She indicated Resident # 150 wanders to her room, and she did not want Resident # 150 to wander to her room. Interview with Nurse Assistant (NA)# 1 revealed Resident # 150 wanders into other residents' rooms according Resident # 24 and they have been redirecting the resident. Observations of Resident # 150 revealed the resident attempting to enter another resident's room and staff redirecting Resident # 150. The Admission MDS assessment dated 06/23/2021 indicated a "No" to question E0900 which asked if Resident #150 had been wandering. An interview was conducted with MDS coordinator on 06/30/2021 at 10:40 AM. She indicated she will update the care plan with Resident # 24's wandering behaviors. An interview was conducted with the Director of Nursing (DON) on 06/30/2021 at 12:29 PM. She indicated her expectation was for the care plan to be current and to reflect Resident 24's wandering behaviors.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		7/23/21

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F 677	Continued From page 8 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews, the facility failed to provide a dependent resident with assistance in eating for 1 of 36 residents reviewed for Activities of Daily Living (Resident #31). Findings included: Resident #31 was admitted to the facility on 02/29/20 with diagnoses which included, in part, Parkinson's Disease, rheumatoid arthritis, chronic pain, muscle weakness, lack of coordination and abnormal posture. A review of Resident #31's quarterly Minimum Data Set (MDS), dated 05/07/21, revealed Resident #31 to be cognitively intact, able to understand and able to make herself understood. The MDS indicated Resident #31 required extensive assistance of one person with eating. A review of Resident #31's Care Plan, last revised 05/07/21, revealed Resident #31 to have an Activities of Daily Living (ADL) self-care performance deficit related to Parkinson's Disease, rheumatoid arthritis, generalized weakness and advanced age. Interventions included, in part, Resident #31 was dependent on staff for meal intake. During an observation of the lunch meal on 06/28/21 at 12:57 p.m., Nursing Assistant (NA) #2 was observed removing Resident #31's meal tray	F 677	1. Resident #31 was provided assistance with noon meal by the assigned certified nursing assistant immediately. 2. A random sample of 2 residents identified for dependent eating will be observed weekly for 4 weeks to ensure that timely assistance in feeding is provided. 3. All licensed nurses and certified nursing assistants will be re-educated on the process of passing trays to residents who are dependent for eating by the staff development coordinator by 7/23/21. Director of Nursing or designee will complete quality monitoring tool for dependent residents for eating to ensure that residents are assisted as soon as the tray is delivered 2 x weekly for 4 weeks, 1 x weekly for 2 weeks and monthly for two months. 4. Results of monitoring will be reported to the QAPI committee quarterly for two quarters.	

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F 677	Continued From page 9	F 677		

from the cart in the hall and bringing it into the resident's room. NA #2 placed the meal tray on Resident #31's overbed table and told the resident he would be back to feed her. NA #2 then left the room with the tray untouched.

During an observation of and interview with Resident #31 on 06/28/21 at 1:10 p.m., Resident #31 was observed sitting up in her bed, her upper extremities folded across her chest with noticeable arthritic nodules on her fingers causing some of her fingers to cross over each other. Her overbed table was noticed to be parked parallel to her bed, on her left side. When asked if she was able to maneuver the overbed table over her bed, remove the dome from the plate of food and feed herself, Resident #31 held up her arthritic hands and stated she was not able. When asked how she felt about NA #2 leaving her tray untouched and then leaving the room, Resident #31 stated, "I can't do anything about it."

During an interview with NA #2 on 06/28/21 at 2:42 p.m., NA #2 stated he normally passed out all his residents' meal trays and later would return to assist and feed those residents who were dependent on staff. NA #2 stated, "to be honest with you, the lunch rush gets so busy and I'm just trying to get the trays out." NA #2 explained he had 3 dependent residents in his area and he typically passed out their trays and stated he always fed the one resident who was alert and oriented first. NA #2 stated, "in all honesty, I think I get a little too comfortable with the residents and forget to do some of the things that I am supposed to do."

During an interview with the Administrator on 07/02/21 at 12:40 p.m., the Administrator stated

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F 677	Continued From page 10 leaving a meal tray in the room of a resident who required extensive assistance with eating without providing assistance at that time was not the facility's policy. The Administrator explained meal trays are to remain on the meal cart until such time it could be taken into a resident's room and the resident be assisted and fed. She further explained it was her expectation dependent residents be fed immediately when the tray is served. During an interview with the Director of Nursing (DON) on 07/02/21 at 1:24 p.m., the DON explained it was her expectation dependent diners be assisted and fed immediately once the meal tray is brought into a resident's room.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide care in a safe manner to prevent a fall from the bed for 1 of 2 sampled residents (Resident #350). The findings included: Resident #350 was admitted to the facility on 10/15/20. The resident diagnoses included	F 689	1. Resident #350 no longer resides in the facility. 2. the facility Director of Nursing will complete an audit of residents identified with low air loss mattresses to ensure that the care plan reflects two person assist when providing ADL care related to bed mobility and positioning in bed. 3. Staff Development Coordinator or	7/23/21

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F 689	Continued From page 11 cerebral infarction, generalized muscle weakness, contractures, hemiplegia, and hemiparesis. The quarterly Minimum Data Set (MDS) assessment dated 3/9/21 indicated Resident #350 was moderately impaired and totally dependent on staff to accomplish activities of daily living (ADL) to include bathing, dressing, toileting, bed mobility, and transfers. The MDS also indicated he required two+ persons physical assist for transfers and bed mobility. Resident #350's care plan dated 10/22/20 indicated he was at risk for falls related to deconditioning. Interventions included 2 side rails (initiated 2/19/21), anticipate and meet needs, place call light within reach, bed in low position and educate resident/resident representative/caregivers about safety reminders. A report of resident fall completed by Nurse #1 dated 3/25/21 indicated Resident #350 was being positioned by Nursing Assistant #1 during a bath when he fell off the bed onto the floor. The report indicated that Resident #350 was alert, denied any pain and could move all extremities. He had equal hand grasps and his pupils were equal and reactive to light. The report further stated that Physician was notified of the fall on 3/25/21 at 2:30 pm and no new orders were given. During an interview on 7/2/21 at 1:00 pm, Nursing Assistant #1 (NA#1) indicated she was getting ready to dress Resident #350 after giving him a bath when he fell off the bed. She verbalized that she pulled the resident close to her and turned him away from her to tuck a chuck pad under him and when she pressed down on the mattress	F 689	designee will provide re-education, to licensed nurses and nursing assistants, regarding residents identified with low air loss mattresses will require two person assist when providing ADL care, to include bed mobility and positioning. The facility Director of Nursing will complete quality monitoring observation for 2 sampled residents will low air loss mattresses to ensure that the residents are receiving two person assistance with positioning and bed mobility when providing ADL care to the resident in the bed 1 x weekly for 4 weeks, bi-monthly for two months. 4. The Director of Nursing will report findings of quality monitoring observation to the QAPI committee quarterly for two quarters.	

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F 689	Continued From page 12	F 689		

the resident slipped and fell off on the opposite side of the bed. Resident #350 was positioned on his left on the bed and when he hit the floor he was lying on his right. NA#1 revealed Resident #350 was bleeding from his forehead. She verbalized that this was her first time caring for the resident and there was nothing to keep the resident from falling when the air mattress pressure shifted as she pushed down on the mattress. During a follow up interview on 7/8/21 at 2:44 pm, NA#1 verbalized that she was not aware that Resident #350 required 2-person physical assist for bed mobility.

During an interview on 7/2/21 at 2:06 pm, Nurse #1 revealed she was the primary nurse for Resident #350 when he fell. She was made aware of Resident #350's fall by NA #1 and went to the room to assess the resident. When she walked into the room, Resident #350 was lying on the floor on his right side. He was bleeding from his forehead and denied any pain at that time. He had equal hand grasps and his pupils were equal and reactive to light. He was alert and could move all extremities.

A nursing note written by Nurse #2 dated 3/26/21 indicated Resident #1 had a band aid to the right side of his head with no active bleeding.

Attempts to interview Nurse #2 were unsuccessful.

During an interview on 7/2/21 at 3:00 pm, the Assistant Director of Nursing (ADON) revealed she was the one who completed the incident report for Resident #350's fall. The ADON communicated that NA#1 pushed down on the air mattress and the pressure shifted which resulted

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 07/09/2021

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

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in Resident #350 falling to the floor. She indicated there was nothing to keep the resident from falling because there were no side rails on the bed and that after this fall the facility decided that residents on air mattresses would require two-person assist for ADLs.

During an interview on 7/2/21 at 3:45 pm with the Director of Nursing (DON), she indicated Resident #350 was on an air mattress and fell when NA#1 was dressing him. She communicated that she had decided with the ADON after this fall that residents on air mattresses would require two-person assist. During a follow up interview on 7/8/21 at 2:50 pm, the DON stated there should have been two people positioning Resident #350 as coded in the MDS required level of assistance.