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 06/29/2023

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
E 000	Initial Comments An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 06/20/2023 through 06/22/2023. Additional information was obtained offsite on 06/29/2023. Therefore, the exit date was 06/29/2023. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# F9W111.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation survey were conducted on 06/20/2023 through 06/22/2023. Additional information was obtained offsite on 06/29/2023. Therefore, the exit date was 06/29/2023. Event ID# F9W111. The following intakes were investigated NC00203536, NC00197757, NC00199836, NC00202792, and NC00203465. 1 of the 10 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.80 at tag F880 at a scope and severity J. Immediate Jeopardy began on 06/20/2023 and was removed on 06/22/2023.	F 000		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes,	F 693		7/12/23

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

Electronically Signed | 07/10/2023

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F 693	Continued From page 1 both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to administer tube feeding in accordance with a physician's order for 1 of 1 resident (Resident #10) reviewed for feeding tubes. Findings included: Resident #10 was admitted to the facility on 4/4/34 with diagnoses that included dysphagia requiring a feeding tube. A Care Plan dated 4/6/23 focused on nutrition included a goal for Resident #10 to maintain adequate nutritional status as evidenced by stable/slow weight gain, no signs of malnutrition, and tolerating tube feeding (TF). Interventions	F 693	On 6-21-23 Resident #10 enteral feeding rate was adjusted to the current physician order of Jevity 1.5 at 70 ml by charge nurse continuous. The attending physician and responsible party were notified of the resident not receiving the correct rate of enteral feeding on 6-21-23. On 6-21-23 Director of Nursing/ designee reviewed facility residents identified with orders with enteral feeding to ensure the residents were receiving the correct enteral feeding and rate. No other issues were identified. On 7/5/23 Director of Nursing /designee initiated education regarding ensuring that	

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F 693	Continued From page 2 included Registered Dietitian (RD) to evaluate and make diet change recommendations as needed, weight monthly and per orders, and monitor for weight loss and signs of malnutrition. Resident #10's admission Minimum Data Set (MDS) dated 5/9/23 indicated a moderate cognitive impairment. He received over half of his daily calories and fluids from his TF. A physician's order dated 5/30/23 for standard TF formula with the goal rate of 70 milliliters per hour (ml/hr) over 24 hours per day. An observation was made on 6/20/23 at 10:30 AM of Resident #10's standard TF formula running at 55 ml/hr. An observation was made on 6/20/23 at 3:20 PM of Resident #10's standard TF formula running at 55 ml/hr. During an interview on 6/20/23 at 3:25 PM, Nurse #2 confirmed Resident #10's TF was ordered for 70 ml/hr. She indicated the TF was running at the wrong rate. Nurse #2 indicated she had not adjusted the pump on her shift and did not know how long it was running at 55 ml/hr. The night shift nurse could not be reached for interview on multiple attempts. A telephone interview was conducted on 6/21/23 at 11:00 AM with the RD. She revealed Resident #10 should be receiving standard TF formula at 70 ml/hr. She indicated Resident #10 had weight loss in the month of May and his rate was increased to provide extra calories. Resident #10 declined his weight for the month of June. The	F 693	physician orders are reviewed to include administration of enteral feeding at the correct rate. Staff identified as not receiving the education by 7/7/2023 will receive prior to working their next scheduled shift. The Director of Nursing/designee will conduction Quality Review audit of three residents identified with physician orders for enteral feeding to ensure that correct enteral feeding and rate is being administrated per orders 3 times a week for four weeks, then weekly for three weeks then monthly for one month. The results of the Quality Monitoring Audit will be reviewed by The Quality Assessment Improvement Committee monthly for three months. The Committee will review the findings and determine if further action is needed.	

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F 693	Continued From page 3 RD was not able to assess if Resident #10 had further weight loss. During an interview on 6/21/23 at 2:35 PM, the Director of Nursing (DON) revealed nursing staff should be checking the TF formula and rate every shift to ensure accuracy. During an interview on 6/22/23 at 8:50 AM, the Administrator revealed nursing staff should be checking the TF rate every shift to ensure accuracy.	F 693		
F 880 SS=K	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. 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;	F 880		7/12/23

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F 880	Continued From page 4 §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 (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.	F 880		

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F 880	Continued From page 5 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 observations, record review, and staff interviews the facility staff failed to disinfect a shared blood glucose meter between residents in accordance with the instructions provided by the manufacturer of the blood glucose meter and the disinfectant wipes used for 3 of 3 residents whose blood glucose levels were checked (Resident #6, Resident #7, and Resident #8) by 3 of 3 nurses (Nurse #1, Nurse #2, and Nurse #3). This occurred while there was a resident (Resident #9) with a known bloodborne pathogen in the facility. This deficient practice had a high likelihood of transmitting bloodborne pathogens within the facility. Immediate Jeopardy began on 6/20/2023 when Nurse #1 was observed performing a blood glucose test on Resident #6 using a shared blood glucose meter put the in the medication cart without cleaning or disinfecting per the manufacturer's instructions. Immediate Jeopardy was removed on 6/22/2023 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity E (no actual harm with more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put in place are effective. The findings included: A review of the facility's policy entitled "Blood Glucose Monitoring and Disinfecting" (Revised in April 2022) read in part "Clean and disinfect the	F 880	On 6/20/23 Nurse #1, Nurse #2 and Nurse #3 failed to clean shared blood glucose meters which were used during medication administration. Nurse #1, #2 and #3 were immediately educated by the Director of Nursing on F880 following manufacturer's guidelines for cleaning and disinfection of blood glucose monitoring. Including the following education: Skills Competency Assessment of Glucometer cleaning to include direct observation and return demonstration and Storage individual resident's Glucometer in medication cart in individual bag. On 6/20/23, 89 residents have been reviewed by the Director of Nursing /Designee for use of blood glucose meters. Residents identified with orders for glucose monitoring were given individualized glucose meters, labeled and placed in bag in medication administration cart by Director of Nursing. On 6/20/23 21 residents identified to receive blood glucose monitoring were assessed by the charge nurse and no negative outcomes as related to Infection Control during medication pass glucometer cleaning were observed. On 6/20/23 all current glucometers were cleaned and placed in bag, labeled and placed in medication cart. The local public health authority was notified on 6/21/2023 on the improper cleaning of the shared glucometer with	

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F 880	Continued From page 6 meter with disinfecting wipes (per manufacture guidelines)." The manufacturer's guidelines for cleaning the blood glucose meter used at the facility included: a) wear appropriate protective gear such as disposable gloves. b) Open the cap of the disinfectant container and pull out 1 towelette and close the cap. c) Wipe the entire surface of the meter 3 times horizontally and 3 times vertically using one towelette to clean blood and other body fluids. d) dispose of the used towelette in a trash bin. She meter should be cleaned prior to each disinfection step. The manufacturer's guidelines for disinfecting the blood glucose meter used at the facility included: a) Pull out 1 new towelette and wipe the entire surface of the meter 3 times horizontally and 3 times vertically using a new towelette to remove blood borne pathogens. b) Dispose of the used towelette in a trash bin c) Allow exteriors to remain wet for the corresponding contact time for each disinfectant. d) After disinfection the user's gloves should be removed to be thrown away and hands washed before proceeding to the next patient. The disinfectant wipes used at the facility for blood glucose meter disinfection were approved by the EPA (Environmental Protection Agency) for cleaning and disinfecting their (brand name) blood glucose meter. The instructions on the label of the disinfection wipes stated may be used on blood glucose meters and indicated to allow surfaces to remain wet for two minutes and let air dry.	F 880	corrective actions taken and inquire about any immediate monitoring of residents potentially affected by the Director of Nursing. Recommendations from the Public Health Nurse for addition lab for anyone receiving finger stick blood sugar monitoring were completed on 6/23/203. No other issues identified through this additional monitoring. On 6/20/23, the Director of Nursing initiated education to the Licensed Nurses on following manufacturer’s guidelines for cleaning and disinfection of blood glucose monitoring. Including the following education: Skills Competency Assessment of Glucometer cleaning to include direct observation and return demonstration and to ensure storage individual resident’s Glucometer in medication cart in individual bags. After 6/20/23 Licensed Nurses not previously educated on glucometer cleaning with skills competency and storage of glucometer will be educated prior to working their next scheduled shift. Newly Hired Licensed Nurses will be educated during the Orientation process going forward. The Director of Nursing has been notified by the Regional Director of Clinical Services of this responsibility on 6/20/2023. The Director of Nursing / Designee will observe a sample cleaning and disinfection of blood glucose monitoring meters beginning 7/5/23 daily for 7 days on various shifts then 3 times a week for four weeks.	

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F 880	Continued From page 7 The medication cart assignments on 6/20/23 during the first shift indicated 3 nurses (Nurse #1, Nurse #2, and Nurse #3) were assigned to medication carts. On 6/20/2023 at 11:24 AM an observation and interview were conducted with Nurse #1 who was a facility employee. Nurse #1 performed a glucose check on Resident #6 and when she completed the task, she disposed of the test strip and lancet, performed hand hygiene, and placed the blood glucose meter in the right top drawer of the medication cart without cleaning or disinfecting it. She revealed that to clean the blood glucose meter "I just wipe it like this" and she removed the blood glucose meter from the medication cart demonstrated wiping it with an unopen alcohol swab and replaced it back into the top right top drawer of the medication cart. She indicated this was her normal practice for cleaning and disinfecting the blood glucose meter. No observation was made of her cleaning and disinfecting the blood glucose meter. She further stated that the same blood glucose meter was used for all the residents requiring blood glucose monitoring on her assignment. She stated that there were residents on her assignment that required blood glucose checks, but they were not due until later in the day. No other blood glucose meters were noted in the medication cart at this time. Nurse #1 stated that she had received training on how to clean the blood glucose meters when she hired, she thought by the Director of Nursing but was not sure. On 6/20/2023 at 11:42 AM an observation and interview were conducted with Nurse #2 who was a facility employee. Nurse #2 performed a blood	F 880	An Ad Hoc Meeting was held at the facility with Tammara Lumpkin, RN, PHN III, Infection Control Trainer for Granville Vance- Region 7 on 7/10/2023 to review plan and training. No other recommendations were made. We will have monthly reviews for 3 months. The results of the Quality Monitoring Audit will be reviewed by The Quality Assessment Improvement Committee monthly for three months. The Committee will review the findings and determine if further action is needed for 3 months.	

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glucose check on Resident #7 and when she completed the task, she disposed of the test strip and lancet, stated she needed to clean the blood glucose meter, took a disinfectant wipe from the container, and wiped down the blood glucose meter one time then removed her gloves, and performed hand hygiene. She then stated she needed to let the blood glucose meter dry, and 5-10 seconds later placed the blood glucose meter in the top right-hand drawer of the medication cart. No other blood glucose meters were observed in the medication cart. Nurse #2 indicated that this was her normal practice for cleaning and disinfecting the blood glucose meter. She revealed that the same blood glucose meter was used for all the residents requiring blood glucose monitoring on her assignment. She stated that she received training when she was hired by the facility on using the blood glucose meter but could not remember if it was the Director of Nursing or the Infection Control Nurse who completed the training.

On 6/20/2023 at 11:55 AM observed Nurse #3 who was a facility employee, perform a blood glucose check on Resident #8 and when she completed the task, she disposed of the test strip and lancet a, placed the blood glucose meter on the medication cart, removed her gloves, performed hand hygiene, and left the medication cart to assist a nursing assistant with patient care. Continuous observation of the medication cart for 10 minutes was conducted, and Nurse #3 did not return to the medication cart during this time.

An interview with the Minimum Data Set Nurse on 6/20/23 at 1:22 PM revealed there was one current resident (Resident #9) who had a diagnosis of a blood borne pathogen.

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The current Director of Nursing was interviewed on 06/20/23 at 3:17 PM and stated that she had started two weeks ago. She indicated she was unable to answer any questions related to blood glucose cleaning and disinfecting.

An interview was conducted with the Infection Preventionist on 6/21/23 at 9:27 AM revealed that she had recently been recently hired and could not answer questions on past training of cleaning and disinfecting the blood glucose meters. She indicated that staff were to follow the blood glucose manufacturer's instructions for cleaning and disinfection.

The Administrator stated that the blood glucose meters should be cleaned and disinfected per manufacturer instructions after each resident's blood glucose was checked. She stated that she could not explain why Nurse #1, Nurse #2, and Nurse #3 did not clean and disinfect the blood glucose meters per manufacturer instructions.

The facility's Administrator was informed of the immediate jeopardy on 6/20/2023 at 2:47 PM.

The facility provided the following credible allegation of immediate jeopardy removal.
o Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and
On 6/20/23 Nurse #1, Nurse #2 and Nurse #3 failed to clean shared blood glucose meters which were used during medication administration. Nurse #1, #2 and #3 were immediately educated by the Director of Nursing on F880 following manufacturer's guidelines for cleaning and disinfection of blood glucose

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F 880	Continued From page 10	F 880		

monitoring. Including the following education: Skills Competency Assessment of Glucometer cleaning to include direct observation and return demonstration and Storage individual resident's Glucometer in medication cart in individual bag.

On 6/20/23, 89 residents have been reviewed by the Director of Nursing for use of blood glucose meters. Residents identified with orders for glucose monitoring were given individualized glucose meters, labeled and placed in bag in medication administration cart by Director of Nursing.

On 6/20/23 21 residents identified to receive blood glucose monitoring were assessed by the charge nurse and no negative outcomes as related to Infection Control during medication pass glucometer cleaning were observed.

On 6/20/23 all current glucometers were cleaned and placed in bag, labeled, and placed in medication cart.
The local public health authority will be notified on 6/21/2023 on the improper cleaning of the shared glucometer with corrective actions taken and inquire about any immediate monitoring of residents potentially affected by the Director of Nursing.
o Ths facility currently does not have any contact nursing staff however will add to the contract nursing staff orientation should we have any in the future.

On 6/20/23, the Director of Nursing initiated education to the Licensed Nurses on F880 following manufacturer's guidelines for cleaning and disinfection of blood glucose monitoring. Including the following education:

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F 880	Continued From page 11	F 880		

"Skills Competency Assessment of Glucometer cleaning to include direct observation and return demonstration
"Storage individual resident's Glucometer in medication cart in individual bag

After 6/20/23 Licensed Nurses not previously educated on glucometer cleaning with skills competency and storage of glucometer will be educated prior to working their next scheduled shift. Newly Hired Licensed Nurses will be educated during the Orientation process going forward. The Director of Nursing has been notified by the Regional Director of Clinical Services of this responsibility on 6/20/2023.

Education is being provided in person and via phone. Prior to next shift nurse will complete skills competency assessment. The Executive Director is tracking who has received education. Validation of understanding has been documented on Skills Competency Assessment: Glucometer.

Date of IJ Removal: 6/22/2023

The facility's credible allegation of immediate jeopardy removal was validated on 6/22/2023. The validation was evidenced by observations and interviews conducted with regards to the required infection control practices for the use of blood glucose meters. All nurses who were interviewed reported they had received the required in-service training and were made aware of the facility's policy to use individually assigned blood glucose meters for each resident requiring blood glucose monitoring. The education included review of the facility's infection control policy, manufacturer instructions related to blood glucose meter disinfection, and a return

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CARY HEALTH AND REHABILITATION	**6590 TRYON ROAD CARY, NC 27518**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12 demonstration. The nurses reported each resident's individual blood glucose meter was now stored in the medication cart. Multiple observations confirmed the glucometers were stored inside a non-porous container and located in the medication carts. Multiple observations were made of nursing staff cleaning and disinfection the blood glucose meters per manufacturer's instructions. The credible allegation was validated, and the immediate jeopardy was removed on 6/22/2023.	F 880		