PRINTED: 01/07/2025 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				P. WING		С	
		345403	B. WING _			11/	22/2024
NAME OF PI	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
CARY HE	ALTH AND REHABILITAT	TION			90 TRYON ROAD		
				C	ARY, NC 27518		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
F 000	investigation survey through 11/22/24. The compliance with the r	certification and complaint was conducted on 11/18/24 ne facility was found in requirement CFR 483.73, lness. Event ID #G8DF11.	F	000			
	survey was conducte 11/22/24. Event ID# intakes were investig NC00222744, NC002 NC00221939,NC002	212346, NC00223363,					
	Intake NC00223809 i jeopardy.	resulted in immediate					
	5 of the 32 complaint deficiency.	allegations resulted in a					
	(J) CFR 483.25 at tag F6 (J)	was identified at: 580 at a scope and severity 684 at a scope and severity 692 at a scope and severity					
	The tags F684 and F Quality of Care.	692 constituted Substandard					
		egan on 10/31/24 and was . An extended survey was					
F 580	, ,	jury/Decline/Room, etc.)	F t	580			12/18/24
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the data of automatical provided. For purpose, the phone findings and place of correction and disclosable 14.

other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

AND BLAN OF CORRECTION IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345403	B. WING		C 11/22/2024
	ROVIDER OR SUPPLIER	TION		STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY, NC 27518	11/22/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
F 580 SS=J	§483.10(g)(14) Notification (i) A facility must impressed that the resistant with his consistent in injury and physician intervention (B) A significant charmental, or psychosod deterioration in heal status in either life-th clinical complication (C) A need to alter the aneed to discontinuate treatment due to advocmmence a new for (D) A decision to transident from the fact §483.15(c)(1)(ii). (ii) When making no (14)(i) of this section all pertinent informatics.	day(i)-(iv)(15) ication of Changes. mediately inform the resident; dent's physician; and notify, r her authority, the resident then there is- lving the resident which has the potential for requiring on; nge in the resident's physical, cial status (that is, a th, mental, or psychosocial preatening conditions or s); reatment significantly (that is, e an existing form of verse consequences, or to rm of treatment); or nsfer or discharge the	F 58	0	
	(iii) The facility must resident and the res when there is- (A) A change in roor as specified in §483 (B) A change in resid State law or regulati (e)(10) of this sectio (iv) The facility must	dent rights under Federal or ons as specified in paragraph n. record and periodically (mailing and email) and			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	, ,	TE SURVEY MPLETED
		345403	B. WING		1	C 1/ 22/2024
	AME OF PROVIDER OR SUPPLIER CARY HEALTH AND REHABILITATION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 580 Continued From page 2 representative(s). §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, and staff, family member, Physician Assistant, and Medical Director interviews the facility failed to notify the physician of a significant change in condition when staff were unable to obtain a urine sample on 3 instances (10/31/24 at approximately 5:30 AM) for a resident identified with complaints of burning urination and decreased fluid intake. Resident #294 was first identified with decreased nutritional and fluid intake on 10/29/24 requiring staff to push fluids (deliberately drink beyond		STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY, NC 27518			
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 580	representative(s). §483.10(g)(15) Admission to a compethat is a composite of §483.5) must discloss its physical configural locations that compripart, and must specification changes between under §483.15(c)(9). This REQUIREMENT by: Based on record revemember, Physician ADirector interviews the physician of a signification when staff were unally on 3 instances (10/3: AM and 9:00 PM and 5:30 AM) for a reside of burning urination at Resident #294 was finutritional and fluid in staff to push fluids (dwhat thirst dictates to 11/1/24. On 10/30/2: burning urination (dy urinalysis (used to de blood, protein, glucos bacterial infection) ar sensitivity (used to dinfection and determined in the staff to push fluids (dwinter the staff to push fluids).	osite distinct part. A facility istinct part (as defined in e in its admission agreement tion, including the various se the composite distinct by the policies that apply to en its different locations If is not met as evidenced iew, and staff, family assistant, and Medical refacility failed to notify the cant change in condition pole to obtain a urine sample 1/24 at approximately 5:00 in 11/1/24 at approximately ant identified with complaints and decreased fluid intake. The interest identified with decreased of the one of 10/29/24 requiring eliberately drink beyond avoid dehydration) through the resident complained of suria) and was ordered a retect abnormalities such as see, and indirect indicators of	F 5	,	to the to altered hizes that he of s to lents hg ke, inability catheter for UA itivity dered on mpted to	
	PM and 11/1/24 at apevidenced by the ina and out catheter (ins	/24 at approximately 9:00 opproximately 5:30 AM as bility to collect urine via an in erting a thin, hollow tube into e resident had no recent		10/31/2024 at approximately 5:00 9:00 PM, 11/01/2024 at approxim 5:30 AM and was unable to collect sample. A review of Resident #29 orders indicated resident was pre	ately ct urine 94	

Facility ID: 923078

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMR MC). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUC G		(X3) DATE COMP	SURVEY
		345403	B. WING _				C 22/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDE	RESS, CITY, STATE, ZIP CODE		ZZ/ZUZ-4
TO THE OT THE	TO VIDERY ON OUT FEILING			6590 TRYON			
CARY HE	ALTH AND REHABILITAT	ION		CARY, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B ROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	÷ 3	F 5	80			
	episodes of urination.	The first notification to a		Lasix 20	0mg daily to be administered da	aily	
		made to the Physician			sician's orders.	•	
	Assistant when she a	rrived at the facility on					
	11/1/24 at approximate	tely 10/10:30 AM. During this		A qualit	ty review of current residents wi	th	
		ntinued to administer the		an orde	er for UA/C&S between 10/20/20	024	
		etic) 20 milligrams once daily			n 11/20/2024 were audited by th	ie	
	at 9:00 AM despite sig	-		I	r of Clinical Services and Unit		
	_	ot contact the physician			ers on 11/20/2024 to ensure a		
		administration. On 11/1/24		I	ample was obtained. nine (9)		
		y member requested the e hospital. Emergency			its with orders for UA/C&S and B) with no further change in		
		IS) were contacted at 3:42		, ,	on that required notification to the	ne	
	,	4 was transferred to the		I	an. No discrepancies were note		
		ere he was identified with			three (23) residents identified a		
		tachypnea (rapid and		1 -	a physician order to administer		
		por perfusion (occurs when			s were audited by the Director o		
	there is inadequate b	ood circulation to organs		Nursing	g and Unit Managers to ensure	no	
	and tissues and can b	e an early sign of		signs a	nd symptoms of dehydration as	;	
		oblems and can lead to		I	ced by the inability to collect uri		
	life-threatening condit	,		I	dent was identified with signs a		
		nat occurs when the body's			ms of dehydration as evidenced	d by	
		low 95°F), severe lactic			bility to collect urine, therefore		
	`	n the body produces too		I	tion to the physician was not		
		the liver can't metabolize it		warrant	.ea.		
	J ,,	v vasopressor requirements nedication that are used to		On 11/2	20/2024, a root cause analysis v	Nas	
	treat people with low				ted by the Director of Clinical	was	
		shock (a life-threatening			es and the Executive Director		
		s when your blood pressure		I	ng notifying the physician for		
	drops to a dangerous				nt #294 when staff were unable	to	
		gan dysfunction. Resident		obtain a	a urine sample. It was determir	ned	
		on 11/1/24. This deficient		_	n the root cause analysis that th	е	
		1 of 3 residents (Resident			failed to follow policy and		
		tification of significant			ures to notify the physician		
	changes.			1 -	ng change in condition as it rela	ates	
		10/04/04			eased fluid intake for Resident		
		egan on 10/31/24 when e physician of a significant			eceiving Lasix and unable to obtained sample.	tain	

change in condition when Resident #294

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			A. BOILDI	_		, ا	С
		345403	B. WING				22/2024
NAME OF P	ROVIDER OR SUPPLIER	L	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 1111	
				6	590 TRYON ROAD		
CARY HEA	ALTH AND REHABILITAT	TION		c	ARY, NC 27518		
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 580	Continued From page	e 4	F	580			
	exhibited signs and s	ymptoms of dehydration and			The Director of Clinical Services and		
	_	btain a urine specimen via			Nurse Managers re-educated licensed		
		r when the resident had no			nurses on notifying the physician for		
	recent episodes of ur	ination. Immediate jeopardy			residents identified as having a change	in :	
	was removed on 11/2	1/24 when the facility			condition via a Situation, Background,		
		le allegation of immediate			Assessment and Recommendation		
		e facility will remain out of			(SBAR) as it relates to assessing		
		e and severity of "D" (no			residents with signs and symptoms of		
		ential for more than minimal			dehydration on 11/20/2024. The licens		
		te jeopardy) to ensure			nurse is to assess the resident, including	-	
	•	ed and monitoring systems			vitals, complete the SBAR and notify the	e	
	put into place and are	e ellective.			attending physician when there is a		
	The findings included				change in the status or condition of the resident. The Director of Nursing and/		
	The illulings illoluded	•			Unit Managers re-educated licensed	ול	
	Resident #294 was a	dmitted to the facility on			nurses on recognizing signs and		
		es included dementia, type 2			symptoms of dehydration to ensure		
	_	to thrive, generalized			prompt physician notification for chang	e in	
	muscle weakness, ch	ronic kidney disease, and			condition on 11/20/2024. Staff (license	:d	
	congestive heart failu	re.			nurses/Certified Nursing Assistants) wl	10	
					were not educated on 11/20/2024, will	be	
		ed 10/7/24 indicated give			educated by the Director of Nursing		
		illigram by mouth one time a			and/or Unit Manager prior to working the		
		ng from fluid retention).			floor. Newly hired staff will be educated	ŧd ∣	
		ed to treat fluid retention that			during orientation by the Director of		
	_	estive heart failure, kidney			Nursing and/or Unit Manager on notifyi	•	
	increases the flow of	ical conditions. (Lasix			the physician for residents identified as having a change in condition via SBAR		
	dehydration.)	unite and can lead to			it relates to assessing residents with si		
	donyaration.)				and symptoms of dehydration.	9110	
	Resident #294's adm	ission Minimum Data Set					
	(MDS) assessment d				The Director of Clinical Services and/o	r	
	, ,	gnitively intact. He required			Nurse Managers re-educated licensed	ĺ	
	supervision or touching	ng assistance with toileting.			nurses on notifying the physician via	ſ	
		clean up assistance with			change in condition (SBAR) for resider		
	•	l as frequently incontinent of			with an order for UA/C&S and unable t		
		id was also coded as taking			obtain a urine sample on 11/20/2024.		
		294's overall discharge goal			licensed nurse is to assess the residen		
	was to return to the c	ommunity. He was not			including vitals, complete the SBAR an	d '	

Facility ID: 923078

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345403	B. WING _				C 22/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	,	
					590 TRYON ROAD		
CARY HEA	ALTH AND REHABILITA	TION			CARY, NC 27518		
	0.11.11.42.70.4.0	TATELLENIA OF DEFINITION		_			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From pag	ue 5	F 5	580			
	coded for hospice ca	are.			notify the attending physician when the	ere	
					is a change in the status or condition o		
	A facility 24-hour cor	ndition report completed by			the resident.		
		9/24 indicated Resident #294					
		on day shift. The facility's			The Director of Clinical Services and/o	r	
		port is a form that nurses			Nurse Managers re-educated certified		
		of all the residents during or			nursing assistants on signs and		
	at the end of their sh	ift to communicate any			symptoms of dehydration and immedia	itely	
	pertinent information	to the next shift and nursing			report the change in condition to the	-	
	management. (Breal	kfast and lunch meals are			licensed nurse on 11/20/2024. Newly		
		y shift which starts at 7:00			hired staff will be educated during		
	AM and ends at 3:00) PM.)			orientation by the Director of Clinical		
					Services and/or Unit Managers. Staff		
	_	with Nurse #5 on 11/18/24 at			(licensed nurses/Certified Nursing		
		that she had cared for			Assistants) not educated on 11/20/202		
		0/29/24 from 7:00 AM to 7:00			will be educated by the Director of Nur		
		ted that normally Resident #			and/or the Unit Manager prior to workir	ıg	
		than 25% of his tray food			the floor.		
		/29/24 he had eaten and					
		during breakfast, lunch and			Date of Immediate Jeopardy Removal	=	
		mented it in the 24 hour			11/21/2024		
		the oncoming night shift			The Discrete of Oliminal Commission and the	_	
	nurse (Nurse # 4).				The Director of Clinical Services and/o	Г	
	Λ facility 24 hour cor	ndition report completed by			Nurse Managers re-educated certified nursing assistants on identifying a chai	nge	
		0/24 indicated Resident #294				ige	
		ourning with urination on night			in condition to include signs and symptoms of dehydration and to		
		PM to 10/30/29 7:00 AM			immediately report any change in		
	shift).	1 W to 10/30/29 7:00 AW			condition to the licensed nurse on		
	Sility.				11/20/2024. Education includes any tir	me	
	During an interview o	on 11/19/24 at 3:53 PM with			an order is given but not able to be		
	_	I that she was assigned to			completed for any reason, the floor nur	rse	
		94 on 10/29/24 at 7:00 PM to			or clinical manager will call the physicia		
		. Nurse #4 stated that during			for additional instructions. Newly hired		
		to had informed her and			staff will be educated during orientation		
	_	4-hour condition report that			the Director of Clinical Services and/or	•	
		a decreased oral intake with			Unit Managers. Staff (licensed		
		se #4 verbalized that			nurses/Certified Nursing Assistants) no	ot	
		plained of burning with			educated on 11/20/2024, will be educa		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION		SURVEY PLETED
		345403	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER	0.0.00		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	/22/2024
	ALTH AND REHABILITAT	ION	6590 TRYON ROAD CARY, NC 27518		590 TRYON ROAD		
	OUR MARK OT	ATEMENT OF DEFINITION					
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	÷ 6	F 5	580			
	the Provider in the ph 24-hour condition rep oncoming day shift no stated that Resident # concern during her sh burning with urination physician's book and Resident #294 was awas a sign of urinary Resident #294's med indicated Lasix 20 mg 10/30/24 at 9:00 AM III.59 AM ordered by indicated urinalysis (Usensitivity (C & S) for	arse (Nurse #1). Nurse #4 #294 was stable and the only hift was complaints of which she noted in the she pushed fluids while wake because she thought it tract infection. ication administration record y was administered on by Nurse #1. e order dated 10/30/2024 at Physician Assistant (PA) #2			by the Director of Nursing and/or Unit Manager prior to working the floor. The Director of Clinical Services and/or Nurse Managers will provide quality monitoring daily in clinical review (Monday-Friday) for 5 days, then 3 time per week for 3 weeks, then 2 times per week for 4 weeks and then weekly for weeks to ensure any resident who has any change in condition. This will include any resident who is ordered diuretics, the facility is monitoring fluid intake and an acute change will have a SBAR completed and the physician notified. The provided intake will be initiated. An new orders for urinalysis to ensure no dehydration is noted through review of results.	es 4 de he y Any	
	on day shift (7:00 AM Nurse #1 and evening PM) completed by Nu for a UA/C&S for Res (10/31/24). During an interview o Nurse #1, she indicat Resident #294 on 10/when she came to wo 7:00 AM she was info shift nurse (Nurse #4/complained of pain w shift (10/29/24 at 7:00 AM). Nurse #1 verbal out a urinary tract infeher shift (10/30/24 7:00 AM).	to 3:00 PM) completed by g shift (3:00 PM to 11:00 arse #6 indicated the need ident #294 in the morning In 11/19/24 at 10:20 AM with ed that she had cared for 30/24. Nurse #1 stated that ork on 10/30/24 at around armed by the off going night that Resident #294 had ith urination during the night of PM to 10/30/24 at 7:00 ized that a UA/C&S to rule ection was ordered during 00 AM- 7:00 PM) but she did a urine sample since it			The Executive Director will bring to QA monthly for 3 months. The Director of Nursing will report all results of quality monitoring audits and to the QAPI committee. Findings will be reviewed to the QAPI committee monthly and Qual monitoring audits will be updated as indicated.	ру	

Facility ID: 923078

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(>	(X3) DATE SURVEY COMPLETED	
	345403	B. WING			C 11/22/2024	
NAME OF PROVIDER OR SUPPLIER CARY HEALTH AND REHABILI	TATION	•	STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY, NC 27518			
PREFIX (EACH DEFICI			PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
AM the following of Resident #294 was 10/30/24. An interview was of PM with Nurse #6 for four hours and 10/30/24 from 7:00 aware that Resides sample but he did have been picked 6:00 AM. He notif #2) to collect the unit over at 11:00 PM. Iaboratory specimilaboratory staff in 6:00 AM. A facility 24-hour of on night shift (10/37:00 AM) complete (10/31/24 7:00 AM) Nurse #1 indicated for Resident #294 During an interview Nurse #2, she staff Resident #294 on PM to 10/31/24 at when she took owe she was notified be that a urine sampl #294. She indicated Resident # 294 was waking him up to go indicated that Resident # 294 was waking him up to go indicated that Resident # 294 was waking him up to go indicated that Resident # 294 was waking him up to go indicated that Resident # 294 was waking him up to go indicated that Resident # 294 was waking him up to go indicated that Resident # 294 was waking him up to go indicated that Resident # 294 was waking him up to go indicated that Resident # 294 was waking him up to go indicated that Resident # 294 was waking him up to go indicated that Resident # 294 was waking him up to go indicated that Resident # 294 was waking him up to go indicated that Resident # 294 was waking him up to go indicated that Resident # 294 was waking him up to go indicated that Resident # 294 was waking him up to go indicated that Resident # 294 was waking him up to go indicated that Resident # 294 was waking him up to go indicated # 294 was waking him up to go indicated # 294 was waking him up to go indicated # 294 was waking him up to go indicated # 294 was waking him up to go indicated # 294 was waking him up to go indicated # 294 was waking him up to go indicated # 294 was waking him up to go indicated # 294 was waking him up to go indicated # 294 was waking him up to go indicated # 294 was waking him up to go indicated # 294 was waking him up to go indicated # 294 was waking him up to go indicated # 294 was waking him up to go indicated # 294 was waking him up to go indicated # 294 was waking h	conducted on 11/20/24 at 1:40. He stated that he had filled in cared for Resident #294 on 0 PM to 11:00 PM and he was ent #294 required a urine not obtain it because it wouldn't up until the morning around fied the third shift nurse (Nurse urine specimen when she took Nurse #6 explained that the ens were picked up by the morning at approximately condition report dated 10/31/24 ed by Nurse #2 and day shift It to 3:00 PM) completed by dithe need for a UA and C&S	F	580			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE COMP	
		345403	B. WING _			11/	22/2024
	ROVIDER OR SUPPLIER	TION		STREET ADDRESS, CITY 6590 TRYON ROAD CARY, NC 27518	, STATE, ZIP CODE	1 11/2	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFII TAG	(EACH COR	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 580	she notified the onco #1). Nurse #2 indicat incontinence brief wa catheter attempt. Nur was not Resident #29 was not familiar with that she did not notify unable to obtain the continence brief that water during her shift incontinence brief the #2 stated that Resident water during her shift incontinence brief the #2 stated that Nurse condition from the behad told NA #2 to offe Resident to drink water during her shift incontinence brief the #2 stated that Nurse condition from the behad told NA #2 to offe Resident to drink water during her shift incontinence brief the #2 stated that Nurse condition from the behad told NA #2 to offe Resident #294's med indicated Lasix 20 mg 10/31/24 at 9:00 AM During an interview was 10:20 AM she stated work on 10/31/24 at a informed by the off great work o	but was unsuccessful and ming day shift nurse (Nurse ed Resident #294's s wet during the in and out see #2 also indicated that she ba's regular nurse and she his baseline. She verified of the physician that she was ordered urine specimen. ducted on 11/20/24 at 2:12 and cared for Resident #294 at 1/24 on night shift. NA #2 at 1/24 took only a few sips of s and when she changed his are was very little urine. NA #3 was aware of Resident's ginning of her shift when she er and encourage the er when she went to check ication administration record g was administered on by Nurse #1. with Nurse #1 on 11/19/24 at that when she came back to around 7:00 AM she was bing night shift Nurse (Nurse alle was still needed for she had not been able to g the night shift. Nurse #1 of attempt to obtain the urine day shift. She indicated that more like he was the previous	F	580			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345403	B. WING _			C 11/22/2024
	ROVIDER OR SUPPLIER ALTH AND REHABILITAT	TION		STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY, NC 27518	,	11122224
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 580	push fluids. Nurse #1 normally ate and drar tray, and he also drar gave him during med 10/31/24 he took only She further stated that 0 out of 120 milliliters supplementation) on 9:00 AM and 5:00 PM consumed 100 % of the #1 verified that she discussed in the work of the	stated that Resident #294 ak most of what was on his ak most of the water she ication administration, but on a sips with the medication. At Resident #294 consumed of his med pass (nutritional 10/31/24 at approximately If whereas previously he the supplementation. Nurse and not notify the physician of tige of condition from dition report completed by 24 on night shift (10/31/24 100 AM) indicated the nurse Illect urine unsuccessfully. Togress note written by 2024 at 6:13 AM indicated the nurse that a UA/C&S was attempted to push fluids, uld only take small sips. The the UA/C&S was around and she was unable to urine came out. The writer ds throughout the shift, hall sips. The first attempt to reported to the supervisor. To obtain the UA/C&S was at and was again unsuccessful.	F 5	80		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION		DATE SURVEY COMPLETED
		345403	B. WING			C
	ROVIDER OR SUPPLIER ALTH AND REHABILITA	1		STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY, NC 27518	l	11/22/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 580	11/1/2024 at 6:31 AN to collect urine twice, and Nurse #3 would (Nurse #1). An interview was cor PM with the Nurse #5 for Resident #294 on through 11/1/24 at 7: had received report finurse (Nurse #1) than needed for Resident obtain the specimen 10/31/24 and at appr 11/1/24 via an in and was unsuccessful. Since barely any urine and processed. She state incontinence brief was and she was pushing was only taking small much. Nurse #3 reposhift nurse (Nurse #1 unsuccessful in obtain an in and out cathete Resident #294's vital day shift and were strould not recall if she during her shift and in documented them if parameters. Nurse # did not seem different cared for him, he was be in any acute distremand the proverified she did not not puring an interview of the provention of the p	Indicated writer attempted however, was unsuccessful report off to oncoming nurse and oncoming and oncomin	F 58			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345403	B. WING		C 11/22/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY, NC 27518	11/22/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 580	11/1/24 during the 7: #1 stated that during that Resident #294 w than usual, and he ha whereas previously h also stated that previ but she had to feed h 10/31/24 and 11/1/24 as he usually did. NA she changed Reside minimal urine. NA #1 was giving Resident was not as responsiv not shouting like he w showers. She verbali aware of Resident #2 NA #1 to encourage fluids and also to give kept pulling off his clo Resident #294's med indicated Lasix 20 m 11/1/24 at 9:00 AM b A Physician order da ordered by PA #1 ind intravenous (PIV) acc into a superficial vein surface of the skin]). midline (a long flexib vein in the upper arm medication into the b A Physician order da indicated Sodium Ch 0.9 %. Use 2 liters in for poor oral intake for	ant #294 on 10/30/24 through 100 AM to 3:00 PM shift. NA those 3 days she noticed was eating and drinking less and become incontinent he was using the urinal. She ously he could feed himself, him and offer drinks on a but he did not eat or drink a #1 also stated that when not #294's briefs there was further stated that when she #294 a shower on 11/1/24 he was a usual, he was quiet and would normally do during fized that Nurse #1 was 1294's condition and had told Resident #294 to drink his the him a shower because he othes. Illication administration record g was administered on y Nurse #1. Ited 11/1/24 at 10:15 AM Iticated obtain peripheral cess (small catheter inserted in [a vein located close to the If unable to obtain, obtain a le tube that is inserted into a into deliver fluids or	F 58		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING			(3) DATE SURVEY COMPLETED	
		345403	B. WING			C	
NAME OF PROVIDER OR SUPPLIER CARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY, NC 27518			1/22/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 580	replenish lost water at 10:20 AM, Nurse #1 to work on 11/1/24 at informed by the off g #3) that a urine sample indicated the resident during medication at Nurse #1 revealed the Resident #294's Las 11/1/24 at approximate resident's decreased and that she did not provider about it. She seemed more confus and she notified Phywhen she came to the and 11:00 AM on 11/knew the PA would comorning and she would not been able to and the resident was was probably a sign examine Resident #2 and IV fluids. Nurse at to insert a peripheral was dehydrated and vein. She stated that regarding the PIV be midline if a PIV was a vascular team (a cor specialized in insertia come and insert a mesident #294's fam	(Sodium Chloride is used to and salt in the body.) with Nurse #1 on 11/19/20 at stated that when she came that around 7:00 AM she was oing night shift nurse (Nurse ole was still needed. She at drank only sips of water alministration on 11/1/24. In the she had administered in the stated Resident #294 and attely 9:00 AM despite the almost or ask the elected and fluid intake think to hold it or ask the elected Resident #294 and attely between 10:00 AM 11/24. She stated that she ome to the facility that all let the PA know that they obtain the urine specimen and trinking much which of dehydration. PA #1 went to 1294 and ordered a midline with stated she did not attempt a line because Resident #294 she could not find a visible she did not notify the PA cause the PA had ordered a mot obtained. She called the	F 58	30			
	not answer the phon	e, and she left a message for ber arrived at the facility at					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVICE COMPLETED			
		345403	B. WING _			C 11/22/2024
	ROVIDER OR SUPPLIER	TION		STREET ADDRESS, CITY, STATE, ZI 6590 TRYON ROAD CARY, NC 27518	P CODE	11/22/2027
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F 580	around 3:00 PM and the vascular team we insert the midline. The Resident #294 to be a Department (ED) due and Nurse #1 stated the Unit Manager and called emergency me came to transfer Resident #294 was some noted that the Hadrover the past 3 days. UA/C&S, unable to preven with catheter. To indicated the resident altered mental status was clinically dehydrated to obtain a PIV on 11. liters for 3 days (11/12) progress note indicated the resident UA/C&S given During an interview of Physician Assistant # she was notified by Nother facility at around Resident #294 had a they had not been ab for a UA and C&S. The she went to assess Redehydrated but was resident was	the Nurse informed her that the enroute to the facility to be family member wanted sent to the Emergency to the worsening condition whe agreed. She informed the facility Provider and edical services (EMS) who ident #294 to the hospital. In (PA) progress note written that 11:52 AM indicated een by PA at the request of the of change in condition. The lay responsive. This was a smally being agitated and gotherapy. The roommate mot seen Resident #294 eat Nursing attempted to obtain rovide adequate sample the progress note also that a change in condition, and deed. An order was provided (1/1/24 and ordered IVF 2/1/24 to 11/4/24). The ed staff were unable to	F	580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	` ′	TE SURVEY MPLETED C 1/22/2024 (X5) COMPLETION DATE
			A. BOILD			(
		345403	B. WING			11/	22/2024
	ROVIDER OR SUPPLIER ALTH AND REHABILITA	TION	•	659	REET ADDRESS, CITY, STATE, ZIP CODE 90 TRYON ROAD ARY, NC 27518		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION
F 580	obtain a midline so tifluids. The PA stated orders (PIV and midl that if they could not ahead and obtain the second order. The PResident #294's bas primary care provide stated that she could contacted her to let I obtained an IV access not have expected to obtain the PIV since obtain the midline if obtained. PA #1 state provider was a case. Resident's status. SI Resident was declinated in IV access then they they needed the Resident was a case. An interview was confused that she was a stated that she	ble to obtain PIV access to hat they could administer IV a she normally put the two line) on the same order so obtain a PIV they could go e midline without needing a PA stated she did not know beline since she was not the er for Resident #294. She also do not recall if the facility they have the highest form they had not seen they had not the order explicitly stated to PIV access was unable to be seed the timeline to contact a subject of the highest had they could not get an would contact the Provider if sident to be sent to the seen they had not seen to the seen they are to the seen the highest had a send the Resident out amily request. The UM not aware if the Provider was ability to obtain the urine in condition until 11/1/24 ame to the facility between	F	580			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY, NC 27518			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 580	11/18/24 at 3:02 PM that she received a on 11/1/24 at approtent that Resident #294 wanted to give her a decided to come to going on when she and was put on hold facility around 3:00 naked and disorient crusty and she atter he drank it. The fam told her she was was come and insert an informed Nurse #1 to be sent to the hold istress and Nurse An EMS report date was contacted at 3: transportation due to at the facility at 4:02 was altered mental impression was sepaltered mental statuelectrocardiogram (atrial fibrillation (irrecharacterized by ray Vital signs obtained noted as blood pression and the side of the sid	t #1 (Family Member) on I. The family member stated voice message from Nurse #1 ximately 1:30 PM indicating was doing okay and that she an update. The family member the facility to check what was tried to call back the facility I. When she arrived at the PM she found the Resident ed, his mouth was dry and inpted to give him a drink and hilly member stated Nurse #1 witing for vascular team to intravenous line and she that she wanted the Resident spital because he was in #1 called 911. In the state of the temperature of family choice. EMS arrived I. PM and primary impression status and secondary wisis. The chief complaint was is with onset of 10/30/24. An ECG) at 4:05 PM indicated	F 580			
	of consciousness w stimulation on the A unresponsive scale level of consciousne telephone order at 4 due to Resident #25	As responds to painful NPU (alert, voice, pain, used to measure patient's ess). EMS obtained a 4:22 PM to administer IV fluids and meeting the criteria for the not administered due to				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	O BE COMPLETION		
F 580	facility at 4:39 PM withe receiving hospita PM. EMS assessmen Resident #294 was leminimal alertness, he his skin was cold and with increased respir saturation readings were sident having cold arrived at the ED at 8. An ED progress note Resident #294's vital blood pressure: 72/5 respirations 29 at 5:433 %, and temperaturate of alertness and on his own with cold pupils without response to painful shad not been eating days, and today he wand encouraged the who then emergently #294 was found to be condition in which to the body). Because of were unable to reliable reading. Discussion whad voiced wishes to sustain his life. After goals of his care, fancontinue to be full cowas critically ill at the	an IV access. EMS departed th Resident #294 and notified I of sepsis indication at 5:00 at at 5:05 PM indicated ethargic, non-verbal with the had rapid mouth breathing, I dry, lung sounds were clear actory rate and oxygen were inconsistent due to the hands. Resident #294 5:41 PM. dated 11/1/24 indicated that signs were noted as follows: 8, heart rate: 138, and 55 PM and oxygen saturation: re: 93.4 degrees Fahrenheit ress note indicated Resident ally ill, obtunded (reduced I consciousness), breathing distal extremities with dilated use bilaterally and no timuli. Facility stated that he or drinking anything for 3 was found naked by his family nurse to take his vital signs a called for 911. Resident in metabolic acidosis (a proposition in the condition of the con	F 58				

AND DUAN OF CORRECTION IDENTIFICATION NUMBER		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345403	B. WING		C 11/22/2024	
	ROVIDER OR SUPPLIER ALTH AND REHABILITA		B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY, NC 27518		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE COMPLETION	
F 580	hypothermia, severe vasopressor requires shock with end orga death. Resident #29 During an interview PA #2 she stated that provider for Resident the telephone order due to dysuria per not that she could not rest that they had not obtain the Resident's calso stated the timel a case-by-case basi. An interview was condition and the fact supposed to do to make condition. He indicate showed signs of a Uwhen they could not ordered an IV access. Resident was sent on obtained. The MD all had been sent out enhance been any differ UA had been obtained positive for a UTI the Resident on oral ant would have probably MD was asked if the notified him when the adequately as well a administration, the Mall administration and the provided the p	e lactic acidosis, and new ments, consistent with septic in dysfunction as cause of 4 died at 8:26 PM on 11/1/24. In 11/20/24 at 3:07 PM with at she was the primary care it #2 and that she had given on 10/30/24 for the UA/C&S ursing reports. PA #2 stated reall the facility notifying her tained the urine sample or ondition was declining. She ine to contact a provider was is based on Resident's status. Inducted with the facility D) on 11/19/24 at 4:37 PM. as aware of Resident #294's cility did what they were anage the Resident TI, a UA was ordered and obtain a urine sample, they is for hydration, but the ut before the IV access was so stated that if the Resident arlier the outcome would not ent. He also stated that if the end on 11/1/24 and was be yould have started the ibiotics and the outcome of been the same. When the facility staff should have resident not drinking is with continued Lasix ID stated the facility did en asked if the facility staff	F 58	0		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345403	B. WING	B. WING		C 11/22/2024	
	ROVIDER OR SUPPLIER ALTH AND REHABILITAT	TION		6	STREET ADDRESS, CITY, STATE, ZIP CODE 5590 TRYON ROAD CARY, NC 27518		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	PIV access, he stated been contacted and to the resident was sent. An interview was comply with the Director of stated that if nurses wourine specimen on 10 at 9:00 PM and 11/1/2 decreased oral intake contacted the on call provider in the facility should have notified to they were in the build obtained the ordered about the Lasix admit oral intake and inability specimen. The DON the staff to notify the paccess was unable to specifically stated that obtain PIV access the midline via the vascul. The Administrator was jeopardy on 11/20/24. The facility provided to allegation of immediating a result of the noncorrect Resident #294 no lon Resident was transfered 11/01/2024 due to alter the sent and the state of the noncorrect resident was transfered 11/01/2024 due to alter the sent and the state of the noncorrect resident was transfered 11/01/2024 due to alter the sent and the state of the noncorrect resident was transfered 11/01/2024 due to alter the sent and the state of the noncorrect resident was transfered 11/01/2024 due to alter the sent and the sent	nim when they didn't obtain it that the vascular team had hey were on the way when it out to the hospital. ducted on 11/20/24 at 4:30 of Nursing (DON). The DON were not able to obtain the 0/31/24 at 5:00 AM, 10/31/24 24 at 5:30 AM with a nurses should have provider if there was no . She also stated nurses he PA on 10/31/24 when ing that they had not urine sample and inquired nistration due to decreased try to obtain the urine indicated she did not expect physician/PA when the PIV to be obtained as the order it if staff were unable to at they were to obtain a lar team. Is notified of immediate at 6:04 PM. The following credible te jeopardy removal: Sients who have suffered, or serious adverse outcome as	F	580			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION	COMF	(X3) DATE SURVEY COMPLETED		
		345403	B. WING			C / 22/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY, NC 27518	, 117	22/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 580	of notifying the physical urine sample for recomplaints of burning fluid intake, including dehydration as evide collect urine via an intesident had a dry brown of Resident record revealed and Culture and Sensitivity was ordered on 10/3 attempted to push fluon 10/31/2024 at app 9:00 PM, 11/01/2024 and was unable to coof Resident #294 orderescribed Lasix 20m daily per physicians. A quality review of cut for UA/C&S between 11/20/2024 were aud Clinical Services and 11/20/2024 to ensure Nine (9) residents wire eight (8) with no furth required notification to discrepancies were residents identified a administer diuretics word Nursing and Unit Mand symptoms of del the inability to collect identified with signs a as evidenced by the	ed from the noncompliance cian as it relates to obtaining sidents identified with gurination and decreased signs and symptoms of need by the inability to and out catheter when the ief. #294's electronic medical reder for UA w/ reflex, Urine ty with Diagnosis of Dysuria 0/2024. The facility staff ides and obtain urine sample proximately 5:00 AM and at approximately 5:30 AM obllect urine sample. A review ers indicated resident was an daily to be administered orders. Internet residents with an order 10/20/2024 through itted by the Director of Unit Managers on a urine sample was obtained. Ith orders for UA/C&S and the rehange in condition that	F 58				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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F 580	Continued From page	e 20	F 58	0			
	completed by the Dir the Executive Director physician for Resider unable to obtain a uridetermined through the facility failed to for to notify the physicial condition as it relates Resident #294 receiv obtain urine sample. 2) Specify the action the process or systematic adverse outcome from when the action will be seen as the executive process.	the root cause analysis that allow policy and procedures or regarding change in to decreased fluid intake for ring Lasix and unable to the entity will take to alter or failure to prevent a serious or occurring or recurring, and the complete					
	Managers re-educate notifying physician for having a change in control Background, Assessi (SBAR) as it relates the signs and symptoms 11/20/2024. The licent resident, including vit notify the attending put change in the status. The Director of Nursi re-educated licensed and symptoms of delights physician notification 11/20/2024. Staff (licent Nurse Assistants) nowill be educated by the Unit Manager prior to hired staff will be educated.	al Services and Nurse and licensed nurses on a residents identified as condition via Situation, ment and Recommendation to assessing residents with of dehydration on a sed nurse is to assess the als, complete the SBAR and hysician when there is a correction of the resident. In any and Unit Managers are deducated on 11/20/2024, and Director of Nursing and or working the floor. Newly acated during orientation by any or Unit Manager on					

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F 580	having a change in crelates to assessing symptoms of dehydra. The Director of Clinic Managers re-educate notifying physician vi (SBAR) for residents and unable to obtain The licensed nurse is including vitals, compattending physician vistatus or condition of The Director of Clinic Managers re-educate assistants on signs a and immediately report he licensed nurse or staff will be educated Director of Clinical Sc Staff (licensed nurses Assistance) not educated by the Dire Manager prior to wor Date of Immediate Je On 11/22/24 the facility provided immediate jeopardy recompleted by the Dire Clinical Services and included all current re UA/C&S from 10/20/3 which was revealed residence.	r residents identified as condition via SBAR as it residents with signs and action. cal Services and Nurse and licensed nurses on a change in condition with an order for UA/C&S urine sample on 11/20/2024. So to assess the resident, olete the SBAR and notify the when there is a change in the other the resident. cal Services and Nurse and Certified nursing and symptoms of dehydration for the change in condition to an 11/20/2024. Newly hired a during orientation by the ervice and or Unit Managers. So Certified Nurse atted on 11/20/2024, will be cotor of Nursing and or Unit king the floor.	F 580				

CLIVILIN	3 FOR MEDICARE &	WEDICAID SERVICES				OIVID IVC	7. 0930 - 0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345403	B. WING_				00/2024	
		343403	5: :::::0 _			111/2	22/2024	
NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
CARVILE	NITH AND DEHABILITAT	TON		65	590 TRYON ROAD			
CART HEA	ALTH AND REHABILITAT	ION		С	ARY, NC 27518			
	OLIMANA DV OT	ATEMENT OF DEFICIENCIES	I		T		0.45	
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	=	(X5) COMPLETION	
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	TAG	`	CROSS-REFERENCED TO THE APPROPRIA		DATE	
.,		,			DEFICIENCY)			
			1					
F 580	Cantinual From page	. 22						
F 360	Continued From page		F:	580				
		ired notification to physician						
	and no discrepancies	were noted. The audits also						
	included all residents	with orders for diuretics and						
	23 residents were ide	entified as having a physician						
	order to administer di	uretics and to ensure no						
	signs and symptoms	of dehydration as evidenced						
	by the inability to colle	•						
		ion on the education they						
	· •	gn-in sheets. The education						
	· ·	that the Director of Clinical						
		Managers re-educated all						
		e following on 11/20/24:						
		r residents identified as						
	having a change in co							
	_	ment and Recommendation						
	, ,	o assessing residents with						
		of dehydration; assess the						
	_	als, complete the SBAR and						
		hysician when there was a						
		or condition of the resident;						
	and how to recognize	dehydration. The Director						
	of Clinical Services ar	nd Nurse Managers						
	re-educated certified	nursing assistants on signs						
	and symptoms of deh	ydration and to immediately						
		condition to the licensed						
		1. Interviews confirmed that						
		ld be educated during						
		ector of Clinical Service						
		s. Interviews with nursing						
		had been educated on all						
		ed in immediate jeopardy						
	removal plan.							
		rdy removal date of 11/21/24						
	was verified.							
F 641	Accuracy of Assessm	ients	F6	341			12/18/24	
SS=D	CFR(s): 483.20(g)							
				- 1				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345403	B. WING		C 11/22/2024
	ROVIDER OR SUPPLIER	TION		STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY, NC 27518	11122224
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 641	Continued From page		F 64	1	
	resident's status. This REQUIREMENT by:	st accurately reflect the			
	interview, the facility of Data Set (MDS) asset	iew, observation, and staff failed to code the Minimum essment accurately in the dication for 1 of 30 sampled esident # 55).		Resident #55's Minimum Data Set (I was corrected in the area of hypnotic medications to accurately reflect the resident's status dated 09/01/2024. Resident #55 was coded as severely cognitively impaired, and hypnotics w	
	Findings included: Resident #55 was admitted to the facility on			taken during the look back period. However, Resident #55 was no long taking hypnotic medication and the M	er
		noses including dementia.		has been corrected.	NDO
	09/01/2024 had Resiccognitively impaired, during the look back The August and Sept	Data Set (MDS) dated dent #55 coded as severely and hypnotics were taken period. ember 2024 Medication ds (MAR) did not reveal an		A quality review was completed on a current resident's MDS in the area of hypnotic medications (Section N) to validate the most recent MDS assessment. They have all been validated and coded to accurately re the status of the residents by the MD Coordinator on 12/18/2024.	flect
	An interview with the was conducted on 11 DON stated she look April 2024 for Reside been a hypnotic orde the MDS was coded	Director of Nursing (DON) /19/2024 at 2:49 PM. The at MARs as far back as nt #55 and there had not red. The DON also stated incorrectly and expected the ne assessment accurately.		An ad hoc Quality Assurance Performance Improvement committe was held on 12/18/2024 to formulate approve a plan of correction for the deficient practice. The Executive Director educated the	and
	An interview with the on 11/19/2024 at 2:58 stated she was the or	MDS nurse was conducted B PM. The MDS Nurse ne who completed the MDS ere was a data entry error 5 was not receiving		Coordinator to ensure accurate coding when a resident is no longer on a hy medication (Section N) on 12/13/202 The Regional MDS Coordinator revise education again on 12/18/2024. The Director of Clinical Services and	ng pnotic 4. ewed

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	TION	STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY, NC 27518			<u>, 11/</u>	<i></i>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	Continued From page An interview with the conducted on 11/22/2 Administrator stated I assessments to be considered.	Administrator was 2024 at 1:08 PM. The ne expected the MDS	F6	541	Unit Managers will conduct random quareviews of 5 resident MDS assessment in the areas of hypnotic medication (Section N) to ensure the MDS is code accurately for 5 residents 2 times per week for 8 weeks and then weekly for 4 weeks. The Executive Director will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by the QAPI committee monthly and quality monitoring.	d 4	
F 684 SS=J	CFR(s): 483.25 § 483.25 Quality of care is a further applies to all treatment facility residents. Base assessment of a residents received	are ndamental principle that nt and care provided to ed on the comprehensive dent, the facility must ensure treatment and care in essional standards of	F6	584	(audit) will be updated as indicated.		12/18/24
	practice, the compreh care plan, and the res This REQUIREMENT by: Based on record rev member, Physician A Director interviews, the recognize the serious in condition, the import need for urgent medi- emergent situation. Of decrease in food and by staff. Resident #1	nensive person-centered sidents' choices. is not met as evidenced siew, and staff, family assistant, and Medical ne facility staff failed to sness of a significant change or tance of and identify the cal attention to address an			Resident #294 no longer resides in the facility. Resident was transferred to the local hospital on 11/01/2024 due to alte mental status. The center recognizes that all patients have the potential to be affected from the noncompliance of ensuring staff recognize significant changes in condition and providing necessary medical services for resident identified with complaints of burning	e ered hat	

OL. T. L. T	OT OTT MEDIO TITLE OF	THE DIGITIES CENTRICES				<u> </u>	. 0000 0001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			20,20	_		С	
		345403	B. WING			11/22/2024	
NAME OF P	ROVIDER OR SUPPLIER	ı		S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE		
0457/115		rion.		6	590 TRYON ROAD		
CARY HEA	ALTH AND REHABILITAT	IION		С	ARY, NC 27518		
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	, ,	
PRÉFIX TAG	,	EFICIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION)		X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 684	F 684 Continued From page 25 F 684						
		/30/24 at 7:00 AM) and an		001	urination and decreased fluid intake,		
		(UA) and urine culture and			including signs and symptoms of		
		s obtained from Physician			dehydration as evidenced by the inabili	tv	
		0/24. No attempts were			to collect urine via an in and out cathet	-	
		rine specimen for the UA			when the resident had a dry brief.		
		and 5:00 AM and the nurse					
		Another nurse attempted to			A review of Resident #294 electronic		
	obtain the urine spec				medical record revealed an order for U	Α	
	10/31/24 and the morning of 11/1/24 but was not successful. Resident #294 was administered his diuretic daily 10/29/24 through 11/1/24 despite				with reflex, Urine Culture and Sensitivit	y	
					with Diagnosis of Dysuria was ordered	on	
					10/30/2024. The facility staff attempted	d to	
	decreased intake. Th	ne poor intake continued and			push fluids and obtain urine sample on		
	by 10/31/24 Resident	t #294 had become			10/31/2024 at approximately 5:00 AM a	and	
	· ·	here was minimal urine			9:00 PM, 11/01/2024 at approximately		
		was changed, and staff had			5:30 AM and was unable to collect a ur	ine	
	to feed him. The mor				sample. A review of Resident #294		
		valuate Resident #294 who			orders indicated resident was prescribe		
		d a change in condition,			Lasix 20mg daily to be administered da	ılly	
		, decreased oral intake, and			per physician orders.		
	was clinically dehydra	s for 3 days, but the nurse			A quality review of current residents wi	·h	
		ert a peripheral line because			an order for UA/C&S between 10/20/20		
	· ·	ehydrated, and she could			through 11/20/2024 were audited by th		
		. The nurse contacted the			Director of Clinical Services and Unit		
		ain IV access. On 11/1/24			Managers on 11/20/2024 to ensure a		
		ly member arrived at the			urine sample was obtained. Nine (9)		
		ely 3:00 PM and requested			residents with orders for UA/C&S and		
	the resident be sent t	o the hospital and the facility			eight (8) with no further change in		
	requested non emerg	gent transport. The specimen			condition that required notification to th	е	
	for the urinalysis had	still not been collected and			physician. No discrepancies were note	ed.	
		been initiated. EMS arrived			23 residents were identified as having		
	at the facility at 4:02 I				physician order to administer diuretics		
	impression was altere				were audited by the Director of Nursing		
		n was sepsis. The chief			and/or Unit Managers to ensure no sign		
		d mental status with onset of			or symptoms of dehydration as evidend	ed	
		294 was transferred to the			by the inability to collect urine. The		
		ent (ED) where the progress			Director of Nursing and/or Unit Manage	er	
		ent #294 presented critically			assessed current residents to include		
	III, obtunded (reduced	d level of alertness and			obtaining vital signs (blood pressure,		

CENTER	3 FOR WEDICARE &	MEDICAID SERVICES				OIVID IVC	7. 0930 - 0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
						(С
		345403	B. WING			11/22/2024	
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CARVUE	ALTU AND DEUADII ITAT	TION		65	590 TRYON ROAD		
CART HE	ALTH AND REHABILITAT	HON		C	ARY, NC 27518		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 684	Continued From page	e 26	F	684			
		athing on his own, with cold			increased heart rate, oxygen saturation	1	
		h dilated pupils without			temperature), observation of dry crack		
	I .	and no response to painful			lips, poor skin turgor and/or altered me		
	1 -	ified with altered mental			status and chart review to ensure there		
		ipid and shallow breathing),			was no change in status or condition the		
		rs when there is inadequate			required notifying the physician and		
	1	rgans and tissues and can			obtaining necessary medical services t	:O	
	I .	rculatory or heart problems			include signs and symptoms of		
	and can lead to life-th			dehydration on 11/20/2024.			
	hypothermia (a medi	cal emergency that occurs			-		
	when the body's temp	perature drops below 95°F),			On 11/20/2024, a root cause analysis v	vas	
	severe lactic acidosis	s (occurs when the body			completed by the Director of Clinical		
	produces too much la	actic acid and the liver can't			Services and the Executive Director		
	I .	ough), and new vasopressor			regarding staff failure to recognize the		
	1	ressors are a medication that			seriousness of a significant change in		
		ple with low blood pressure)			condition and obtaining necessary		
	most consistent with	•			medical services to address an emerge		
	_	tion that happens when your			situation for Resident #294. The change	је	
		to a dangerously low level			in condition included complaints of		
		h end organ dysfunction.			burning urination, decreased fluid intak		
		at 8:26 PM on 11/1/24. This			and signs or symptoms of dehydration		
	(Resident #294) revie	curred for 1 of 3 residents			evidenced by the inability to collect uring		
	standards of care.	ewed for professional			via an in and out catheter. Nursing sta also continued to administer resident	a II	
	Standards of Care.				Lasix despite signs and symptoms of		
	Immediate ieonardy ł	began on 10/31/24 when			dehydration. It was determined throug	h	
		ze the seriousness of			the root cause analysis that the facility		
		nge in condition and obtain			staff failed to follow policy and procedu		
	necessary emergent	-			to recognize the seriousness of a	.00	
		was removed on 11/21/24			significant change in condition and not	ify	
	when the facility impl				the physician to obtain necessary med	-	
		ate jeopardy removal. The			services to address an emergency		
	•	t of compliance at a scope			situation.		
		no actual harm with potential					
	` `	al harm that is immediate			The Director of Clinical Services and/o	r	
	jeopardy) to ensure education is completed and				Nurse Managers re-educated all licens	ed	
	monitoring systems p	out into place and are			nurses on how to recognize the		
	effective.				seriousness of a significant change in		
					condition through assessing the reside	nt,	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345403	B. WING		С		
	20,4252.02.01.02.152	345403	D. WING _		11/22/2	2024	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
CARY HE	ALTH AND REHABILI	TATION		6590 TRYON ROAD			
-,				CARY, NC 27518			
(X4) ID PREFIX TAG			PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE CO E APPROPRIATE	(X5) OMPLETION DATE		
F 684	Continued From p	age 27	F 6	84			
	The findings include	-		observation, and chart review	w to include		
	The infantys molac	dea.		medications, and notify the p			
	Resident #294 wa	s initially admitted to the facility		obtain necessary medical se	-		
		last readmission to the facility		address an emergent situation			
		agnoses included fracture of		emphasis on signs and symp			
		bone between hip and knee),		dehydration and continued a			
		diabetes, adult failure to thrive,		of diuretics, on 11/20/2024.			
	generalized muscl	le weakness, chronic kidney		(licenses nurses/Certified Nu	ırsing		
	disease, and cong	jestive heart failure. He was		Assistants) not educated on	11/20/2024,		
	admitted to the fac	cility for rehabilitation therapy		will be educated by the Direct	ctor of Nursing		
	services after hos	pitalization following the femur		and/or Unit Manager prior to			
	fracture.			floor. Newly hired staff will b			
				during orientation by the Dire			
		ge summary dated 10/7/24		Nursing and/or Unit Manage	rs.		
		t #294 was admitted to the		T. D	,		
		/24 to 10/7/24 due to inability to		The Director of Clinical Servi			
		home after he was discharged n 7/23/24 and readmitted to the		Nurse Managers re-educated nursing assistants on signs a			
		4. He had an unwitnessed		symptoms of dehydration an			
		arly morning on 9/25/2024 at		report the change in condition			
	_	he thought he smelled smoke		licensed clinical staff on 11/2			
		ot up to investigate. Plain films		Newly hired staff will be educ			
	revealed right fem	· ·		orientation by the Director of	9		
				Services and/or the Unit Mar			
	Resident #294 und	derwent a right hip					
	hemiarthroplasty of	on 9/28/2024 and was		Date of Immediate Jeopardy	Removal =		
	discharged to SNF	on 10/7/24 with physical and		11/21/2024			
	occupational thera	apy recommendations.					
				The Director of Clinical Servi			
		I nursing facility (SNF)		the Nurse Managers re-educ			
		dicated Resident #294 was		licensed nurses on how to re	•		
		nd reason for admission was		seriousness of a significant of	_		
		toms had begun 11 weeks ago		condition through assessing			
		s were reported as being te indicated that the resident		observation and chart review includes medications and no			
		pe 2 diabetes, coronary artery		physician to obtain necessar			
		pe 2 diabetes, coronary aftery ected major neurocognitive		services to address an emer			
		presented to the hospital for		with emphasis on signs and	•		
		adult. Resident #294 was		dehydration and continued a			

Facility ID: 923078

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CENTER	3 FOR WEDICARE &	WIEDICAID SERVICES				OIVID IVC	7. 0930-0391	
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		345403	B. WING				C	
		345403	B. WING			11/	22/2024	
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
CARY HEA	ALTH AND REHABILITAT	ION			590 TRYON ROAD			
				С	ARY, NC 27518			
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E 004			_					
F 684	Continued From page		F	684				
		tal on 6/27/24 through 7/2/24			of diuretics on 11/20/2024. Education			
		self. He was discharged			includes any time an order is given but			
		7/2/24 and admitted to a			able to be completed for any reason, the			
		and was discharged from			floor nurse or clinical manager will call			
		unity on 7/23/24 but he was			physician for additional instructions. S	taff		
	unable to care for sel				(licensed nurses/Certified Nurse	4		
		pital on 7/25/24. He was			Assistants) not educated on 11/20/202			
	living in a trailer without access to running water or sewer and likely not consistently taking his				will be educated by the Director of Nurs and/or Unit Manager prior to working the			
	-	known to only be able to			floor. Newly hired staff will be educated			
		elf but not to perform other			during orientation by the Director of	•		
		g (ADL) or instrumental			Clinical Services and/or Unit Managers	:		
		g (IADLs) independently,			omnour convioce ana, or ornit warragers	•		
		athe himself or use toilet,			The Director of Clinical Services and/o	r		
		s as commodes instead. Per			Nurse Managers re-educated certified			
	review of prior record				nursing assistants on signs and			
	· ·	y to follow-up with medical			symptoms of dehydration and immedia	tely		
		Cardiology follow-up for 3			report the change in condition to the	•		
	years despite signification	ant cardiac history) and was			licensed clinical staff on 11/20/2024.			
	paranoid about medic	cations, such as			Newly hired staff will be educated durir	ıg		
		alapril (medication used to			orientation by the Director of Clinical			
		sure) because he did "not			Services and/or Unit Managers.			
	-	emonstrating inability to						
		ns regarding his health. The			The Director of Nursing and/or Nurse			
	•	n note indicated Resident			Managers will provide quality monitorin	-		
		nditions, syndromes and			daily in clinical (Monday through Friday			
	•	s that would likely require			review for 5 days, then 3 times per wee			
		changes, other treatment			for 3 weeks, then 2 times per week for	4		
	_	uations. Resident was at			weeks and then weekly for 4 weeks to			
		sening medical (including			ensure any resident who is ordered diuretics the facility is monitoring fluid			
		d was at significant risk for pital and these multiple			intake, any acute change, an SBAR is			
		ntensive management.			completed and the physician is notified			
	morbidities required ii	monave management.			For any new order for diuretics the order			
	Resident #294's care plan last revised on 10/8/24			to monitor fluid intake will be initiated a				
		a that indicated Resident had			new orders for urinalysis to ensure no			
		cit related to diuretic use			dehydration is noted through review of	lab		
	with the goals for Res				results.			

symptoms of dehydration. Interventions included:

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
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F 684	facility policy; monitor protocol and record; abnormalities; monitor needed any signs/sy obtain and monitor la ordered and report reup as indicated. A physician order darcode. Resix oral tablet 20 moday for edema (swell Lasix is a diuretic uscan result from congresses or other medincreases urine outpole dehydration. Resident #294's adm (MDS) assessment of Resident #294 as considered behaviors or rejection supervision or touch the required setup or eating. He was code bowel and bladder are a diuretic. His weight height was 68 inchest discharge goal was the was not coded for A 24-hour facility corn Nurse #5 dated 10/2 had poor oral intake PM). The facility's 24	nt intake and output as per r vital signs as ordered/per notify physician of significant or/document/report as mptoms of dehydration; ab/diagnostic work as esults to physician and follow ted 10/7/24 indicated give nilligram by mouth one time a ling from fluid retention). The detection that estive heart failure, kidney dical conditions. Lasix ut and can lead to hission Minimum Data Set dated 10/12/24 coded gnitively intact. He had no nof care. He required ang assistance with toileting. It clean up assistance with das frequently incontinent of a was 137 pounds, and his serious motion of cerum to the community.	F6	The Executive Director will monthly for 3 months. The Nursing will report all result monitoring audits and to the committee. Findings will be the QAPI committee month monitoring (audits) will be u indicated.	Director of s of quality e QAPI e reviewed by ly and quality		

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	ROVIDER OR SUPPLIER	TION		STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY, NC 27518	111/22/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 684	communicate any penext shift and nursing During an interview v 2:45 PM, she stated Resident #294 on 10 PM. Nurse #5 indicat 294 consumed more and drinks but on 10 drank less than 25% her shift and she dooreport and informed to nurse (Nurse # 4). Vital signs document by Nurse #5 were bloopulse:79, oxygen sat temperature: 98°F. Phone interviews we Assistant (NA) #3, th Resident #294 during 3:00 PM) on 10/29/24 A 24-hour facility con Nurse #4 dated 10/30 was complaining of the shift (10/29/24 11:00 shift). During an interview of Nurse #4, she stated care for Resident #29 10/30/24 at 7:00 AM. shift change Nurse #4 documented in the 24	the end of their shift to rtinent information to the granagement. with Nurse #5 on 11/18/24 at that she had cared for /29/24 from 7:00 AM to 7:00 ed that normally Resident # than 25% of his tray food (29/24 he had eaten and during the three meals on tumented it in the 24 hour the oncoming night shift ed on 10/29/24 at 1:43 PM food pressure (BP): 110/61, for attempted with Nursing e NA who worked with gother first shift (7:00 AM to 4, and were unsuccessful. dition report completed by 0/24 indicated Resident #294 for an ingular with urination on night PM to 10/30/29 7:00 AM on 11/19/24 at 3:53 PM with that she was assigned to 94 on 10/29/24 at 7:00 PM to Nurse #4 stated that during 5 had informed her and 4-hour condition report that decreased oral intake with	F 68	34	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER	R: A. BUILDII	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
345403	B. WING		C	
		OTREET ARRESTS OF A COLUMN OTHER THE COLUMN	11/22/2024	
NAME OF PROVIDER OR SUPPLIER CARY HEALTH AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD		
CART HEALTH AND REHADILITATION		CARY, NC 27518		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FUL TAG REGULATORY OR LSC IDENTIFYING INFORMATIO		PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		
Resident #294 complained of burning with urination during her shift and she left a note for the Provider in the physician book, noted it in 24-hour condition report and informed the oncoming day shift nurse (Nurse #1). Nurse # stated that Resident #294 was stable and the concern during her shift was complaints of burning with urination which she noted in the physician's book, and she pushed fluids while Resident #294 was awake because she thoug was a sign of urinary tract infection. Resident #294's medication administration regindicated Lasix 20 mg was administered on 10/30/24 at 9:00 AM by Nurse #1. A Physician telephone order dated 10/30/202 11:59 AM ordered by Physician Assistant (PA indicated urinalysis (UA), urine culture and sensitivity (C & S) for a diagnosis of dysuria. During an interview on 11/19/24 at 10:20 AM Nurse #1, she indicated that she had cared for Resident #294 on 10/30/24. Nurse #1 stated when she came to work on 10/30/24 at aroun 7:00 AM she was informed by the off going ni shift nurse (Nurse #4) that Resident #294 had complained of pain with urination during the n shift (10/29/24 at 7:00 PM to 10/30/24 at 7:00 AM). Nurse #1 verbalized that a UA/CS to rule a urinary tract infection was ordered during he shift (10/30/24 7:00 AM - 7:00 PM) but she did attempt to obtain a urine sample since it woulnot have been picked up until around 6:00 AM following morning. She stated that she was pushing fluids and Resident #294's vital signs were stable. Nurse #1 stated she did not obtaurine specimen and put in the refrigerator because it was normally collected on night sh	or the #4 conly eght it cord 4 at a) #2 with or that d ght d hight e out er d not d A the siin	384		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345403	B. WING			C		
	ROVIDER OR SUPPLIER ALTH AND REHABILITA	l		STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY, NC 27518	I	11/22/2024		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 684	Continued From pag	e 32	F 68	34				
	be sent out in the mo	rning.						
	by Nurse #1 were BF	ed on 10/30/24 at 3:13 PM 2: 128/60, pulse:65, oxygen I temperature: 97.5°F.						
	on day shift (7:00 AM Nurse #1 and evenin PM) completed by No	dition report dated 10/30/24 I to 3:00 PM) completed by g shift (3:00 PM to 11:00 urse #6 indicated the need dent #294 in the morning						
	PM with Nurse #6. If for four hours and ca 10/30/24 from 7:00 F aware that Resident sample, but he did no wouldn't have been part AM in the morning. If nurse (Nurse #2) to when she took over a explained that the lat picked up by laborated approximately 6:00 A Resident #294 was seconversation with him his 9:00 PM medication.	le stated that he had filled in red for Resident #294 on M to 11:00 PM and he was #294 required a urine of obtain it because it bicked up until around 6:00 He notified the third shift collect the urine specimen at 11:00 PM. Nurse #6 poratory specimens were bry staff in the morning at LaM. Nurse #2 stated that table and carried on the when he went to administer ons, he was in no pain and was with no concerns. Nurse						
	#6 stated he did not and refrigerate it duricollected by third shift when it was sent out A 24-hour facility con on night shift (10/30/17:00 AM) completed	collect the urine specimen ng his shift since a sample 't would have been fresher						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345403	B. WING _			C 11/22/2024	
	ROVIDER OR SUPPLIER	TION		STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY, NC 27518		11/22/2027	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	Continued From pag	ue 33	F 6	84			
	Nurse #1 indicated t for Resident #294.	he need for a UA and C&S					
	Nurse #2, she stated Resident #294 on the 11:00 PM to 10/31/2 stated that when she that night, she was represented in the that night, she was represented in the that night, she was represented in the that a uring resident #294. She came on shift Resided id not recall waking fluids. Nurse #2 indices in the urine special that it is not the unit obtain the urine special that it is not the that is in the unit of the unit						
	PM with NA #2 who on 10/30/24 and 10/ stated that Resident water during her shift incontinence brief th #2 stated she worke 11:00 PM through 13 was aware of Rebeginning of her shift	hducted on 11/20/24 at 2:12 had cared for Resident #294 31/24 on night shift. NA #2 #294 took only a few sips of its and when she changed his ere was very little urine. NA d with Nurse #3 (10/31/24 at 1/1/24 at 7:00 AM) and Nurse sident's condition from the it when she had told NA #2 to the Resident to drink water					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A. BUILDING		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345403	B. WING _			C 11/22/2024	
	ROVIDER OR SUPPLIER	TION		STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY, NC 27518	,	11122224	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	Continued From pag	e 34	F6	884			
	needed to obtain urin not recall if she had a bout Resident #294 night shift.	eck on him because they ne. NA #2 stated she could reported any information to Nurse #2 on 10/30/24 dication administration record					
	indicated Lasix 20 m 10/31/24 at 9:00 AM	g was administered on by Nurse #1.					
	Nurse #1, she stated work on 10/31/24 at informed by the off g #2) that a urine sample Resident #294 since obtain the urine during stated that she did not sample on 10/31/24 until the following makes be picked up. She in was still not at baselithan usual and not ensure she continued to pust Resident #294 norm what was on his tray the water she gave hadministration, but on with the medication. Resident #294 const of his med pass (nut	on 11/19/24 at 10:20 AM with that when she came back to around 7:00 AM she was oing night shift Nurse (Nurse ble was still needed for she had not been able to ag the night shift. Nurse #1 ot attempt to obtain the urine day shift since it would wait orning at around 6:00 AM to adicated that Resident #294 ne; he was less talkative ating/drinking as usual and the fluids. Nurse #1 stated that ally ate and drank most of and and and he also drank most of and he					
	whereas previously h supplementation. No the resident was not eating and drinking a been ordered the da not been able to obta	nately 9:00 AM and 5:00 PM ne consumed 100 % of the rse #1 stated she recognized at his baseline and was not as he usually did. The UA had by before and Nurse #2 had ain the specimen the #1 stated she did not think					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345403	B. WING _			C 11/22/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY, NC 27518		1 117	22/2024
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684		e 35 during her shift to be sent to for the next shift so it could	F	884			
	be sent out the follow	ing day because it was night shift and sent out in					
	by Nurse #1 were BP	ed on 10/31/24 at 3:43 PM : 101/66, pulse:58, oxygen temperature: 97.2°F.					
	Nurse #3 dated 11/1/2 7:00 PM to 11/1/24 7:	dition report completed by 24 on night shift (10/31/24 00 AM) indicated the nurse llect urine unsuccessfully.					
	Nurse #3 dated 11/1// report was given to the needed. The nurse at however, resident wo first attempt to obtain PM on 10/31/24 and a not enough urine can to push fluids through getting small sips. The urine was reported to attempt to obtain the 11/1/24 and was again nurse (Nurse #1) and made aware of the at still in need of a spec	rogress note written by 2024 at 6:13 AM indicated are nurse that a UA/C&S was attempted to push fluids, uld only take small sips. The the UA/CS was around 9:00 she was unable to collect as are out. The writer continued tout the shift, again, only a first attempt to collect the the supervisor. The second UA/C&S was at 5:33 AM on an unsuccessful. Oncoming the Unit Manager were tempts and that patient is timen or the medical doctor ditted to get further orders.					
	11/1/2024 at 6:31 AM to collect urine twice,	e written by Nurse #3 dated indicated writer attempted however, was unsuccessful report off to oncoming nurse					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
							C
		345403	B. WING			11/2	22/2024
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		-
CARVILE	ALTILAND DELIADU	FATION		65	90 TRYON ROAD		
CARY HE	ALTH AND REHABILI	IATION		CA	ARY, NC 27518		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	PM with the Nurse for Resident #294 through 11/1/24 at had received reponurse (Nurse #1) the needed for Reside obtain the specime 10/31/24 and at ap 11/1/24 via an in a was unsuccessful. barely any urine, aprocessed. She strincontinence brief and she was push was only taking shough was only taking	age 36 conducted on 11/20/24 at 1:54 #3 who was assigned to care on 10/31/24 at 7:00 PM 7:00 AM. Nurse #3 stated she rt from the off going day shift hat a urine specimen was nt #294 and she attempted to en at around 9:00 PM on oproximately 5:30 AM on and out catheter both times but She stated that there was and it was too thick to be atted that Resident #294's was dry during both attempts, fing fluids but Resident #294 hall sips and could not get in eported to the oncoming day #1) that she had been taining the urine specimen via eter. Nurse #3 stated that tal signs were completed on 24 and were stable. She stated recall if she had obtained any ere shift and if she did, she mented them if they were s. Nurse #3 stated that so verbal and did not seem to be so otherwise she would have cian to send him out. W on 11/19/24 at 3:05 PM with (NA) #1 she stated that she dent #294 on 10/30/24 through 7:00 AM to 3:00 PM shift. NA and those 3 days she noticed It was eating and drinking less had become incontinent by he was using the urinal. She	F	684			

PRINTED: 01/07/2025 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345403	B. WING _				22/2024
	ROVIDER OR SUPPLIER	TION		6	TREET ADDRESS, CITY, STATE, ZIP CODE 590 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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	as he usually did. NA she changed Resider minimal urine. NA #1 was giving Resident # was not as responsive not shouting like he wishowers. She verbalize aware that Resident # eating as he normally encourage Resident # also to give him a shooff his clothes. NA #1 was not alert and ories her shift, and they we the Resident to the horizontal to the horizo	im and offer drinks on but he did not eat or drink #1 also stated that when it #294's briefs there was further stated that when she #294 a shower on 11/1/24 he e as usual, he was quiet and rould normally do during zed that Nurse #1 was #294 was not drinking and id did and had told NA #1 to #294 to drink his fluids and ower because he kept pulling indicated Resident #294 ented when she completed are getting ready to transfer ospital. (PA) progress note written 4 at 11:52 AM indicated een by PA at the request of in of change in condition. The alter the progress in the responsive. This was a sually being agitated and gotherapy. The roommate mot seen Resident #294 eat Nursing attempted to obtain vide adequate sample even orgress note also indicated ange in condition, altered used oral intake, and was	F	684			
	clinically dehydrated. obtain a PIV on 11/1/2 (intravenous fluids) 2	An order was provided to					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345403	B. WING _			C 11/22/2024		
	ROVIDER OR SUPPLIER ALTH AND REHABILITA	TION		STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY, NC 27518	<u>'</u>			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 684	decreased oral intak in 300s (normal rang milligrams per decilitindicated unable to dehydration. During an interview Physician Assistant she was notified by the facility at around Resident #294 had at they had not been a for a UA and CS. Th went to assess Residehydrated but was	meters for insulins with e, although blood sugar was ge between 70 and 100 ter). The progress note also	Fé	584				
	(PIV) line and if unal obtain a midline so the fluids. The PA stated #294's baseline since care provider for Resthat she could not resher to let her know the IV (intravenous) accordered by PA #1 indicated by PA #1 indicated as superficial vein surface of the skin]).	ble to obtain PIV access to hat they could administer IV II she did not know Resident e she was not the primary sident #294. She also stated call if the facility contacted hat they had not obtained an ess. ated 11/1/24 at 10:15 AM dicated to obtain peripheral ecess (small catheter inserted in [a vein located close to the II unable to obtain, obtain a ole tube that is inserted into a in to deliver fluids or						
	indicated Sodium Ch 0.9 %. Use 2 liters in	ated 11/1/24 ordered by PA #1 hloride Intravenous Solution htravenously in the morning or 3 Days. Administer 2 liters						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345403	B. WING	B. WING		C 11/22/2024	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	11/22/2027	
CARY HEA	ALTH AND REHABILITA	TION		6590 TRYON ROAD CARY, NC 27518			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	Continued From pag	ge 39	F 68	4			
	per hour for 3 days.	ormal saline at 100 milliliters (Sodium Chloride is used to and salt in the body.)					
	During an interview 10:20 AM, Nurse #1 to work on 11/1/24 a informed by the off g #3) that a urine sam #1 stated she check times that morning a morning medication took with 25% of his supplementation. No administered Reside 10/31/24 and 11/1/2 despite the resident fluid intake and that ask the provider about #294 seemed more days, and she notifice #1 when she came of AM and 11:00 AM of examine Resident # and IV fluids. Nurse to insert a peripheral was dehydrated and vein. She called the entity that is special catheters) between	with Nurse #1 on 11/19/20 at stated that when she came at around 7:00 AM she was going night shift nurse (Nurse ple was still needed. Nurse ed on Resident #1 several and she had administered his at around 9:00 AM which he med pass nutritional arse #1 revealed that she had ent #294's Lasix on 10/30/24, 4 at approximately 9:00 AM as decreased oral food and she did not think to hold it or out it. She stated Resident confused than the previous 2 ed Physician Assistant (PA) to the facility between 10:00 in 11/1/24. PA #1 went to 294 and ordered a midline #1 stated she did not attempt I line because Resident #294 I she could not find a visible vascular team (a contracted zed in inserting intravenous 10:00 AM and 11:00 AM to midline and also called					
	for the midline inser- not answer the phor her. The family men around 3:00 PM and the vascular team w insert the midline. N	tion. The family member did tion. The family member did tie, and she left a message for aber arrived at the facility at I the Nurse informed her that as enroute to the facility the facility that the facility members are the facility members and the facility members are the facility at the facility members and the facility at the facility members are the facility at the facility a					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3	3) DATE SURVEY COMPLETED
		345403	B. WING _			C 11/22/2024
	ROVIDER OR SUPPLIER	TION		STREET ADDRESS, CITY, STATE, ZIP COD 6590 TRYON ROAD CARY, NC 27518	DE	11/22/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION DATE
F 684	Continued From pag	e 40	F	684		
F 684	earlier in the day. The Resident #294 to be Department (ED) due and Nurse #1 stated the Unit Manager and called emergency medicame to transfer Resident An interview was community and the Unit Manager (UM) on 11 stated that she was resident and wan hospital due to altere Nurse #1 to go ahead to the hospital per fail verbalized she was renotified about the inal sample and change if when the Provider care	ne family member wanted sent to the Emergency to the worsening condition she agreed. She informed d the facility Provider and edical services (EMS) who ident #294 to the hospital.	F	584		
	Resident #294 was be the facility, but the fathat wanted the Residue the interview the UM intravenous access hadministered but whe Resident #294's mediate they were not. An interview was contemergency Contact in 11/18/24 at 3:02 PM. That she received a von 11/1/24 at approximate the Resident #294's mediate in the she received a von 11/1/24 at approximate in the received a von 11/1/24 at approximate in the received and the rece	reing provided treatment at mily member was the one dent to be sent out. During initially told the surveyor that had been obtained and fluids en she further looked in lical records she stated that is had been administered but adducted with Resident #294's #1 (Family Member) on The family member stated oice message from Nurse #1 imately 1:30 PM indicating				
	the facility, but the fa that wanted the Residual the interview the UM intravenous access hadministered but who Resident #294's mediate they were not. An interview was con Emergency Contact in 11/18/24 at 3:02 PM. that she received a von 11/1/24 at approximat Resident #294 with the resident #294 with the received in the received a von 11/1/24 at approximat Resident #294 with the received a von 11/1/24 at approximat Resident #294 with received a von 11/1/24 at approximation receive	mily member was the one dent to be sent out. During initially told the surveyor that had been obtained and fluids en she further looked in lical records she stated that is had been administered but adducted with Resident #294's #1 (Family Member) on The family member stated oice message from Nurse #1				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		(X3) DATE COMP	
		345403	B. WING _			11/5	22/2024
	ROVIDER OR SUPPLIER ALTH AND REHABILITAT	TION		STREET ADDRESS, CITY, STATE, ZIP CO 6590 TRYON ROAD CARY, NC 27518	DE	11/2	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 684	going on when she tr and was put on hold. facility at around 3:00 naked and disoriented crusty, and she attern he drank it. The famil told her she was wait come and insert an ir informed Nurse #1 th to be sent to the hosp distress and Nurse # member also stated to Resident's vital signs the room and Nurse # oxygen to the Reside oxygen saturations. During an interview on Nurse #1 she stated to Resident #294's vital transferred to the ED what they were, all sh oxygen saturation was administered oxygen. Emergency medical so 11/1/24 indicated that PM for a non-emerge family choice. EMS a PM and primary impressatus and secondary. The chief complaint we with onset of 10/30/24 (ECG) at 4:05 PM inco (irregular heart rhythri irregular heart cost. As a cost of the cost of the cost 103/72, pulse: 65, res	the facility to check what was fied to call back the facility. When she arrived at the PM she found the Resident down, his mouth was dry and upted to give him a drink and by member stated Nurse #1 ing for vascular team to utravenous line and she at she wanted the Resident bital because he was in a called 911. The family that Nurse #1 checked the during their conversation in the factorial that the conversation in the state of the during their conversation in the state of the during their conversation in the state of the state of the could remember was that the she had checked signs before he was but she could not recall the could remember was that is below 90 % and she services (EMS) report dated the EMS was contacted at 3:42 and transportation due to the state of the facility at 4:02 the signs was altered mental the impression was sepsis. Was altered mental status the facility at 4:02 the signs obtained by EMS and as blood pressure:	F 6	984			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3	(X3) DATE SURVEY COMPLETED		
		345403	B. WING			C	
	ROVIDER OR SUPPLIER ALTH AND REHABILITAT		B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY, NC 27518	I	11/22/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 684	responds to painful si (alert, voice, pain, un measure patient's lev obtained a telephone administer IV fluids d the criteria for sepsis administered due to i access. EMS departer Resident #294 and not sepsis indication at 3:05 PM indicated lethargic, non-verbal had rapid mouth breadry, lung sounds were respiratory rate and owere inconsistent due hands. Resident #294 PM. Emergency departments 11/1/24 indicated that were noted as follows heart rate: 138, and rand oxygen saturation 93.4 degrees Fahren progress note indicated critically ill, obtunded and consciousness), cold distal extremities response bilaterally a stimuli. Facility stated or drinking anything found naked by his fanurse to take his vital called for 911. Residemetabolic acidosis (a acid accumulates in toold extremities, they	timulation on the AVPU responsive scale used to rel of consciousness). EMS order at 4:22 PM to ue to Resident #294 meeting. IV fluids were not nability to establish IV red facility at 4:39 PM with orified the receiving hospital at 5:00 PM. EMS assessment Resident #294 was with minimal alertness, he originally the increased oxygen saturation readings read to the resident having cold a rived at the ED at 5:41 resident #294's vital signs is blood pressure: 72/58, respirations 29 at 5:45 PM in: 33 %, and temperature:	F 68	4			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		345403	B. WING		11/22/2024	
	ROVIDER OR SUPPLIER	TION		STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY, NC 27518		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 684		nt had voiced wishes to have	F 684	1		
	wanted the patient to They understood that moment. The ED not presentation with alter tachypnea (rapid and perfusion (occurs who circulation to organs early sign of circulated can lead to life-threathypothermia (a medi when the body's tem severe lactic acidosis produces too much lametabolize it fast end requirements (vasop are used to treat peomost consistent with life-threatening condiblood pressure drops after an infection) with	his goals of his care, family continue to be full code. It he was critically ill at that te indicated that Resident's cred mental status, if shallow breathing), poor en there is inadequate blood and tissues and can be an ory or heart problems and tening conditions), cal emergency that occurs perature drops below 95°F), is (occurs when the body actic acid and the liver can't bugh), and new vasopressor ressors are a medication that ple with low blood pressure)				
	Medical Director (ME The MD stated he was condition and the fact supposed to do to make a condition. He indicate showed signs of a U when they could not ordered an IV access Resident was sent or obtained. The MD also had been sent out each	nducted with the facility b) on 11/19/24 at 4:37 PM. as aware of Resident #294's ility did what they were anage the Resident's ed that when the Resident II, a UA was ordered and obtain a urine sample, they as for hydration, but the at before the IV access was so stated that if the Resident arlier that day on 11/1/24 the ave been any different. He				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345403	B. WING _			C 11/22/2024	
	ROVIDER OR SUPPLIER	TION		STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY, NC 27518	_	11/22/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	F 684 Continued From page 44		F 6	84			
	11/1/24 and was posi have started the Res	UA had been obtained on itive for a UTI they would ident on oral antibiotics and ave probably been the					
	PM with the Director stated nurses should the provider regardin Resident #294 was not the Resident had concurination and they had urine specimen. The evaluated the resider fluids which they were vascular team obtain stated that it was the	ducted on 11/20/24 at 4:30 of Nursing (DON). The DON have had a discussion with g Lasix administration if ot drinking adequately since inplained of burning with d not obtained the ordered DON indicated once PA #1 int on 11/1/24 she ordered IV is going to administer once it among that wanted the put and the Resident was quest.					
	The Administrator wa jeopardy on 11/20/24	s notified of immediate at 6:04 PM.					
	are likely to suffer, a a result of the noncor Resident #294 no lor Resident was transfe 11/01/2024 due to alt center recognizes the potential to be affected of ensuring staff recognition and providing services for residents burning urination and	nte jeopardy removal: pients who have suffered, or serious adverse outcome as					

NAME OF PROVIDER OR SUPPLIER CARY HEALTH AND REHABILITATION STREET ADDRESS, CITY, STATE, ZIP CODE SERVIN ROAD CARY, NC. 27518 SUMMARY STATEMENT OF DEPICIENCIES (ACAY) DEPICIENCY MUST BE PRECEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION) FOR SUMMARY STATEMENT OF DEPICIENCIES TAG CONTINUED From page 45 evidenced by the inability to collect urine via an in and out catheter when the resident had a dry brief. A review of Resident #294's electronic medical record revealed an order for UA will reflux. Urine Culture and Sensitivity with Diagnosis of Dysuria was ordered on 10/30/2024. The facility staff attempted to push fluids and obtain urine sample on 10/31/2024 at approximately 5:30 AM and was unable to collect urine sample. A review of Resident #294 orders indicated resident was prescribed Lasix 20mg daily to be administered daily per physicians' orders. A quality review of current residents with an order for UA/C&S between 10/20/2024 through 11/20/2024 were audited by the Director of Clinical Services and Unit Managers on 11/20/2024 to read united a briangle was obtained. Nine (9) residents with orders for UA/C&S and eight (8) with no further change in condition that required notification to physician. No discrepancies were noted. 23 residents were identified as having and britt Managers to ensure no signs and symptoms of dehydration as evidenced by the inability to collect urine. The Director of Nursing and or Unit Manager assessed current residents to include obtaining vital signs (blood pressure, increased heart rate,	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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FREEIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 684 Continued From page 45 evidenced by the inability to collect urine via an in and out catheter when the resident had a dry brief. A review of Resident #294's electronic medical record revealed an order for UA w/ reflux, Urine Culture and Sensitivity with Diagnosis of Dysuria was ordered on 10/30/2024. The facility staff attempted to push fluids and obtain urine sample on 10/31/2024 at approximately 5:30 AM and 9:00 PM, 11/01/2024 at approximately 5:30 AM and was unable to collect urine sample, A review of Resident #294 orders indicated resident was prescribed Lasix 20mp daily to be administered daily per physicians' orders. A quality review of current residents with an order for UA/C&S between 10/20/2024 through 11/20/2024 were audited by the Director of Clinical Services and Unit Managers on 11/20/2024 were audited by the Director of UA/C&S and eight (8) with no further change in condition that required notification to physician. No discrepancies were noted, 23 residents were identified as having a physician order to administer diuretics and were audited by the Director of Nursing and Unit Managers to ensure a sidents were identified as having a physician order to administer diuretics and were audited by the Director of Nursing and Unit Managers as evidenced by the inability to collect urine. The Director of Nursing and or Unit Manager assessed current residents to include obtaining	0.0.15	CLIMMADY CT	ATEMENT OF DEFICIENCIES			CTION	0/5)	
evidenced by the inability to collect urine via an in and out catheter when the resident had a dry brief. A review of Resident #294's electronic medical record revealed an order for UA w/ reflux, Urine Culture and Sensitivity with Diagnosis of Dysuria was ordered on 10/30/2024. The facility staff attempted to push fluids and obtain urine sample on 10/31/2024 at approximately 5:00 AM and 9:00 PM, 11/01/2024 at approximately 5:30 AM and was unable to collect urine sample. A review of Resident #294 orders indicated resident was prescribed Lasix 20mg daily to be administered daily per physicians' orders. A quality review of current residents with an order for UA/C&S between 10/20/2024 through 11/20/2024 were audited by the Director of Clinical Services and Unit Managers on 11/20/2024 to ensure a urine sample was obtained. Nine (9) residents with orders for UA/C&S and eight (8) with no further change in condition that required notification to physician. No discrepancies were noted. 23 residents were identified as having a physician order to administer diuretics and were audited by the Director of Nursing and Unit Manager as evidenced by the inability to collect urine. The Director of Nursing and or Unit Manager assessed current residents to include obtaining	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOOT CROSS-REFERENCED TO THE APP	OULD BE	COMPLETION	
and out catheter when the resident had a dry brief. A review of Resident #294's electronic medical record revealed an order for UA w/ reflux, Urine Culture and Sensitivity with Diagnosis of Dysuria was ordered on 10/30/2024. The facility staff attempted to push fluids and obtain urine sample on 10/31/2024 at approximately 5:00 AM and 9:00 PM, 11/01/2024 at approximately 5:30 AM and was unable to collect urine sample. A review of Resident #294 orders indicated resident was prescribed Lasix 20mg daily to be administered daily per physicians' orders. A quality review of current residents with an order for UA/C&S between 10/20/2024 through 11/20/2024 were audited by the Director of Clinical Services and Unit Managers on 11/20/2024 to ensure a urine sample was obtained. Nine (9) residents with orders for UA/C&S and eight (8) with no further change in condition that required notification to physician. No discrepancies were noted. 23 residents were identified as having a physician order to administer diuretics and were audited by the Director of Nursing and Unit Managers to ensure no signs and symptoms of dehydration as evidenced by the inability to collect urine. The Director of Nursing and or Unit Manager assessed current residents to include obtaining	F 684	Continued From page	45	F 68	34			
oxygen saturation, temperature), observation of dry cracked lips, poor skin turgor and or altered mental status and chart review to ensure there was no change in status or condition that required notifying the physician and obtaining necessary medical services to include signs and symptoms of dehydration on 11/20/2024.		evidenced by the inat and out catheter where brief. A review of Resident record revealed an or Culture and Sensitivit was ordered on 10/30 attempted to push flui on 10/31/2024 at app 9:00 PM, 11/01/2024 and was unable to co of Resident #294 order prescribed Lasix 20m daily per physicians of A quality review of cut for UA/C&S between 11/20/2024 were audi Clinical Services and 11/20/2024 to ensure obtained. Nine (9) re UA/C&S and eight (8) condition that required No discrepancies were identified as having a administer diuretics a Director of Nursing ar no signs and symptor evidenced by the inat Director of Nursing ar assessed current resivital signs (blood presoxygen saturation, tendry cracked lips, poor mental status and chawas no change in stanotifying the physicial medical services to in	willity to collect urine via an in the resident had a dry #294's electronic medical der for UA w/ reflux, Urine y with Diagnosis of Dysuria 1/2024. The facility staff ds and obtain urine sample roximately 5:00 AM and at approximately 5:30 AM and at approximately 5:30 AM llect urine sample. A review ers indicated resident was g daily to be administered orders. Trent residents with an order 10/20/2024 through ted by the Director of Unit Managers on a urine sample was sidents with orders for with no further change in d notification to physician. The noted were audited by the noted Unit Managers to ensure the noted Unit Managers to ensure the noted Unit Manager to ensure the noted Unit Manager to ensure the noted Unit Manager dents to include obtaining soure, increased heart rate, in					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345403	B. WING			C
	ROVIDER OR SUPPLIER ALTH AND REHABILITAT			STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY, NC 27518	I	11/22/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 684	completed by the Director the Executive Director recognized the serious change in condition a medical services to a situation for Resident condition included courination, decreased symptoms of dehydral inability to collect urin Nursing staff also coresident Lasix despite dehydration. It was decause analysis that the policy and procedure seriousness of a sign and notify the physici medical services to a situation.	ector of Clinical Services and or regarding staff failed to usness of a significant and obtaining necessary ddress an emergent are 4294. The change in amplaints of burning fluid intake and signs or ation as evidenced by the are via an in out catheter. Intinued to administer a signs and symptoms of the etermined through the root are facility staff failed to follow as to recognize the difficant change in condition and to obtain necessary ddress an emergency	F 68	34		
	the process or system adverse outcome from when the action will be the Director of Clinic Managers re-educate to recognize the serior change in condition the resident, observation medications, and not necessary medical seemergent situation with symptoms of dehydra administration of dium (licensed nurses/ Cereducated on 11/20/20 Director of Nursing an working the floor. New	al Services and Nurse ad all licensed nurses on how busness of a significant brough assessing the and chart review to include fify the physician to obtain bervices to address an atth emphasis on signs and attion and continued betics, on 11/20/2024. Staff betified Nurse Assistants) not all 24, will be educated by the and or Unit Manager prior to				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE S	
		345403	B. WING _			11/2	; 2/2024
	ROVIDER OR SUPPLIER ALTH AND REHABILITAT	TION		STREET ADDRESS, CITY, STATE, ZIP 6590 TRYON ROAD CARY, NC 27518	CODE	111/2	212024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page Clinical Services and The Director of Clinic Managers re-educate assistants on signs a and immediately report the licensed 11/20/20 educated during orier Clinical Service and of Date of Immediate Jet 11/21/2024. On 11/22/24 the facility removal was validate The facility provided of immediate jeopardy recompleted by the Direct Clinical Services and included all current retually CS from 10/20/20 which was revealed refor UA/CS and eight (condition that require and no discrepancies included all residents 23 residents were ideorder to administer disigns and symptoms by the inability to colleincluded assessment	or Unit Managers. al Services and Nurse ad certified nursing and symptoms of dehydration but the change in condition to 24. Newly hired staff will be attation by the Director of but Unit Managers. copardy Removal					
	poor skin turgor and of chart review to ensur- status or condition that physician and obtaini services to include sign	oxygen saturation, ation of dry cracked lips, or altered mental status and e there was no change in at required notifying the ng necessary medical gns and symptoms of //2024. The facility provided					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	_ ` ´	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345403	B. WING _			C 11/ 22/2024	
	ROVIDER OR SUPPLIER	TION		STREET ADDRESS, CITY, STATE, ZIP COD 6590 TRYON ROAD CARY, NC 27518		112212027	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE	
	include sign-in sheets indicated that the Dirk Nurse Managers reed on how to recognize its significant change in the resident, observational include medications, obtain necessary medemergent situation with symptoms of dehydrational administration of diurn Director of Clinical Sere-educated certified and symptoms of dehydrational symptoms of dehydration of the change in onurses on 11/20/2022 newly hired staff wou orientation by the Director Unit Managers staff verified the staff information as indicated removal plan. The implication of the composition of	e education they provided to s. The education information ector of Clinical Services and educated all licensed nurses the seriousness of a condition through assessing tion, and chart review to and notify the physician to dical services to address an oth emphasis on signs and etion and continued etics, on 11/20/2024. The ervices and Nurse Managers nursing assistants on signs and to immediately condition to the licensed etic. Interviews confirmed that the educated during ector of Clinical Service is. Interviews with nursing had been educated on all the immediate jeopardy mediate jeopardy removal validated. Eatus Maintenance e-(3) mutrition and hydration. It and gastrostomy tubes, andoscopic gastrostomy and don a resident's esment, the facility must terminal contents acceptable parameters	F 6			12/18/24	
	of nutritional status, s	uch as usual body weight or t range and electrolyte					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			COMPLETED		
		345403	B. WING		C 11/22/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY, NC 27518	11/22/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	5.475
F 692	demonstrates that the preferences indicate §483.25(g)(2) Is offer maintain proper hydromaintain proper hydromaintain proper hydromaintain proper hydromaintain provider orders a the This REQUIREMENT by: Based on record rever member, Physician Architector interviews the staff recognized the symptoms of dehydromaintaintaintaintaintaintaintaintaintaint	resident's clinical condition is is not possible or resident otherwise; red sufficient fluid intake to ation and health; red a therapeutic diet when problem and the health care rapeutic diet. This not met as evidenced riew, and staff, family assistant (PA), and Medical refacility failed to ensure seriousness of signs and ation for a resident receiving regularly and who had reseriousness of signs and ation for a resident receiving regularly and who had resident #294 was first resed nutritional and fluid requiring staff to push fluids reyond what thirst dictates to be rough 11/1/24. Resident	F 692	· ·	e ered that ms IA 24. ds 124 024 e to
	11/1/24 at 10:15 AM intravenous (PIV) ac into a superficial veir surface of the skin]) to the resident and s	the PA ordered a peripheral cess (small catheter inserted [a vein located close to the coprovide intravenous fluids taff did not attempt to insert ability to find a visible vein		was prescribed Lasix 20mg daily to be administered daily per physician order A quality review of current residents wi an order for UA/C&S between 10/20/2 through 11/20/2024 were audited by the	s. th 024

CENTER	3 FOR WEDICARE &	MEDICAID SERVICES				OIVID IVC	<u>7. 0930-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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		345403	B. WING			1	22/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
				65	590 TRYON ROAD		
CARY HE	ALTH AND REHABILITAT	TION		C	ARY, NC 27518		
(X4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 692	Continued From page	e 50	F	692			
		se veins to be difficult to		_	Director of Clinical Services and/or the		
	, -	on, Resident #294's family			Unit Managers on 11/20/2024 to ensur		
		ne resident be sent to the			urine sample was obtained. No reside		
		Medical Services (EMS)			were identified as having an issue with		
		42 PM and Resident #294			collection that would indicate dehydrat		
	was transferred to the	e emergency room where he			23 residents were identified as having		
	was identified with all				physician order to administer diuretics		
		shallow breathing), poor			were audited by the Director of Nursing		
		en there is inadequate blood			and/or Unit Managers to ensure no sig	•	
	circulation to organs	and tissues and can be an			and symptoms of dehydration as		
	early sign of circulato	ry or heart problems and			evidenced by the inability to collect urin	ne.	
	can lead to life-threatening conditions), The Director of Nursing and/or Unit						
		cal emergency that occurs			Managers assessed current residents	to	
		perature drops below 95°F),			include obtaining vital signs (blood		
	severe lactic acidosis	s (occurs when the body			pressure, increased heart rate, oxygen		
	•	actic acid and the liver can't			saturation and temperature), observati		
		ough), and new vasopressor			of dry cracked lips, poor skin turgor an		
	, ,	ressors are a medication that			altered mental status and chart review		
		ple with low blood pressure)			ensure no other residents exhibited sig		
	most consistent with	,			and symptoms of dehydration that was	not	
		tion that happens when your			addressed and communicated to the	_	
		to a dangerously low level			physician on 11/20/2024. No concerns	;	
		h end organ dysfunction. at 8:26 PM on 11/1/24. This			were identified during this audit.		
		curred for 1 of 3 residents			On 11/20/2024, a root cause analysis v	Nac	
		ewed for dehydration.			completed by the Director of Clinical	vas	
	(11031dCHt #234) 10110	swed for derivariation.			Services and the Executive Director		
	Immediate ieonardy h	pegan on 10/31/24 when			regarding staff failure to recognize the		
		ze the seriousness of signs			signs and symptoms of dehydration an	ıd	
		nydration for Resident #294			then to provide necessary medical	_	
		ble to collect urine via an in			services to address an emergent situa	tion	
		n the resident had no recent			for Resident #294. The resident had		
		and decreased fluid intake.			decreased fluid intake and signs or		
		was removed on 11/21/24			symptoms of dehydration as evidenced	d by	
	when the facility impl				the inability to collect urine via an in an	•	
		ate jeopardy removal. The			out catheter. Nursing staff also continu		
		t of compliance at a scope			to administer resident Lasix despite sig	ıns	
	and severity of "D" (n	o actual harm with potential			and symptoms of dehydration. It was		
	for more than minima	al harm that is immediate			determined through the root cause		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245402		-		С	
		345403	B. WING _		•	11/22/2024	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
CARY HEA	ALTH AND REHABILITAT	ION		6590 TRYON ROAD			
OAKI IILA	ALITAND REHADILITA			CARY, NC 27518			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 692	Continued From page	e 51	F 6	92			
	jeopardy) to ensure e monitoring systems p effective. The findings included			analysis that the facility staff follow policy and procedures the seriousness of signs and dehydration and notify the p obtain necessary medical se	s to recognize d symptoms of hysician to ervices to		
	Resident #294 was a 10/7/24. His diagnose femur (thigh bone bet dementia, type 2 diab generalized muscle with disease, and congest admitted to the facility services after hospital fracture. Resident #294's care had a care focus area potential for fluid deficient with the goals for Resignation and documer facility policy; monitor protocol and record; rabnormalities; monitor needed any signs/syrobtain and monitor la ordered and report reup as indicated. A physician order date	dmitted to the facility on es included fracture of right tween hip and knee), betes, adult failure to thrive, weakness, chronic kidney ive heart failure. He was of for rehabilitation therapy lization following the femural plan last revised on 10/7/24 at that indicated Resident had cit related to diuretic use sident to be free of ation. Interventions included: In the intake and output as per evital signs as ordered/per notify physician of significant or/document/report as included; and the interventions of dehydration;		The Director of Clinical Serv Nurse Managers re-educate nurses on how to recognize symptoms of dehydration the assessing the resident, observant review to include medinotify the physician to obtain medical services to address situation with emphasis on symptoms of dehydration an administration of diuretics or Staff (licensed nurses/Certific Assistants) not educated on will be educated by the Direct and/or Unit Managers prior to the floor. Newly hired staff will be during orientation by the Direct Clinical Services and/or Unit The Director of Clinical Services and/or Unit Managers re-educate nursing assistants on signs a symptoms of dehydration and report the change in conditional licensed clinical staff on 11/2	ation. rices and ad all licensed signs and rough ervation, and cations, and n necessary an emergent signs and nd continued n 11/20/2024. ied Nurse 11/20/2024 ctor of Nursing to working the pe educated ector of t Managers. rices and/or ad certified and nd immediately on to the		
	Lasix is a diuretic use can result from conge	ng from fluid retention). ed to treat fluid retention that estive heart failure, kidney ical conditions. (Lasix urine and can lead to		Newly hired staff will be edu orientation by the Director of Services and/or Unit Manage Date of Immediate Jeopardy 11/21/2024	f Clinical ers.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		E SURVEY IPLETED
			7 50.125	_			С
		345403	B. WING _			1 4	1/22/2024
NAME OF PI	ROVIDER OR SUPPLIER	l		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				6	590 TRYON ROAD		
CARY HE	ALTH AND REHABIL	ITATION		С	ARY, NC 27518		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		
PRÉFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 692	Continued From p	F	692				
	Resident #294's a	dmission Minimum Data Set			The Director of Clinical Services and		
	(MDS) assessme	nt dated 10/12/24 coded			Nurse Managers re-educated all licens	sed	
		cognitively intact. He was			nurses on how to recognize signs and		
		tly incontinent of bowel and			symptoms of dehydration through		
		also coded as taking a diuretic.			assessing the resident, observation ar		
		overall discharge goal was to			chart review to include medications ar		
		munity. He was not coded for			notify the physician to obtain necessar	•	
	hospice care.				medical services to address an emerg	ent	
	A facility 24 hour	andition report completed by			situation. This education includes		
		condition report completed by 0/29/24 indicated Resident #294			emphasis on signs and symptoms of dehydration and continued administration	tion	
		ke on day shift. The facility's			of diuretics. Education conducted on	.1011	
			11/20/2024. Staff (licensed				
		tus of all the residents during or			nurses/Certified Nursing Assistants) n	ot	
		shift to communicate any			educated on 11/20/2024 will be educa		
		ion to the next shift and nursing			by the Director of Nursing and/or Unit		
	management.				Manager prior to working the floor. No	∍wly	
					hired staff will be educated during		
		w with Nurse #5 on 11/18/24 at			orientation by the Director of Clinical		
		ed that she had cared for			Services and/or Unit Managers.		
		10/29/24 from 7:00 AM to 7:00					
		icated that normally Resident #			Date of Jeopardy Removal = 11/21/20	24	
		ore than 25% of his tray food			The Discrete of Olivies of Occasions and the		
		10/29/24 he had eaten and			The Director of Clinical Services and/o		
		5% during breakfast, lunch and ocumented it in the 24 hour			Nurse Managers re-educated all licens		
		ed the oncoming night shift			nurses on how to recognize signs and symptoms of dehydration through		
	nurse (Nurse # 4)				assessing the resident, observation ar	nd	
	Harse (Naise # 4)	•			chart review to include medications ar		
	During an intervie	w on 11/19/24 at 3:53 PM with			notify the physician to obtain necessar		
		ted that she was assigned to			medical services to address an emerg		
	'	#294 on 10/29/24 at 7:00 PM to			situation with emphasis on signs and		
	10/30/24 at 7:00 A	AM. Nurse #4 stated that during			symptoms of dehydration and continue	∍d	
	_	e #5 had informed her and			administration of diuretics. Education		
		e 24-hour condition report that			includes any time an order is given bu		
		d a decreased oral intake with			able to be completed for any reason, t		
	food and drinks. N			floor nurse or clinical manager will call	the		
		and the only concern during her			physician for additional instructions.		
	∣ shift was complaiı	nts of burning with urination			Newly hired staff will be educated duri	ng	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
		345403	B. WING			C 1/22/2024	
NAME OF P	ROVIDER OR SUPPLIER	L	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD	•	1/22/2024	
				6590 TRYON ROAD			
CARY HEA	ALTH AND REHABILITAT	TION		CARY, NC 27518			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 692	Continued From page	e 53	F 69	92			
	which she noted in th	e physician's book and she		orientation by the Director of	Clinical		
		lesident #294 was awake		Services and/or Unit Manage			
	because she thought	it was a sign of urinary tract		_			
	infection. Nurse #4 st	ated that Resident #294 did		The Director of Clinical Service	ces and/or		
	not drink much fluids because it was at night and			Nurse Managers re-educated	l certified		
	he slept most of the r	night.		nursing assistants on signs a			
				symptoms of dehydration and			
		e order dated 10/30/2024 at		immediately report the chang			
		Physician Assistant (PA) #2		to the licensed clinical staff or			
	- ,	JA), urine culture and		Newly hired staff will be educ	•		
	sensitivity (C & S) for	a diagnosis of dysuria.		orientation by the Director of			
	Desident #204's med	ication administration record		Services and/or Unit Manage	rs.		
	Resident #294's medication administration record indicated Lasix 20 mg was administered on			The Director of Nursing and/o	or Murco		
	10/30/24 at 9:00 AM			Managers will provide quality			
	10/00/24 at 5.00 / tivi	by Naise #1.		daily (Monday through Friday	_		
	During an interview o	n 11/19/24 at 10:20 AM with		clinical review for 5 days, the			
	_	ed that she had cared for		week for 3 weeks, then 2 time	•		
	· ·	/30/24. She stated that she		for 4 weeks and then weekly	•		
	was pushing fluids be	ecause Resident #294 had		This monitoring will be to ens			
		g with urination and that		resident who is ordered diure	•		
	could have been a si	gn of a urinary tract infection.		facility is monitoring fluid inta	ke, any acute		
	Nurse #1stated that F	Resident #294 was less		change an SBAR is complete	ed and the		
	talkative than usual o	n 10/30/24.		physician is notified and for a	ny new order		
				for diuretics the order to mon			
		n 11/20/24 at 3:38 PM with		intake will be initiated and an			
		that she had cared for		for urinalysis to ensure no de			
		ht shift (10/30/24 at 11:00		noted through review of lab re	esults.		
		00 AM). Nurse #2 stated that					
		he assignment that night,		The Executive Director will br	•		
		ne off going nurse (Nurse #6)		monthly for 3 months. The D			
		as needed for Resident hat when she came on shift		Nursing will report all results			
				monitoring audits to the QAP Findings will be reviewed by			
		sleep and she did not recall e him any fluids. Nurse #2		committee monthly and quali			
		nt #294 slept throughout her		(audits) will be updated as inc			
		ted to obtain the urine		(addits) will be updated as III	uicai c u.		
	·	nd out catheter at around					
	-	but was unsuccessful and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345403	B. WING				C (22/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY, NC 27518			/22/2024
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 692	Continued From page	e 54	F 6	692			
	#1). Nurse #2 indicate	ming day shift nurse (Nurse ed Resident #294's s wet during the in and out					
	PM with NA #2 who he on 10/30/24 and 10/3 stated that Resident water during her shift incontinence brief the #2 stated that Nurse condition and had told	ducted on 11/20/24 at 2:12 had cared for Resident #294 h1/24 on night shift. NA #2 #294 took only a few sips of s and when she changed his here was very little urine. NA #3 was aware of Resident's d her to offer and encourage water when she went to					
		ication administration record g was administered on by Nurse #1.					
	10:20 AM, she stated to work on 10/31/24 a informed by the off go #2) that a urine samp Resident #294 since obtain the urine durin indicated that Reside was the previous day noted he was not at halkative than usual a usual and she continuot drink much. Nurse #294 normally ate an his tray, and he also gave him during med 10/31/24 he took only She further stated that	with Nurse #1 on 11/19/24 at a that when she came back at around 7:00 AM she was bing night shift Nurse (Nurse ble was still needed for she had not been able to g the night shift. She nt #294 was more like he (10/30/24) when she had his baseline. He was less nd not eating/drinking as used to push fluids and he did to a #1 stated that Resident d drank most of what was on drank most of the water she ication administration, but on a sips with the medication. It Resident #294 consumed of his med pass (nutritional)					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	X2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		345403	B. WING			C I 1/22/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 6590 TRYON ROAD CARY, NC 27518		11/22/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 692	9:00 AM and 5:00 PM consumed 100 % of consumed 100 % of a facility 24-hour con Nurse #3 dated 11/1/7:00 PM to 11/1/24 7 attempted twice to consume and a facility 24-hour consumers and a facility 24-hour consumers and a facility 24 at 6:31 AM to collect urine twice, and Nurse #3 would (Nurse #1). An interview was cor PM with the Nurse #3 would (Nurse #1).	10/31/24 at approximately M whereas previously he the supplementation. dition report completed by 24 on night shift (10/31/24:00 AM) indicated the nurse ollect urine unsuccessfully. progress note written by 2024 at 6:13 AM indicated the nurse that a UA/C&S was attempted to push fluids, ould only take small sips. The 1 the UA/C&S was around and she was unable to 1 urine came out. The writer ids throughout the shift, mall sips. The first attempt to 1 reported to the supervisor. It to obtain the UA/C&S was at 1 and was again unsuccessful.	F 6'	92			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILD	_		Ι,	С
		345403	B. WING				22/2024
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CADVIE	ALTH AND REHABILIT	ATION		6	590 TRYON ROAD		
CART HE	ALI II AND REHADILII	ATION		(CARY, NC 27518		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692	needed for Resider obtain the specimer 10/31/24 and at app 11/1/24 via an in an was unsuccessful. Sharely any urine an processed. She staincontinence brief wand she was pushir was only taking smamuch. Nurse #3 rep shift nurse (Nurse #3 unsuccessful in obtain in and out cather Resident #294 was in any acute distressinformed the physic stated that when she specimen at 5:30 Aday shift nurse so the morning and they can IV because he whad not been able the was probably defined cared for Resident #294 than usual, and he whereas previously also stated that prebut she had to feed 10/31/24 and 11/1/24 and 11	at a urine specimen was at #294 and she attempted to a at around 9:00 PM on broximately 5:30 AM on d out catheter both times but She stated that there was d it was too thick to be ted that Resident #294's was dry during both attempts, ag fluids but Resident #294 all sips and could not get in borted to the oncoming day et1) that she had been aining the urine specimen via ter. Nurse #3 stated that verbal and did not seem to be as otherwise she would have sian to send him out. She he did not obtain the urine M she notified the oncoming nat she could notify the PA that ould probably get an order for was not drinking much, they o obtain the urine sample and	F	692			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345403	B. WING		C 11/22/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY, NC 27518	11/22/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	D BE COMPLETION
F 692	was giving Resident was not as responsive not shouting like he was howers. She verball aware of Resident #2 NA #1 to encourage fluids and also to give kept pulling off his clear Resident #294's medindicated Lasix 20 m 11/1/24 at 9:00 AM be A Physician order day ordered by PA #1 indicated sodium Ch 0.9 %. Use 2 liters in for poor oral intake for intravenous fluids no per hour for 3 days. replenish lost water at During an interview with 10:20 AM, Nurse #1 to work on 11/1/24 at informed by the off g #3) that a urine samp stated that she knew facility that morning a know that they had in specimen and the resident production of the product of	further stated that when she #294 a shower on 11/1/24 he re as usual, he was quiet and would normally do during fized that Nurse #1 was 294's condition and had told Resident #294 to drink his e him a shower because he othes. Ilication administration record g was administered on y Nurse #1. Ited 11/1/24 at 10:15 AM licated obtain PIV access in, obtain a midline (a long isserted into a vein in the fluids or medication into the loride Intravenous Solution travenously in the morning or 3 Days. Administer 2 liters rmal saline at 100 milliliters (Sodium Chloride is used to	F 69		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		345403	B. WING			11/	22/2024
	ROVIDER OR SUPPLIER ALTH AND REHABILITA	TION		6590	EET ADDRESS, CITY, STATE, ZIP CODE TRYON ROAD LY, NC 27518		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692	during medication ac Nurse #1 revealed the Resident #294's Last 11/1/24 at approximate resident's decreased and that she did not provider about it. Nut say why she had ad had been unable to and the Resident was stated Resident #29 than the previous 2 dephysician Assistant the facility between 11/1/24. PA #1 went and ordered a midling stated she did not at line because Resides she could not find a vascular team (a conspecialized in insertic come and insert and resident #294's famfor the midline insert not answer the phore her. The family memaround 3:00 PM and the vascular team winsert the midline. The Resident #294 to be Department (ED) duand Nurse #1 stated the Unit Manager and called emergency moderned to transfer Resident #294 progress note.	and the hard and she came to think to hold it or ask the urine specimen as not drinking much. She as seen and IV fluids. Nurse #1 was dehydrated and IV fluids. Nurse #1 tempt to insert a peripheral and IV fluids. Nurse #1 tempt to insert a peripheral and IV fluids. Nurse #1 tempt to insert a peripheral and IV fluids. Nurse #1 tempt to insert a peripheral and IV fluids. Nurse #1 tempt to insert a peripheral and IV fluids. Nurse #1 tempt to insert a peripheral and IV fluids. Nurse #1 tempt to insert a peripheral and #294 was dehydrated and visible vein. She called the intracted entity that is ng intravenous catheters) to addition. The family member did be, and she left a message for other arrived at the facility at I the Nurse informed her that there enroute to the facility to the family member wanted a sent to the Emergency e to the worsening condition I she agreed. She informed and the facility Provider and edical services (EMS) who seident #294 to the hospital. Written by PA #1dated 11/1/24 and Resident #294 was seen	F	692			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
		345403	B. WING _			C I1/22/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO. 6590 TRYON ROAD CARY, NC 27518	· ·	11/22/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 692	change in condition. responsive. This wa usually being agitate nursing/therapy. The had not seen Reside days. Nursing attempunable to provide adcatheter. The progres resident had a changemental status, decresclinically dehydrated. obtain a PIV on 11/1/for 3 days (11/1/24 to also indicated staff with given dehydration. During an interview of PA #1, she stated that #1 when she came to AM on 11/1/24 that Fin condition, and they a urine sample for a explained that when #294, he seemed de to questions. She gaperipheral intravenou obtain PIV access to could administer IV finot know Resident #1 not the primary care She also stated that facility contacted her not obtained an IV access to Could administer IV finot know Resident #1 not the primary care She also stated that facility contacted her not obtained an IV access to Could administer IV finot know Resident #2 not the primary care She also stated that facility contacted her not obtained an IV access to Could administer IV finot know Resident #2 not the primary care She also stated that facility contacted her not obtained an IV access to Could administer IV finot know Resident #2 not that facility contacted her not obtained an IV access to Could administer IV finot know Resident #3 not the primary care She also stated that facility contacted her not obtained an IV access to Could administer IV finot know Resident #3 not the primary care She also stated that facility contacted her not obtained an IV access to Could administer IV finot know Resident #4 not the primary care She also stated that facility contacted her not obtained an IV access to Could administer IV finot know Resident #4 not the primary care She also stated that facility contacted her not obtained that she was resident #4 not the primary care She also stated that she was resident #4 not the primary care She also stated that she was resident #4 not the primary care She also stated that she was resident #4 not the primary care She also stated that she was resident #4 not the primary care She also stated	of nursing for evaluation of The resident was minimally an anoted change from d and interactive per roommate reported that he not #294 eat over the past 3 ofted to obtain UA/C&S, requate sample even with as note also indicated the lee in condition, altered ased oral intake, and was an An order was provided to (24 and ordered IVF 2 liters of 11/4/24). The progress note rere unable to obtain UA/C&S of the facility at around 10:30 resident #294 had a change of had not been able to obtain UA and C&S. The PA she went to assess Resident hydrated but was responsive we an order to insert a list (PIV) line and if unable to obtain a midline so that they luids. The PA stated she did 294's baseline since she was provider for Resident #294. She could not recall if the to let her know that they had coess.	F 6	92			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		COMPLETED	
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	ROVIDER OR SUPPLIER		B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY, NC 27518	<u> </u>	11/22/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 692	the resident and wan hospital due to altered Nurse #1 to go ahead to the hospital per fait that Resident #294 wat the facility but the that wanted the Resident interview, the UN that an intravenous and fluids administer looked in Resident #3 stated that she though administered but the An interview was corn Emergency Contact and 11/18/24 at 3:02 PM. That she received a won 11/1/24 at approximate the going on when she transided to come to the going on when she transided to come to the going on when she transided and disoriented crusty and she atternshed and disoriented crusty and she atternshed to the hospital the room and Nurse #1 the	er was in the facility to see ted him to be sent to the d mental status and she told d and send the Resident out mily request. The UM stated vas being provided treatment family member was the one dent to be sent out. During I initially told the surveyor vaccess had been obtained ed but when she further 294's medical records she int the fluids had been	F 69	92		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345403	B. WING		1	C 1 /22/2024
NAME OF PROVIDER OR SUPPLIER CARY HEALTH AND REHABILITATION		ION		STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY, NC 27518		7227
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 692	Continued From page	e 61	F 69	92		
	contacted at 3:42 PM transportation due to at the facility at 4:02 F was altered mental st impression was sepsi altered mental status electrocardiogram (Edatrial fibrillation (irregicharacterized by rapid Vital signs obtained b noted as blood pressi respirations: 8, oxyge of consciousness was stimulation on the AVI unresponsive scale u level of consciousness telephone order at 4:2 due to Resident #294 sepsis. IV fluids were inability at 4:39 PM with the receiving hospital PM. EMS assessment Resident #294 was leminimal alertness, he his skin was cold and with increased respiral saturation readings were sident having cold harrived at the ED at 5 An ED progress note Resident #294's vital blood pressure: 72/58 respirations 29 at 5:4:33 %, and temperature.	family choice. EMS arrived PM and primary impression atus and secondary s. The chief complaint was with onset of 10/30/24. An CG) at 4:05 PM indicated dar heart rhythm d and irregular heartbeat). YEMS at 4:17 PM were care: 103/72, pulse: 65, in saturation: 94 % and level is responds to painful PU (alert, voice, pain, sed to measure patient's s). EMS obtained a 22 PM to administer IV fluids meeting the criteria for not administered due to in IV access. EMS departed the Resident #294 and notified of sepsis indication at 5:00 that 5:05 PM indicated thargic, non-verbal with had rapid mouth breathing, dry, lung sounds were clear atory rate and oxygen ere inconsistent due to the nands. Resident #294:41 PM. dated 11/1/24 indicated that signs were noted as follows:				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345403	B. WING _		11	C I/ 22/2024	
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP C	•	1/22/2024	
CARY HE	ALTH AND REHABILI	TATION		6590 TRYON ROAD CARY, NC 27518			
(X4) ID PREFIX TAG	(EACH DEFICIE	'STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 692	level of alertness a on his own with copupils without respressonse to painful had not been eating days, and today he and encouraged the who then emerger #294 was found to condition in which the body). Becaus were unable to relige reading. Discussion had voiced wishes sustain his life. Aft goals of his care, for continue to be full was critically ill at a findicated that Resignental status, tack hypothermia, seven vasopressor requires shock with end orgodeath. Resident #200 An interview was a Medical Director (Note the IV accessive the IV access	age 62 itically ill, obtunded (reduced and consciousness), breathing and distal extremities with dilated conse bilaterally and no all stimuli. Facility stated that he ag or drinking anything for 3 are was found naked by his family the nurse to take his vital signs at the part of th	F	692			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	E CONSTRUCTION	COMPLETED	
		345403	B. WING		C 11/22/2024
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE S590 TRYON ROAD CARY, NC 27518	11/22/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 692	with no recent episod not elaborate and he everything right. An interview was cor PM with the Director stated that if nurses urine specimen on 15 should have notified normally in the buildithat if nurses notice at the resident is not ac should notify the one provider in the buildinurses should have I provider regarding La Resident #294 was resident #294 was resident #294 was resident with urination and the ordered urine specim. The Administrator was jeopardy on 11/20/24. The facility provided allegation of immedia 1) Identify those reciare likely to suffer, a a result of the nonco. Resident #294 no lon Resident was transference in the potential to be affect.	e and inability to obtain urine des of urination, the MD did reiterated that the facility did anducted on 11/20/24 at 4:30 of Nursing (DON). The DON were not able to obtain the 0/31/24 at 5:00 AM they the PA because PAs are ng daily. She further stated any signs of dehydration and lequately drinking they call provider if there is no ng. The DON also stated that had a discussion with the asix administration if not drinking adequately on inistering the 9:00 AM Lasix ad complained of burning ey had not obtained the nen. as notified of immediate at 6:04 PM. the following credible ate jeopardy removal:	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	, ,	DATE SURVEY COMPLETED	
		345403	B. WING _			C 11/22/2024	
	ROVIDER OR SUPPLIER	TION		STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY, NC 27518		11/22/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 692	dehydration. A review of Resident record revealed an or Culture and Sensitivi was ordered on 10/3 attempted to push fluon 10/31/2024 at approximate and an arrow was in a dry brief and urine sample. A reviindicated resident was daily to be administed orders. A quality review of cut for UA/C&S between 11/20/2024 were aud Clinical Services and 11/20/2024 to ensure obtained. No resider an issue with lab coll dehydration. 23 resident was a physician or and were audited by Unit Managers to ensure of the control of	#294's electronic medical rder for UA w/ reflux, Urine ty with Diagnosis of Dysuria 0/2024. The facility staff aids and obtain urine sample proximately 9:00 PM and stimately 5:30 AM the resident distaff was unable to collect a new of Resident #294 orders as prescribed Lasix 20mg ared daily per physicians' arrent residents with an order 10/20/2024 through lited by the Director of Unit Managers on a urine sample was not see identified as having nection that would indicate lents were identified as rder to administer diuretics the Director of Nursing and soure no signs and symptoms	F 6				
	collect urine. The Di Manager assessed of obtaining vital signs of heart rate, oxygen satisfies observation of dry creamed or altered mental ensure no other residusymptoms of dehydra and communicated to	denced by the inability to rector of Nursing and or Unit urrent residents to include (blood pressure, increased aturation, temperature), acked lips, poor skin turgor I status and chart review to dents exhibited signs and ation that was not addressed to the physician on terns were identified during					

PRINTED: 01/07/2025 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345403	B. WING	B. WING		11/	22/2024
NAME OF PROVIDER OR SUPPLIER CARY HEALTH AND REHABILITATION		ION		6	TREET ADDRESS, CITY, STATE, ZIP CODE 590 TRYON ROAD CARY, NC 27518	1111	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692	the Executive Director recognize the signs a and then to provide in to address an emerg #294. The resident had and signs or symptom evidenced by the inabout catheter. Nursing administer resident Lasymptoms of dehydra through the root caus staff failed to follow perecognize the serious symptoms of dehydra to obtain necessary man emergency situation. 2) Specify the action of the process or system adverse outcome from when the action will be the Director of Clinical Managers re-educate to recognize signs and through assessing the chart review to include physician to obtain neaddress an emergent signs and symptoms accontinued administrated 11/20/2024. Staff (lice Nurse Assistants) not will be educated by the Unit Manager prior to	t cause analysis was ector of Clinical Services and r regarding staff failure to nd symptoms of dehydration necessary medical services ent situation for Resident ad decreased fluid intake ns of dehydration as oility to collect urine via an in staff also continued to asix despite signs and ation. It was determined e analysis that the facility olicy and procedures to mess of signs and ation and notify the physician nedical services to address on. The entity will take to alter in failure to prevent a serious in occurring or recurring, and it complete al Services and Nurse in all licensed nurses on how do symptoms of dehydration are resident, observation, and it medical services to situation with emphasis on of dehydration and	F	692			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		TE SURVEY MPLETED
		345403	B. WING			C 11/ 22/2024
	ROVIDER OR SUPPLIER	TION		STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY, NC 27518	11/22/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 692	Managers. The Director of Clinic Managers re-educate assistants on signs a and immediately repthe licensed 11/20/20 educated during orie Clinical Service and Date of Immediate July 11/21/2024. On 11/22/24 the facil removal was validate The facility provided immediate jeopardy completed by the Dir Clinical Services and included all current rual/C&S from 10/20/which was revealed for UA/C&S with no chaving an issue with indicate dehydration residents with orders	cal Services and Nurse ed certified nursing and symptoms of dehydration ort the change in condition to 024. Newly hired staff will be ntation by the Director of or Unit Managers. eopardy Removal lity's immediate jeopardy ed by the following: documentation to support removal that included audits rector of Nursing/Director of d Unit Managers. The audits esidents with an order for 2024 through 11/20/2024 nine (9) residents with orders other residents identified as lab collection that would . The audits also included all	F 69.			
	signs and symptoms by the inability to col included assessmen include obtaining vita increased heart rate, temperature), observ poor skin turgor and chart review to ensure exhibited signs and s	vation of dry cracked lips, or altered mental status and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345403	B. WING _		,	C 1/22/2024	
	ROVIDER OR SUPPLIER	TION		STREET ADDRESS, CITY, STATE, ZIP COD 6590 TRYON ROAD CARY, NC 27518		1/22/2024	
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F 919 SS=D	the education they proceed the Director of Clinical Managers re-educated 11/20/24 on how to resymptoms of dehydraresident, observation, medications, and notinecessary medical seemergent situation wisymptoms of dehydra administration of diured Clinical Services and re-educated licensed assistants on 11/20/2 dehydration (decreas cracked lips, low bloomate, sunken eyes, all skin turgor). Interview staff would be educated Director of Clinical Sellnterviews with nursing been educated on all immediate jeopardy recommendated. Resident Call System CFR(s): 483.90(g)(1) (1) (1) (2) (2) (3) (3) (4) (4) (4) (4) (4) (5) (6) (7) (6) (7) (7) (6) (7) (7) (7) (7) (7) (7) (7) (7) (7) (7	r provided documentation on ovided to include sign-in in information indicated that all Services and Nurse and all licensed nurses on accognize signs and ation through assessing the indicated the physician to obtain a price to address an atthemphasis on signs and ation and continued actics. The Director of Nurse Managers in nursing staff and nursing 4 on signs and symptoms of a pressure, increased heart attered mental status, poor as confirmed that newly hired and during orientation by the price and/or Unit Managers. The price and/or Unit Managers are staff verified the staff had information as indicated in the emoval plan.	F 6			12/18/24	

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NAME OF P	ROVIDER OR SUPPLIER	0.0.00		STREET ADDRESS, CITY, STATE, ZIP CODE	11/22/2024
NAME OF T	TO VIDER OR OUT FIER			6590 TRYON ROAD	
CARY HEA	ALTH AND REHABILITAT	ION	l	CARY, NC 27518	
	OLUMBA DV OT	ATEMENT OF REFIGIENCIES	<u> </u>		
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F 919	Continued From page	e 68	F 919		
	§483.90(g)(2) Toilet a	esident's bedside; and nd bathing facilities. is not met as evidenced			
	Based on observation	n, record review, and		The Director of Nursing made sure the	•
		erviews, the facility failed to		call light was plugged in, in working or	
		plugged into the wall panel		and in reach of Resident #6. The Direct	ctor
		ent to allow them to call for		of Nursing made sure the call was in	.
		The deficient practice was		reach and not in a place where it could	be
		eviewed for accommodation		pulled out of the system.	
	of needs (Resident #6	0).		The Maintenance Director and Designe	
	Findings included:			audited the entire facility to ensure all	5 C
	i manigo moladoa.			residents had their call light within read	ch.
	Resident #6 was adm	itted to the facility on		in working order and that they were no	
	05/07/2014.	,		a place that could detach the light from	
				the system on 12/18/2024 with no furth	
	The quarterly Minimu	m Data Set (MDS) dated		call light system errors. Maintenance t	hen
	08/05/2024 had Resid	dent #6 coded as		installed missing clips to call bells to	
	moderately cognitively			secure the call bell to prevent it from	
		erself understood and can		being disabled from the call bell system	n.
		esident #6 was always			
	incontinent with bowe	l and bladder.		Any resident can be affected by this	
	A 1 (* 1.			deficient practice.	
		nterview were conducted		A 11 0 17 A	
		1/18/2024 at 10:43 AM.		An ad hoc Quality Assurance	
		er room, in her bed with		Performance Improvement committee	n d
		One end of her call bell the top of the bed and the		was held on 12/18/2024 to formulate a approve a plan of correction for the	riu
	•	button was tied around the		deficient practice.	
		panel was not visible from		denoient practice.	
	•	was asked if she could use		The Director of Nursing and Executive	
		to call for assistance. The		Director completed education for the	
		loes use her call bell and		licensed clinical staff, certified nursing	
		n. The light outside of the		assistants, all departments and all	
	-	ot light up. The panel behind		contracted vendors (Therapy, Dietary,	
		as checked to see if the light		Housekeeping/Laundry) to make sure	call
		come on and the plug for		lights are within reach, in working orde	
	the call light was not	olugged in. The call bell was		and not in a place where it could be	

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		345403	B. WING			C 11/22/2024	
NAME OF P	ROVIDER OR SUPPLIER	0.0.00		STREET ADDRESS, CITY, STATE, ZIP (11/22/2024	
TO UNE OF TH	TO VIDER OR GOLF EIER				3052		
CARY HEA	ALTH AND REHABILITAT	TION		6590 TRYON ROAD			
				CARY, NC 27518			
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F 919	Continued From page	∍ 69	F 9	19			
F 919	wrapped and tied aro Resident #6 stated, s regularly. The last tim last evening without a to Resident #6's room knotted up and tied to started to untangle the the wire into the outle push the call light, and An interview with Nur 11/18/2024 at 11:11 A residents should have and working. The Nur she came in to check ago and the Nursing care to Resident #6's and thought she would were working and with An interview with NA 11/18/2024 at 11:34 A usually made sure the before she left the room panel to make sure it notice if the call bell with the room. The NA als how it happened. The come out when Resident bed. An interview with the was conducted 11/18 DON stated all staff at	und the resident's bedrail.	F 9	detached from the system before leaving the resident education also included er bell is equipped with a clip ease of accessibility of the An ongoing audit will be considered and/or Unit Managers for stimes per week X 12 week lights are within reach, in wand not in a place where it detached from the system before leaving the resident The Executive Director will monthly for 3 months. The Nursing will report all result monitoring audits to the Question Findings will be reviewed the committee monthly and qualits will be updated as in	t's room. This assuring the call to the bed for resident. I onducted of Nursing residents for 3 is to ensure call working order could be for all residents t's room. I bring to QAPI is Director of the Director of the QAPI committee. The possible		
	expected her staff to call lights were plugg	the Residents room. She make sure the Residents ed in and within the leaving their rooms.					

Facility ID: 923078

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345403	B. WING	B. WING		C 11/22/2024	
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