DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	R-C 03/20/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS The purpose of the 03/20/12 survey was to determine if the facility had removed the immediate jeopardy from tag F329 that was cited during the survey on 03/02/12. The immediate jeopardy was removed on March 13, 2012. The facility remained out of compliance at a Scope and Severity level "D"- an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy. The facility will remain out of compliance until it provides an acceptable plan of correction and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance committee.	{F 000}	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations.	
{F 329} SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	{F 329}	1. Resident #2 was discharged to home from the facility on 2/14/12. 2. Identification of other residents who may be affected: ➢ An audit was completed by the Director of Nursing and Unit Managers of current facility residents (116 out of 116) completed by 03/02/12 regarding orders for lab tests (routine, and one time) in the last 30 days in order to verify labs were drawn, result were obtained, results were reported to physicians, and new orders were obtained as necessary. Physicians were notified of any deviations and clarification orders were obtained as needed.	3/27/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alicia Barnes	Administrator	3/27/12

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 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.

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{F 329}	Continued From page 1 drugs. This REQUIREMENT is not met as evidenced by: Based on record review, interviews with facility staff, laboratory manager, physician, physician assistant, nurse practioner and the medical director, the facility failed to conduct Prothrombin time (PT) and International Normalization Ratio (INR) tests as ordered to monitor coagulation status for 1 of 3 residents receiving Coumadin resulting in hospitalization for decreased appetite, lethargy, increased temperature, swollen and purple colored tongue, reddened chin and elevated PT/INR (Resident #2). Immediate Jeopardy (IJ) began on 12/26/11. The facility was notified of immediate jeopardy on 03/01/12 at 11:47 AM. The facility provided a credible allegation of compliance on 03/15/12. The immediate jeopardy was removed effective 03/13/12 during a survey on 03/20/12. The credible allegation of compliance was validated on 03/20/12. Validation of the Credible Allegation of Compliance was accomplished through record reviews and interviews with nursing staff, unit managers, director of nursing, and administrator. The facility provided evidence of the audits that were conducted to ensure that the laboratory tests were done as ordered by residents' physicians. The facility provided evidence of policy and procedures for ordering and monitoring	{F 329}	➢ An audit was completed by the Director of Nursing on 03/01/12 of current facility residents (115 out of 115) regarding orders for STAT labs in the last 30 days in order to verify labs were drawn, results were obtained, results were reported to physicians, and new orders were obtained as needed. Physicians were notified and clarification orders were obtained as needed. ➢ On 3/5/12, an audit was completed of residents (12 out of 12) receiving Coumadin as of that date in order to verify labs were drawn, results were obtained, results were reported to physicians, and new orders were obtained as necessary. Physicians were notified of any deviations and clarification orders were obtained as needed. . 3. System changes have been put in place by the facility to prevent the alleged deficient practice from occurring in the future. ➢ Education was provided to the all nurses regarding system changes listed below by the DON/Unit Manager/Weekend Supervisor/Regional Director of Clinical Services by 3/5/12.	

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{F 329}	Continued From page 2 laboratory tests. The facility provided evidence of in-services of all nursing staff regarding the process of handling laboratory tests for anticoagulation monitoring. The validation process included record review of sampled residents that had orders for anticoagulation monitoring to make sure laboratory tests were done as ordered. The validation process included review of the facility's monitoring tools, which demonstrated active and ongoing monitoring of laboratory tests for anticoagulation therapy Based on staff interviews and record review, the immediate jeopardy was removed during the survey dated 03/20/12. The facility remained out of compliance at a Scope and Severity level "D"- an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy. The facility will remain out of compliance until it provides an acceptable plan of correction and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance committee.	{F 329}	▪ Nurses on the floor receiving any Laboratory order will: ♦ Document the lab order on the 24-hour report ♦ Document the order on the MAR ♦ Document on lab log ♦ Clarify with the physician as to any medications to be held pending results of the lab ♦ Notify the lab of the order and complete a lab slip ♦ Call results to the physician when received ♦ In the event that a STAT lab has not been obtained within 4 hours, the nurse will notify the Director of Nursing and the physician for further guidance ♦ Fax lab orders to pharmacy for inclusion on monthly records	

3. System changes have been put in place by the facility to prevent the alleged deficient practice from occurring in the future (continued)

    - ♦ Copies of telephone orders are to be placed in the file folder marked DON located at each nursing station

- Telephone orders and 24 hour report will be reviewed by the Unit Manager/Director of Nursing Monday – Friday at the morning meeting and by the Weekend Supervisor on Saturday/Sunday to assure that labs are appropriately placed in lab book, results received, and appropriate notification to MD/PA has occurred.
- The facility has implemented a new anti-coagulant therapy program for residents receiving Coumadin
    - ♦ Two nurses must verify correct dose of anti-coagulant prior to administration and sign on MAR.
    - ♦ An anti-coagulant flow sheet is in use for residents receiving Coumadin. The DON/Unit Manager/Weekend Supervisor are responsible to ensure the form is in place for residents receiving Coumadin.
    - ♦ The anti-coagulant flow sheet documents current dosage, draw date of lab, date lab results were received, notification of MD, dosage change, next lab date.
    - ♦ Two nurses verifying the current dosage is accurate and signing the anti-coagulant flow sheet.

➢ Re-education was provided to the all nurses by the Regional Director(s) of Clinical Services 3/9-3/13/12 and added to facility orientation for new nurses regarding the above system changes.

4. Beginning on 3/5/12, the DON/designee will complete an audit of the anti-coagulant flow sheets and anti-coagulant order audit daily for current residents receiving anti-coagulant medication. The audit will be completed daily for one month, and then the Unit Manager will complete the audit daily when he/she is in the facility, and the DON will complete an audit weekly. The DON/designee will report the results of the QI monitoring to the RM/QI committee monthly for six months to ensure substantial compliance.