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 _____	07/25/2013

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 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and resident interviews the facility failed to provide maintenance services necessary to maintain a safe, clean, orderly, and comfortable interior on 3 of 4 resident halls (100, 200, & 300). The findings include: On 07/22/2013 at 11:30 a.m. a tour of the facility was conducted. During the tour the following areas were observed to be in disrepair and in need of maintenance: 100 Hall - To the left of resident room 108's door a hole was observed in the hall wall just below the hall's hand rail. The 100/200 hall resident common shower/bath room across from the nurse's station was observed to have 13 missing tiles on shower stall floor. The edges of the tiles around the missing tiles were observed to have sharp edges and could come in contact with any resident in a shower chair; The electrical (GFI) wall socket to the right of the sink was observed to only have 1 screw holding the socket in place (second screw was in plate but not securing the socket to the electrical box). The bottom portion of the electrical socket was observed to be bent outward 3/4" from the wall allowing easy	F 253	1. The corrective action taken for the areas identified during the survey was to repair, tighten, replace, adjust or install new products as indicated. The Maintenance Director, or his assistant, corrected all items listed. 2. The corrective action developed to address other areas in the building in need of repair was to do a comprehensive inspection of all resident rooms, bathrooms, common areas, shower rooms and hallways to identify places that need repairs, adjustments or replacements completed. Included with this POC is an attachment of the inspection. The areas of concern are identified as a 1, 2 or 3 with a 1 being highest priority of repair, 2 medium level of priority and 3 low level of priority. We will systematically go through the building addressing these areas based on the level of priority assigned.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	8/20/13

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.

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 _____	07/25/2013

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 253	Continued From page 1 observation of the socket wiring and/or the possibility of water from the sink to be splashed under the cover plate/socket and into the electrical box; The sink next to the shower stall was observed to be continuously running/dripping. The water faucet handles were observed to be fully closed but would not shut off the flow of running/dripping water. The sink was observed to have a yellow stain color where the running/dripping water was hitting the sink bowel; The towel bar next to the shower stall under the wall cabinet was missing the bar and the left end towel bar holder. The left metal towel bar bracket was observed still attached to the wall. The metal bracket was observed to have sharp edges and observed to be at a height easily within reach of any resident in a shower chair or shower bed. The door to resident room 112 was observed to not open or shut properly. The bottom of the door would drag on floor and stick/stop when the door was ½ open/shut. An interview was conducted with Resident # 30. Resident #30 indicated the door had been warped and would stick when opening and closing the door since 03/22/2013. Resident #30 indicated the warped/sticking door made it very difficult to enter and/or exit the room when in the resident's wheel chair. 300 Hall - An observation of the wall to the right of the door of resident room 322 revealed a hole in the wall just below the hand rail. The 300/400 hall common shower/bath room was observed to have an open (no cover) 4" drain hole in floor where a bath tub used to be next to the shower stall. The open drain hole was in close proximity of any resident seated in a shower	F 253	3. All staff will be in-serviced as to the use of the Maintenance Log Request Books. The staff will be instructed to assist in identifying areas that need repair or replacement by listing them in one of the Log Books. There will be a Log Book at each nursing station and one at the Reception Desk at the main entrance to the facility. The Maintenance Director or his assistant will check the books at least twice a day 5 days per week for any new requests for repair/maintenance. The Inspection Sheets will be done for all areas of the facility on a monthly basis to ensure repairs are being completed. The Maintenance Director or his assistant will be responsible for this inspection. The Executive Director will meet monthly with the Maintenance Director to monitor the progress of work being done. 4. The results of the inspections will be addressed at least quarterly during our Quality Assurance / Performance Improvement Committee meeting. Any areas of concern will be addressed as needed during this meeting.	08/20/13

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 _____	07/25/2013

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 253	Continued From page 2 chair whose feet could touch the floor and possibly get caught in the hole; Two copper pipes were observed to be coming 8 - 10 inches out of the back wall next to the shower stall and the open drain hole approximately 1 1/2 feet from the floor. The pipe's ends were observed to have been crimped flat and had sharp edges and corrosion on the crimped ends which faced the center of the room. The pipes were at a level that any resident in a shower chair could easily hit the pipes with their legs or hands. There was no covering over the pipes to protect any residents from possible injury; The shower stall was observed to have a dark substance on the white/tan tile grout in the shower stall corners and along the shower side walls at the floor; The grab bar next to the commode was observed to be loose on the wall mounts; The sink next to the shower stall was observed to have a missing hot water handle. There was no way for staff or a resident to turn on and use the hot water at this sink. On 07/23/2013 at 10:10 a.m. an observation was made of resident room 101. The towel bar at the resident's sink was observed to have loose towel bar brackets and loose wall mounts. On 07/23/13 at 2:25 p.m. a second observation was made of the items previously noted on 07/22/13 and found to be in need of maintenance repair and/or replacement. None of the items were observed to have been repaired or replaced. On 07/24/13 at 5:05 p.m. a third observation was made of the items previously noted on 07/22/13 and 07/23/2013 and found to be in need of maintenance repair and/or replacement. None of	F 253		

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 _____	07/25/2013

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 253	Continued From page 3 the items were observed to have been repaired or replaced. On 07/24/2013 at 4:10 p.m., an interview was conducted with the staff nurse covering the 100/200 halls. The nurse was asked how information of an item found in need of repair or replacement was documented and the facility's maintenance manager notified. The nurse indicated each nurse's station had a maintenance request binder and there was a binder also at the receptionist's desk. The nurse indicated that in each binder there were lined log sheets that staff would fill out indicating what item and where it was located needed to be fixed. The nurse indicated the maintenance manager would check the books daily and repair the items. The nurse also indicated the maintenance manager would sign off the repair on the entered line in the log book when he completed the repair. On 07/25/13 at 7:15 a.m. a fourth observation was made of the items previously noted on 07/22/13, 07/23/2013, and 07/24/2013 and found to be in need of maintenance repair and/or replacement. None of the items were observed to have been repaired or replaced. On 07/25/13 at 8:40 a.m. a review was conducted of the 100/200 hall's maintenance request log book which covered maintenance request dating back to June 2011. There were no entries in the logs showing any one had identified any of the observed items found to be in need of maintenance repair or replacement. On 07/25/13 at 11:55 a.m. a review was conducted of the 300/400 hall's maintenance request log book which covered maintenance	F 253		

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 _____	07/25/2013

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 253	Continued From page 4 request dating back to January 2012. There were no entries in the logs showing any one had identified any of the observed items found to be in need of maintenance repair or replacement. On 07/25/13 at 2:10 p.m. a review was conducted of the receptionist's area maintenance request log book which covered maintenance requests dating back to August 2011. There were no entries in the logs showing any one had identified any of the observed items found to be in need of maintenance repair or replacement. 07/25/2013 at 4:30 p.m., an observation was conducted with the facility's maintenance manager of each of the items observed during the previous 4 days (07/22-25/2013) and found in need of maintenance repair and/or replacement. The maintenance manager indicated during the observation of each item that he had not previously known the items were in need of repair and/or replacement and he had not seen any of the items documented in any of the facility's maintenance book's logs. 07/25/2013 at 4:50 p.m., an interview was conducted with the facility's maintenance manager. The maintenance manager was asked to explain the process for items found by staff/residents/visitors in need of repair and/or replacement. The maintenance manager indicated there were three maintenance log books - one at each nurse's station and one at the front receptionist's desk area. The broken items would be reported to the facility's staff who would document the things found/observed to be broken or needing repair/replacement. The maintenance manager indicated he would review each of the binder's logs several times a day and	F 253		

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 _____	07/25/2013

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 253	Continued From page 5	F 253		

repair and/or replace the items documented in the logs. The maintenance manager indicated there was no other place that a maintenance request would be logged except the three maintenance request books (binders). The maintenance manager did indicate he carried a spiral notebook around and would write information from the morning Stand Up meetings and/or other verbal requests for maintenance repair/replacement in it.

07/25/2013 at 5:05 p.m., a review of the maintenance manager's spiral notebook was conducted with the maintenance manager. There was no documentation in the maintenance manager's spiral notebook to indicate any of the items observed and noted during the week's observations and additionally observed with the maintenance manager on 07/25/2013 were known by him as needing maintenance repair and/or replacement. The maintenance manager was asked if he knew or had been informed about any of the items observed needing to be repaired or replaced. The maintenance manager indicated he was never informed verbally or in writing (via the log books or other means) of any of the items observed and he had not deferred any maintenance nor had any staff informed him verbally or in writing the items were to be maintenance deferred for a later date.

On 07/25/2013 at 6:40 p.m., an interview was conducted with the facility's administrator concerning the items observed and found in need of repair and or replacement. The administrator provided documentation indicating the facility was planning a renovation in the future. There were no specific dates to indicate when such renovations were to take place. The

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 _____	07/25/2013

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 253	Continued From page 6 documentation did indicate general areas of the facility that were to be renovated and the approximate dollar amounts which were to be spent in each area. There was no information the administrator could provide to indicate the facility knew about each of the items observed during the week and observed with the maintenance manager which needed maintenance repair and/or replacement for resident safety and comfort. The administrator could not provide any information to indicate the items observed were documented in any of the facility maintenance request book logs or other sources to indicate the facility knew the items were in need of maintenance repair and/or replacement. The administrator could not provide any information to indicate the facility's maintenance manager knew about the items and/or the items were being deferred for ordered parts and to be repaired at a later date.	F 253		
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	F 329		

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 _____	07/25/2013

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 329	Continued From page 7 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 drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to act on the pharmacist's recommendation and action documented by the physician to discontinue accuchecks and sliding scale insulin for 1 of 10 sampled residents (Resident #68) reviewed for unnecessary drugs. Findings include: Resident #68 was admitted to the facility 7/7/2007 and re-admitted 8/3/2010. Her diagnoses included diabetes mellitus (DM) type II, gastric esophageal reflux, coronary artery disease, and dementia. Review of the Quarterly Minimum Data Set (MDS) dated 5/13/2013 found that Resident #68 had short and long term memory deficits and was moderately impaired in decision making. The MDS also noted that Resident #68 received 5 insulin injections during the 7 day look-back period. The Care Plan dated 5/21/2013 was reviewed. A problem documented was at risk for hypoglycemic or hyperglycemic episodes	F 329	1. The corrective action taken for this concern was to obtain a telephone order for resident #68 to discontinue accu checks and sliding scale insulin. 2. The corrective action we took to ensure other residents will not potentially be affected was to complete an audit on current residents for further incomplete pharmacy recommendations. 3. The systematic change made to ensure this does not happen in the future was to educate the Medical Records department regarding all signed pharmacy recommendations are to be given to the Director of Clinical Services (DCS) for follow through with the appropriate personnel (attending physician, Medical Director, etc.). 4. The DCS will audit 10 charts monthly for 3 months, then quarterly for 6 months. The results of the DCS's monitoring will be presented and discussed at the monthly Quality Assurance / Performance Improvement Committee meeting. Any additional training required will be provided as needed when an issue is discovered.	08/20/13

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 _____	07/25/2013

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 329	Continued From page 8 secondary to diabetes mellitus. Interventions included monitoring blood sugars and administering medications as ordered. Physician's orders reviewed included accuchecks before meals and at bedtime with a sliding scale to administer Novolog 100 unit/ml (milliliters) SQ (subcutaneous) injection as follows: For blood sugar 60-199 = 0 units; 200-249 = 3 units; 250-299 = 5 units; 300-349 = 6 units; 350-400 = 7 units > 400 or < 60 call physician. The Medication Administration Records (MAR) for 6/1-6/30/2013 and 7/1-7/31/2013 in review documented that Resident #68 had accuchecks done before each meal at 6:30 am, 11:30 am, and 4:30 pm and at bedtime at 9:00 pm resulting in insulin injections being given. The MARs indicated the start date for the accuchecks and insulin injections was 8/3/2010. A Pharmacy Consultation Report dated 6/26/2013 was reviewed. The pharmacist's recommendation read as follows: Please re-evaluate the use of sliding scale insulin as monotherapy. Do we need to start an oral DM medication? In reviewing most recent MAR in chart use of sliding scale insulin is mostly at 11:30 am and 21:00 pm. Also, please consider reviewing frequency of accuchecks to determine if this can be decreased. The Physician's Response was: I accept the recommendations above, please implement as written. The physician also hand wrote DC (discontinue) accuchecks and sliding scale and signed the report.	F 329		

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 _____	07/25/2013

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 329	Continued From page 9 In an interview on 7/24/2013 at 4:21 pm Nurse # 1 was asked who was responsible for entering orders from physician signed pharmacy recommendations into the chart and the corresponding changes on the MAR. The nurse responded that she thought the pharmacy printed out a sheet which was given to the Director of Nurses (DON) and the DON then updated the MAR. Nurse #1 indicated that was the way it was done months ago with the former DON. At 4:35 pm on 7/24/2013 the DON stated in an interview that the physician came to the facility every Thursday and signed pharmacy recommendations at that time. The signed recommendations were then given to the DON. Asked who gave them to her, the DON responded that typically the physician did, but she never received this recommendation. The DON stated that when she received a pharmacy recommendation, she printed it on colored paper and put that copy on the chart. The original was given to the physician for his review. When the physician returned the signed recommendation, the DON or her designee wrote the order in the chart, updated the MAR, and replaced the colored copy with the signed one in the chart. After rechecking all signed recommendations received since 6/26/2013, the DON stated that she did not receive this one for stopping accuchecks and sliding scale insulin.	F 329		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all	F 431		

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 _____	07/25/2013

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 431	Continued From page 10 controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews the facility failed to discard expired medications in 3 of 9 medication storage areas and date opened insulin in 2 of 9 medication storage areas.	F 431	1. The corrective action taken was to remove all expired medications or undated medications from the med carts as well as the medication rooms. 2. The corrective action taken to ensure no other residents would be affected was to complete a full audit of all medications located in each medication cart, medication room and emergency drug box in the building. The pharmacy nurse consultant completed this audit with assistance from our administrative nurses. 3. The systematic process that was completed to ensure compliance in the future was the education to licensed staff by the DCS, ADCS and Unit Supervisor on dating medications when opening as well as reviewing medications for expiration dates and to include dating insulin bottles when opened to be dispensed. This same education will be used during orientation for new licensed staff member hired in the future. 4. The Director of Clinical Services, ADCS or Unit Supervisor will audit 5 medication carts and both medication rooms weekly for 2 months, then biweekly for 2 months then monthly for 2 months. The DCS will bring the results of the monitoring to be presented and discussed at the monthly Quality Assurance / Performance Improvement Committee Meeting. Any concerns identified during the audits will be addressed at that time with additional training being provided as necessary.	08/20/13

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 _____	07/25/2013

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 431	Continued From page 11 Findings include: 1) On 7/24/2013 at 10:55 am with Nurse #3 present an observation was made of the medication cart for the split 100/200 hall. Found in the cart were Novolin R insulin with an opened date of 6/10/2013 with discard after 28 days printed on the label, Novolog insulin with an opened date of 6/1/2013 with expires 28 days after opening printed on the label, Humulog insulin with an opened date of 6/24/2013 with discard 28 days after opening printed on the label, Lantus insulin with an opened date of 6/10/2013 and expires 28 days after opening printed on the label, Humulin R insulin with an opened date of 6/10/2013 with discard 28 days after opening printed on the label, and Lantus insulin with an opened date of 6/1/2013. There were also 2 opened bottles of Lantus insulin and one of Humulog insulin with no date opened. When asked who was responsible for checking medications in the medication carts for expiration dates, Nurse #3 said the nurse using the cart was responsible for checking. The nurse also indicated that the pharmacist checked the carts monthly when there. Per the Pharmacist's Review notes, the pharmacist was last at the facility 6/28/2013. At 2:45 pm on 7/24/2013 an observation was made with Nurse #2 present of the 100 hall medication cart. Found in the cart were Novolog insulin with a date opened of 6/22/2013 with discard 28 days after opening printed on the label and Ipratropium Bromide0.5/Albuterol Sulfate by Sandoz with an expiration date of 5/2013. There was also one opened bottle of Novolin R with no date opened. When asked who was responsible	F 431		

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 _____	07/25/2013

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 431	Continued From page 12 for checking for expired medications, Nurse #2 responded that nurses checked their own carts and the pharmacist went through the carts once a month. In an interview on 7/24/2013 at 4:38 pm the Director of Nurses (DON) stated her expectation was that nurses would check the expiration date on medications before giving it to be sure it wasn't expired and insulin should have the date opened recorded on the label. The DON added that there was not a designated person or shift responsible for checking for expired medications and the pharmacy checked the carts at the end of the month. The DON was unable to located a medication storage policy, but provided an Insulin Storage Recommendations sheet from a company that supplies their insulins. The sheet indicated that all of the above insulins once opened expired in 28 days except Novolin R which expired in 42 days after opening. 2) On 07/24/13 at 3:30 p.m. an observation was made of the 100/200 hall's medication room with the 100/200 hall charge nurse. During the observation of the left side of the medication room's wall there were several shelves of colored plastic bins observed. In one of the bins five - 5cc new/full (unused) Heparin flush syringes were observed. The charge nurse indicated any staff nurses would get one of the Heparin flush syringes when need to conduct patient care or follow a physician's order. Two of the five - 5cc Heparin flush syringes located in the same bin were observed to be expired (by 54 days) and documented the following information on the syringes: Lot 216041N Expiration 05/13.	F 431		

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 _____	07/25/2013

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 431	Continued From page 13 On 07/24/13 at 3:37 p.m., an interview with the charge nurse was conducted. The charge nurse indicated the 2 Heparin flush syringes were expired and should not have been available for use with the unexpired Heparin flush syringes.	F 431		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to ensure 2 of 2 resident common use shower rooms had call light systems that were 100% functional. The findings include: On 07/22/2013 between 11:30 a.m. and 12:30 p.m. a tour of the facility was conducted. During the tour the 100/200 hall resident common use shower/bath room and the 300/400 hall resident common use shower/bath room was observed. Each of the common use shower/bath rooms was observed to have 3 call light pull chord/switches (commode area, shower stall, and bath area). Each of the 3 call light switches was activated in each common use shower/bath room. During these tests/activations it was revealed that 1 switch in each common use shower/bath rooms was not 100% operational and did not operate the hall's call light located just outside the shower/bath room door to indicate where	F 463	1. The corrective action taken to repair the call bell light above the door for each shower room was to replace the burned out bulbs. 2. The corrective action taken to ensure no other potential call bell issue existed was to complete a full test audit of each call bell pull station in the resident rooms, resident bathrooms and all pull stations in the common shower rooms. This audit completed by the Maintenance Director tested to ensue that when activated the call bell system enunciated the call bell had been activated and that the light above the door for each pull station functioned properly. 3. The call bell system will be tested weekly for the next month, then biweekly for one month and quarterly for the next 6 months by the Maintenance Director or his assistant. 4. The results of the tests of the call bell system will be discussed at our monthly Quality Assurance / Performance Improvement Committee Meeting. The Executive Director will monitor to ensure the tests are completed and any needed repairs are made.	08/20/13

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 _____	07/25/2013

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 463	Continued From page 14 assistance was needed. On 07/23/13 at 2:25 p.m. a second observation was made of the items previously noted on 07/22/13 and found to be in need of maintenance and/or repair which included the 100/200 hall's and 300/400 hall's common use shower/bath room call light. The common use shower/bath room's call light system was still observed not to be 100% operational as the hall light indicating where assistance was needed would not come on when tested. On 07/24/13 at 5:05 p.m. a third observation was made of the items previously noted on 07/22/13 and found to be in need of maintenance and/or repair which included the 100/200 hall's and 300/400 hall ' s common use shower/bath room call light. The common use shower/bath room's call light system was still observed not to be 100% operational as the hall light indicating where assistance was needed would not come on when tested. On 07/24/2013 at 4:10 p.m., an interview was conducted with the staff nurse covering the 100/200 halls. The nurse was asked how information of an item found in need of repair or replacement was documented and the facility's maintenance manager was notified. The nurse indicated each nurse's station had a maintenance request binder and there was a binder also at the receptionist's desk. The nurse indicated that in each binder there were lined log sheets that staff would fill out indicating where and what was broken and needed to be fixed. The nurse indicated the maintenance manager would check the books daily and repair the items. The nurse	F 463		

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 _____	07/25/2013

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 463	Continued From page 15 indicated the maintenance manager would sign off the repair entry line in the log book when he completed the repair. On 07/25/13 at 7:15 a.m. a fourth observation was made of the items previously noted on 07/22/13 and found to be in need of maintenance and/or repair which included the 100/200 hall's and 300/400 hall's common use shower/bath room call light. The common use shower/bath room's call light system was still observed not to be 100% operational as the hall light indicating where assistance was needed would not come on when tested. On 07/25/13 at 8:40 a.m. a review was conducted of the 100/200 hall's maintenance request log book which covered maintenance request dating back to June 2011. There were no entries in the logs showing any one had identified any of the observed items found to be in need of maintenance repair or replacement. On 07/25/13 at 11:55 a.m. a review was conducted of the 300/400 hall's maintenance request log book which covered maintenance request dating back to January 2012. There were no entries in the logs showing any one had identified any of the observed items found to be in need of maintenance repair or replacement. On 07/25/13 at 2:10 p.m. a review was conducted of the receptionist's area maintenance request log book which covered maintenance requests dating back to August 2011. There were no entries in the logs showing any one had identified any of the observed items found to be in need of maintenance repair or replacement.	F 463		

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 _____	07/25/2013

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 463	Continued From page 16 07/25/2013 at 4:30 p.m., an observation was conducted with the facility's maintenance manager of each of the 100/200 hall's and 300/400 hall's common use shower/bath room's call light systems. The maintenance manager indicated during the observations of the call light systems that both were supposed to be 100% operational and he had not previously known the items were in need of repair and/or replacement and he had not seen either of the items documented in any of the facility's maintenance book's logs requesting repair. 07/25/2013 at 4:50 p.m., an interview was conducted with the facility's maintenance manager. The maintenance manager was asked to explain the process for items found by staff/residents/visitors in need of repair and/or replacement. The maintenance manager indicated there were three maintenance log books - one at each nurse's station and one at the front receptionist's desk area. The staff would document things found/observed to be broken or needing repair/replacement. He would review the binder's logs several times a day and repair and/or replace the items documented in the logs. The maintenance manager indicated there was no other place that a maintenance request would be logged except the three maintenance request books (binders). The maintenance manager did indicate he carried a spiral notebook around and would write information from the morning Stand Up meetings and/or other verbal requests for maintenance repair/replacement in the spiral log book. 07/25/2013 at 5:05 p.m., a review of the maintenance manager's spiral notebook was conducted with the maintenance manager. There	F 463		

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 _____	07/25/2013

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 463	Continued From page 17 was no documentation in the maintenance manager's spiral notebook to indicate he had been notified of either of the two common use shower/bath rooms having non functional call light switches and/or lights. The maintenance manager was asked if he knew or had been informed about the call light systems in the common use shower/bath rooms needing to be repaired or replaced. The maintenance manager indicated he was never informed verbally or in writing (via the log books or other means) of either of the call light systems not being 100% functional nor had any staff informed him verbally or in writing the items were to be maintenance deferred for a later date. On 07/25/2013 at 6:40 p.m., an interview was conducted with the facility's administrator concerning the items observed and found in need of repair and or replacement. The administrator provided documentation indicating the facility was planning a renovation in the future. There were no specific dates to indicate when such renovations were to take place. The documentation did indicate general areas of the facility that were to be renovated and the approximate dollar amounts which were to be spent in each area. There was no information the administrator could provide to indicate the facility knew about each of the items observed during the week and observed with the maintenance manager which needed maintenance repair and/or replacement for resident safety and comfort. The administrator could not provide any information to indicate the items observed were documented in any of the facility maintenance request book logs or other sources to indicate the facility knew the items were in need of maintenance repair and/or replacement. The	F 463		

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 _____	07/25/2013

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 463	Continued From page 18 administrator could not provide any information to indicate the facility's maintenance manager knew about the items and/or the items were being deferred for ordered parts to be repaired at a later date.	F 463		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/14/2013

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
K 000	INITIAL COMMENTS A Based on observation on 08/14/2013 the facility is one (1) story, type 111 protected ,fully sprinkled ,with delayed egress locks.	K 000	K 012 1. The unsealed penetration around the sprinkler riser has been sealed. 2. An inspection of the other sprinkler risers, water lines, electrical and cable penetrations through ceilings and fire or smoke partitions have been inspected by the Maintenance Director or his designee to ensure they are sealed. 3. The measures we will take in the future to ensure compliance will be to have all work performed by contractors inspected for breaches in ceilings and smoke or fire partitions prior to the service provider leaving the building. Any identified areas will be properly sealed during the inspection. 4. The Maintenance Director or his designee will report all service calls for contractors to the Administrator. The Administrator will monitor to ensure the Maintenance Director or his designee has inspected for breaches and that they were sealed. The Maintenance Director will report any issues to the Monthly Quality Assurance, Performance Improvement Committee meeting in the future.	09/13/13
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: A. Based on observation on 08/14/2013 there was an unsealed penetration around the sprinkler riser in the riser room. 42 CFR 483.70 (a)	K 012		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 08/14/2013 the following doors failed to close and latch :	K 029		

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

Administrator | 8/30/13

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

CD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/14/2013

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
K 029	Continued From page 1 a. House Keeping Supply near room 117 b. Wheel chair and Ambulatory Storage c. Dry storage in the kitchen d, Laundry 42 CFr 483.70 (a)	K 029	K 029 1. The corrective action taken for the identified doors not closing properly was to adjust the doors to close properly. 2. The Maintenance Director and his Assistant have inspected the other doors in the facility to ensure they open, close and latch properly. 3. The systematic change we have implemented is to inspect all doors in the facility monthly for the next three months, then quarterly for two quarters. 4. The monitoring of this process will be done by the Maintenance Director. The results of the inspections will be brought to our Quality Improvement, Performance Improvement Committee meeting each month.	09/13/13
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: A. Based on observation and staff interview on 08/14/2013 the staff did not know the fire drill procedure. 42 CFR 483.70 (a)	K 050	K 050 1. The Staff has been inserviced on the proper procedures for a fire drill. 2. All new staff when hired will be trained in the proper procedures for a fire drill to ensure if there ever was a fire, the staff would know how to respond. 3. The systemic changes we will make are that we will have a wrap up meeting after each fire drill to ensure everyone who participated in the drill understands proper fire procedures.	
K 061 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 08/14/2013 one(1)	K 061		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/14/2013

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
K 061	Continued From page 2 tamper alarm on the back-flow device for the sprinkler failed to transfer a signal and the alarm for riser #2 failed also. 42 CFR 483.70 (a)	K 061	K 050 4. The Executive Director will monitor on a monthly basis the results of the fire drills and to ensure wrap up meetings with staff are being done. The results of the drills will be presented to the Quality Assurance, Performance Improvement committee during our monthly meetings. K 061 1. The tamper alarms for both the back-flow device and for riser #2 have been repaired and function properly. 2. While the service contractor was here he inspected the two other tamper alarms to ensure they were functioning properly. 3. The systemic change we will make is to have the Maintenance Director or his designee to test the tamper alarms monthly for the next 3 months and quarterly going forward to ensure the alarms are functioning properly. 4. The results of the monthly and quarterly monitoring of the tamper alarms will be reported to the Quality Assurance, Performance Improvement committee during our monthly meetings.	09/13/13 09/13/13