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	345403	A. BUILDING ______ B. WING ______	C 12/21/2017

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 survey team entered the facility on 12/12/17 to conduct a complaint survey and exited on 12/14/17. Additional information was obtained on 12/15/17, 12/18/27, 12/19/17, 12/20/17, and 12/21/17. Therefore, the exit date was changed to 12/21/17.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, family interview, and staff interview the facility failed to assure the accurate administration and documentation of medications and blood sugars for one (Resident #13) of five sampled residents whose medications were reviewed. The findings included: 1a. Record review revealed Resident #13 was admitted to the facility on 11/12/2017 at 4PM with a diagnosis of diabetes. The record was initially reviewed on 12/14/17 as a closed record. According to the resident's initial care plan, dated 11/12/2017, the resident was to have meds as ordered under the problem of diabetes with the goal to have no complications. Review of admission orders dated 11/12/2017 revealed orders for insulin Levemir 26units in AM	F 658	F658 483.21(b)(3)(i) Services Provided Meet Professional Standards The deficiency occurred as a result of inadequate staff training and quality monitoring. Missed communication opportunities with pharmacy contributed as well. 1. Resident #13 no longer resides in the facility. Nurse #9, #7, and #6 was re-educated on 1-16-2018 by the Director of Clinical Services on administering medications as ordered and signing of medication administration records. 2. A Quality Review of current residents	1/17/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 01/12/2018

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 658 Continued From page 1
and 18units at bedtime.

There were no orders indicated on the MAR until 11/14/2107 for blood sugars to be taken.

The first time the resident's blood sugar was recorded was on 11/14/17 at 11 AM when it registered 561. There was no notation the nurses tried to clarify with the physician regarding blood sugar checks prior to 11/14/17.

Interview with the director of nursing on 12/14/17 at 5:15 PM revealed it was her expectation that if an Insulin dependent resident was admitted to the facility, then nurses should clarify with the physician regarding how often blood sugar readings needed to be done. An interview with the DON again on 12/21/17 at 3:30 PM revealed her expectation for nursing standards of practice was that any blood sugars that were obtained would have been documented in the record.

1b. Record review revealed Resident # 13 also had an order on admission for Glucotrol 10mg twice daily before meals on the November MAR scheduled for 6:30 AM and 4:30 PM which was not given until the 4:30 PM dose on 11/14/2017. The 6:30 AM dose on 11/14/2017 was initialed and circled with no explanation of why it was not given in documentation. The other doses were blank, with no explanation of why they had not been administered.

According to records the following nurses were responsible for resident's Glucotrol on the following dates:
11/12/2017 on the 3PM to 11PM shift - Nurse #9
11/13/2107 on the 7AM to 3 PM shift - Nurse #6
11/13/2017 on the 3PM to 11PM shift - Nurse #7

F 658

medication administration records has been conducted to ensure blood glucose monitoring obtained / documented per standard. A Quality Review of current residents medication administration records has been conducted to ensure current medications administered and signed per physicians' orders.
12-15-2017.

3. Director of Clinical Services to re-educate nurses on accurate administration and documentation of medications for diabetic residents and obtaining and documentation of blood glucose monitoring by 1-16-2018.

Director of Clinical Services/ Assistant Director of Clinical Services , Unit Manager/Designee to complete quality monitoring on 5 diabetic residents weekly for 12 weeks, then monthly using the quality improvement monitoring tool to ensure medications administered, documented and blood glucose monitoring obtained and documented as ordered by the physician. Opportunities to be corrected by the Director of Clinical Services and or Assistant Director of Clinical Services as identified during quality reviews. Quality Monitoring Schedule modified based on findings.

Administrator will ensure full implementation of the plan of correction.

4. The results of quality reviews to be submitted to the Quality Assurance and Performance Improvement Committee

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11/14/2107 on the 7AM to 3PM shift - Nurse #6

According to records, Nurse #6 arrived early on 11/13/2017 and 11/14/2017 and was responsible for the 6:30 AM doses of glucotrol on those dates.

Interview with the Director of Nursing (DON) on 12/21/2017 at 3:30 PM revealed Nurse #9 was currently out of the country and unavailable for interview. The DON did not know why the Glucotrol was blank for the evening dose of 11/12/2107.

Nurse #6 was interviewed on 12/21/2017 at 10:10 AM. Nurse #6 reported the following: She did not recall why she did not sign for the 11/13/2017 dose of Glucotrol, but stated she always gave medications as ordered to her knowledge. Her circled initials for the 11/14/2017 dose of Glucotrol meant there was an issue but she did not recall what the issue was.

Interview with the DON of 12/21/2017 at 3:30PM revealed she had followed up with Nurse #6. According to the DON, Nurse #6 had recalled the resident had already eaten his breakfast on 11/14/17 and therefore the resident's diabetic medication was not given at 6:30 AM because the resident had eaten. Thus it was clarified with the DON that the resident had an omitted dose of Glucotrol on the AM his blood sugar registered 561 at 11:00 AM.

Nurse #7 was interviewed on 12/21/2017 at 3:45 PM. Nurse #7 reported the following. She gave Resident #13 his Glucotrol but did not sign for it.

Interview with the Director of Nursing (DON) on 12/21/2017 at 3:30 PM revealed it was her

Provider's plan of correction (F 658):

(QAPI) by the Director of Clinical Services for review by the Interdisciplinary members each month. The QAPI committee to evaluate the effectiveness and amend as needed.

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F 658	Continued From page 3 expectation that nurses sign for medications they administer, and if a medication was circled as not administered then nurses should write an explanation on the back of the MAR.	F 658		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel	F 690		1/17/18

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F 690	Continued From page 4 receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews the facility failed to provide the securing of indwelling catheter and failed to document that the indwelling catheter was changed monthly for November for 1 of 1 resident (Resident #7). The findings included: Resident #7 was admitted to facility 09/11/2017 with indwelling catheter in place due to sacral pressure ulcer. Resident was non-interviewable. Review of record related to indwelling catheter cares revealed no orders from 09/11/2107 to 09/14/2017. Record review revealed order on 09/14/2017 for Resident #7 for indwelling catheter care per facility protocol. Facility protocol orders include: 1) secure indwelling catheter to resident with leg strap every shift. Observation of indwelling catheter tubing with licensed practical nurse (LPN) #8 on 12/14/2017 at 11:30AM revealed that indwelling catheter tubing was not secured to resident. Interview with Nurse #8 at time of observation stated that she is aware that catheter is to be secured to resident and did so immediately after observation. Nurse stated that all catheters are to be secured and did not know why this resident's was not.	F 690	F690 483.25(e)(1)(3) Bowel/Bladder Incontinence, Catheter, UTI The deficiency was the result of inadequate staff training and quality monitoring. 1. Director of Clinical Services validated Resident #7s indwelling catheter tubing was properly secured to his leg via leg strap on 12-14-17. Resident #7 indwelling catheter was changed on 12-15-2017. Resident #7s indwelling catheter tubing remains secured. Nurse #5 was re-educated on documentation of changing of catheters on treatment administration record on 12-14-2017. 2. Quality Observation Rounds conducted for residents with catheters by the Director of Clinical Services to ensure catheters are secured with leg straps on 12-14-2017. Follow up based on findings. A Quality Review of current residents with catheters Treatment Administration Records (TAR) has been conducted by Director of Clinical Services to ensure care of catheters documented to include changing of catheters as indicated.	

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F 690	Continued From page 5 Order dated 10/11/2107 in record stated exchange indwelling catheter every month. Record review revealed indwelling catheter exchange documented on 10/11/2107. Exchange scheduled for 11/11/2017 on medication administration record (MAR) revealed no documentation of being completed. As of the date of this review, 12/14/2017, the order was not written on the December MAR to exchange the indwelling catheter. Interview on 12/21/2017 with Nurse #5 that worked night of scheduled exchange of catheter, 11/11/2017, stated that he did exchange the catheter but failed to document. Interview with director of nursing (DON) on 12/14/2107 stated that her expectations for catheter care is completion as ordered and documentation on each resident.	F 690	1-16-2018. 3. The Director of Clinical Services to re-educate nurses on securing of catheter tubing and care of catheters documented to include changing of catheters by 1-16-2018. 3. The Director of Clinical Services/ Assistant Director of Clinical Services and or Unit Manager to complete quality monitoring on 3 residents three times weekly for 12 weeks, then monthly to ensure catheter tubing secured and documentation of catheter care is complete, including changing of catheters. Opportunities to be corrected by the Director of Clinical Services/ Assistant Director of Clinical Services and or Unit Manager as identified during quality reviews. Quality Monitoring schedule modified based on findings. Administrator will ensure full implementation of the plan of correction. 4. The results of quality reviews to be submitted to the Quality Assurance and Performance Improvement Committee (QAPI) by the Director of Clinical Services for review by the Interdisciplinary members each month. The QAPI committee to evaluate the effectiveness and amend as needed.	
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 755		1/17/18

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F 755	Continued From page 6 them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview the facility failed to provide pharmaceutical services for three (Resident # 3, # 12, and # 13) of five sampled residents whose medications were reviewed. The facility failed to acquire ordered medications upon the admission of three sampled residents. The findings included:	F 755	F755 483.45(a)(b)(1)(3) Pharmacy Srvcs/Procedures/Pharmacist/Records The deficiency occurred as a result of inadequate staff training and quality monitoring. Missed communication opportunities with pharmacy contributed	

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F 755	Continued From page 7 1a. Resident # 3 was admitted to the facility on 11/14/17 with a diagnosis of Clostridium Difficile; a gastrointestinal infection. According to the resident's hospital discharge orders and facility admission orders, dated 11/14/17, the resident was to receive an oral antibiotic solution of Vancomycin 125 milligrams every six hours for treatment of the Clostridium Difficile. Review of the resident's facility admission note, dated 11/14/17, revealed Resident # 3 arrived at the facility on 11/14/17 at 4:00 PM. Review of the resident's November, 2017 MAR (Medication Administration Record) revealed the Vancomycin was transcribed to the MAR to be given on a 12:00 AM; 6:00 AM; 12:00 Noon, and 6:00 PM schedule. Further review of the November, 2017 MAR revealed the following information: On 11/14/17 the MAR was blank beside the Vancomycin order indicating no doses were given on the day of admission following the resident's arrival at 4 PM. Only one dose would occur on 11/14, the midnight dose was 11/15. On 11/15/17 at 6 AM Nurse # 10's initials were circled indicating the Vancomycin was not given. On 11/15/17 at 12 Noon, Nurse # 4's initials were circled indicating the Vancomycin was not given. On 11/15/17 at 6 PM, Nurse # 9's initials were circled indicating the Vancomycin was not given. Review of the facility's list of emergency medications revealed Vancomycin oral solution was not maintained in their back up supply and therefore would not have been available for administration until the pharmacy delivered the	F 755	as well. 1. Residents #3, #12, and #13 no longer reside at the facility. Nurse #10, #4 and #9 have been re-educated by the Director of Clinical Services on pharmacy procedures for ordering of medications to include for new admissions, calling of pharmacy to validate receiving of new admission orders , time of arrival of medications, use of back up medications and back up narcotics on 1-16-2018. Nurse #10, #4, and #9 have also been re-educated by the Director of Clinical Services on proper documentation of medication administration. 2. A Quality Review of current residents Medication Administration Records (MAR) has been conducted by Director of Clinical Services/Assistant Director of Clinical Services and or Unit Manager on 1-16-2018 for missing documentation and or circling of medications to ensure medications are being administered as ordered. Follow up based on findings of review. 3. The Director of Clinical Services to re-educate nurses on pharmacy procedures for ordering of medications to include for new admissions, calling of pharmacy to validate receiving of new admission orders and time of arrival of medications, use of back up medications and back up narcotics by 1-16-2018. The Director of Clinical Services to re-educate	

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medication.

Interview with a pharmacy manager on 12/18/17 at 10:00 AM revealed the Vancomycin was not dispensed to the facility until the day after the resident's admission. The pharmacist stated it was dispensed on 11/15/17, and it was received by the facility on that date at 10:44 PM. According to the pharmacist, the pharmacy had no records the facility staff called to request the medication earlier.

Nurse # 10 was interviewed on 12/19/17 at 2:45 PM and reported the following. She had not given the dose at 12:00 AM on 12/14/17. The nurse stated she had left the MAR blank because she had anticipated the Vancomycin would come in around 12:30 to 1:00 AM, but it did not arrive. She stated she also did not give the 6:00 AM dose on 11/15/17 because it had not arrived. She called the pharmacy before the end of her shift, and was told the Vancomycin would arrive that day. In shift change report she told the 7:00 AM to 3:00 PM nurse that there needed to be follow up about the missing medication.

Nurse # 4 was interviewed on 12/18/17 at 4:35 PM. Nurse # 4 did not specifically remember Resident # 3, but stated if she had circled her initials on the MAR this would indicate she had not given the medication. The nurse reported it was her standard of practice to always call the pharmacy when a medication was not available for administration.

On 12/18/17 at 4:35 PM an attempt was made to reach Nurse # 9, who had admitted the resident on 11/14/17 and also cared for the resident on the evening of 11/15/17. The nurse could not be

F 755

nurses on proper documentation of medication administration by 1-16-2018.

The Regional Director of Clinical Services to re-educate the Director of Clinical Services by 12-15-2017 on ordering of back up narcotics to include ordering of back up narcotics twice weekly to ensure supply is stocked per PAR level.

The Director of Clinical Services/ Assistant Director of Clinical Services and or Unit Manager to complete quality monitoring on 10 residents medication administration records weekly for 12 weeks then monthly to ensure medications given timely with no missing documentation , circling or medications without explanation or medication unavailable. Opportunities to be corrected by the Director of Clinical Services/Assistant Director of Clinical Services and or Unit Manager as identified during these reviews. Quality review modified based on findings.

Administrator will ensure full implementation of the plan of correction.

4. The results of these quality reviews to be submitted to the Quality Assurance and Performance Improvement Committee (QAPI) by the Director of Clinical Services for review by the Interdisciplinary members each month. The QAPI committee to evaluate the effectiveness and amend as needed.

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reached.

The Director of Nursing (DON) was interviewed on 12/19/17 at 1:40 PM and reported the following. Nurse # 9 was currently out of the country and unavailable for interview. Prior to Nurse # 9 leaving, the DON had the opportunity to talk with him about the missed doses of Vancomycin. Nurse #9 reported to the DON that he had called the pharmacy after his 11/14/17 evening shift to report that the Vancomycin had not arrived and was needed. The DON confirmed Nurse # 9's circled initials on 11/15/17 at 6:00 PM meant he did not give the Vancomycin. It was confirmed with the DON the resident missed four doses of Vancomycin due to the medication not being available for administration.

During the interview with the pharmacy manager on 12/18/17 at 10:00 AM, the pharmacist stated if the medication had been needed earlier the facility staff should have called.

b. Resident # 3 was admitted to the facility on 11/14/17 with diagnoses of chronic pain, peripheral vascular disease, history of generalized abdominal pain, pelvic fracture, and a history of breast cancer.

Review of the resident's facility admission note, dated 11/14/17, revealed Resident # 3 arrived at the facility at 4:00 PM.
According to the resident's facility admission orders, dated 11/14/17, she was prescribed to have hydrocodone-acetaminophen 5-325 milligrams (mg) every six hours as needed for pain.

Review of the resident's medical record revealed

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on 11/15/17 at 5:00 AM a verbal order was obtained that the resident could receive the alternative pain medication of Oxycodone 5/325 mg until her prescribed medication was received from the pharmacy.

Review of the resident's November 2017 MAR (Medication Administration Record) revealed the first dose of hydrocodone-acetaminophen 5-325 mg was administered on 11/16/17 at 2:10 AM.

Review of the facility's list of emergency medications revealed Hydrocodone-acetaminophen 5-325 mg was a medication the facility maintained in their back up supply. The quantity noted as maintained was 10 doses.

The resident's responsible party (RP) was interviewed on 12/12/17 at 11:40 AM. The RP reported the following. Resident # 3 had chronic pain and usually took her prescribed Hydrocodone-acetaminophen medication on a scheduled basis everyday while at home. When the resident was admitted to the facility, the facility did not have the resident's hydrocodone-acetaminophen medication available when it was needed.

Nurse # 10 was assigned to care for the resident on the 11:00 PM to 7:00 AM shift which began on 11/14/17. Nurse # 10 was interviewed on 12/19/17 at 2:45 PM and reported the resident awakened at 5:00 AM and was crying in pain. The nurse stated the resident's Hydrocodone had not arrived from the pharmacy, and there was none in the emergency back-up supply. The nurse stated she had to call the physician to obtain orders for a substitute since the resident's medication was not

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available. According to the nurse, the medication unavailability caused an approximate ten to fifteen minute delay in the resident receiving her pain medication, because the physician had to be contacted for new orders.

Interview with a pharmacy manager on 12/18/17 at 10 AM revealed the resident's personal supply of Hydrocodone-acetaminophen 5-325 mg was not dispensed to the facility until the day after the resident's admission. The pharmacist stated it was dispensed on 11/15/17, and it was received by the facility on that date at 10:44 PM. According to the pharmacist, the pharmacy had no records the facility staff called to request the medication earlier. The pharmacist stated the facility staff were responsible for ordering and replacing their emergency supply of controlled substances such as hydrocodone-acetaminophen.

Interview with the Director of Nursing on 12/14/17 at 5:00 PM revealed she usually ordered controlled medications weekly to maintain the facility's controlled medication supply.

Interview with the DON on 12/14/17 at 10:50 AM revealed she expected the following to occur when a resident was admitted. The nurses were to verify the admission orders with the attending physician. Then they were to fax and call the pharmacy to alert them there was a new resident.

According to a follow up interview on 12/21/17 at 3:30 PM with the administrator and DON, it was their expectation that residents' medications be available when needed for administration.

2. Record review revealed Resident # 12 was admitted to the facility on 11/9/17. The resident

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had diagnoses of lumbosacral disc disease, neuropathy, and spondylolisthesis (a back bone slides forward over a bone below it). Review of hospital records revealed prior to the facility admission, the resident had been hospitalized from 10/19/17 to 11/9/17. During this time the resident underwent spinal surgery and was found to have an abscess in her spine.

Review of the resident's minimum data set assessment, dated 11/23/17, revealed the resident was cognitively intact.

Review of the resident's admission care plan, dated 11/9/17, revealed pain was identified to be a problem for the resident. Staff were directed to administer medications as ordered.

Review of 11/9/17 admission orders and the resident's November 2017 medication administration record (MAR) revealed the following medications were to be administered:
OxyContin 10 milligrams (mg) every 12 hours; Scheduled on MAR for 8 AM and 8 PM (This is a sustained released medication)
Oxycodone 5 mg immediate release 2 tablets every four hours as needed for pain.
Gabapentin (Used for neuropathy) 600 mg at bedtime; The directions were to take two 300 mg capsules and it was scheduled on the MAR for 9 PM.
Robaxin (used as a muscle relaxer) 750 mg three times per day as needed;

Review of the facility's emergency medication list revealed two of Resident # 12's medications were listed as maintained by the facility in their back up supply. The emergency list contained the following medication and quantities.

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Oxycodone 5 mg -10 tablets.
Gabapentin 300 mg -10 capsules.

Review of the November, 2017 MAR revealed the resident did not receive any OxyContin, Oxycodone, Gabapentin, or Robaxin on her admission date of 11/9/17. This meant she missed her scheduled 8 PM Oxycontin and her 9 PM Gabapentin, and received none of her as needed medications.

The first indication on the MAR the resident received pain medication was on 11/9/17 at 8 PM. Nurse # 1 noted she gave Percocet 5/ 325 mg per an order for a one time dose.

Resident # 12 was interviewed on 12/13/17 at 10:15 AM. Resident # 12 reported the following. Although the nursing staff addressed her pain, she felt there had been a problem with the pharmacy having her medications available when she needed them. The resident reported she had arrived prior to 7 PM, and had not received her night time medications. The resident reported there had been a problem in getting her prescribed pain medication, Robaxin, and Gabapentin. The resident indicated she usually took all three medications at bed time on a routine basis.

Interview with Nurse # 1 on 12/14/17 at 5 PM revealed the following. Resident # 12 arrived at the facility at 5:30 PM on 11/9/17. When the resident arrived, Nurse # 1 faxed the medication orders and called the pharmacy to alert them there was a new resident. The nurse recalled the resident started hurting as the evening progressed, and her medications were not available. The resident's medications did not

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arrive at any time on the 3 PM to 11 PM shift. She called the physician to let him know there was no oxycodone available and was given an order to substitute Percocet which she administered around 8 PM. She did not administer the resident's Robaxin, OxyContin, or Gabapentin on 11/9/17. According to the nurse, the Robaxin and OxyContin would not have been available in the facility's back up medication supply. The nurse stated the Gabapentin had been available in a different dosage than prescribed for Resident # 12 in the back up medication supply. There were 100 mg capsules, and the resident would have needed to take 6 of them to make her dose. According to Nurse # 12, the resident did not want to take 6 pills to make up her dose of 600 mg since she was ordered to receive two of the 300 mg pills.

Interview with a pharmacy manager on 12/14/17 at 1:15 PM revealed the following information. According to pharmacy records, Resident # 12's OxyContin and Oxycodone orders were received by the pharmacy at 6:16 PM on 11/9/17. On 11/9/17 at 6:49 PM the resident's other medication orders were received by the pharmacy. The resident's Oxycodone, OxyContin, Robaxin, and Gabapentin were received by the facility on 11/10/17 at 1:15 AM. If the medications were needed earlier than the time they arrived, then the nurse would have needed to call and let the pharmacy know so that a stat medication order could be filled. The pharmacist did not have records the facility had called to have the medications sent sooner than 1:15 AM.

Interview with the Director of Nursing on 12/14/17 at 5 PM revealed she usually ordered controlled medications weekly to maintain the facility's

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controlled medication supply, and the pharmacy oversaw the change -over of the other emergency/back up medications located in a kit.

Interview on 12/21/17 at 3:30 PM with the administrator and DON revealed it was their expectation that residents' medications be available when needed for administration.

3. Record review revealed Resident #13 was admitted to the facility on 11/12/2017 at 4PM with a diagnosis of diabetes. The resident's record was initially reviewed on 12/14/17 as a closed record.

Review of admission orders dated 11/12/2017 revealed orders for Levemir Insulin 26 units in AM and 18 units at bedtime.

Review of the resident's November, 2017 medication administration record (MAR) revealed the Levemir orders had been crossed out. Beside the crossed out order a notation was written on the MAR which read, "rewritten." During the review of the closed record on 12/14/17, there was no notation in the closed record the order had been rewritten. There was no documentation the resident had received Insulin on 11/12/17 and 11/13/17.

The first notation the Insulin order was rewritten was on 11/14/2017. On 11/14/17 an order appeared on the MAR for Basaglar 20 units every morning and 20 units at bedtime. (According to the facility's "Facility Formulary and Coverage" records, the facility had the medical director's approval to automatically substitute Basaglar for Levemir Insulin.)

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F 755	Continued From page 16 According to the November, 2017 MAR, the resident's blood sugar registered 561 on 11/14/17 at 11 AM. This was the first documented blood sugar reading on the MAR. During the 12/14/17 review of the November, 2017 MAR, it was found that the first dose of Basaglar Insulin was administered at 8:00 PM on 11/14/17. Review of the facility's back up medication supply list revealed the facility did not stock any Insulin in their back up supply. According to an interview with a pharmacist on 12/14/17 at 5:00 PM the resident's Basaglar Insulin (approved substitute for Levemir) was not delivered until the evening after his admission. The date and time was 11/13/17 at 6:25 PM. On 12/14/17 at 5:15 PM interview with the administrator and Director Of Nursing revealed they were not aware there had been any problems with Insulin administration or acquisition for Resident # 13. At the time they could not find any documentation in the closed record that Resident # 13 had received any Insulin on 11/12/17 and 11/13/17 on the resident's MAR. They also could not locate where the order had been rewritten on the resident's MAR for the Levemir Insulin. The resident's responsible party was interviewed on 12/15/17 at 4:20 PM. According to the RP, it was her understanding from talking to a staff nurse that the resident had not received any Insulin for the first two days of his admission. Interview with Nurse # 8 on 12/21/17 at 9:15 AM	F 755		

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revealed she had been approached by Resident # 13's RP about missing Insulin doses. The nurse recalled that it was either 11/14/17 or 11/15/17 when the family approached her. According to the nurse she looked at the MAR after being approached by the family and saw that the resident had not received his Insulin on the first days he had been at the facility as the RP had stated. The nurse stated the error had been corrected on the MAR at the time it was brought to her (Nurse # 8's) attention. Nurse #8 stated she had mentioned the error to the nurse case manager, but did not talk to the Director of Nursing.

On 12/15/17 at 4:29 PM the administrator provided an additional sheet of the resident's MAR noting the resident had received Levemir beginning 11/12/17 through 11/16/17. According to the administrator, the missing MAR from the closed record had been located on another resident's chart on 12/15/17.

A follow up interview was held with the DON and administrator on 12/21/17 at 3:30 PM. They confirmed there had been a problem with the acquiring of the Insulin. The DON reported the following during the interview. She confirmed that until Resident # 13's Insulin arrived on 11/13/17 at 6:25 PM, there would not have been any back-up Insulin in the facility for the nurses to administer to Resident # 13. The DON stated that following 12/14/17, she had talked to Nurse # 9. Nurse # 9 had cared for Resident # 13 on his admission date of 11/12/17. Nurse #9 reported to the DON he had found a discharged resident's unused Insulin. Nurse #9 had also reported to the DON that he relabeled the Insulin to be used for Resident # 13. According to the DON, this was

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F 755	Continued From page 18 not an acceptable facility practice, and she did not know why any unused Insulin had not been returned to the pharmacy. The DON stated that Nurse # 9 was currently out of the country as of 12/21/17 and was not available for interview. According to the administrator and the DON, no staff member had alerted them that Nurse # 8 and the RP had concerns that the Insulin had never been given on the first two days in the facility and prior to his blood sugar registering 561. They also had not been aware a nurse was relabeling Insulin. Interview with the administrator and DON revealed it was their expectation that residents' medications be available when needed for administration and be administered per order.	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (Resident # 3) out of five sampled residents whose medications were reviewed, the facility omitted four consecutive doses of a prescribed antibiotic. The findings included: Record review revealed Resident # 3 was admitted to the facility on 11/14/17. Prior to the resident's facility admission she had been hospitalized from 10/30/17 until 11/14/17. During the resident's hospitalization it was identified she was positive for Clostridium Difficile (an infection of the gastrointestinal tract). According to the resident's hospital discharge	F 760	F760 483.45(f)(2) Residents are Free of Significant Med Errors The deficiency occurred as a result of inadequate staff training and quality monitoring. Missed communication opportunities with pharmacy contributed as well. 1. Resident #3 No longer resides at the facility. Nurse #10, #4 and #9 have been re-educated by the Director of Clinical	1/17/18

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orders and facility admission orders dated 11/14/17, the resident was to receive an oral antibiotic solution of Vancomycin 125 milligrams every six hours for treatment of the Clostridium Difficile.

Review of the resident's facility admission nurse's note revealed Resident # 3 arrived at the facility on 11/14/17 at 4:00 PM.

Review of the resident's November, 2017 MAR (medication administration record) revealed the Vancomycin was transcribed to the MAR to be given on a 12:00 AM; 6:00 AM; 12 Noon, and 6:00 PM schedule.

Further review of the resident's November, 2017 MAR revealed the following Information:
The MAR on 11/14/17 was blank beside the Vancomycin order indicating no doses were given on the day of admission following the resident's arrival at 4:00 PM.
The 12:00 AM dose due on 11/15/17 was written on the MAR under the date of 11/14/17 as "2400." It was blank.
On 11/15/17 at 6:00 AM Nurse # 10's initials were circled indicating the Vancomycin was not given.
On 11/15/17 at 12:00 Noon, Nurse # 4's initials were circled indicating the Vancomycin was not given.
On 11/15/17 at 6:00 PM, Nurse # 9's initials were circled indicating the Vancomycin was not given.

Review of the facility's list of emergency medications revealed Vancomycin oral solution was not maintained in their back up supply and therefore would not have been available for administration until the pharmacy delivered the medication.

F 760

Services on pharmacy procedures for ordering of medications to include for new admissions, calling of pharmacy to validate receiving of new admission orders , time of arrival of medications, use of back up medications and back up narcotics on 1-16-2018. Nurse #10, #4, and #9 have also been re-educated by the Director of Clinical Services on proper documentation of medication administration.

2. A Quality Review of current residents Medication Administration Records (MAR) has been conducted by Director of Clinical Services/Assistant Director of Clinical Services and or Unit Manager on 1-16-2018 for missing documentation and or circling of medications to ensure medications are being administered as ordered. Follow up based on findings of review.

3. The Director of Clinical Services to re-educate nurses on pharmacy procedures for ordering of medications to include for new admissions, calling of pharmacy to validate receiving of new admission orders and time of arrival of medications, use of back up medications and back up narcotics by 1-16-2018. The Director of Clinical Services to re-educate nurses on proper documentation of medication administration by 1-16-2018.

The Director of Clinical Services/ Assistant Director of Clinical Services and or Unit Manager to complete quality monitoring on 10 residents medication

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Interview with a pharmacy manager on 12/18/17 at 10:00 AM revealed the Vancomycin was not dispensed to the facility until the day after the resident's admission. The pharmacist stated it was dispensed on 11/15/17, and it was received by the facility on that date at 10:44 PM. According to the pharmacist the staff were to call if they had needed the medication sooner.

Nurse # 10 was interviewed on 12/19/17 at 2:45 PM. Nurse #10 stated she had not given Resident #3 the dose of Vancomycin at 12:00 AM on 11/15/17. The nurse stated she had left the MAR blank because she had anticipated the Vancomycin would come in around 12:30 AM to 1:00 AM on 12/15/17, but it did not arrive. She stated she also did not give the 6:00 AM dose on 11/15/17 because it had not arrived. She called the pharmacy and was told the Vancomycin would arrive that day. In shift change report she told the 7:00 AM to 3:00 PM nurse that there needed to be follow up about the missing medication.

Nurse # 4 was interviewed on 12/18/17 at 4:35 PM. Nurse # 4 did not specifically remember Resident # 3, but stated if she had circled her initials on the MAR this would indicate she had not given the Vancomycin medication on 11/15/17. The nurse reported it was her standard of practice to always call the pharmacy when a medication was not available for administration.

An attempt was made to reach Nurse # 9 on 12/18/17 at 4:35 PM, and the nurse could not be reached.
The Director of Nursing (DON) was interviewed on 12/19/17 at 1:40 PM. The DON stated that

F 760

administration records weekly for 12 weeks then monthly to ensure medications given timely with no missing documentation , circling or medications without explanation or medication unavailable. Opportunities to be corrected by the Director of Clinical Services/Assistant Director of Clinical Services and or Unit Manager as identified during these reviews. Quality review modified based on findings.

Administrator will ensure full implementation of the plan of correction.

4. The results of these quality reviews will be submitted to the Quality Assurance and Performance Improvement Committee (QAPI) by the Director of Clinical Services for review by the Interdisciplinary members each month. The QAPI committee to evaluate the effectiveness and amend as needed.

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F 760	Continued From page 21 Nurse # 9 was currently out of the country and unavailable for interview. Prior to Nurse # 9 leaving, the DON had the opportunity to talk with him about the missed doses of Vancomycin. Nurse #9 reported to the DON that he had called the pharmacy after his 11/14/17 evening shift to report that the Vancomycin had not arrived and was needed. The DON confirmed Nurse # 9's circled initials on 11/15/17 at 6:00 PM meant he did not give the Vancomycin. It was confirmed with the DON Resident # 3 missed four consecutive doses of the Vancomycin due to the medication not being available.	F 760		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility ' s Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions that the committee put into place in April, 2017. This was for a recited deficiency area which requires facilities to provide care according to professional standards of practice. The facility was originally cited on a complaint investigation completed on 4/24/17. The most recent repeat deficiency area was in the area of assuring professional standards of nursing practice were met. The continued failure of the facility during two federal surveys of record show a pattern of the facility ' s	F 867	F867 483.75()(2)(ii) QAPI/QAA Improvement Activities The deficiency was the result of inadequate training and quality monitoring. 1. The Executive Director held a Quality Assurance Performance Improvement (QAPI)meeting on (1-15-2018) with the Interdisciplinary Team including the Director of Clinical Services, Assistant	1/17/18

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inability to sustain an effective Quality Assurance Program.

Findings included:

This tag is cross referred to:

F 658 Based on record review and staff interview the facility failed to assure the accurate administration and documentation of medications and blood sugars for one (Resident #13) of five sampled residents whose medications were reviewed.

During a complaint investigation on 4/24/17 the facility was cited for failure to administer an antibiotic per a physician's order for one resident. During the complaint investigation on 12/21/17, the facility failed to monitor blood sugars per professional standards of practice prior to the resident's blood sugar registering 561. Also the facility failed to document the administration of the resident's diabetic medication per professional standards of practice prior to a resident's blood sugar registering 561.

The facility's administrator was interviewed on 12/18/17 at 11 AM regarding the facility's quality assurance methods. The administrator stated the facility had continued to do the quality assurance audits they implemented in April, 2017 and as of December, 2017 the audits were being done on a monthly basis per the planned schedule which was implemented. According to the administrator, the facility had not identified any problems with professional standards of practice through their monthly audits.

F 867

Director of Clinical Services, Social Services, Dietary Manager, Admissions Director, MDS Coordinator, Activities Director, Medical Director, Medical Records Director and Business Office Manager focusing on the citation professional standards of practice. The facility QAPI reviewed and to continue to review the Plan of Correction(PoC) for maintaining compliance in these areas.

2. During the QAPI meeting (12-28-2017) the Regional Director of Clinical Services along with the Executive Director re-educated the attendees on the QAPI process and attaining and maintaining compliance to include identifying, correcting, and monitoring of any identified deficiency to assure compliance and quality are maintained.

3. The QAPI Committee to continue to meet on at least a monthly basis identifying trends , as well as reviewing past identified areas of improvement with updated interventions as required. The Regional Vice President of Operations and or the Regional Director of Clinical Services to attend the Quality Assurance Performance Improvement meeting for 3 months for validation. Opportunities of Quality Improvement to be as identified and performance improvement plans instituted as indicated.

Administrator will ensure full implementation of the plan of correction.

4. The results of quality reviews submitted

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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 867	Continued From page 23	F 867	to the QAPI Committee for review by IDT members each month for 12 months. The QAPI Committee to evaluate the effectiveness and amend as needed.	