	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE S COMPL	
			A. BUILDING		C	
		345403	B. WING		_	, 1/2019
NAME OF PF	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CODI		
CARY HEA	ALTH AND REHABILITAT	ION		0 TRYON ROAD		
			CA	RY, NC 27518		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 000			
F 000		8.73, Emergency t ID #ONZD11.	F 000			
		certification survey was				
F 623 SS=B	complaint investigation	encies cited as a result of the on survey Event ID ONZD11. Before Transfer/Discharge -(6)(8)	F 623			1/14/19
	§483.15(c)(3) Notice Before a facility trans resident, the facility m (i) Notify the resident representative(s) of the the reasons for the m language and manne facility must send a c representative of the Long-Term Care Omt (ii) Record the reason discharge in the reside accordance with para and	before transfer. fers or discharges a nust- and the resident's ne transfer or discharge and ove in writing and in a r they understand. The opy of the notice to a Office of the State oudsman. ns for the transfer or lent's medical record in ograph (c)(2) of this section; ce the items described in				
	(c)(8) of this section, discharge required ur	of the notice. d in paragraphs (c)(4)(ii) and the notice of transfer or nder this section must be t least 30 days before the				

Electronically Signed

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

01/14/2019

	DEPARTMENT OF HEALTH AND HUMAN SERVICES CATERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345403 NAME OF PROVIDER OR SUPPLIER CARY HEALTH AND REHABILITATION (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 623 Continued From page 1 resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would					FORM	APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	• •		E CONSTRUCTION	(X3) DATE COMP	
		345403	B. WING				_ 11/2019
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CARY HE	ALTH AND REHABILITAT	ION			5590 TRYON ROAD CARY, NC 27518		
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	resident is transferred (ii) Notice must be may before transfer or disc (A) The safety of indivi- be endangered under this section; (B) The health of indivi- be endangered, under this section; (C) The resident's hea- allow a more immedia under paragraph (c)(1 (D) An immediate tran- required by the reside under paragraph (c)(1 (E) A resident has not days. §483.15(c)(5) Conten- notice specified in par- must include the follor (i) The reason for tra- (ii) The effective date (iii) The location to wh transferred or dischar (iv) A statement of the including the name, a and telephone number receives such requess to obtain an appeal for completing the form a hearing request; (v) The name, address telephone number of Long-Term Care Omb (vi) For nursing facility and developmental di	a or discharged. ade as soon as practicable charge when- viduals in the facility would paragraph (c)(1)(i)(C) of viduals in the facility would r paragraph (c)(1)(i)(D) of alth improves sufficiently to ate transfer or discharge, 1)(i)(B) of this section; nsfer or discharge is ent's urgent medical needs, 1)(i)(A) of this section; or t resided in the facility for 30 ts of the notice. The written ragraph (c)(3) of this section wing: nsfer or discharge; of transfer or discharge; of the entity which ts; and information on how orm and assistance in and submitting the appeal s (mailing and email) and the Office of the State pudsman; y residents with intellectual	F	623			

Facility ID: 923078

If continuation sheet Page 2 of 24

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	02/11/2019 APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345403	B. WING _				C 11/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	ALTH AND REHABILITAT			6	590 TRYON ROAD		
		ION		С	CARY, NC 27518		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	the protection and add developmental disabili C of the Developmental and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing faciliti disorder or related dis- email address and tel agency responsible for advocacy of individual established under the for Mentally III Individual §483.15(c)(6) Change If the information in the effecting the transfer must update the recip as practicable once the becomes available. §483.15(c)(8) Notice if In the case of facility of the administrator of the written notification priot to the State Survey Ag State Long-Term Care the facility, and the re well as the plan for the relocation of the resid 483.70(I). This REQUIREMENT by: Based on record revious provide written notifica- resident's representate when the residents wo	the agency responsible for vocacy of individuals with lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and y residents with a mental sabilities, the mailing and ephone number of the or the protection and ls with a mental disorder Protection and Advocacy uals Act. es to the notice. the notice changes prior to or discharge, the facility tients of the notice as soon he updated information in advance of facility closure closure, the individual who is he facility must provide or to the impending closure gency, the Office of the e Ombudsman, residents of sident representatives, as e transfer and adequate tents, as required at § f is not met as evidenced ews, staff interviews, and vs, the facility failed to ation to the resident, tive and/or the ombudsman ere discharged to the	F	523	Resident #78 no longer resides at the facility. Resident #76 no longer resides the facility. Resident #76 no longer resides the facility. Resident #10 was readmitt to the facility on 11/20/2018.	ed	
	hospital or home. This	s was evident for 3 of 3			The Director of Nursing and / or Nursin	g	

Facility ID: 923078

If continuation sheet Page 3 of 24

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 0 FORMAE OMB NO. 0	PPROVED
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SUF COMPLET	RVEY
		345403	B. WING		C 01/11/2	2019
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP COL		
CARY HE	ALTH AND REHABILITAT	ION		6590 TRYON ROAD CARY, NC 27518		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE CA	(X5) OMPLETION DATE
F 623	Continued From page	23	F 62	3		
	residents reviewed fo Resident #76, and Re	r discharge (Resident #10, esident #78).		Supervisor reviewed the last discharges to identify notifica responsible party of discharg	ation to ge as well as	
		admitted to the facility on		the Ombudsman on 1/10/19. was educated by the Executi on notification to the Ombuds 1/10/19. The Executive direc	ive Director sman on	
	and cognitive commu Resident #10's most Data Set (MDS) asse	ses that included epilepsy nication deficit. Review of recent quarterly Minimum ssment dated 10/4/18 0 was assessed as severely		the Business office manager Admissions Director to follow next business day of a facility discharge by calling the resp to inform them of the bed hol	and the y up on the y based onsible party ld. The	
	Review of a nurse's r Resident #10 was se evaluation of seizures	-		Admission Director and / or E Director will be responsible for written notification the family The Director of Nursing will p	or sending	
	Resident #10 was rea the hospital on 11/20/			quality improvement monitor based transfers two times a eight weeks, the monthly for for offering bed hold and noti	ing of facility week for three months	
	resident representativ	harge was provided to the ve for the resident's hospital No written notice was		Ombudsman. The Executive Director introc plan to the Quality Improvem committee on 1/11/19. The B Director is responsible for thi	nent Executive	
	1/9/19 at 4:25 PM she that written notice of resident or resident's	vith the Social Worker on e indicated she was unaware discharge was sent to the representative and gent hospital transfers.		results of the quality improve monitoring will be reviewed n QAPI meeting. The QAPI co meeting consists of but not li Medical Director, Executive I	ment nonthly at the ommittee mited to the	
	She reported the Adn resident or resident's hospitalization.	nissions office contacted the representative after		DON, Activities Director, Soc MDS Nurse, Maintenance, A Laundry and Housekeeping, minimum of one direct care of	cial Services, ctivities, and a	
	1/10/19 at 11:08 AM	vith the Administrator on she indicated it was her otice of discharge would be		Quality improvement monitor based on findings.	ring modified	

Facility ID: 923078

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	<i>I</i> APPROVED 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	
		345403	B. WING				C 11/2019
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
CARY HE	ALTH AND REHABILITAT	ION			5590 TRYON ROAD CARY, NC 27518		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	sent to the resident or with a copy forwarded required by regulation transfers by the Admis stated the facility wou written notices as req During an interview w 1/11/19 at 3:51 PM sh received written notices of resid facility in several mon 2. Resident #76 was 9/6/17 with diagnoses obstructive pulmonary and dementia. Review of a nurse's n Resident #76 was trans an evaluation after a fanurse's note dated 12 did not return to the fa Review of a nurse's n the resident represent resident in another fact the hospital. A review of the medic written notice of disch resident representativ transfer on 12/2/18. During an interview w 1/9/19 at 4:25 PM she that written notice of or resident or resident's	r resident's representative d to the ombudsman as as for emergent hospital ssions Coordinator. She ld begin sending these uired. With the Ombudsman on he indicated she had not dent's discharges from the ths. admitted to the facility on a that included chronic y disease, hyperlipidemia ote dated 12/2/18 revealed nsferred to the hospital for fall. Review of an additional //2/18 revealed Resident #76 acility. ote dated 12/2/18 revealed tative elected to place the cility upon discharge from al record revealed no harge was provided to the re for the resident's hospital	F	623			

Facility ID: 923078

If continuation sheet Page 5 of 24

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDI	NG .			C
		345403	B. WING				11/2019
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CARY HEA	ALTH AND REHABILITAT	ION			6590 TRYON ROAD CARY, NC 27518		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 623	She reported the Adm resident or resident's hospitalization. During an interview w 1/10/19 at 11:08 AM s expectation written no sent to the resident of with a copy forwarded required by regulation transfers by the Admis stated the facility wou written notices as req During an interview w 1/11/19 at 3:51 PM sh received written notice from the facility in sev 3. Resident #78 was a 10/3/18 with diagnose fibrillation and corona A review of Resident included a Discharge authored by the Phys helped care for the re facility. The note repo on 10/16/18 for a plar non-coverage by his i planned to return to h services and follow-up physician. Further review of the revealed there was no the Ombudsman rece	hissions office contacted the representative after with the Administrator on she indicated it was her otice of discharge would be r resident's representative d to the ombudsman as hs for emergent hospital ssions Coordinator. She ild begin sending these uired. with the Ombudsman on he indicated she had not es of resident's discharges veral months. admitted to the facility on es which included atrial ry artery disease. #78's medical record Note dated 10/16/18 and ician's Assistant (PA) who sident during his stay at the orted Resident #78 was seen and discharge due to nsurance. The resident is home with Home Health p with his primary care	F	623			
		eived written notification of arge from the facility on					

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	
		345403	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER		· [ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CARY HE	ALTH AND REHABILITAT	ION			90 TRYON ROAD ARY, NC 27518		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	Continued From page	9 6	F 6	523			
	with the facility's Soci interview, the Social V notify the Ombudsma discharges/transfers.	ducted on 1/9/19 at 4:25 PM al Worker. During the Norker reported she did not n in writing of resident					
	at 3:41 PM with the O the Ombudsman repor- received monthly upd of residents from the Ombudsman reported	was conducted on 1/11/19 mbudsman. Upon inquiry, orted she had not routinely ates on transfers/discharges facility. When asked, the d she did not receive a Resident #78's discharge in					
F 641	PM with the facility's I During the interview, expect the Ombudsm discharges. Accuracy of Assessm		F 6	541			1/14/19
SS=D	§483.20(g) Accuracy The assessment mus resident's status. This REQUIREMENT by: Based on observation interviews and record accurately code the M assessment to reflect anticoagulant for 1 of Unnecessary Medical reflect the use of oxyg	t accurately reflect the is not met as evidenced ns, staff and resident review, the facility failed to linimum Data Set (MDS) the provision of an 5 residents reviewed for tions (Resident #37) and to			Resident #69 MDS was modified on 1/11/19 to accurately reflect resident condition by the Regional MDS Nurse. Resident #37 MDS was modified on 1/10/19 to accurately reflect resident condition by the Regional MDS Nurse. On 1/8/19 the Executive Director, Socia Services, Regional MDS and Regional	al	

Event ID: ONZD11

Facility ID: 923078

If continuation sheet Page 7 of 24

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	02/11/2019 APPROVED 0. 0938-0391
-	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		LETED
		345403	B. WING				C 11/2019
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	ALTH AND REHABILITAT			659	90 TRYON ROAD		
CARTHE		IEN		CA	ARY, NC 27518		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	Continued From page	27	F 6	41	DON completed a quality improvement		
	Findings included: 1. Resident #37 was a 7/18/18. Her active di hypertension and pull Review of Resident # November 2018 revea ordered to receive Eli medication) 5 milligra Review of Resident # administration record revealed Resident #3 day as ordered from Review of Resident # dated 11/22/18 reveal as not receiving an ar section N0410 question During an interview of	admitted to the facility on agnoses included anemia, monary embolism. 37's physician's orders for aled Resident #37 was quis (an anticoagulant ms by mouth twice a day. 37's medication for November 2018 7 received Eliquis twice a 11/1/18 to 11/30/18. 37's MDS assessment led Resident #37 was coded nticoagulant medication in on E.			DON completed a quality improvement monitor of current resident's MDS's coding for accuracy related to anticoagulants. On 1/14/19 a quality improvement monitor of current resider MDS's coding for accuracy related to oxygen was completed. Any issues identified were addressed. The Regional MDS coordinator re-educated the MDS Coordinator and Assistant MDS coordinator on 1/8 - 14/2019 related to accuracy of the MDS The Director of Clinical Services, Executive Director, and / or Nursing supervisor to perform quality improvem monitoring of accuracy of the MDS relat to anticoagulants and the use of oxyge one time a week for four weeks, and monthly for three months. The Executive Director introduced this plan to the Quality Assurance	the S. ent	
	Nurse #1 stated Resid anticoagulant medicar reference date for the concluded Resident # dated 11/22/18 was n it did not reflect the re anticoagulant medicar During an interview of MDS Coordinator stat the use of an anticoag captured correctly on was not correct on the for Resident #37.	dent #37 did receive an tion during the assessment MDS dated 11/22/18. She 37's MDS assessment ot coded correctly because esident received an tion. n 1/10/19 at 10:08 AM the ted it was her expectation			Performance Improvement Committee 1/11/2019. The Executive Director is responsible for the plan. Results of Quality Improvement Monitoring to be reviewed at monthly QAPI committee meeting. QAPI committee meeting consists of but not limited to Medical Director, Executive Director, Director of Clinical Services, Activities Director, Social Services, Maintenance director, MDS Nurse, Dietary manager, housekeeping and laundry manager, an one direct caregiver. Quality improvement monitoring scheduled modified based on findings.	ŗ	

Facility ID: 923078

If continuation sheet Page 8 of 24

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE	
		345403	B. WING				C
NAME OF PI	ROVIDER OR SUPPLIER	343403			TREET ADDRESS, CITY, STATE, ZIP CODE	01/	11/2019
				65	590 TRYON ROAD		
	ALTH AND REHABILITAT	ION		С	ARY, NC 27518		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 641	medications be accur MDS assessments. H assessment for Resid incorrect and would b 2. Resident #69 was i facility on 12/7/16, wit 1/23/17. The resider included chronic obst and chronic hypoxem respiratory failure. A review of Resident to orders included an or the provision of oxyge nasal cannula due to respiratory failure. A review of Resident to Data Set (MDS) asse completed. The asse #69 had intact cogniti making. Section O of she received oxygen An interview was com AM with Resident #65 interview, the residen in a wheelchair in her in place. The oxygen and set to provide oxy Upon inquiry, the resi oxygen (via nasal car her room. An interview was com	ated it was his expectation ately captured on resident le concluded the MDS lent #37 dated 11/22/18 was e corrected. initially admitted to the th re-entry from a hospital on ht's cumulative diagnoses ructive pulmonary disease ic (low blood oxygen levels) #69's current physician der initiated on 1/23/17 for en at 4 liters per minute via chronic hypoxemic #69's quarterly Minimum ssment dated 12/18/18 was essment revealed Resident ve skills for daily decision if the MDS did not indicate therapy while a resident. ducted on 1/11/19 at 9:17 0. At the time of the t was observed to be sitting room with a nasal cannula concentrator was turned on ygen at 4 liters per minute. dent reported she wore her mula) whenever she was in	F	541			
	AM with MDS Nurse # upon review of Reside	#1. MDS Nurse #1 reported					

Facility ID: 923078

If continuation sheet Page 9 of 24

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/11/20 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345403	B. WING		C 01/11/2019
	ROVIDER OR SUPPLIER	ΓΙΟΝ	65	REET ADDRESS, CITY, STATE, ZIP CODE 90 TRYON ROAD ARY, NC 27518	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 641	stated this MDS had An interview was con PM with the facility's During the interview, expect a resident's M		F 641		
F 644 SS=D	CFR(s): 483.20(e)(1) §483.20(e) Coordinat A facility must coordin pre-admission screen (PASARR) program L of this part to the max		F 644		1/14/19
	from the PASARR lev PASARR evaluation	prating the recommendations vel II determination and the report into a resident's anning, and transitions of			
	all residents with new serious mental disorc related condition for I a significant change i	ng all level II residents and /ly evident or possible ler, intellectual disability, or a evel II resident review upon n status assessment. F is not met as evidenced			
	facility failed to refer a evident diagnosis of a Preadmission Screen	iew and staff interviews the a resident with a newly a serious mental illness for a ning and Resident Review 1 of 2 residents reviewed		Resident #37 PASRR was sent for rev and the MDS was updated on 1/8/19 by the MDS coordinator. On 1/8/19 the Executive Director, Socia	y

Facility ID: 923078

STREETACOPECTORS (x) PSOMEDSUPPLEACUA DENTFICATION MARGER (x) DULTIFIE CONSTRUCTION A BUILDING			ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/11/2019 MAPPROVED D: 0938-0391
345403 BUMBO 01/11/2019 STREET ADDRESS, CITY: STATE, ZP CODE Search TYCN ROD CARY HEALTH AND REHABILITATION STREET ADDRESS, CITY: STATE, ZP CODE Search TYCN ROD CARY, NC 27518 SUMMAY STATEMENT OF DEFICIENCIES PEAL DEFICIENCY ON USE DETINING INFORMATION) PEAL OF CONSECTION CRAY, NC 27518 COMMENT FLAN OF CONSECTION CRAY, NC 27518 COMMENT FLAN OF CONSECTION CRAY, NC 27518 COMMENT FLAN OF CONSECTION CRAY, NC 27518 F 644 Continued From page 10 for PASARR, (Resident #37) F 644 F 644 Continued From page 10 for PASARR, (Resident #37) F 644 Review of Resident #37's PASARR Level I Determination Notification letter dated 7/12/18 revealed the resident had to the facility on 8/18/18. Her primary diagnosis was caute responsible for making the resident fact and the facility on 8/18/18. Review of Resident #37's hospital discharge summary dietd 8/18'r evealed the resident's diaproses included aspiration pneumonia, acute encephalopathy, alcohol abuse, hyponaternia, diabetes mellius. hypertension, respiratory failure, and dementia associated vitil adochol amult, hyponaternia, diabetes mellius, hypertension, respiratory failure, and dementia associated to the safed the 30'n's revealed the resident fact diagnoses included aspiration pneumonia, acute encephalopathy, alcohol abuse, hyponaternia, diabetes mellius, hypertension, respiratory failure, and dementia associated with alcohol amult. Revident 450'n's revealed Resident 437'did not have a diagnos	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· /			COMF	LETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 201 CODE CARY HEALTH AND REHABILITATION Street ADDRESS, CITY, STATE, 201 CODE (M1)0 PREFIX TAG SUMMARY STREEMENT OF DEFICIENCIES (EACH DEFICIENCY MOST BE PRECEDD BY FULL RECOLLECTOR OF LSC DENTFLYING INFORMATION) D PREFIX PAC PREVIDENT ADDRESS, CITY, STATE, 201 CODE F644 Continued From page 10 for PASARR, (Resident #37) D FIndings included: PREVIDENT ADDRESS, CITY, STATE, 201 CODE D PREVIDENT ADDRESS, CITY, STATE, 201 CODE Review of Resident #37 S PASARR Level 1 Determination Notification letter dated 7/12/18 revealed the resident was assessed to be Level 1. There were no further PASARR referrals for Resident #37 in the medical record. F 644 Review of Resident #37 had no mental health related diagnoses including bipolar diapoes included aparation pneumonia, acute encephalopasthy, alcohol abuse, hypomatemia, diabetes mellius, hypertension, respiratory failure, and dementia associated with alcoholism without behavioral disturbances. Resident #37 did not have a diagnosis of bipolar disorder. The Regional MDS Coordinator and the PASIRR if needed. The Executive Director to perform Quality Improvement monitoring of new Admission PASRR one time a veek for eight weeks, then monthy times three months. Review of a psychiatric services related to staff reporting and/wis, agreesion, methy aggression, and physical aggression, and progress note specified facility staff reported the resident had mod fluctuation and was not easily redirectable. The diagnoses included anxilty, unspecified scalify staff reported the resident had mod fuctuation and was no			345403	B. WING				-
CARY INC 27518 CARY, NC 27518 (M) ID PRETIX TAG SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MIST GE RECEDENT PLL RECOULTIONY OR LSC DENTIFYING MECHANING) ID PRETIX RECOULTIONY OR LSC DENTIFYING MECHANING) PROVIDERS PLANOC CORRECTION (EACH DEPICIENCY MIST GE RECEDENT PLL RECOULTIONY OR LSC DENTIFYING MECHANING) D PRETIX RECOULTIONY OR LSC DENTIFYING MECHANING SUBJECT D PRETIX RECOULTIONY OR LSC DENTIFYING MECHANING SUBJECT D PRETIX RECOULTIONY OR DEPICIENCIES (EACH DEPICIENCY MIST GE RECOULTION SUBJECT D PRETIX RECOULTIONY OR DEPICIENCIES (EACH DEPICIENCY MIST GE RECOULTION SUBJECT D PRETIX RECOULTIONY OR DEPICIENCIES (EACH DEPICIENCY MIST GE RECOULTION SUBJECT D PRETIX RECOULTIONY OR DEPICIENCIES (EACH DEPICIENCY MIST GE RECOULTIONY (EACH DEPICIENCY MIST GE RECOULTION (EACH DEPICIENCY MIST GE RECOULTIONY (EACH DEPICIENCY MIST GE RECOULTION (EACH DEPICIENCY MIST GE RECOULTION (EACH DEPICIENCY MIST GE RECENTS (EACH DEPICIENCY MIST GE RECOULTION (EACH DEPICIENCY MIST GE RECOULTION (EACH DEPICIENCY MIST GE RECOULTING (EACH DEPICIENC OF AND AND (EACH DEPICIENC OF AND AND (EACH DEPICIENCY MIST GE RE	NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PRETRY TAG LEACH CORRECTS ACTION SHOLLD BE REGULTORY OR LSC IDENTIFYING INFORMATION) PRETRY TAG LEACH CORRECTS ACTION SHOLLD BE CROSS-REFERENCES ON SHOLD BE CROSS-REFERENCES ON SHOLLD BE CROSS-REFERENCE	CARY HEA	ALTH AND REHABILITAT	ΓΙΟΝ					
for PASARR. (Resident #37) Services, and Regional Director of Nursing and the Regional MDS Findings included: Nursing and the Regional MDS Review of Resident #37's PASARR Level 1 Determination Notification letter dated 7/12/18 Determination Notification letter dated 7/12/18 correct level PASRR in their medical record. Resident #37 was readmitted to the facility on 8/18/18. Her primary diagnosis was acute respiratory failure. Resident #37 had no mental health related diagnoses including bipolar disorder noted on readmission to the facility on 8/18/18. The Regional MDS coordinator and the Assistant MDS coordinator on 1/8/19 on accurate coding related to PASRR. The Director of Nursing educated psychological services on notifying the facility of any added or changed diagnosis to a resident #37's hospital discharge summary dated A/8/18 revealed the resident *37 vas seen by psychiatric progress note dated 88/14 revealed Resident #37 was seen by psychiatric services for an initial consult. Resident #37 was seen by psychiatric services rolated to staff reporting anxiety, agitation, verbal aggression, and physical aggression, and physical aggression, and dementia. PassRel f needed. The Executive Director is responsible for the plan. Results of Quality Improvement Monitoring of Director is responsible for the plan. Results of Quality Masurance	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	3E	COMPLETION
for PASARR. (Resident #37) Services, and Regional Director of Nursing and the Regional MDS Findings included: Nursing and the Regional MDS Review of Resident #37's PASARR Level 1 Determination Notification letter dated 7/12/18 Determination Notification letter dated 7/12/18 correct level PASRR in their medical record. Resident #37 was readmitted to the facility on 8/18/18. Her primary diagnosis was acute respiratory failure. Resident #37 had no mental health related diagnoses including bipolar disorder noted on readmission to the facility on 8/18/18. The Regional MDS coordinator and the Assistant MDS coordinator on 1/8/19 on accurate coding related to PASRR. The Director of Nursing educated psychological services on notifying the facility of any added or changed diagnosis to a resident #37's hospital discharge summary dated A/8/18 revealed the resident *37 vas seen by psychiatric progress note dated 88/14 revealed Resident #37 was seen by psychiatric services for an initial consult. Resident #37 was seen by psychiatric services rolated to staff reporting anxiety, agitation, verbal aggression, and physical aggression, and physical aggression, and dementia. PassRel f needed. The Executive Director is responsible for the plan. Results of Quality Improvement Monitoring of Director is responsible for the plan. Results of Quality Masurance	F 644	Continued From page	e 10	F 64	14			
 Findings included: Findings included: Review of Resident #37's PASARR Level I Determination Notification letter dated 71/218 revealed the resident was assessed to be Level I. There were no further PASARR referrals for Resident #37 was readmitted to the facility on 8/18/18. Review of Resident #37's hospital discharge summary dated 8/8/18 revealed the residents diaposes included aspiration pneumonia, acute encephalopathy, alcohol abuse, hyponatremia, diaposes included aspiration pneumonia, acute encephalopathy, alcohol abuse, hyponatremia, diaposes included aspiration pneumonia, acute encephalopathy, alcohol abuse, hyponatremia, diagnossi of bipolar disorder. Review of a psychiatric progress note dated 80/18 revealed Resident #37 was seen by psychiatric services for an initial consult. Resident #37 ray as seen by psychiatric services for an initial consult. Resident #37 ray as seen by psychiatric services for an initial consult. Resident #37 ray as seen by psychiatric services for an initial consult. Resident #37 ray as seen by psychiatric services for an initial consult. Resident #37 ray as seen by psychiatric services for an initial consult. Resident #37 ray as seen by psychiatric services for an initial consult. Resident #37 ray as seen by psychiatric services for an initial consult. Resident #36 reporting anxiety, agitation, werbal aggression, and physical aggression, and dementia. Nuesting and the cliganose included axiety, unspecified schizophrenia, depression, and dementia. Nuesting and the facility consult as a staff reporting anxiety, agitation, werbal aggression, and physical aggression, and dementia. 	-					Services, and Regional Director of		
Monitoring of current residents PASRR to current liagnosis to validate residents had the correct level PASRR in their medical record. Any issues identified were addressed.Resident #37 in the medical record.The Regional MDS Coordinator record any issues identified were addressed.Resident #37 was readmitted to the facility on 8/18/18. Her primary diagnosis was acute respiratory failure. Resident #37's hospital discharge summary dated 8/8/18 revealed the resident's diagnoses included aspiration pneumonia, acute encephalopathy, alcohol abuse, hyponatremia, diabetes mellitus, hypertension, respiratory failure, and dementia associated with alcoholism without behavioral disturbances. Resident #37 was seen by psychiatric services for an initial consult. Resident #37 was seen by psychiatric services related to staff reporting anxiety, agitation, werbal aggression, and physical aggression, and dementia.Monitoring will be responsible for making the referral to PASRR if needed of Name time a week for eight weeks, then monthy times three months. New Psychological progress note specified facility staff reported the resident thad mood fluctuation and was not easily redirectable. The diagnoses included anytopy aggression, and dementia.Monitoring will be resident had mood fluctuation and was not easily redirectable. The diagnoses included anytopy aggression, and dementia.Monitoring will be reviewed at monthy QAPI committee								
Review of Resident #37's PASARR Level I Determination Notification letter dated 7/12/18 revealed the resident was assessed to be Level I. There were no further PASARR referrais for Resident #37 in the medical record.current diagnosis to validate resident had the correct level PASRR in their medical record. Any issues identified were addressed.Resident #37 was readmitted to the facility on 8/18/18. Her primary diagnosis was acute respiratory failure. Resident #37 had no mental health related diagnoses including bipolar disorder noted on readmission to the facility on 8/18/18.The Regional MDS Coordinator re-educated the MDS coordinator and the Assistant MDS coordinator and the Assistant MDS coordinator on 1/8/19 on accurate coding related to PASRR. The Director of Nursing educated psychological services on notifying the facility of any added or changed diagnosis to a readient so that the facility can determine if a new PASRR is needed on 1/9/19. The Social Worker will be responsible for making the referral to PASRR if needed. The Executive Director to perform Quality Improvement monitoring of new admission PASRR one time a week for eight weeks, then monthly times three months.Review of a psychiatric progress note dated 89/18 revealed Resident #37 was seen by psychiatric services related to #37 was seen by psychiatric services related to #37 was seen by psychia		Findings included:					_	
Determination Notification letter dated 7/12/18 revealed the resident was assessed to be Level I. There were no further PASARR referrals for Resident #37 in the medical record.the correct level PASRR in their medical record. Any issues identified were addressed.Resident #37 was readmitted to the facility on 8/18/18. Her primary diagnoses including bipolar disorder noted on readmission to the facility on 8/18/18.The Regional MDS Coordinator re-educated the MDS coordinator on 1/8/19 on accurate coding related to PASRR. The Director of Nursing educated psychological services on notifying the facility of any added or changed diagnoses in cluded aspiration pneumonia, acute encephalopathy, alcohol abuse, hyponatremia, diabetes mellitus, hypertension, respiratory failure, and dementia associated with alcoholism without behavioral disturbances. Resident #37 did not have a diagnosis of bipolar disorder.The Regional MDS Coordinator re-educated the MDS coordinator re-educated the MDS coordinator on 1/8/19 on accurate coding related to PASRR. The Director of Nursing educated psychiatric services and the facility on 18/19 favealed Resident #37 kas seen by psychiatric services for an initial consult. Resident #37 was seen by psychiatric services related to staff reporting anxiety, agitation, verbal aggression, and physical aggression. The progress note specified facility saff reported the resident had mood fluctuation and was not easily redirectable. The diagnoses included anxiety, unspecified schizophrenia, depression, and dementia.The Executive Director is responsible for the plan. Results of Quality Improvement Monitoring will be reviewed at monthly QAPI committee		Review of Resident #	137's DASARD Lavel L					
revealed the resident was assessed to be Level I. There were no further PASARR referrals for Resident #37 in the medical record. Resident #37 was readmitted to the facility on 8/18/18. Review of Resident #37 hospital discharge summary dated 8/8/18 revealed the resident's diagnoses included aspiration pneumonia, acute encephalopathy, alcohol abuse, hyponatremia, diabetes mellitus, hypertension, respiratory failure, and dementia without behavioral disturbances. Resident #37 did not have a diagnosis of bipolar disorder. Review of a psychiatric progress note dated 8/9/18 revealed Resident #37 was seen by psychiatric services related to #37 was seen by psychiatric services related to #37 was seen by ps						C C		
Resident #37 in the medical record. Resident #37 was readmitted to the facility on 8/18/18. Her primary diagnosis was acute respiratory failure. Resident #37 had no mental health related diagnoses including bipolar disorder noted on readmission to the facility on 8/18/18. Review of Resident #37's hospital discharge summary dated 8/8/18 revealed the resident's diagnoses included aspiration pneumonia, acute encephalopathy, alcohol abuse, hyponatremia, diabetes mellitus, hypertension, respiratory failure, and dementia associated with alcoholism without behavioral disturbances. Resident #37 did not have a diagnosis of bipolar disorder. Review of a psychiatric progress note dated 8/9/18 revealed Resident #37 was seen by psychiatric services for an initial consult. Resident #37 was seen by psychiatric services related to staff reporting anxiety, agitation, verbal aggression, and physical aggression. The progress note specified facility staff reported the resident had mood fluctuation and was not easily redirectable. The diagnoses included anxiety, unspecified schizophrenia, depression, and dementia. Review of a chility staff reported the resident had mood fluctuation and was not easily redirectable. The diagnoses included anxiety, unspecified schizophrenia, depression, and dementia.		revealed the resident	was assessed to be Level I.					
 Resident #37 was readmitted to the facility on 8/18/18. Her primary diagnosis was acute respiratory failure, Resident #37 had no mental health related diagnoses including bipolar disorder noted on readmission to the facility on 8/18/18. Review of Resident #37's hospital discharge summary dated 8/8/18 revealed the resident's diagnoses included aspiration pneumonia, acute encephalopathy, alcohol abuse, hyponatremia, diabetes mellitus, hypertension, respiratory failure, and dementia associated with alcoholism without behavioral disturbances. Resident #37 did not have a diagnosis of bipolar disorder. Review of a psychiatric progress note dated 8/8/18 revealed Resident #37 was seen by psychiatric services for an initial consult. Resident #37 was seen by psychiatric services related to staff reporting naniely, agitation, verbal aggression, and physical aggression. The progress note specified facility staff reported the resident han owof fluctuation and was not easily redirectable. The diagnoses included anxiety, unspecified schizophrenia, depression, and dementia. 						addressed.		
Resident #37 was readmitted to the facility on 8/18/18. Her primary diagnosis was acute respiratory failure. Resident #37 had no mental health related diagnoses including bipolar disorder noted on readmission to the facility on 8/18/18.re-educated the MDS coordinator and the Assistant MDS coordinator on 1/8/19 on accurate coding related to PASRR. The Director of Nursing educated psychological services on notifying the facility of any added or changed diagnosis to a resident so that the facility can determine if a new PASRR is needed on 19/19. The Social Worker will be responsible for making the referral to PASRR if needed. The Executive Director to perform Quality Improvement monitoring of new admission PASR one times three months. New Psychological progress note added 8/9/18 revealed Resident #37 was seen by psychiatric services for an initial consult. Resident #37 was seen by psychiatric services for an initial consult. Resident #37 was seen by psychiatric services related to staff reporting anxiety, agitation, verbal aggression, and physical aggression, and progress note specified schizophrenia, depression, and dementia.The Executive Director is responsible for making the referal to PASRR if needed. The Executive Director to perform Quality Improvement monitoring of new admission PASR one time a week for eight weeks, then monthy times three months.Review of a psychiatric progress note dated 8/9/18 revealed Resident #37 was seen by psychiatric services related to staff reporting anxiety, agitation, verbal aggression, and physical aggression, and dementia.re-educated the MDS coordinator and the Assistant MDS coordinator and the accurate the fac		Resident #37 in the n	nedical record.			The Devianel MDC Coordinates		
8/18/18. Her primary diagnosis was acute respiratory failure. Resident #37 had no mental health related diagnoses including bipolar disorder noted on readmission to the facility on 8/18/18.Assistant MDS coordinator on 1/8/19 on accurate coding related to PASRR. The Director of Nursing educated psychological services on notifying the facility of any added or changed diagnosis to a resident so that the facility can determine if a new PASRR is needed on 1/9/19. The Social Worker will be responsible for making the referral to PASRR if needed. The Executive Director to perform Quality Improvement monitoring of new admission PASRR one time a week for eight weeks, then monthly times three months.Review of a psychiatric progress note dated 8/9/18 revealed Resident #37 was seen by psychiatric services rolated to staff reporting anxiety, agitation, verbal aggression, and physical aggression. The progress note specified facility staff reported the resident had mood fluctuation and was not easily redirectable. The diagnoses included anxiety, unspecified schizophrenia, depression, and dementia.Assistant MDS coordinator on 1/8/19 on accurate coding related to PASRR. The Director for Nursing and / or Executive Director for any new diagnosis to perform ance Improvement Committee on 19/19. The Executive Director is responsible for the plan. Results of Quality Improvement Monitoring will be reviewed at monthly QAPI committee		Resident #37 was rea	admitted to the facility on			-	the	
respiratory failure. Resident #37 had no mental health related diagnoses including bipolar disorder noted on readmission to the facility on 8/18/18. Review of Resident #37's hospital discharge summary dated 8/8/18 revealed the resident's diagnoses included aspiration pneumonia, acute encephalopathy, alcohol abuse, hyponatremia, diabetes mellitus, hypertension, respiratory failure, and dementia associated with alcoholism without behavioral disturbances. Resident #37 did not have a diagnosis of bipolar disorder. Review of a psychiatric progress note dated 8/9/18 revealed Resident #37 was seen by psychiatric services for an initial consult. Resident #37 was seen by psychiatric revices related to staff reporting anxiety, agitation, verbal aggression, and physical aggression. The progress note specified facility staff reported the resident had mood fluctuation and was not easily redirectable. The diagnoses included anxiety, unspecified schizophrenia, depression, and dementia.			-					
disorder noted on readmission to the facility on 8/18/18.psychological services on notifying the facility of any added or changed diagnosis to a resident so that the facility can determine if a new PASR is needed on 1/9/19. The Social Worker will be responsible for making the referral to PASRR if needed. The Executive Director to perform Quality Improvement failure, and dementia associated with alcoholism without behavioral disturbances. Resident #37 did not have a diagnosis of bipolar disorder.psychological services on notifying the facility of any added or changed diagnosis to a resident so that the facility can determine if a new PASRR is needed on 1/9/19. The Social Worker will be responsible for making the referral to PASRR if needed. The Executive Director to perform Quality Improvement monitoring of new admission PASRR one time a week for eight weeks, then monthly times three months. New Psychological progress notes will be reviewed prior to fling by the Director of Nursing and / or 8/9/18 revealed Resident #37 was seen by psychiatric services related to staff reporting anxiety, agitation, verbal aggression. The progress note specified facility staff reported the resident had mood fluctuation and was not easily redirectable. The diagnoses included anxiety, unspecified schizophrenia, depression, and dementia.The Executive Director is responsible for the plan. Results of Quality Improvement Monitoring will be reviewed at monthly QAPI committee			-					
8/18/18.facility of any added or changed diagnosis to a resident so that the facility can determine if a new PASRR is needed on 1/9/19. The Social Worker will be responsible for making the referral to PASRR if needed. The Executive Director to perform Quality Improvement monitoring of new admission PASRR one times a week for eight weeks, then monthly times three months.Review of a psychiatric progress note dated 8/9/18 revealed Resident #37 was seen by psychiatric services for an initial consult. Resident #37 was seen by psychiatric services related to staff reporting anxiety, agitation, verbal aggression, and physical aggression. The progress note specified facility staff reported the resident had mood fluctuation and was not easily redirectable. The diagnoses included anxiety, unspecified schizophrenia, depression, and dementia.facility of any added or changed diagnosis to a resident so that the facility can determine if a new PASRR is needed on 1/9/19. The Executive Director to perform Quality Improvement monitoring of new admission PASR one time a week for eight weeks, then monthly times three months.Review of a psychiatric services related to staff reporting anxiety, agitation, verbal aggression, and physical aggression, and dementia.Facility of any added or changed diagnosis to a resident so that the facility can test the facility can test test test test test test test test								
Review of Resident #37's hospital discharge summary dated 8/8/18 revealed the resident's diagnoses included aspiration pneumonia, acute encephalopathy, alcohol abuse, hyponatremia, diabetes mellitus, hypertension, respiratory failure, and dementia associated with alcoholism without behavioral disturbances. Resident #37 did not have a diagnosis of bipolar disorder.to a resident so that the facility can determine if a new PASRR is needed on 1/9/19. The Social Worker will be responsible for making the referral to PASRR fi needed. The Executive Director to perform Quality Improvement monitoring of new admission PASRR one times three months. New Psychological progress notes will be reviewed prior to filing by the Director for any new diagnosis one time a week for eight weeks, then monthly times three months.Review of a psychiatric progress note dated 8/9/18 revealed Resident #37 was seen by psychiatric services for an initial consult. Resident #37 was seen by psychiatric services related to staff reporting anxiety, agitation, verbal aggression, and physical aggression. The progress note specified facility staff reported the resident had mood fluctuation and was not easily redirectable. The diagnoses included anxiety, unspecified schizophrenia, depression, and dementia.The Executive Director is responsible for the plan. Results of Quality Improvement Monitoring will be reviewed at monthly QAPI committee			admission to the facility on					
Review of Resident #37's hospital discharge summary dated 8/8/18 revealed the resident's diagnoses included aspiration pneumonia, acute encephalopathy, alcohol abuse, hyponatremia, diabetes mellitus, hypertension, respiratory failure, and dementia associated with alcoholism without behavioral disturbances. Resident #37 did not have a diagnosis of bipolar disorder.determine if a new PASRR is needed on 1/9/19. The Social Worker will be responsible for making the referral to 		8/18/18.					OSIS	
summary dated 8/8/18 revealed the resident's diagnoses included aspiration pneumonia, acute encephalopathy, alcohol abuse, hyponatremia, diabetes mellitus, hypertension, respiratory failure, and dementia associated with alcoholism without behavioral disturbances. Resident #37 did not have a diagnosis of bipolar disorder.1/9/19. The Social Worker will be responsible for making the referral to PASRR if needed. The Executive Director to perform Quality Improvement monitoring of new admission PASRR one time a week for eight weeks, then monthly times three months. New Psychological progress notes will be reviewed prior to filing by the Director of Nursing and / or Executive Director for any new diagnosis one time a week for eight weeks, then monthly times three months.#37 was seen by psychiatric services related to staff reporting anxiety, agitation, verbal aggression, and physical aggression. The progress note specified facility staff reported the resident had mood fluctuation and was not easily redirectable. The diagnoses included anxiety, unspecified schizophrenia, depression, and dementia.The Executive Director is resident do the plan. Results of Quality Improvement Monitoring will be reviewed at monthly QAPI committee		Review of Resident #	37's hospital discharge			-	on	
diagnoses included aspiration pneumonia, acute encephalopathy, alcohol abuse, hyponatremia, diabetes mellitus, hypertension, respiratory failure, and dementia associated with alcoholism without behavioral disturbances. Resident #37 did not have a diagnosis of bipolar disorder. Review of a psychiatric progress note dated 8/9/18 revealed Resident #37 was seen by psychiatric services for an initial consult. Resident #37 was seen by psychiatric services related to staff reporting anxiety, agitation, verbal aggression, and physical aggression. The progress note specified facility staff reported the resident had mood fluctuation and was not easily redirectable. The diagnoses included anxiety, unspecified schizophrenia, depression, and dementia. diagnoses included anxiety, unspecified schizophrenia, depression, and progress note specified facility staff reported the reviewed at monthly QAPI committee							011	
diabetes mellitus, hypertension, respiratory failure, and dementia associated with alcoholism without behavioral disturbances. Resident #37 did not have a diagnosis of bipolar disorder.to perform Quality Improvement monitoring of new admission PASRR one time a week for eight weeks, then monthly times three months. New Psychological progress notes will be reviewed prior to filing by the Director of Nursing and / or Executive Director for any new diagnosis one time a week for eight weeks, then monthly times three months.#37 was seen by psychiatric services for an initial consult. Resident #37 was seen by psychiatric services related to staff reporting anxiety, agitation, verbal aggression, and physical aggression. The progress note specified facility staff reported the resident had mood fluctuation and was not easily redirectable. The diagnoses included anxiety, unspecified schizophrenia, depression, and dementia.The Executive Director is responsible for the plan. Results of Quality Improvement Monitoring will be reviewed at monthly QAPI committee								
failure, and dementia associated with alcoholism without behavioral disturbances. Resident #37 did not have a diagnosis of bipolar disorder.monitoring of new admission PASRR one time a week for eight weeks, then monthly times three months. New Psychological progress notes will be reviewed prior to filing by the Director of Nursing and / or Executive Director for any new diagnosis one time a week for eight weeks, then monthly times three months.Review of a psychiatric progress note dated 8/9/18 revealed Resident #37 was seen by psychiatric services for an initial consult. Resident #37 was seen by psychiatric services related to staff reporting anxiety, agitation, verbal aggression, and physical aggression. The progress note specified facility staff reported the resident had mood fluctuation and was not easily redirectable. The diagnoses included anxiety, unspecified schizophrenia, depression, and dementia.The Executive Director introduced this plan to the Quality Assurance Performance Improvement Committee on 1/11/2019. The Executive Director is responsible for the plan. Results of Quality Improvement Monitoring will be reviewed at monthly QAPI committee							ector	
 without behavioral disturbances. Resident #37 did not have a diagnosis of bipolar disorder. Review of a psychiatric progress note dated 8/9/18 revealed Resident #37 was seen by psychiatric services for an initial consult. Resident #37 was seen by psychiatric services related to staff reporting anxiety, agitation, verbal aggression, and physical aggression. The progress note specified facility staff reported the resident had mood fluctuation and was not easily redirectable. The diagnoses included anxiety, unspecified schizophrenia, depression, and dementia. without behavioral disturbances. Resident #37 did not have a diagnosis of bipolar disorder. time a week for eight weeks, then monthly times three months. New Psychological progress notes will be reviewed prior to filing by the Director of Nursing and / or Executive Director for any new diagnosis one time a week for eight weeks, then monthly times three months. The Executive Director introduced this plan to the Quality Assurance Performance Improvement Committee on 1/11/2019. The Executive Director is responsible for the plan. Results of Quality Improvement Monitoring will be reviewed at monthly QAPI committee 								
not have a diagnosis of bipolar disorder.times three months. New Psychological progress notes will be reviewed prior to filing by the Director of Nursing and / or Executive Director for any new diagnosis one time a week for eight weeks, then monthly times three months.#37 was seen by psychiatric services related to staff reporting anxiety, agitation, verbal aggression, and physical aggression. The progress note specified facility staff reported the resident had mood fluctuation and was not easily redirectable. The diagnoses included anxiety, unspecified schizophrenia, depression, and dementia.The Executive Director introduced this plan to the Quality Assurance Performance Improvement Committee on 1/11/2019. The Executive Director is responsible for the plan. Results of Quality Improvement Monitoring will be reviewed at monthly QAPI committee								
Review of a psychiatric progress note datedprogress notes will be reviewed prior to filing by the Director of Nursing and / or Executive Director for any new diagnosis one time a week for eight weeks, then monthly times three months.#37 was seen by psychiatric services related to staff reporting anxiety, agitation, verbal aggression, and physical aggression. The progress note specified facility staff reported the resident had mood fluctuation and was not easily redirectable. The diagnoses included anxiety, unspecified schizophrenia, depression, and dementia.The Executive Director for any new diagnosis one time a week for eight weeks, then monthly times three months.The Executive Director introduced this plan to the Quality Assurance Performance Improvement Committee on 1/11/2019. The Executive Director is responsible for the plan. Results of Quality Improvement Monitoring will be 						•	•	
 8/9/18 revealed Resident #37 was seen by psychiatric services for an initial consult. Resident #37 was seen by psychiatric services related to staff reporting anxiety, agitation, verbal aggression, and physical aggression. The progress note specified facility staff reported the resident had mood fluctuation and was not easily redirectable. The diagnoses included anxiety, unspecified schizophrenia, depression, and dementia. 8/9/18 revealed Resident #37 was seen by psychiatric services related to staff reporting anxiety, agitation, verbal aggression. The progress note specified facility staff reported the resident had mood fluctuation and was not easily redirectable. The diagnoses included anxiety, unspecified schizophrenia, depression, and dementia. 8/9/18 revealed Resident #37 was seen by psychiatric services for an initial consult. Resident weeks, then monthly times three months. 9/10 The Executive Director introduced this plan to the Quality Assurance Performance Improvement Committee on 1/11/2019. The Executive Director is responsible for the plan. Results of Quality Improvement Monitoring will be reviewed at monthly QAPI committee 								
psychiatric services for an initial consult. Resident #37 was seen by psychiatric services related to staff reporting anxiety, agitation, verbal aggression, and physical aggression. The progress note specified facility staff reported the resident had mood fluctuation and was not easily redirectable. The diagnoses included anxiety, unspecified schizophrenia, depression, and dementia.one time a week for eight weeks, then monthly times three months.Image: transformation of the staff reported the resident had mood fluctuation and was not easily redirectable. The diagnoses included anxiety, unspecified schizophrenia, depression, and dementia.The Executive Director introduced this plan to the Quality Assurance Performance Improvement Committee on 1/11/2019. The Executive Director is responsible for the plan. Results of Quality Improvement Monitoring will be reviewed at monthly QAPI committee								
#37 was seen by psychiatric services related to staff reporting anxiety, agitation, verbal aggression, and physical aggression. The progress note specified facility staff reported the resident had mood fluctuation and was not easily redirectable. The diagnoses included anxiety, unspecified schizophrenia, depression, and dementia.monthly times three months.#37 was seen by psychiatric services related to staff reporting anxiety, agitation, verbal aggression. The progress note specified facility staff reported the resident had mood fluctuation and was not easily redirectable. The diagnoses included anxiety, unspecified schizophrenia, depression, and dementia.The Executive Director introduced this plan to the Quality Assurance Performance Improvement Committee on 1/11/2019. The Executive Director is responsible for the plan. Results of Quality Improvement Monitoring will be reviewed at monthly QAPI committee			5					
staff reporting anxiety, agitation, verbal aggression, and physical aggression. The progress note specified facility staff reported the resident had mood fluctuation and was not easily redirectable. The diagnoses included anxiety, unspecified schizophrenia, depression, and dementia.The Executive Director introduced this plan to the Quality Assurance Performance Improvement Committee on 1/11/2019. The Executive Director is responsible for the plan. Results of Quality Improvement Monitoring will be reviewed at monthly QAPI committee								
aggression, and physical aggression. The progress note specified facility staff reported the resident had mood fluctuation and was not easily redirectable. The diagnoses included anxiety, unspecified schizophrenia, depression, and dementia.The Executive Director introduced this plan to the Quality Assurance Performance Improvement Committee on 1/11/2019. The Executive Director is responsible for the plan. Results of Quality Improvement Monitoring will be reviewed at monthly QAPI committee								
progress note specified facility staff reported the resident had mood fluctuation and was not easily redirectable. The diagnoses included anxiety, unspecified schizophrenia, depression, and dementia.plan to the Quality Assurance Performance Improvement Committee on 1/11/2019. The Executive Director is responsible for the plan. Results of Quality Improvement Monitoring will be reviewed at monthly QAPI committee						The Executive Director introduced this	;	
redirectable. The diagnoses included anxiety, unspecified schizophrenia, depression, and dementia. 1/11/2019. The Executive Director is responsible for the plan. Results of Quality Improvement Monitoring will be reviewed at monthly QAPI committee						plan to the Quality Assurance		
unspecified schizophrenia, depression, and dementia.responsible for the plan. Results of Quality Improvement Monitoring will be reviewed at monthly QAPI committee						•	e on	
dementia. Quality Improvement Monitoring will be reviewed at monthly QAPI committee								
reviewed at monthly QAPI committee			renia, depression, and				•	
							C	
Interview of a psychiatric progress note dated I I I I I I I I I I I I I I I I I I I		Review of a psychiat	ric progress note dated			meetings QAPI committee meeting		

Event ID: ONZD11

Facility ID: 923078

If continuation sheet Page 11 of 24

		ID HUMAN SERVICES MEDICAID SERVICES			FORM	02/11/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	IPLE CONSTRUCTION	(X3) DATE S COMPL	SURVEY ETED
		345403	B. WING		C 01/1	1/2019
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
CARY HE	ALTH AND REHABILITAT	TION		6590 TRYON ROAD CARY, NC 27518		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE
F 644	11/21/18 revealed Remedication managem reporting outbursts at diagnoses were chan and bipolar disorder. Review of Resident # assessment dated 11 was assessed as mo- impaired. The residen directed towards othe lookback period. Her anemia, hypertension psychotic disorder. B as an active diagnosi Review of Resident # revealed bipolar disor diagnosis with an ons During an interview of Social Worker stated 2018 was the last PA the resident. She furt PASARR Level I. She was not referred to ha new onset diagnosis stated the primary dia was Respiratory Failu diagnosis for bipolar psychiatric consult in to their system in Dec did not know why the not refer Resident #3 level II referral. During an interview of Administrator stated in	esident #37 was seen for nent and facility staff it the nurses' station. The iged to anxiety, dementia, 37's minimum data set /22/18 revealed the resident derately cognitively in had verbal symptoms ers 1 to 3 days of the 7 day active diagnoses included in, dementia, depression, and ipolar disorder was not noted s. 37's active diagnoses rder was added to her active set dated of 12/26/18. in 1/8/19 at 3:58 PM the the PASARR screen in July SARR screen performed on	F 64	consists of but not limite Director, Executive Dire Clinical Services, Activi Social Services, Mainte Dietary Manager, Hous Manager, laundry mana and a minimum of one of Quality Improvement M scheduled modified bas	ector, Director of ties Director, enance director, ekeeping ager, MDS Nurse direct caregiver.	

				LE CONSTRUCTION		. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPL		
			A. BOILDING			2	
		345403	B. WING			, 11/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
				6590 TRYON ROAD			
CARY HE	ALTH AND REHABILITA	HON		CARY, NC 27518			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR(DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 644	Continued From page	e 12	F 64				
1 011		olar disorder was identified, it	F 044	*			
		the social worker completed					
F 759		rror Rts 5 Prcnt or More	F 75	9		1/14/19	
SS=D	CFR(s): 483.45(f)(1)						
	§483.45(f) Medication The facility must ens						
	percent or greater; This REQUIREMEN	tion error rates are not 5 Γ is not met as evidenced					
	by: Based on observation	ons, staff interviews, and		Resident #52 physician was notified	ed of		
	record review, the fac			medication of error on 1/8/19 by Re			
	medication error rate			Director of Clinical Services and ne	ew		
		cation errors out of 27		orders were obtained. Resident #7			
	medication opportuni			physician was notified of medicatio			
		of 7.4% for 2 of 9 residents esident #75) observed		on 1/8/19 by Regional director of C Services and no new orders were	JIIIICai		
	during medication pa	,		received. Both residents responsib	ble		
				parties were notified by the Region	al		
	The findings included	1.		director of Clinical Services on 1/8/ The Nurse involved was re-educate	-		
	1. Resident #52 was	admitted to the facility on		the 5 rights to Medication Administ			
	5/30/17 with re-entry	from a hospital on 9/11/17.		on 1/8/19 by the Director of Nursing			
	-	loses included end stage					
	renal disease requirir	ng nemodialysis.		On 1/8/19 Regional director of Clin services reviewed medication orde			
	On 1/8/19 at 3:56 PM	1, Nurse #1 was observed as		identify any other residents on the	i 5 lU		
		ministered medications to		medication and administration time	es were		
	Resident #52. The a	dministered medications		changed to follow manufacturers			
		f 0.8 grams (g) sevelamer		recommendations.			
		ately 90 milliliters (ml) water		The Director of Nursing and / at N	roing		
	-	is a medication used to sphorus levels in patients		The Director of Nursing and / or Nu Supervisor educated licensed nurs	-		
		lue to severe kidney disease.		the 5 rights of medication administr			
				and following manufacturers			

Facility ID: 923078

If continuation sheet Page 13 of 24

	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`,	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING		C		
		345403	B. WING		01/11/2019		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
CARY HE	ALTH AND REHABILITAT	ION		6590 TRYON ROAD CARY, NC 27518			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIO		
F 759	sevelamer 0.8 g to be total dose of 2.4 g) by with meals. The seve administration at 8:00 PM. According to Lexi-Color on-line drug informati should be administered An interview was con with Nurse #1. Upon the pharmacy auxilia containing packets of the pharmacy. The a "Take this medication Nurse #1 reported sh to provide this medication Nurse #1 reported sh to provide this medication of the meal. On 1/8/19 at 5:26 PM conducted as the eve delivered to Resident hours after the sevela the resident). An interview was con	#52's January 2019 uded a current order for e given as 3 packets (for a / mouth three times daily elamer was scheduled for 0 AM, 12:00 PM, and 5:00 mp, a comprehensive on resource, sevelamer ed with meals. ducted on 1/8/19 at 5:16 PM request, the nurse reviewed ary label on the bag i sevelamer dispensed from uxiliary label read, in part: with a meal." At that time, e was not aware of the need ation with a meal. Upon ted she probably should e medication within ½ hour I, an observation was ening meal trays were #52's hall (one and one-half amer was administered to ducted on 1/9/19 at 10:02	F 759	P recommendations 1/8-14/19. The Director of Nursing and / or nursing supervisor to perform random qualit monitoring of medication administration for the five rights and following manufactures recommendations or a week, each shift, for eight weeks, monthly for two months. Nurses with have not received education, will be educated before working their next assigned shift by the nursing super. The Executive Director introduced to plan to the QAPI committee on 1/1. The Director of Nursing is responsite the plan. The results of the quality monitoring will be reviewed monthly QAPI meeting. QAPI members incompute the director, director of nursing activities, social services, maintenational housekeeping, dietary, MDS Nurse a minimum one direct caregiver.	ity ation he time , then ho e visor. this 1/19. ble for y at the duded ng, ince, e and at		
	the interview, the pha reviewed the manufact indicated sevelamer s She also reported cal medication for addition	cility's consultant ant Pharmacist #1). During irmacist stated she had cturer's instructions, which should be given with a meal. ling the manufacturer of the onal information and was told in between the medication					

Facility ID: 923078

If continuation sheet Page 14 of 24

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345403	B. WING				C 11/2019	
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
CARY HEALTH AND REHABILITATION					6590 TRYON ROAD CARY, NC 27518			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 759	administration and me effective the medication prior to the meal was stated, "Yes." A telephone interview at 10:52 AM with Con Consultant Pharmacis consulted to the facilit the med pass observa administration in relat mealtime was discuss he thought, "It would An interview was con PM with the facility's I Upon inquiry, the DO informed of the med p concerns identified wi in relation to meals. A timing of Resident #5 administration, the DO definitely follow the do medication with meals hours prior to the meal hours prior to the meal 2. Resident #75 was 1/25/16 with reentry ff Her diagnoses include (a circulatory problem reduce blood flow to to commonly affecting th A review of Resident Physician Orders incl mg cilostazol to be gir twice daily for a diagn	eal consumption, the less on would be. When asked if one and one-half hours too long of a time span, she was conducted on 1/10/19 isultant Pharmacist #2. St #2 reported he had ty for the past year. When ation of sevelamer ion to Resident #52's sed, the pharmacist stated be a timing issue." ducted on 1/10/19 at 5:08 Director of Nursing (DON). N stated he had been bass observations and ith the timing of medications When asked about the 2's sevelamer DN stated the facility would boctor's order to give this s, not one and one-half al service. admitted to the facility on rom a hospital on 7/15/18. ed peripheral artery disease in which narrowed arteries the extremities, most he legs).	F	759	9			

Facility ID: 923078

If continuation sheet Page 15 of 24

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		345403	B. WING				C 11/2019
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
CARY HEALTH AND REHABILITATION					6590 TRYON ROAD CARY, NC 27518		
(X4) ID PREFIX TAG				IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 759	works by preventing of from sticking together vessels in the legs to cilostazol was schedu 9:00 AM and 9:00 PM On 1/8/19 at 8:59 AM she prepared medicat Resident #75. The m milligram (mg) tablet of applesauce. On 1/8/7 was administered to t the medication admin observed to have a pa on the bedside table p observation was also drank from a vanilla s breakfast tray) immed was given. According to Lexi-Cor on-line drug information should be administered hours after meals. A review of the meal s facility indicated the re breakfast trays at 8:30 tray delivery was not An interview was com AM with Nurse #2. U reviewed the pharmation bubble pack card con dispensed from the pl read: "Take 30 minute food." Upon review of	on and a vasodilator. It certain blood cells (platelets) and by widening blood increase blood flow. The iled for administration at i. , Nurse #2 was observed as tions for administration to edications included one-50 of cilostazol crushed in 19 at 9:06 AM, the cilostazol he resident. At the time of istration, Resident #75 was artially eaten breakfast meal blaced in front of her. An made of the resident as she hake (provided on her liately after the medication mp, a comprehensive on resource, cilostazol ed 30 minutes before or 2 schedule provided by the esident's hall was to receive 0 am. The exact timing of	F	759	9		

Facility ID: 923078

If continuation sheet Page 16 of 24

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345403	B. WING				C 11/2019	
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•		
CARY HE	ALTH AND REHABILITAT	ION			6590 TRYON ROAD CARY, NC 27518			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 759	scheduled administra also acknowledged th and had eaten some of the med administra An interview was com- with one of the facility (Consultant Pharmaci the pharmacist report cilostazol administrati brought to her attentio Pharmacist #1 stated staff the medication n 30 minutes before bre absorption of the drug manufacturer's specif pharmacist reported t the cilostazol were ch PM. A telephone interview at 10:52 AM with Con Consultant Pharmacis consulted to the faciliti the interview, the obs administration during was discussed. The the manufacturer spe administered 30 minu meals. However, Con questioned the signifi- instructions on the tim administration in relat An interview was com- PM with the facility's I Upon inquiry, the DOI	ion within one hour of the tion time. However, she he resident had her meal tray of her breakfast at the time tition. ducted on 1/9/19 at 9:15 AM 's consultant pharmacists ist #1). During the interview, ed the timing of the on to Resident #75 was on on 1/8/19. Consultant she explained to the facility eeded to be given at least eakfast due to the g. Based on the ications/instructions, the he administration times for anged to 6:30 AM and 4:00 was conducted on 1/10/19 usultant Pharmacist #2. st #2 reported he had ty for the past year. During ervation of cilostazol Resident #75's mealtime pharmacist acknowledged cified cilostazol should be thes before or 2 hours after nsultant Pharmacist #2 cance of the manufacturer's ning of cilostazol ion to meals.	F	759				

Facility ID: 923078

If continuation sheet Page 17 of 24

		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		345403	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER		1	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CARY HE	ALTH AND REHABILITAT	ION			5590 TRYON ROAD CARY, NC 27518		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 759 F 883 SS=D	concerns identified wi in relation to meals. A timing of Resident #75 the DON stated the fa doctor's order or the r on how the medicatio stated cilostazol shou before or 2 hours afte Influenza and Pneum CFR(s): 483.80(d)(1)(§483.80(d) Influenza immunizations §483.80(d)(1) Influenza immunizations §483.80(d)(1) Influenza immunizations §483.80(d)(1) Influenza policies and procedur (i) Before offering the each resident or the r receives education re potential side effects of (ii) Each resident is of immunization Octobel annually, unless the in contraindicated or the immunized during this (iii) The resident or the has the opportunity to (iv)The resident's med documentation that in following: (A) That the resident of immunization; and (B) That the resident of immunization or did n	th the timing of medications When asked about the 5's cilostazol administration, icility should follow the nanufacturer's instructions in was to be given. He Id be administered 1/2 hour r a meal. ococcal Immunizations (2) and pneumococcal za. The facility must develop es to ensure that- influenza immunization, esident's representative garding the benefits and of the immunization; fered an influenza r 1 through March 31 mmunization is medically e resident has already been a time period; e resident's representative o refuse immunization; and dical record includes dicates, at a minimum, the pror resident's representative on regarding the benefits		883			1/14/19

Event ID: ONZD11

Facility ID: 923078

If continuation sheet Page 18 of 24

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	02/11/2019 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE SURV COMPLETED	
		345403	B. WING				C 11/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				6	590 TRYON ROAD		
CARTINE	ALTH AND REHABILITAT	ION		c	CARY, NC 27518		
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 883	 §483.80(d)(2) Pneum must develop policies that- (i) Before offering the immunization, each representative receive benefits and potential immunization; (ii) Each resident is of immunization, unless medically contraindica already been immunization already been immunization that the opportunity to (iv) The resident's medical of the comportant of the state opport of the resident of the pneumococcal immunization; and (B) That the resident of the pneumococcal immure the pneumococcal immure the pneumococcal immure the precedent of the state of	ococcal disease. The facility and procedures to ensure pneumococcal esident or the resident's es education regarding the side effects of the ffered a pneumococcal the immunization is ated or the resident has zed; e resident's representative or fuse immunization; and dical record includes dicates, at a minimum, the or resident's representative on regarding the benefits ects of pneumococcal either received the nization or did not receive munization due to medical fusal. is not met as evidenced iews and record reviews, the an effective immunization the resident's medical ord of vaccination and nization status for two of five r pneumococcal nt #58 and Resident #69).	F	883	Resident #58 consent for Pneumococc Vaccine reflects she got it in the community prior to coming to the facilit dated 1/11/19. Resident #69 was offer the Pneumococcal Vaccine on 1/14/19 new orders received from the physiciar Quality improvement monitoring of curr residents to identify other residents tha may desire to have Pneumococcal Vaccine was completed 1/11- 14/19 by Regional director of Clinical Services a	y ed ; n. rent t the	

Event ID: ONZD11

Facility ID: 923078

If continuation sheet Page 19 of 24

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345403	B. WING				C 11/2019
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				6	590 TRYON ROAD		
	HEALTH AND REHABILITATION			С	ARY, NC 27518		
(X4) ID PREFIX TAG				×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 883	 8/17) used by the facil Advisory Committee of recommends two pneadults 65 years of age or older and have not you should receive or (pneumococcal conjul 12 months get a dose polysaccharide vaccine preumonia vaccine, a received the PPSV23 second vaccine, PCV 1. Resident #58 was 2/8/13. The resident #58 was cure A review of Resident #58 was cure A review of Resident arevealed there was not whether the resident and the pneumococcal vaccine A review of the resident arevealed there was not pneumococcal vaccine A review of the resident arevealed there was not pneumococcal vaccine A review of the resident arevealed there was not pneumococcal vaccine A review of the resident and the pneumococcal vaccine A review of the resident assessment indicated pneumococcal vaccine A review was not received was and the facility's factor and Administrator. Up Administrator reported to a resident should b resident's Medication 	lity read, in part: "The on Immunization Practice umococcal vaccines for e and olderIf you are 65 had a pneumonia vaccine, ne dose of PCV13 gate vaccine) now, and in of PPSV23 (pneumococcal ne). If you have had a fter the age of 65, then you and should receive the 13." admitted to the facility on s cumulative diagnoses ecord review revealed rently 86 years old. #58's medical record o documentation to indicate received or refused either of es. nt's most recent quarterly IDS) assessment dated ed. Section O of the MDS I the resident's ation was not up to date. neumococcal vaccination noted as, "Not offered." ducted on 1/10/19 at 3:58 Director of Nursing (DON) oon inquiry, the d any vaccination provided e documented on the Administration Record	F	383	or Director of Nursing. On 1/14/19 the Director of Nursing re-educated licensed Staff on administering and/or offering the Pneumococcal Vaccine to new admissions to the facility. The Director Clinical Services and / or the Nursing Supervisor will perform random quality monitoring of new admissions for offer / providing the pneumococcal vaccine times a week for four weeks, one time week for eight weeks, then monthly for three months. Once consent obtained and/ or vaccine administered, it will be recorded in the medical record and / or EMR for tracking. Nurses who did not receive the educat will be educated before working their m assigned shift by the nursing superviso The executive director introduced this plan to the QAPI committee on 1/11/19. The Director of Nursing is responsible the plan. Results of the Quality Improvement monitoring will be review monthly at the QAPI committee meetin QAPI committee consists of but not limited to : medical director, executive director, Director, Social Services, Activities Director, Social Services, Maintenance Director, Dietary Manage Housekeeping manager, MDS Nurse a a minimum of one direct caregiver. Quality improvement monitoring sched modified based on findings.	ng two a r ion, ext or. for ed g.	
	to a resident should b resident's Medication	e documented on the				ule	

Facility ID: 923078

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345403	B. WING				C / 11/2019
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1	
CARY HE	ALTH AND REHABILITAT	ION			6590 TRYON ROAD CARY, NC 27518		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE				BE	(X5) COMPLETION DATE	
TAG F 883	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			88:	DEFICIENCY)		
	records. The Regional vaccination consents were another source Upon their request, a conducted on 1/11/19 Administrator and Dire The Administrator and	which included vaccination al MDS Coordinator stated kept in the medical record of information. follow-up interview was					

Facility ID: 923078

If continuation sheet Page 21 of 24

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345403	B. WING				C 11/2019
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
CARY HEA	Y HEALTH AND REHABILITATION				590 TRYON ROAD CARY, NC 27518		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 883	had a problem with the A follow-up interview of 11:10 AM with MDS N interview, the MDS N Resident 58 's 12/13, indicate her pneumoor up to date because the in the medical record received the pneumoor further inquiry, the MDS of facility use to keep a l immunization status of no longer up to date. 2. Resident #69 was in facility on 12/7/16, with 1/23/17. The resident included chronic obsta and chronic hypoxem respiratory failure. Re Resident #69 was cur A review of Resident a revealed there was no resident's Immunization whether the resident of the pneumococcal vac	d the facility recognized they is issue. was conducted on 1/11/19 at Aurse #1. During the urse #1 reported she coded (18 MDS assessment to coccal vaccination was not here was no documentation to indicate the resident had coccal vaccination. Upon DS Coordinator joined the Coordinator reported the log for monitoring the of residents, but the log was initially admitted to the th re-entry from a hospital on nt's cumulative diagnoses ructive pulmonary disease ic (low blood oxygen levels) cord review revealed trently 72 years old. #69's medical record to documentation on the on Record to indicate received or refused either of ccines.	F	883			
		noted as, "Not offered."					

If continuation sheet Page 22 of 24

	-	ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 02/11/20 DRM APPROVE NO. 0938-039	
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345403	B. WING				C 01/11/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	•	•	
CARY HE	ALTH AND REHABILITA	TION		659	00 TRYON ROAD			
				CA	RY, NC 27518			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 883	Continued From pag	e 22	F	383				
	An interview was cor	nducted on 1/10/19 at 3:58						
		Director of Nursing (DON)						
	and Administrator.							
	· ·	ed any vaccination provided be documented on the						
		n Administration Record						
		inization Record kept in the						
	medical record.							
	-	was conducted on 1/11/19 at ministrator. At that time, the						
		ed a copy of Resident #69's						
	· ·	from her thinned chart. The						
		esident was vaccinated with						
		No additional immunization to indicate whether or not						
	Resident #69 had re							
	vaccination. Upon fu	urther inquiry, the						
		ed there may be logs with						
		n information in the facility. ation could not be located at						
		cent change of staff. The						
		ed an audit of "the entire						
	building" would need							
	determine residents'	vaccination status.						
	An interview was cor	nducted on 1/11/19 at 10:07						
		#1 in the presence of the						
		dinator. During the interview,						
		asked what resources were accination status of residents						
		S assessment. The nurse						
	stated she looked in	the resident's medical record						
	for this information.							
		available in the facility's						
		s, the residents' MARs, and secord kept on the chart. She						
	also noted that new							
		k which included vaccination						

Facility ID: 923078

If continuation sheet Page 23 of 24

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 02/11/2019 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED	
		345403	B. WING			(01/	C 11/2019
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	TE, ZIP CODE	•	
CARY HE	ALTH AND REHABILITAT	ION		590 TRYON ROAD			
				CARY, NC 27518			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 883	records. The Regionary vaccination consents were another source Upon their request, a conducted on 1/11/19 Administrator and Dir The Administrator and Dir The Administrator and a facility policy/proced monitoring/document Administrator reporter had a problem with the A follow-up interview 11:10 AM with MDS N interview, the MDS N Resident 69's 12/18/1 indicate her pneumoor up to date because the in the medical record received the pneumoor further inquiry, the MDS facility use to keep a	al MDS Coordinator stated kept in the medical record of information. follow-up interview was at 10:35 AM with the ector of Nursing (DON). d DON reported there wasn't dure which addressed the ation of vaccinations. The d the facility recognized they is issue. was conducted on 1/11/19 at Nurse #1. During the urse #1 reported she coded 8 MDS assessment to soccal vaccination was not here was no documentation to indicate the resident had coccal vaccinator. Upon DS Coordinator joined the Coordinator reported the	F 883		EFICIENCY)		

Facility ID: 923078

If continuation sheet Page 24 of 24