STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 surveyor entered the facility on 2/24/25 to conduct a complaint survey and exited on 2/26/25. Additional information was obtained offsite 2/27/25 and 2/28/25. Therefore, the exit date was changed to 2/28/25. (Event CIXE11). The following intakes were investigated NC00226896, NC00227022, NC00227261, NC00227699. Three of the eight complaint allegations resulted in deficiencies. Intakes NC00227022 and NC00227261 resulted in immediate jeopardy. Past Noncompliance was identified at CFR 483.11 at tag F600 at a scope and severity (J) Tag F 600 constituted Substandard Quality of Care. Noncompliance began on 2/6/25. The facility came back in compliance effective 2/8/25. A partial extended survey was completed.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 584		3/20/25

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

Electronically Signed | 03/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 584	Continued From page 1 (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, and interviews with resident and staff, the facility failed to provide housekeeping services to ensure a clean bathroom for a bathroom which was jointly shared by multiple residents. This was for one (Resident # 5) of four sampled residents who were interviewed regarding services at the facility. The findings included:	F 584	The Housekeeper immediately cleaned Resident #5 bathroom to ensure it was a clean, comfortable and homelike environment on 02/25/2025. The Housekeeping Supervisor audited all rooms to ensure they were all clean, comfortable and homelike on 02/25/2025. There were no other deficiencies	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 584	Continued From page 2 Resident # 5 was admitted to the facility on 8/1/24. A review of Resident # 5's quarterly Minimum Data Set assessment, dated 12/2/24, revealed Resident # 5 was cognitively intact and continent. During interviews held with Resident # 5 on 2/24/25 at 10:12 AM and again on 2/25/25 at 8:35 AM, Resident # 5 expressed concerns related to his bathroom being cleaned so that he could use it. Resident # 5 reported the following information. He resided in a room which shared a bathroom with two other residents who had an adjoining door to the bathroom from their room. One of the other residents, who used the bathroom, needed adaptive devices (a riser) over the toilet and this resident also had some confusion. When this resident would use the bathroom, the resident at times would leave fecal matter on the floor, on the toilet, and other places in the bathroom. He had trouble getting staff to clean the bathroom so that he could use it and feel that it was clean. He had talked to staff about the problem. About two weeks ago, the resident from the adjoining room had used the bathroom and there was a lot of feces on the toilet. He had asked NA (Nurse Aide) # 10 to clean the toilet so that he could use it. No one ever came to clean the toilet, and so he cleaned the toilet himself although it was not his feces. During the interview on 2/25/25 at 8:35 AM with Resident # 5, observations were made with Resident # 5 of the condition of his bathroom. The following observations were made. There was brownish black matter on the back of the toilet lid and on the back of the toilet. On a shelf above the toilet, Resident # 5 had stored a	F 584	identified. Any Resident can be affected by this deficient practice. An Ad hoc Quality Assurance Performance Improvement Committee will be held on 03/19/2025 to formulate and approve a plan of correction for the deficient practice. The Housekeeping Supervisor will complete education to all housekeepers by 03/19/2025 on thoroughly cleaning a resident's room/restroom, including multiple visits if the room requires it, to ensure a clean and homelike environment. The Housekeeping Supervisor will complete random audits on 5 rooms per week X 12 weeks to ensure they are clean, comfortable and homelike starting 03/19/2025. The Executive Director will review during the monthly QAPI committee review for 3 months. Corrective action will be completed on 03/20/2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 584	Continued From page 3	F 584		

personal item he used. Beside his personal item, there was a toilet seat that had been removed from the toilet and had brownish black matter on it. There was a part of the toilet riser's adaptive equipment (a funnel piece) which had brownish black matter on it sitting on the shelf. There was trash behind the toilet. There was brownish black matter on the wall beside the sink and the mirror. The mirror had a large amount of white matter on it. During the observation of the bathroom with Resident # 5 on 2/25/25 at 8:35 AM, the resident reported housekeeping had not come in yet that morning. He also reported that the adaptive equipment for the toilet riser, which was on the shelf, was for the resident who shared the bathroom. He (Resident # 5) was concerned it was kept on the shelf with his personal item. Resident # 5 also reported that the toilet seat was broken and so he had taken it off many weeks ago and used the riser when he needed to use the toilet. He had placed the broken toilet seat on the shelf but no one had cleaned it or removed it.

Resident # 5's bathroom was observed again on 2/25/25 at 4:15 PM with the DON (Director of Nursing). The bathroom conditions observed on 2/25/25 at 8:35 AM were still observed on 2/25/25 at 4:15 PM. According to Resident # 5, housekeeping had come in at midday to clean his room, but they had not cleaned his bathroom. The DON reported that the housekeeping staff were contracted workers, and she would report it to the supervisor of housekeeping about the condition of the bathroom.

On 2/25/25 at 4:45 PM Nurse # 6 was interviewed and reported the following information. There was a resident who shared Resident # 5's bathroom from an adjoining room. This resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 584	Continued From page 4	F 584		

at times would drop his pants on the way to the bathroom and would miss the toilet. He (Nurse # 6) was also aware of an incident in which Resident # 5 had reported he (Resident # 5) had cleaned up the other resident's feces after asking Nurse Aide # 10 to help and no one helped him. He (Nurse # 6) had talked to NA # 10 after the incident and NA # 10 had not realized it was her job to clean obvious signs of feces and then alert housekeeping to disinfect surfaces. Nurse # 6 recalled this incident occurred about a month ago.

NA # 10 was interviewed on 2/26/26 at 1:55 PM and reported the following information about the incident in which she was asked to help clean the bathroom. She recalled Resident # 5 asking her for help to get his toilet bowl cleaned when she was walking down the hallway to help another resident. She told him she would tell housekeeping, which she did. She did not know what housekeeping did after she told them. Resident # 5 was not her assigned resident that day and she went to care for another resident.

The Housekeeping Director was interviewed on 2/26/25 at 10:00 AM and reported the following information. He had not been aware of the condition of Resident # 5's bathroom the previous day (2/25/25) until the DON had called him after the 4:15 PM observation made by her and the surveyor. The bathroom should have been cleaned and not left in the condition it was throughout the day. If there were broken, dirty items such as a toilet seat sitting up on a shelf used to store personal items, then there should be some type of communication between maintenance and his staff to rectify that issue.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 584	Continued From page 5 On 2/26/25 at 11:20 AM the housekeeper (Housekeeper #1), who had been assigned to Resident # 5's hall on 2/25/25, was interviewed with the Housekeeping Director and reported the following information. Housekeeper # 1 was aware that one of the residents who used Resident # 5's bathroom at times had explosive diarrhea. He had cleaned the bathroom on 2/25/25 around 7:30 AM or 8:00 AM and did not have time to go back during the day to clean again. He had not cleaned the walls when he initially cleaned the bathroom, and he did not clean any adaptive equipment that was on the shelf that had brownish black matter when he had cleaned. The Housekeeping Director further reported during this interview on 2/26/25 at 11:20 AM that his housekeeping staff were responsible for cleaning small drips of fecal matter. If there were large amounts of stool or emesis then nursing staff were to clean, and then his staff would disinfect. No one had mentioned a problem to him that Resident # 5's bathroom needed more frequent checks and cleaning. After 5:00 PM, there was one of his staff members who worked in laundry. They could also provide housekeeping services to the nursing staff if needed after his routine housekeepers left for the day.	F 584		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 600	Continued From page 6 corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with staff, Psychiatric Nurse Practitioner, Responsible Party (RP), and the Police Detective, the facility failed to protect the right of two cognitively impaired residents (Residents # 1 and # 7) to be free from abuse. On the evening of 2/6/25 Resident # 2 returned from an outing and was observed by staff to show signs of being inebriated. That evening he was also observed at the bedside of Resident # 1, who was cognitively impaired and who did not have the ability to invite him into her room. After his removal from Resident # 1's room by staff, Resident # 2 was observed in Resident # 1's room a second time with the curtain pulled so that he and Resident # 1 were out of view. During this second incident, Nurse Aide # 1 and Nurse # 1 entered the room and walked around the curtain and witnessed Resident # 2 with his hand under Resident # 1's right leg lifting it up while Resident # 1's brief was open on the right side exposing part of her private area. Resident # 2 was seated in his wheelchair at Resident # 1's bedside at the time with his hand between Resident # 1's thighs to the point that only above his wrist was visible. Resident # 1 was in her bed clenching her brief which was unfastened on the right side and with part of her private area exposed. Resident # 1	F 600	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 600	Continued From page 7	F 600		

was saying "No, no, no." Resident # 1's RP reported during interview that if Resident # 1 could have spoken about what had occurred to her, it would have made her sad and cry, and furthermore Resident # 1 would have called out to God asking why it had happened to her in her old age after she had lived through hard times. In addition, Resident # 6, who had a history of aggressive and volatile behaviors, was observed by staff standing over her cognitively impaired roommate (Resident # 7) and pulling her hair. At the time, Resident # 7 was observed screaming and crying. A reasonable person would expect to be safe from abuse in their home and could experience trauma, fear and anxiety. This was for two (Residents # 1 and # 7) of two sampled residents reviewed for abuse.
Example #2 was cited at a lower scope and severity of G.

The findings included:

Resident # 2 was admitted to the facility on 1/22/24. The resident's diagnoses included muscle weakness and right leg below knee amputation.

Resident # 2's annual MDS (Minimum Data Set) assessment, dated 1/28/25, coded the resident as cognitively intact. The resident was also coded as totally independent with bathing, dressing, and transfers. The resident was assessed to be able to walk 150 feet with supervision. The resident's age was less than 65 years of age.

On 2/6/25 at 1:12 PM a nurse documented in a progress note that Resident # 2 signed out with a friend for a leave of absence at 1:10 PM. He left

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 600	Continued From page 8	F 600		

the facility in stable condition.

On 2/6/25 at 7:29 PM the DON (Director of nursing) entered the following information in a progress note. At 6:15 PM Resident # 2 had been noted to be in a female resident's room and her brief was undone. Resident # 2 was removed from the room and placed on one on supervision. Appropriate staff, family, police, and physician were notified. Investigation with the police and detectives resulted in Resident # 2 being arrested.

A review of the facility's investigative file revealed Resident # 1 was the resident whose brief was undone when Resident # 2 was found in the room.

A review of Resident # 1's record revealed the following information. Resident # 1 had been admitted to the facility on 9/1/22 and was elderly. Resident # 1's diagnoses in part included a history of stroke, hemiplegia, hemiparesis, anxiety, and heart disease.

Resident # 1's 1/21/25 quarterly MDS assessment coded the resident as severely cognitively impaired and as being totally dependent on staff for her dressing and hygiene needs. She was also assessed to need substantial to maximum assistance to turn in bed and was dependent on staff for transfers.

Resident # 1's care plan, updated on 1/31/25, included the information that the resident was dependent on staff for intellectual; physical, and emotional needs secondary to her hemiparesis, hemiplegia, and a language barrier.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 600	Continued From page 9	F 600		

Review of physician orders revealed a hospice consultation was ordered for Resident # 1 on 2/3/25.

Further review of Resident # 1's record revealed the DON made a nursing entry on 2/6/25 at 8:42 PM that was entered as a "late entry." The DON documented the following information within the entry. At 6:15 PM a male resident was noted going in Resident # 1's room and upon nursing staff entering the room Resident # 1's brief was found open on the right side and the male resident was observed touching the resident. All appropriate parties were notified. The police were notified for investigation. The family members were notified, and Resident # 1 was sent to the hospital for evaluation.

Review of 2/6/25 hospital ED (emergency department) notes revealed the following notations by the ED physician. Resident # 1 was assessed for possible sexual assault and found to have no overt signs of trauma. The resident had advanced dementia and had no recall of the event. The physician talked to the family who declined sexual disease testing and declined "to send off testing and to pursue sexual assault nursing examination." Resident # 1's family member reported the resident was starting hospice and she just wanted to focus on her being kept comfortable.

Review of the facility's investigative file revealed typed statements the DON had obtained from Nurse Aide (NA) # 1 and Nurse # 1 during the facility's investigation.

NA # 1's statement read as typed, "[Resident # 1] had returned from being out with friends/family,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 600	Continued From page 10	F 600		

he appeared to have been drinking, as we were passing dinner trays noticed he went into [Resident # 1's] room. Myself and the nurse removed him from the room and redirected him to his room across the hall. As we were continuing to pass trays, we saw him enter her room again and we went down the hall to get him again. As we entered the room, we noticed that she was uncovered, and his right hand was under her leg with her brief undone. The nurse yelled at him to stop, and we immediately removed him from the room back to his room, reported it to supervisor."

NA # 1 was interviewed on 2/24/25 at 4:55 PM and reported the following information about the incident. She had not often cared for Resident # 2 before 2/6/25. Resident # 2 had returned to the facility around 6:00 PM or 6:30 PM on 2/6/25 after being out to celebrate his birthday. When he returned, she could smell "fumes on him" and he appeared to be drunk. While the staff were passing out trays he sat in the hall and was not going to eat. She went to check on Resident # 1 after Resident # 1 had already been served her tray. When she went to Resident # 1's room to check on her, she found Resident # 2 in Resident # 1's room. He was seated in his wheelchair. Resident # 1 was in her bed. Resident # 2 was "messing with her tray" and at the same time he was pulling down her gown. At the time she (NA # 1) first saw Resident # 2 pulling Resident # 1's gown down, the gown was above Resident # 1's waist. Resident # 1's brief was on and intact. At the time, the privacy curtain was open. Resident # 1's covers were down, but that was not unusual because she did not always like the covers on her. She (NA #1) told Nurse # 1, who told Resident # 2 to leave the room. Nurse # 1 also told the supervisor about the situation. Resident #

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 600	Continued From page 11	F 600		

2 did leave the room and went into the hallway. She (NA # 1) continued to take up trays, but she kept an eye on Resident # 2. As she was taking up dinner trays, she noticed that Resident # 2 had disappeared. She went and got Nurse # 1 and informed her. They went back to Resident # 1's room. At that time the door was open and the curtain was closed where you could not see Resident # 1 in her bed. They entered and rounded the curtain together. She (NA # 1) saw Resident # 2 in his wheelchair and Resident # 1 was in her bed. Resident # 2 had his hand under Resident # 1's right leg lifting it up. Resident # 1's brief was open on the right side to the point that part of her private area was exposed. Nurse # 1 yelled for Resident # 2 to get out of the room. He stopped lifting Resident # 1's leg and left the room. Nurse # 1 sent Resident # 2 to his room and notified the supervisor again, who called the DON. At the time when Resident # 2 was found in Resident # 1's room the second time, she was moaning in a way that she usually moaned. She (NA # 1) stood guard over Resident # 1 to protect her after the second incident, and another person was stationed to stand guard over Resident # 2's room where he was. Prior to the incident, no one had mentioned to her, and she was not aware of any incidents in which Resident # 2 allegedly was touching any other resident inappropriately.

During an interview with the Administrator on 2/28/25 at 10:11 AM, the Administrator reported that no staff member had reported during their immediate interviews following the incident that Resident # 2 was touching Resident # 1 in anyway during the first incident on 2/6/25 when Resident # 2 was found in Resident # 1's room. The surveyor agreed to interview NA # 1 again for clarification.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 600	Continued From page 12	F 600		

A second interview with NA # 1 on 2/28/25 at 11:11 AM was conducted with the Administrator per a three- way telephone call. NA # 1 reported the following information. In recalling the events weeks after the initial event had occurred, she may have been recalling the touching of the gown incorrectly when she first spoke to the surveyor. The touching of the gown was possibly during the second incident. She could recall for certainty that in the first incident she was surprised to see Resident # 2 in Resident # 1's room and he had been eating something off the resident's tray at the time. He had been removed from the room. NA # 1 further reported Resident # 1 could move and slide down in bed and that at times her gown would ride up from her movement in the bed.

Review of the statement from Nurse # 1 as typed by the DON read as follows: "[Resident # 2] appeared to be drunk when returned from LOA (leave of absence) with family as he went down the hall, he went into [Resident # 1's] room and myself and a CNA (certified nursing assistant) removed him to his room and told him that we would help her. We went on about passing trays and about 10 minutes later saw him go into the room again. We immediately went down the hall and into the room, I yelled for him to get out. He was sitting in his wheelchair beside the bed, her brief was undone, and his right hand was under her leg and unable to see where it was at. We immediately removed him and placed him in his room with someone watching him 1:1 per supervisor."

Nurse # 1 was interviewed on 2/25/25 at 11:27 AM and reported the following information. She usually worked throughout the facility and did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 600	Continued From page 13	F 600		

care for Resident # 1 and Resident # 2 all the time. On the date of the incident, she had been at the desk when Resident # 2 had returned from an outing. He walked in with a walker and had a prosthesis on at the time. By looking at his eyes and his walk, it appeared he was inebriated when he returned. He went to his room. Later dinner trays came out on the hall. At that time, she recalled Resident # 2 being in his wheelchair without his prosthesis. While dinner trays were on the hall, NA # 1 got her to go to Resident # 1's room because Resident # 2 was in the room. When she entered the room, Resident # 1 was looking at the television. Resident # 2 was seated in his wheelchair in her room. Resident # 1's bedside table was between Resident # 2 and Resident # 1 at the time. Resident # 2 was eating dessert in Resident # 1's room and said he was talking to her. She informed Resident # 2 that the resident did not speak his language, he was not to help feed her, and he needed to leave the room. Resident # 2 did leave. She (Nurse # 1) informed Nurse # 3 (the supervisor for that evening) and she (Nurse # 1) then continued to help with tasks on the hall. Approximately ten minutes later she and NA # 1 met in the hall and went back to check on Resident # 1. At the time, the privacy curtain was pulled where you could not see Resident # 1 from the doorway. They could hear Resident # 1 saying very softly and not loud enough to hear down the hallway, "No, no, no." They rounded the curtain. Resident # 1 was in her bed clenching her brief which was unfastened on the right side. Part of her private area was exposed. Resident # 2 was in his wheelchair and closer to her bed than previously. His hand was between her thighs to the point that only above his wrist was visible, and therefore she could not see exactly where his hand was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 600	Continued From page 14	F 600		

touching. She told him to get out of the room right then and put him in his room. She ran to tell Nurse # 3. One on one was placed with both residents. Prior to the incident, she had only been working in that section of the facility about every two weeks and therefore was not often assigned to care for Resident # 2. She knew Resident # 2 had "fresh tendencies" and he would say he had multiple girlfriends, but she had never witnessed him touching another resident inappropriately. She did not recall anything in report about any special monitoring Resident #2 needed around other residents.

There was no statement from Nurse # 3 (the nursing supervisor) in the investigation file. Nurse # 3 was interviewed on 2/24/25 at 4:02 PM and reported the following information. She had not witnessed either incident. She did know that Resident # 2 had returned that evening and appeared to be inebriated. That evening NA # 1 had told Nurse # 1 about an incident in which Resident # 2 was in Resident # 1's room with his hand under her covers. Nurse # 1 had relayed this to her (Nurse # 3). Resident # 2 and Resident # 1 had immediately been separated and Nurse # 1 had reported it to her (Nurse # 3). She (Nurse # 3) immediately went to a private area to call the DON about the incident. At that time, the DON had already left work and was planning to return to the facility. Immediately after she got off the phone and was returning to the unit, she saw Nurse # 1 and NA # 1 "power walking-running" to her. They reported there was a second incident in which Resident # 2 was found in Resident # 1's room and this time it was her understanding that Resident # 2 had been in Resident # 1's bed. She (Nurse # 3) was told that Resident # 2 had been on top of Resident # 1 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 600	Continued From page 15	F 600		

Resident # 2 "was violating her" while Resident # 1 was saying, "no, no, no." Resident # 2 had been removed by them and put back in his room before Nurse # 1 and NA # 1 came to her. Nurse # 3 stated it had seemed like "a minute" since the first report and all she had done was go call the DON before the second incident with Resident #1 and Resident #2 was reported to her. She immediately called the DON back again after the second incident, and the DON was on her way. The Administrator called and talked to her (Nurse #3) and told her to call the police which was done. She checked Resident # 1's blankets to make sure she was not bleeding but she did not tamper with her brief until emergency services and the police could arrive. Staff did stay one on one with Resident # 2 and Resident # 1.

The DON, who was the person to record Nurse # 1 and NA # 1's statements, was interviewed on 2/24/25 at 12:00 PM, 1:30 PM, and again on 5:10 PM and reported the following information. Resident # 1 had appeared to be drinking when he returned to the facility on 2/6/25. NA # 1 and Nurse # 1 were his assigned caregivers. Nurse # 3 was the supervisor that evening. Nurse # 3 was not the witness to the actual events. Resident # 2 had never been in bed with Resident # 1, and as in the recorded statements, Resident # 2 was found seated in his wheelchair beside Resident #1. He had his hand underneath her leg. The staff could not tell exactly where Resident # 2 had been touching Resident # 1 with his hand. Resident # 1 had been sent out to the hospital and found to have no trauma or penetration.

NA # 3 was interviewed on 2/25/25 at 11:40 AM and reported the following information. She routinely cared for Resident # 1 and Resident # 2.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 600	Continued From page 16	F 600		

Resident # 2 was usually in his room or the dining room when she was assigned to him. She had not seen him in other residents' rooms. In taking care of Resident # 1, Resident # 1 did not use her call bell to call for assistance. Resident # 1 had communication problems.

The Administrator was interviewed on 2/26/25 at 3:30 PM and again on 2/28/25 at 10:11 AM and reported the following information. On 2/6/25 Resident # 2 returned from his outing and appeared inebriated. Staff did find him in Resident # 1's room one time prior to the actual incident and he should not have been in her room. Resident # 2 was not touching Resident # 1 or her clothing in any way during the first incident. He was removed from Resident #1's room. A short time later when the curtain was observed pulled, two staff members entered at the same time. As they rounded the corner of the pulled curtain, one of the staff members had a phone and obtained a photograph of Resident # 2 touching Resident # 1. The photograph was not taken to disrespect or slow the removal of Resident # 2 from Resident # 1. It was taken quickly to provide evidence so that the police could arrest Resident # 2 and remove Resident # 2 from the facility. As one staff member took the photograph, the other staff member was pulling the resident away. Resident # 2 had never been on top of Resident # 1. At the time, as shown in the photographic evidence, he was in a wheelchair beside her. He did not have his prosthesis on and it would have been impossible for him to have been in Resident #1's bed. The Administrator was also interviewed regarding the difference in some of the statements given by the staff to the surveyor. The Administrator reported the following information regarding this.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 600	Continued From page 17	F 600		

Statements had been obtained that night directly following the incident at a time when things were fresh in his staff members' mind. The two witnesses were Nurse # 1 and NA # 1, and their recall at the time was that the resident [Resident #2] had not been touching the resident [Resident #1] or the resident's clothing in anyway during the first incident. Nurse # 3 had not witnessed either incident and Nurse # 3 had been very shaken up about things and there had been a lot of discussion about what had occurred. The Administrator felt like the details had become "conflated" over time and was not sure why Nurse # 3's interview about what occurred was different than what Nurse #1 and Nurse Aide #1 reported at the time of the incidents.

On 2/26/25 the Administrator provided a copy of the photograph that had been provided to the police on 2/6/25. Review of the photograph revealed the following observation. Due to the angle of the photograph, it did not depict any of Resident # 1's private area or Resident # 1's brief. The photograph was taken from the perspective of someone at the foot of the bed. Resident # 2 was seated in his wheelchair with his wheelchair parallel and right next to Resident # 1's bed. His wheelchair was positioned so that he was seated facing Resident #1. Resident # 1 was in bed with the head of the bed slightly elevated and the majority of her right thigh was exposed. The majority of Resident # 2's right forearm was under Resident # 1's right thigh pointed in the direction of her private area. The exact placement of Resident #2's hand was not visible in the photograph.

The police detective, who was investigating the assault, was interviewed on 2/27/25 at 3:51 PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 600	Continued From page 18	F 600		

and reported the following information. The call came into the police at 6:53 PM and they arrived at 7:17 PM. The police detective confirmed Resident # 2 was in his room and under surveillance by facility staff when police arrived. Staff reported that Resident # 2 did not normally associate with Resident # 1 and on that evening Resident # 2 had reported to staff that Resident # 1 was wanting her dinner tray removed. On the evening of 2/6/25 Resident #2 was removed from the facility and jailed.

Resident # 1's RP (Responsible Party) was interviewed on 2/24/25 at 12:38 PM and again on 2/28/25 at 9:20 AM and reported the following information. Resident # 1 had recently been placed on hospice before the incident of 2/6/25. She (the RP) had received a voice mail on 2/6/25 around 8:00 PM from the DON and returned it around 8:15 PM. The DON informed her that Resident # 1 had been assaulted by another resident. The DON further told her Resident # 1 was fine, and as a precaution the facility was sending Resident # 1 to the hospital to be checked. She had been told that staff had entered Resident # 1's room and the resident, who had assaulted Resident # 1, had been in a wheelchair at the time. Family members had been very involved in Resident # 1's care and would visit regularly. Family had noted a male resident sitting in the hallway near doorways and looking into rooms when they visited. She and the family were not aware of any incidents prior to 2/6/25 where anyone had entered Resident # 1's room and touched her inappropriately before 2/6/25. The RP reported Resident # 1 had lived through the hard times during the depression years and through war times. Due to the resident's medical status, she could not speak up

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 600	Continued From page 19	F 600		

for herself regarding what had happened. If the resident could have spoken up for herself and understood what had happened to her, the RP reported Resident # 1 would have been sad, cried, and prayed a lot. The RP further reported Resident # 1 would have asked God, "At my old age why did this happen? Why God, why me?"

The Administrator was informed of immediate jeopardy on 2/27/25 at 11:00 AM and presented the following corrective action plan.

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
At approximately 6:15 PM on 02/06/2025, Resident #2 was found to have his hand under the gown and between the legs of Resident #1 in Resident #1 room which was the "B" bed (closer to window) with privacy curtain pulled. Resident #1 brief was unfastened and hospital gown she was wearing was around her waist but witness statements do not state that Resident #1 was exposed and was covered by hospital gown. Resident #2 was immediately removed from Resident #1 room and placed on 1:1 supervision. Police were contacted and arrived on scene to conduct investigation. Resident #2 was placed under arrest for 2nd degree felony sexual offense and misdemeanor sexual battery. Resident #2 was formally discharged from the facility due to action and arrest with notification to family to collect his personal belongings. As of 02/27/2025, Resident #2 continues incarceration with $10,000.00 jail bond per detective assigned to this case. This was the first incident with Resident #2 being noted to have any touching of Resident #1 or having any contact with Resident #1's clothing per immediate interview with on-site

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 600	Continued From page 20	F 600		

clinical team of Certified Nursing Assistant (CNA) and Licensed Practical Nurse (LPN) who were assigned to both Resident #1 and Resident #2. Based on those immediate interviews, we were not aware of any inappropriate touching and Resident #2 was immediately placed on 1:1 observation when touching was identified. Resident #1 was monitored for psycho-social needs with no concerns identified during bathing and/or incontinent care. Resident #1 did not present with any recall of the adverse event and did not present with any facial grimacing or signs of fear or distress at any time after the event occurred. Resident #1 was relocated to a private room on 02/12/2025 which was when a private room became available.

The Medical Director was notified. Both resident's Responsible Parties were notified. A physical exam to include a skin assessment was conducted by assigned staff LPN for Resident #1 following the adverse event on 02/06/2025. No signs of bruising or trauma were indicated. As an additional precaution, the facility sent Resident #1 to the hospital emergency department for an additional exam. The resident's daughter declined extensive testing as she wished Resident #1 to return to the facility and wanted to keep Resident #1 comfortable. Resident #1 returned at approximately 3:45 AM on 02/07/2025 and no signs of trauma or penetration were identified. Adult Protective Services (APS) was contacted and determined that a formal investigation was not warranted as Resident #2 was no longer a potential threat to Resident #1.

Allegation of abuse was submitted to North Carolina Division of Healthcare Service Regulation (NCDHSR) at 7:38 PM on 02/06/2025.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 600	Continued From page 21	F 600		

Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice.
On 02/06/2025, nursing managers completed skin assessments on residents with a brief interview of mental status (BIMS) of 8 or below and abuse questionnaires for residents with a BIMS of 9 or greater. Abuse and neglect education was provided to staff on 02/06/2025 by the Director of Nursing.

A Resident Council meeting was held on 02/07/2025 to ensure residents understood sexual abuse and to report any allegation of sexual abuse.
Signage was discussed during the meeting and then posted in all common areas on 02/07/2025 as a reminder to Residents and Staff and vendors "IF YOU SEE SOMETHING, SAY SOMETHING".

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
On 02/06/2025, the Facility Administrator and Director of Nursing re-educated current staff (including contracted services) on Abuse/Neglect policy and procedures with emphasis on signs and symptoms of sexual abuse and ways to prevent sexual abuse. This also included timely reporting for Administrator and/or Director of Nursing to provide formal notification to NCDHSR within the required 2-hour window. Education included examples of what to look for including inappropriate touching or unwanted advances. This included covering unwanted intimate touching of any kind especially of breast or perineal area, all types of sexual assault, forced

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 600	Continued From page 22 observation of masturbation and/or pornography, taking sexually explicit photographs and/or audio/video recordings of a resident and maintaining or distributing them. Residents should be monitored for bruises or grip marks, dismissive attitude about any injuries, uncommunicative or unresponsive, unreasonably fearful or suspicious, lack of interest in social contact, unexplained changes in behavior Education forms were signed by trained staff for the verbal education that was provided. Existing staff who were not present on the evening of 02/06/2025 or on 02/07/2025 were required to undergo abuse and neglect training prior to their return to work. This subset of staff were directed to contact unit managers prior to return to work and a list of all employees was cross-referenced and checked off as education was completed. All new hire staff are required to undergo abuse and neglect training during new-hire orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Facility Administrator and Director of Nursing determined on 02/06/2025 to monitor facility performance in an ongoing pursuit of quality control. The Social Worker will interview five residents with a brief interview of mental status (BIMS) of eight or greater per week for twelve weeks to inquire if they have felt abused or have witnessed or suspected abuse or neglect. Skin audits will be conducted by Director of Nursing or designee for 5 randomly selected residents with a BIMS of 8 or below. Immediate action to be taken for any positive findings. Results of these	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 600	Continued From page 23	F 600		

audits/interviews will be brought before the Quality Assurance Performance Improvement (QAPI) Committee monthly with the QAPI Committee responsible for ongoing compliance.

Facility Administrator and Director of Nursing conducted an Ad hoc QAPI on 02/07/2025 with the Interdisciplinary Team (IDT) which includes Executive Director, Director of Nursing, Medical Director, Social Services Director, Activities Director, Dining/Nutrition Supervisor, Minimum Data Set (MDS) Team of RN and LPN, Rehabilitation Director, Housekeeping/Laundry Supervisor, Maintenance Supervisor, LPN Unit Manager, Business Office Director and Human Resources Director to review the event and conduct a root cause analysis for group discussion. Resident #2 was known to be very social and outgoing and friendly with all residents and staff. The root cause was determined to be that although staff did not have any reasonable expectation that this event had the likelihood to occur, it is possible for anyone at any time to make a poor decision with little to no consideration of consequence. In the monthly Quality Assurance and Performance Improvement (QAPI) Meeting, the Interdisciplinary Team (IDT) will review all resident to resident abuse allegations to ensure appropriate interventions are in place and the individualized resident-specific Plan of Care is updated for 8 weeks.

The Administrator will report the results of the monitoring to the QAPI committee to review audits and make recommendations to assure compliance is maintained on an ongoing basis.

The QAPI Committee will determine the need for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 600	Continued From page 24	F 600		

further intervention and auditing beyond three months to ensure compliance is sustained on an ongoing basis.

Compliance Date - 02/08/2025
Alleged date of IJ removal date: 02/08/2025

2. Resident # 6 was admitted to the facility on 3/7/24 with diagnoses of dementia, restlessness, agitation, hypertension, depressive disorder, anxiety, insomnia, muscle weakness, and cognitively communication problems.

A review of Resident # 6's care plan, updated on 11/21/24 and which was in place until her final discharge on 12/23/24, revealed the following information. Resident # 6 independently bathed, toileted, and transferred herself. She was continent. She had exit seeking behaviors. She displayed inappropriate behaviors which included agitation, screaming, inappropriate language, and resistance to care. She had the potential to be verbally and physically aggressive. Resident # 6's care plan directed staff to monitor, document, and report when a resident posed a danger to others. The care plan also indicated a psychiatric consult would be done as indicated.

According to the care plan, Resident # 6 had been on psychoactive medications since 3/20/24.

Review of progress notes revealed a notation by the Social Worker on 11/25/24 at 2:17 PM noting that Resident # 6 had returned to the facility on 11/22/24 after being at the hospital for aggressive and combative behaviors. The Social Worker noted she was continuing to look for appropriate long- term placement in a secured memory care unit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 600	Continued From page 25	F 600		

On 11/25/24 the Psychiatric NP noted she visited the resident, and the resident was calm at the time. The Psychiatric NP noted there had been an issue with noncompliance with the resident taking her medication. The psychiatric NP also noted that because of the resident's history of aggression and the potential for future volatility plans were underway to transfer her to a psychiatric facility for a higher level of care.

On 11/27/24 at 1:15 PM Nurse # 2 documented the following information in a nursing entry. Resident # 6 was being sent to the ED (emergency department) for combative behavior. Both the NP (Nurse Practitioner) and management had been advised with orders to send the resident out. The family was also notified. There were no specific details in the nursing note about what had occurred.

Review of EMS (Emergency Medical Services) records, dated 11/27/24, revealed the following information by the paramedic. "Facility staff stated the pt. (patient) refused to take any of her medications since being discharged from [name of hospital] for the same behavior several days ago. They stated she was striking her roommate and facility staff as well as throwing 'tea and coffee' at them. Pt would not answer questions or speak with EMS, except to say, 'get out of her way.' She would not discuss what made her upset or how she could be assisted. Pt repeatedly made verbal threats of physical violence towards those around her. Pt refused any assessment, attempting to kick officers and strike EMS with her hands." The paramedic further noted that Resident # 6's upper extremities were placed in soft restraints and her lower extremities secured

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 600	Continued From page 26	F 600		

with seatbelts. The resident was given an IM (intramuscular) injection of Haldol (an antipsychotic) and transported to the hospital.

The Activity Director was interviewed on 2/26/25 at 10:05 AM and reported the following information. Resident # 6 had behaviors. She was physically able to walk independently. She could be playful one second and participating with activities and then "the next second" she could be yelling and screaming. When Resident # 6 became upset, she would "chase staff down" and she would say the facility was her building. She would back staff up in a corner and be very loud. At times she would walk into an activity and then leave. Other times she might participate. Her actions were not predictable. On 11/27/24 they were having a social event. She (the Activity Director) first heard Resident # 6 ranting and raving before she was able to see what was happening. When she looked, she saw that a Nurse Aide was between Resident # 6 and another resident. The Nurse Aide was trying to block Resident # 6 from hitting the other resident. EMS (Emergency Medical Services) was called, and it took a "good few minutes" for them to get the resident onto a stretcher and to the hospital.

Nurse Aide (NA # 4) was interviewed on 2/26/25 at 3:45 PM with the Administrator present and reported the following information. She had been in the dining room passing trays to residents on 11/27/24 when Resident # 6 started pushing her chair backwards into another resident's chair. She (NA # 4) got between the two residents. Then Resident # 6 got up and tried to push the table into the resident. She and staff did intervene to protect the other resident. At that time Resident # 6 did not hit the resident. She (NA # 4) thought

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 600	Continued From page 27	F 600		

there had been an episode of behavioral problems earlier that day but did not know what had happened in the earlier incident. She (NA # 4) had witnessed Resident # 6 be violent with staff, but she had never witnessed Resident # 6 hit or hurt another resident.

Nurse # 2 was interviewed on 2/25/25 at 1:50 PM and again on 2/26/25 at 11:45 AM and reported the following information. Resident # 6 had sporadic behavior, and staff never knew when she would go into a rant. Resident # 6 also had a history of breaking windows at the facility. If staff tried to work with her or redirect her, then the resident would become combative with the staff. The staff had to keep their distance from her. The resident would yell, curse, kick and follow staff if they tried to walk away from her. The resident refused to take routine medication from staff to help with her behaviors. She did have some IM (intramuscular) medication they could give but it would take three people to safely give her the medication. On 11/27/24 both EMS and police were called. The one policeman, who responded, had to call for back up to deal with Resident # 6. Resident # 6 roomed with Resident # 7 during November and December 2024. Resident # 7 had communication problems and did not use her call bell. It was a challenge for staff to discern what Resident # 7 wanted or needed. Because of Resident # 6's behaviors, she (Nurse #2) had questioned in her mind if Resident # 6 might ever do anything to Resident # 7, but she (Nurse # 2) had never witnessed Resident # 6 to do so.

According to ED records, dated 11/27/24, Resident # 6 was seen in the ED and was calm during that time. She was discharged back to the facility with instructions to continue her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 600	Continued From page 28	F 600		

medications.

On 12/2/24 the Psychiatric NP again saw Resident # 6 and noted the following information. Resident # 6 had been noncompliant with scheduled medication and topical PRN (as needed) psychoactive medication would be attempted. During the Psychiatric NP's visit, Resident # 6 had been agitated, defensive, and refused to engage in conversation. The Psychiatric NP further noted at the present time, the resident did not appear to pose a danger to herself or others and there were continued discussions at the facility to transition the resident to a different facility that could provide a higher level of behavioral management.

The Psychiatric NP was interviewed on 2/25/25 at 10:22 AM and reported the following information. Resident # 6 had a history of not taking scheduled medication from the staff. In December 2024 she had prescribed a topical medication (Ativan gel) as needed to help with her behavior while thinking the resident might allow the staff to get close enough to her to rub it in her skin when she became agitated. Ordering routine medications did not help the resident because she refused them. The resident suffered from dementia and would "sun-down" and pace. (Sundowning is when individuals experience more confusion and behavioral problems in the late afternoon and evening.) There was an active search to find Resident # 6 alternative placement. Resident # 6 was ambulatory, and the Psychiatric NP felt she needed to be in a locked environment where she could be monitored and better managed.

Per orders and the MAR (medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 600	Continued From page 29	F 600		

administration) record, scheduled psychoactive medications were discontinued on 12/2/24 and there were active orders in December 2024 for psychotropics that could be administered as needed by the IM route or by placing on the resident's skin for absorption.

Review of nursing notes between the dates of 12/4/24 to 12/22/24 revealed there were multiple nursing entries documenting Resident # 6 was confused and would pace in her room and throughout the hallway. Although not all inclusive some examples are as follows. On 12/10/24 at 3:49 PM a nurse noted Resident # 6 would pace the hallways talking to herself loudly and was difficult to redirect. On 12/12/24 at 3:43 PM a nurse noted the resident had thrown tea at a staff member and that the topical Ativan gel had been applied.

On 12/22/24 at 6:52 AM Nurse # 4 documented the following information. "This writer heard yelling in the hall and witness resident in [Resident # 6's room and bed location] grabbing resident in [Resident # 7's room and bed location] by the hair. Zero injuries noted. DON (Director of Nursing) [name of DON] notified; administrator [name of Administrator] notified. 911 called to have resident transported to ED for evaluation per DON. EMS refused to transport resident per son request. Resident placed on 1:1 for observation. Resident in bed resting. No further issues noted."

Review of the facility's investigative file revealed Resident # 7 was the resident whose hair was pulled on 12/22/24 by Resident # 6 and that Resident # 7 was Resident # 6's roommate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 600	Continued From page 30	F 600		

A review of Resident # 7's record revealed the following information. The resident had diagnoses in part which included dementia and anxiety.

Resident # 7's quarterly MDS (Minimum Data Set) assessment, dated 12/7/24 coded Resident # 7 as severely cognitively impaired and as rarely understood by staff and without the ability to make herself understood. Resident # 7 was also coded to be totally dependent on staff for bed mobility and not ambulatory.

Resident # 7's nursing notes included a note on 12/22/24 at 1:30 AM by Nurse # 4 documenting the following information. Resident # 6 had been witnessed standing over Resident # 7 while Resident # 6 was grabbing Resident # 7's hair. Resident # 7 was assessed for injuries and none were found. Resident # 7 did not appear to be in pain. Resident # 7 was moved to a different room for her safety.

Nurse # 4 was interviewed on 2/25/25 at 9:20 AM and reported the following information. The 12/22/24 incident occurred shortly after the change of shift on the 11 PM to 7 AM shift. She could hear yelling and screaming. Nurse Aides were already in the room before she got to the room and reported that Resident # 6 had been pulling Resident # 7's hair. Prior to the incident Resident # 6 had not been displaying behaviors that night, and there had not been anything in report about her having behaviors right before shift change. She (Nurse # 4) did know Resident # 6 had a history of behavioral problems. After the incident on 12/22/24, Resident # 7 was moved to another room.

Nurse Aide # 5 was the NA who had first

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 600	Continued From page 31	F 600		

responded on 12/22/24 to the altercation. NA # 5 was interviewed on 2/26/25 at 4:00 PM and reported the following information. She heard Resident # 7 screaming and entered the room. Resident # 7 was in her bed. Resident # 6 was yanking Resident # 7's hair and Resident # 7 had Resident # 6's hand trying to get her to stop. She (NA # 5) was able to get Resident # 6 to stop. When Resident # 7 was yelling, her words could not be discerned. Resident # 7 looked okay. She (NA # 5) had not ever known Resident # 6 to hit another resident. On 12/22/24 they moved Resident # 7 quickly out of the room. Someone then stayed with Resident # 6.

NA # 6 was interviewed on 2/25/25 at 11:50 AM and reported the following information. She (NA # 6) had also responded on 12/22/24. She could hear yelling from the hallway. When she got to the doorway, she could see Resident # 6 pulling Resident # 7's hair. Resident # 7 was crying and yelling in her native language. She had witnessed Resident # 6 being verbally aggressive to her (NA # 6) but had not witnessed her hitting another resident before. She was aware Resident # 6 had been combative with staff. Prior to the 12/22/24 incident, there had not been anything that night which had led the staff to believe that Resident # 6 would become aggressive with Resident # 7.

On 12/23/24 at 3:05 PM the facility social worker noted Resident # 6 was given a 30-day discharge and the RP (Resident Representative) was aware and expressed understanding.

On 12/23/24 at 3:07 PM the facility social worker noted an updated BIMS (brief interview for mental status) had been completed, and Resident # 6 scored 15 out of 15 points. (BIMS scores of 13 to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 600	Continued From page 32	F 600		

15 indicate cognitively intact).

On 12/23/24 at 4:46 PM a nursing note included documentation that Resident # 6 was alert with confusion and continued to pace in her room and hallways while talking to herself. She was difficult to redirect.

On 12/23/24 at 7:43 PM a nursing note included documentation that at 7:00 PM police arrived to transfer Resident # 6 out of the facility.

On 12/23/24 the facility's Psychiatric NP documented the following notations about Resident # 6, "Her behaviors have escalated to the point of physical aggression, as evidenced by an incident where she reportedly pulled her roommate by the hair and started hitting her. Despite the facility MD's orders to transfer her to the hospital for evaluation, EMS refused the transfer at the behest of her son. During the session, the Client (Resident # 6) demonstrated a refusal to cooperate, exhibiting behaviors characterized by delusional speech. She expressed statements such as, "get out of here! If you touch my chair, like the rest! I don't like you and my friends from small countries! go report me!" These behaviors are consistent with her history of psychiatric conditions and challenges with medication compliance and suggests an altered mental state. She mentioned looking for a friend, referring to the roommate she attacked, and stated, 'I'm always moving her chair,' indicating confusion and disorientation." The Psychiatric NP further noted, "The plan moving forward involves a collaborative approach with the facility MD, psychiatrist, administrator, and staff to ensure the Client receives the higher level of care she requires. It has been agreed upon that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 600	Continued From page 33	F 600		

Client will be transferred to a facility where she can receive the necessary stabilization. This decision is based on her ongoing behavioral challenges, medication noncompliance, and the risk she poses to herself and others. The Client will be sent on an Involuntary Commitment (IVC) to ensure her safety and the safety of those around her."

During the interview with the facility's Psychiatric NP on 2/25/25 at 10:22 AM, the Psychiatric NP reported the following information. It was her understanding when she talked to staff that Resident # 6 had been hitting Resident # 7 and pulling her hair during the incident of 12/22/24. She saw Resident # 6 on 12/23/24 and at that time Resident # 6 was very delusional.

The Administrator was interviewed on 2/26/25 at 3:30 PM and reported the following information. There was not an incident in which Resident # 6 hit another resident. He felt the Psychiatric NP's recall that Resident # 7 had been hit and the EMS records noting Resident # 6 had hit a resident were miscommunication about events that had transpired. The Administrator further reported Resident # 6 had been initially admitted to the facility as a rehabilitation resident and then her family could not take her home because she had combative behavior with them. In the previous year Resident # 6 had shown aggressive behavior with staff. On two occasions she had broken facility windows. They had been attempting to monitor her and sent her to the hospital on multiple occasions. Resident # 6's roommate (Resident # 7) did have a behavior of yelling out at times. On 12/22/24 the staff heard Resident # 7 yelling as being different. It was more of a sustained yell indicating she needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 600	Continued From page 34	F 600		

help. The staff had immediately responded. Resident # 6 was observed pulling Resident # 7's hair but had not hit her. The staff had moved Resident # 7 to another room for safety and one on one was placed with Resident # 6. The family did not want Resident # 6 taken to the hospital that night. Therefore, he (the Administrator) went to the magistrate to take out involuntary commitment papers and Resident # 6 was discharged on 12/23/24.

On 2/25/25 at 6:10 PM NA # 7 was accompanied to Resident # 7's room in an attempt to talk to Resident # 7. NA # 7 reported she had worked with Resident # 7 for 6 months and had developed a system of motions with the resident that at times the resident understood. An attempt was made to communicate with the resident with NA # 7's assistance. The resident was not observed to be able to communicate anything about the incident which had occurred on 12/22/24.

The facility Administrator presented the following corrective action plan.

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
At approximately 12:35 AM on 12/22/2024, Resident #6 was found by staff to be pulling the hair of her roommate, Resident #7. Resident #6 and Resident #7 were separated. Resident #7 was relocated to a room down the hall and a skin and body assessment were immediately completed with no injury noted. Resident #6 was placed on 1:1 observation until local law enforcement and emergency services arrived. When EMS arrived, they contacted Resident #6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 600	Continued From page 35	F 600		

son who stated he did not want Resident #6 to be transferred to the Emergency Department, so EMS chose to defy the physician order to transfer to the ED. Resident #6 was continuously monitored through 1:1 observation until Facility Administrator successfully contacted the Wake County magistrate for an emergency Involuntary Commitment (IVC) on 12/23/2024. At time of transfer to the ED, the Facility Administrator provided a 30-day discharge to the resident and resident's son and copy to ombudsman and in discharge paperwork provided to the hospital with reasons for discharge stating "It is necessary for your welfare and your needs cannot be met in this facility" and "The safety of individuals in this facility is endangered due to the clinical or behavioral status of the resident."

Allegation of abuse was submitted to the North Carolina Division of Health Service Regulation (NCDHSR) at 2:05 AM on 12/22/2024.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice.
Skin assessments were completed by the Director of Nursing or designee on residents with a brief interview of mental status (BIMS) score of 8 or below and abuse questionnaires for residents with a BIMS score of 9 or greater. This was an isolated incident between roommates and no other residents were identified as having been abused.

Any resident can be affected by the deficient practice.

Address what measures will be put into place or systemic changes made to ensure that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 600	Continued From page 36	F 600		

deficient practice will not recur.
Abuse and Neglect education was immediately provided by Facility Administrator, Director of Nursing and Unit Managers on 12/22/2024 to all on-site staff and then continued on 12/23/2024 for all facility staff including contracted providers. Education was mandated for all staff who had not yet worked on 12/22/2024 or 12/23/2024 prior to their return to work and was included as orientation for all new hire staff prior to start of work. Education included types/categories of abuse, definitions of abuse, signs/symptoms of abuse, abuse prevention and reporting of abuse.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.
Facility Administrator and Director of Nursing determined on 12/22/2024 to monitor facility performance in an ongoing pursuit of quality control through the internal quality assurance protocol. On 12/23/2024, the Facility Administrator and Director of Nursing conducted an Ad hoc Quality Assurance Performance Improvement (QAPI) Committee with members including Facility Administrator/Executive Director, Director of Nursing, Medical Director, Social Services Director, Activities Director, Dining/Nutrition Supervisor, Minimum Data Set (MDS) Staff, Rehabilitation Director, Maintenance Supervisor, Housekeeping/Laundry Supervisor, Unit Manager, Business Office Manager and Human Resources Director.

The Director of Nursing completed random audits on 5 residents per week to identify any abuse and neglect for 12 weeks. The Director of Nursing will report all results of quality monitoring audits to the monthly QAPI Committee Meeting each month

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 600	Continued From page 37 for 3 months. Findings will be reviewed by the QAPI Committee and quality monitoring audits will be updated as indicated. The facility's corrective action plans were validated from 2/24/25 through 2/28/25 by the following. Beginning on 2/24/25 at 8:39 AM, a tour of the facility was conducted which lasted until 11:30 AM. Multiple residents and family members were interviewed during this time. These interviews did not reveal abuse was occurring. Staff were observed present and monitoring residents. Resident # 2 and Resident # 6 were not observed to be in the facility. During the complaint investigation staff presented documentation of their in-service training, meetings with residents to review abuse as outlined in their corrective action plan, and audits per their action plan. They also presented signage as outlined in their corrective action plan. Multiple staff members from different shifts were interviewed and reported they were not aware of any other instances of abuse, and they validated they had undergone abuse training. Staff were able to voice points covered during the training. The IJ removal date of 2/08/25 was validated.	F 600		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident	F 806		3/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 806	Continued From page 38 allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews with resident and staff, the facility failed to ensure a system was in place to avoid placing an item on a resident's tray which she preferred not to have. This was for one (Resident # 4) of three sampled residents reviewed for food choices. The findings included: Resident # 1 was admitted to the facility on 1/22/25. Review of Resident # 4's admission Minimum Data Set assessment, dated 1/26/25, revealed the resident was cognitively intact. Review of physician orders revealed Resident # 1 was ordered a regular diet. The Dietary Manager was interviewed on 2/26/25 at 8:55 AM and provided a copy of the way Resident # 4's tray card printed from their system. Observation of the resident's printed dietary card revealed near the top of the card, there was a notation which read, "No Potatoes." The Dietary Manager reported the following information. Resident # 4 had a dislike to potatoes. As noted on her printed tray card, it showed as a "disklike" and she should not be served potatoes. He was aware of one time when she had gotten the potatoes and thought it had not happened again.	F 806	The Dietary Manager immediately audited Resident #4 tray to ensure all preferred foods were placed on the tray and that the tray ticket noted Resident #4 dislikes and were printed on the ticket on 02/26/2025. The Dietary manager audited all trays for 3 meals on 02/27/2025 to ensure the tray tickets for all residents were correct and matched what was served. No other deficiencies were noted during this review. Any Resident can be affected by this deficient practice. An Ad hoc Quality Assurance Performance Improvement Committee will be held on 03/19/2025 to formulate and approve a plan of correction for the deficient practice. The Dietary Supervisor will complete education by 03/19/2025 for all dietary staff to ensure that what is on the resident's ticket for preferences is being served during all meals. The Dietary Supervisor will complete a random audit on 5 resident trays for 3 times per week for 12 weeks to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 806	Continued From page 39 Resident # 4 was interviewed on 2/26/25 at 12:50 PM and reported the following information. The texture and smell of potatoes make her nauseated and she had received them multiple times since she had been admitted to the facility. The Nurse Aides were aware of the problem, and it had been reported to the dietary department, but the potatoes were still served to her even after the problem had been reported to the dietary department. Nurse Aide (NA) #8 was interviewed on 2/26/25 at 2:20 PM and reported the following information. Resident # 4 had received potatoes on her tray even though staff in the kitchen had been told. She knew that NA # 9 had directly spoken to the kitchen staff about the problem. She had also witnessed other residents receive items on their tray that per their tray card they were not supposed to be served. This had happened in recent weeks. NA # 9 was interviewed on 2/26/25 at 2:40 PM and reported while she had worked with Resident # 4, she (NA # 9) knew Resident # 4 had received potatoes on her tray three times and she had spoken to the kitchen staff about the problem because the resident did not like them and was not supposed to be served them. The Administrator was interviewed on 2/26/25 at 5:50 PM and reported there should be a person on the dietary tray line checking the tray cards and the trays to make sure that foods which residents disliked were not served to them.	F 806	that what is on the resident's ticket for preferences is what is served during all meals starting on 03/19/2025. The Executive Director will review during QAPI monthly committee meetings for 3 months. Corrective action will be completed by 03/20/2025.	
F 807 SS=D	Drinks Avail to Meet Needs/Prefs/Hydration CFR(s): 483.60(d)(6)	F 807		3/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 807	Continued From page 40 §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to ensure a resident received a beverage on her tray per her preference. This was for one (Resident # 8) of three residents reviewed for dietary preferences. The findings included: Record review revealed Resident # 8 was admitted to the facility on 2/15/25 after sustaining a hip fracture. Review of Resident # 8's 2/21/25 admission Minimum Data Set assessment, dated 2/21/25, revealed the resident was cognitively intact. Review of physician orders revealed the resident was ordered a regular diet. Lunch observations were made on 2/25/25 starting at 12:00 PM. During this lunch time observation Resident # 8 was observed in her room. She had completed eating her lunch meal and stated the food was good, but the dietary department had not served any drinks on her tray. It was observed there were no cups on the meal tray. She further reported that she had some water in a Styrofoam cup at her bedside which she had before the lunch meal tray was served, and therefore she had drunk the water with her meal since the dietary department had	F 807	The Dietary Manager immediately provided Resident #8 with fluids for meal service on 02/26/2025. The Dietary Manager audited all trays for all 3 meals on 02/27/2025 to ensure all residents were served their preferred fluids with their meals. There were no other deficiencies identified. Any resident can be affected by this deficient practice. An Ad hoc Quality Assurance Performance Improvement Committee meeting will be held on 03/19/2025 to formulate and approve a plan of correction for the deficient practice. The Dietary Supervisor will complete educationo by 03/19/2025 to ensure that all residents will be served the fluid of their choice for all meals. The Dietary Supervisor will complete random audits on 5 resident trays for 3 times per week times 12 weeks to ensure that resident meal service trays have the fluid of choice on them prior to serving meals starting on 03/19/2025. Findings	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 02/28/2025

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 807	Continued From page 41 not sent anything else to drink. She would have preferred to have had tea with the meal. Directly following this observation and interview, Nurse # 5 was asked to view Resident # 8's tray and validated that no beverage had been served with the resident's 2/25/25 lunch meal. The dietary menus were reviewed with the Dietary Manager on 2/26/25 at 8:55 AM. A review of the menu with the Dietary Manager revealed "tea of choice" should have been served with lunch trays on 2/25/25. According to the Dietary Manager food items and beverages are printed on a tray card which includes residents' preferences. Nurse Aide (NA) #8 was interviewed on 2/26/25 at 2:20 PM and NA # 9 was interviewed on 2/26/25 at 2:40 PM. Both Nurse Aides, who worked on Resident # 8's hall, reported there had been problems in recent weeks they had observed with meal tray items not matching meal tray cards. The Administrator was interviewed on 2/26/25 at 5:50 PM and reported there should be a person on the dietary tray line checking the tray cards and the trays to make sure that items were correct on the trays before they were served to residents.	F 807	will be reviewed during the monthly QAPI committee meeting times 3 months or until compliance is achieved. Corrective action will be completed by 03/20/2025.	