STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345403	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Cary Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZI 6590 Tryon Road Cary, NC 27518	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	etc.) that affect the resident. **NOTE- TERMS IN BRACKETS F Based on record review, and staff, facility failed to notify the physician urine sample on 3 instances ([DAT 5:30 AM) for a resident identified w #294 was first identified with decre (deliberately drink beyond what thin complained of burning urination (dy blood, protein, glucose, and indirec diagnose a urinary tract infection a symptoms of dehydration on [DATH evidenced by the inability to collect bladder) when the resident had no was made to the Physician Assista d+[DATE]:30 AM. During this time, milligrams once daily at 9:00 AM dc physician regarding the diuretic add resident #294 was transferred to t tachypnea (rapid and shallow brea to organs and tissues and can be a life-threatening conditions), hypoth drops below 95 F), severe lactic ac can't metabolize it fast enough), an used to treat people with low blood that happens when your blood pres	esident's doctor, and a family member of IAVE BEEN EDITED TO PROTECT C family member, Physician Assistant, a of a significant change in condition wh E] at approximately 5:00 AM and 9:00 ith complaints of burning urination and ased nutritional and fluid intake on [DA rst dictates to avoid dehydration) throug ysuria) and was ordered a urinalysis (u ct indicators of bacterial infection) and u nd determine the best treatment). Resi E] at approximately 9:00 PM and [DAT] : urine via an in and out catheter (inser) recent episodes of urination. The first i nursing staff continued to administer t espite signs and symptoms of dehydra ministration. On [DATE] Resident #294 hergency Medical Services (EMS) were he emergency room where he was ide thing), poor perfusion (occurs when the an early sign of circulatory or heart prot ermia (a medical emergency that occu idosis (occurs when the body produce and new vasopressor requirements (vaso pressure) most consistent with septic ssure drops to a dangerously low level .8:26 PM on [DATE]. This deficient pra cation of significant changes.	ONFIDENTIALITY** 43798 and Medical Director interviews the en staff were unable to obtain a PM and [DATE] at approximately decreased fluid intake. Resident TE] requiring staff to push fluids gh [DATE]. On [DATE] the resident sed to detect abnormalities such as urine culture and sensitivity (used to dent #294 exhibited signs and E] at approximately 5:30 AM as ting a thin, hollow tube into the notification to a medical provider DATE] at approximately , he resident's Lasix (diuretic) 20 tion and did not contact the 's family member requested the a contacted at 3:42 PM and ntified with altered mental status, are is inadequate blood circulation blems and can lead to rs when the body's temperature is too much lactic acid and the liver opressors are a medication that are shock (a life-threatening condition after an infection) with end organ

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

Facility ID: 345403

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345403	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	condition when Resident #294 exhi a urine specimen via an in and out Immediate jeopardy was removed immediate jeopardy removal. The f	TE] when staff failed to notify the physi ibited signs and symptoms of dehydrat catheter when the resident had no rec on [DATE] when the facility implemente acility will remain out of compliance at than minimal harm that is immediate jo put into place and are effective.	ion and staff were unable to obtain ent episodes of urination. ed a credible allegation of a scope and severity of D (no
	The findings included:		
	Resident #294 was admitted to the facility on [DATE]. His diagnoses included dementia, type 2 diabetes, adult failure to thrive, generalized muscle weakness, chronic kidney disease, and congestive heart failure.		
	A physician order dated [DATE] indicated give Lasix oral tablet 20 milligram by mouth one time a day for edema (swelling from fluid retention). Lasix is a diuretic used to treat fluid retention that can result from congestive heart failure, kidney disease or other medical conditions. (Lasix increases the flow of urine and can lead to dehydration.)		
	cognitively intact. He required super assistance with eating. He was code	m Data Set (MDS) assessment dated rvision or touching assistance with toil led as frequently incontinent of bowel a overall discharge goal was to return to t	eting. He required setup or clean u and bladder and was also coded as
	oral intake on day shift. The facility the residents during or at the end of	ompleted by Nurse #5 dated [DATE] in 's 24-hour condition report is a form that f their shift to communicate any pertine nd lunch meals are served during the c	at nurses document the status of a ent information to the next shift and
	on [DATE] from 7:00 AM to 7:00 Pf 25% of his tray food and drinks but	on [DATE] at 2:45 PM, she stated that M. Nurse #5 indicated that normally Re on [DATE] he had eaten and drank les in the 24 hour report and informed the	sident # 294 consumed more than ss than 25% during breakfast, lunc
		ompleted by Nurse #4 dated [DATE] ir on on night shift ([DATE] 11:00 PM to [l	
	(continued on next page)		

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	<ul> <li>Resident #294 on [DATE] at 7:00 F</li> <li>#5 had informed her and document oral intake with food and drinks. Nu during her shift and she left a note report and informed the oncoming and the only concern during her shi physician's book and she pushed flio of urinary tract infection.</li> <li>Resident #294's medication admini AM by Nurse #1.</li> <li>A Physician telephone order dated urinalysis (UA), urine culture and so A facility 24-hour condition report d and evening shift (3:00 PM to 11:00 Resident #294 in the morning ([DA During an interview on [DATE] at 1</li> </ul>	0:20 AM with Nurse #1, she indicated t	ted that during shift change Nurse Resident #294 had a decreased complained of burning with urination noted it in the 24-hour condition ated that Resident #294 was stable tion which she noted in the secause she thought it was a sign vas administered on [DATE] at 9:00 cian Assistant (PA) #2 indicated uria. :00 PM) completed by Nurse #1 the need for a UA/C&S for hat she had cared for Resident
	<ul> <li>#294 on [DATE]. Nurse #1 stated the informed by the off going night shift urination during the night shift ([DA UA/C&amp;S to rule out a urinary tract in did not attempt to obtain a urine satisfollowing morning. Nurse #1stated</li> <li>An interview was conducted on [DA hours and cared for Resident #294 #294 required a urine sample but he morning around 6:00 AM. He notified took over at 11:00 PM. Nurse #6 exist in the morning at approximately 6:00 Af facility 24-hour condition report did took ore at the conduction of the morning at approximately 6:00 Af facility 24-hour condition report did took ore at the conduction of the conduction of the conduction of the conduction of the condition report did took ore at the condition report did too</li></ul>	hat when she came to work on [DATE] t nurse (Nurse #4) that Resident #294 H TE] at 7:00 PM to [DATE] at 7:00 AM). Infection was ordered during her shift ([ mple since it would not have been pick that Resident #294 was less talkative th ATE] at 1:40 PM with Nurse #6. He stat on [DATE] from 7:00 PM to 11:00 PM te did not obtain it because it wouldn't h ed the third shift nurse (Nurse #2) to co kplained that the laboratory specimens 10 AM. ated [DATE] on night shift ([DATE] 11:0 ift ([DATE] 7:00 AM to 3:00 PM) compl	at around 7:00 AM she was had complained of pain with Nurse #1 verbalized that a DATE] 7:00 AM- 7:00 PM) but she ed up until around 6:00 AM the han usual on [DATE]. ed that he had filled in for four and he was aware that Resident have been picked up until the llect the urine specimen when she were picked up by laboratory staff

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	<ul> <li>on night shift ([DATE] at 11:00 PM assignment that night, she was not Resident #294. She indicated that waking him up to give him any fluid she attempted to obtain the urine sunsuccessful and she notified the cincontinence brief was wet during t Resident #294's regular nurse and the physician that she was unable for and [DATE] on night shift. NA #2 si and when she changed his incontin aware of Resident's condition from encourage the Resident to drink was Resident #294's medication admini AM by Nurse #1.</li> <li>During an interview with Nurse #1 of [DATE] at around 7:00 AM she was sample was still needed for Reside shift. Nurse #1 stated that she did that Resident #294 was more like he was less talkative than usual ar stated that Resident #294 normally the water she gave him during medication. She further stated that (nutritional supplementation) on [Date] 7:00 AM) indicated the nurse A facility 24-hour condition report to the nurse that a UA/C&amp;S was need take small sips. The first attempt to to collect as not enough urine camagetting small sips. The first attempt to the UA/C&amp;S was at 5:33 AM</li> </ul>	ompleted by Nurse #3 dated [DATE] or se attempted twice to collect urine unsu written by Nurse #3 dated [DATE] at 6: eded. The nurse attempted to push flui obtain the UA/C&S was around 9:00 F e out. The writer continued to push flui to collect the urine was reported to the I on [DATE] and was again unsuccessfi e of the attempts and that the resident	d that when she took over the that a urine sample was needed for 4 was asleep and she did not recall 94 slept throughout her shift, and round 5:00 AM on [DATE] but was urse #2 indicated Resident #294's 42 also indicated that she was not She verified that she did not notify ared for Resident #294 on [DATE] w sips of water during her shifts A #2 stated that Nurse #3 was d told NA #2 to offer and was administered on [DATE] at 9:00 when she came back to work on urse (Nurse #2) that a urine o botain the urine during the night on [DATE] day shift. She indicated noted he was not at his baseline. continued to push fluids. Nurse #1 as tray, and he also drank most of the took only sips with the milliliters of his med pass 00 PM whereas previously he ot notify the physician of Resident the night shift ([DATE] 7:00 PM to uccessfully. 13 AM indicated report was given ds, however, resident would only PM on [DATE] and she was unable as throughout the shift, again, only e supervisor. The second attempt to ul. Oncoming nurse (Nurse #1) and

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	<ul> <li>urine twice, however, was unsucce</li> <li>An interview was conducted on [DA#294 on [DATE] at 7:00 PM throug off going day shift nurse (Nurse #1) to obtain the specimen at around 9 out catheter both times but was unsuce to be processed. She stated that R was pushing fluids but Resident #2 reported to the oncoming day shift specimen via an in and out cathete shift and were stable. She stated the and if she did, she would have doc Resident #294 did not seem differe seem to be in any acute distress of verified she did not notify the physic During an interview on [DATE] at 3 Resident #294 on [DATE] through I those 3 days she noticed that Reside incontinent whereas previously he himself, but she had to feed him an usually did. NA #1 also stated that further stated that when she was gi usual, he was quiet and not shoutir #1 was aware of Resident #294's ce fluids and also to give him a shower Resident #294's medication admini AM by Nurse #1.</li> <li>A Physician order dated [DATE] at a access (small catheter inserted into unable to obtain, obtain a midline (a fluids or medication into the blood se A Physician order dated [DATE] or Use 2 liters intravenously in the modified of the second secon</li></ul>	:05 PM with Nursing Assistant (NA) #1 [DATE] during the 7:00 AM to 3:00 PM dent #294 was eating and drinking less was using the urinal. She also stated th d offer drinks on [DATE] and [DATE] b when she changed Resident #294's briving Resident #294 a shower on [DATI ng like he would normally do during sho ondition and had told NA #1 to encoura r because he kept pulling off his clothe stration record indicated Lasix 20 mg v 10:15 AM ordered by PA #1 indicated o a superficial vein [a vein located close a long flexible tube that is inserted into	bencoming nurse (Nurse #1). was assigned to care for Resident she had received report from the Resident #294 and she attempted y 5:30 AM on [DATE] via an in and barely any urine and it was too thick dry during both attempts, and she d not get in much. Nurse #3 successful in obtaining the urine s vital signs were completed on day ned any vital signs during her shift ameters. Nurse #3 stated that him, he was verbal and did not ohysician to send him out. She she stated that she had cared for shift. NA #1 stated that during than usual, and he had become hat previously he could feed ut he did not eat or drink as he lefs there was minimal urine. NA #1 E] he was not as responsive as bwers. She verbalized that Nurse age Resident #294 to drink his s. was administered on [DATE] at 9:00 obtain peripheral intravenous (PIV) a vein in the upper arm to deliver ride Intravenous Solution 0.9 %. dminister 2 liters intravenous fluids

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	<ul> <li>[DATE] at around 7:00 AM she was was still needed. She indicated the [DATE]. Nurse #1 revealed that she at approximately 9:00 AM despite t think to hold it or ask the provider a previous 2 days, and she notified P AM and 11:00 AM on [DATE]. She she would let the PA know that the drinking much which was probably a midline and IV fluids. Nurse #1 st was dehydrated and she could not PIV because the PA had ordered a contracted entity that is specialized called Resident #294's family mem answer the phone, and she left a m PM and the Nurse informed her that family member wanted Resident #224 was seen by PA at the request minimally responsive. This was a clinically dehydrated. An order days ([DATE] to [DATE]). The prog dehydration.</li> <li>During an interview on [DATE] at 4 notified by Nurse #1 when she cam change in condition, and they had nexplained that when she went to as questions. She gave an order to insto obtain a midline on the same orde the midline without needing a secons he was not the primary care provint facility contacted her to let her know have expected to be notified if they midline if PIV access was unable to case-by-case basis based on Resident for the same orde to the primary care provint facility contacted her to let her know have expected to be notified if they midline if PIV access was unable to case-by-case basis based on Resident and the same orde to the primary care provint facility contacted her to let her know have expected to be notified if they midline if PIV access was unable to case-by-case basis based on Reside the primary care provint facility contacted her to let her know have expected to be notified if they midline if PIV access was unable to case-by-case basis based on Reside the case-by-case basis based on Reside the primary care provint facility contacted her to let her know have expected to be notified if they midline if PIV access was unable to case-by-case basis based on Reside the case by-case basis based on Reside the case by-case basis based on Reside the case by</li></ul>	on [DATE] at 10:20 AM, Nurse #1 states informed by the off going night shift m resident drank only sips of water durin e had administered Resident #294's La he resident's decreased oral food and t ibout it. She stated Resident #294 seer "hysician Assistant (PA) #1 when she c stated that she knew the PA would cor y had not been able to obtain the urine a sign of dehydration. PA #1 went to e: ated she did not attempt to insert a per find a visible vein. She stated that she midline if a PIV was not obtained. She in inserting intravenous catheters) to o ber to obtain consent for the midline ins ressage for her. The family member arr at the vascular team were enroute to the 294 to be sent to the Emergency Depar agreed. She informed the Unit Manage (EMS) who came to transfer Resident as note written by PA #1dated [DATE] a st of nursing for evaluation of change in oted change from usually being agitate borted that he had not seen Resident #2 as unable to provide adequate sample d a change in condition, altered mental was provided to obtain a PIV on [DATI ress note indicated staff were unable to :30 PM with Physician Assistant #1 (PA he to the facility at around 10:30 AM on not been able to obtain a urine sample sess Resident #294, he seemed dehyd sert a peripheral intravenous (PIV) line Id administer IV fluids. The PA stated s er so that if they could not obtain a PIV and order. The PA stated she did not km der for Resident #294. She also stated w that they had not obtained an IV acce a did not obtain the PIV since the order in be obtained. PA #1 stated the timeline dent's status. She further stated that if the an they would contact the Provider if the an they would contact the Provider if the	urse (Nurse #3) that a urine sample g medication administration on six on [DATE], [DATE] and [DATE] fluid intake and that she did not med more confused than the ame to the facility between 10:00 ne to the facility that morning and specimen and the resident was not xamine Resident #294 and ordered ipheral line because Resident #294 did not notify the PA regarding the called the vascular team (a come and insert a midline and also sertion. The family member did not rived at the facility at around 3:00 e facility to insert the midline. The tment (ED) due to the worsening er and the facility Provider and #294 to the hospital. tt 11:52 AM indicated Resident no condition. The resident was ed and interactive per 294 eat over the past 3 days. even with catheter. The progress status, decreased oral intake, and E] and ordered IVF 2 liters for 3 to obtain UA/C&S given A #1) she stated that she was [DATE] that Resident #294 had a for a UA and C&S. The PA drated but was responsive to and if unable to obtain PIV access the normally put the two orders they could go ahead and obtain ow Resident #294's baseline since that she could not recall if the tess. She indicated she would not explicitly stated to obtain the e to contact a provider was a the Resident was declining and

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		Cary, NC 27518	
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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	<ul> <li>was notified by Nurse #1 on [DATE the facility to see the resident and with told Nurse #1 to go ahead and send she was not aware if the Provider with the provider with the provide the term of the provide the provide the term of term</li></ul>	ated that EMS was contacted at 3:42 PI EMS arrived at the facility at 4:02 PM ry impression was sepsis. The chief con diogram (ECG) at 4:05 PM indicated at irregular heartbeat). Vital signs obtaine e: 65, respirations: 8, oxygen saturation on the AVPU (alert, voice, pain, unres MS obtained a telephone order at 4:22 for sepsis. IV fluids were not administe 4:39 PM with Resident #294 and notifi ment at 5:05 PM indicated Resident #2 uth breathing, his skin was cold and dr gen saturation readings were inconsiste	ent #294's family member was in ue to altered mental status and she amily request. The UM verbalized the urine sample and change in 00 AM and 11:00 AM. (Family Member) on [DATE] at om Nurse #1 on [DATE] at that she wanted to give her an was going on when she tried to call nd 3:00 PM she found the tempted to give him a drink and he vascular team to come and insert ent to be sent to the hospital M for a non-emergent and primary impression was mplaint was altered mental status trial fibrillation (irregular heart d by EMS at 4:17 PM were noted n: 94 % and level of consciousness ponsive scale used to measure PM to administer IV fluids due to red due to inability to establish an ed the receiving hospital of sepsis 294 was lethargic, non-verbal with y, lung sounds were clear with

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Cary Health and Rehabilitation 6590 Tryon Road Cary, NC 27518			
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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	pressure: ,d+[DATE], heart rate: 13 temperature: 93.4 degrees Fahrend critically ill, obtunded (reduced level extremities with dilated pupils without that he had not been eating or drint encouraged the nurse to take his v be in metabolic acidosis (a condition extremities, they were unable to real patient had voiced wishes to have d his care, family wanted the patient moment. The ED note indicated that perfusion, hypothermia, severe lack shock with end organ dysfunction a During an interview on [DATE] at 3 Resident #2 and that she had giver nursing reports. PA #2 stated that s urine sample or that the Resident's was a case-by-case basis based on An interview was conducted with th was aware of Resident #294's cond Resident's condition. He indicated is when they could not obtain a urine sent out before the IV access was earlier the outcome would not have [DATE] and was positive for a UTI would have probably been the sam when they could not obtain the urin continued Lasix administration, the should have notified him when they contacted and they were on the wat An interview was conducted on [DA if nurses were not able to obtain that provider in the facility. She also sta building that they had not obtained to decreased oral intake and inabili staff to notify the physician/PA whe stated that if staff were unable to obtain	I indicated that Resident #294's vital sig 88, and respirations 29 at 5:45 PM and heit at 6:23 pm. The progress note indic of alertness and consciousness), brea- but response bilaterally and no respons- king anything for 3 days, and today he- ital signs who then emergently called fo- in in which too much acid accumulates liably obtain a pulse oximeter reading. I everything done to sustain his life. After to continue to be full code. They unders at Resident's presentation with altered re- tic acidosis, and new vasopressor requ as cause of death. Resident #294 died a :07 PM with PA #2 she stated that she in the telephone order on [DATE] for the she could not recall the facility notifying condition was declining. She also states in Resident's status. The facility Medical Director (MD) on [DA dition and the facility did what they were that when the Resident showed signs of sample, they ordered an IV access for obtained. The MD also stated that if the be been any different. He also stated that they would have started the Resident on the MD tated the facility did everything rig ( didn't obtain PIV access, he stated that it when the resident not drink MD stated the facility did everything rig ( didn't obtain PIV access, he stated that they when the resident was sent out to the ATE] at 4:30 PM with the Director of Nu e urine specimen on [DATE] at 5:00 AN ake nurses should have notified the PA the ordered urine sample and inquired ity to obtain the urine specimen. The DC on the PIV access was unable to be obt batin PIV access that they were to obtain the provacess that they were to obtain the provacess that they were to obtain the provace that the provace t	oxygen saturation: 33 %, and cated Resident #294 presented athing on his own with cold distal e to painful stimuli. Facility stated was found naked by his family and or 911. Resident #294 was found to in the body). Because of his cold Discussion with family revealed r discussion regarding his goals of stood that he was critically ill at that mental status, tachypnea, poor irements, consistent with septic at 8:26 PM on [DATE]. was the primary care provider for e UA/C&S due to dysuria per her that they had not obtained the ed the timeline to contact a provider TE] at 4:37 PM. The MD stated he e supposed to do to manage the of a UTI, a UA was ordered and hydration, but the Resident was a Resident had been sent out t if the UA had been obtained on on oral antibiotics and the outcome ty staff should have notified him sing adequately as well as with ght. When asked if the facility staff at the vascular team had been a hospital. rsing (DON). The DON stated that <i>A</i> , [DATE] at 9:00 PM and [DATE] on call provider if there was no on [DATE] when they were in the about the Lasix administration due ON indicated she did not expect the ained as the order specifically in a midline via the vascular team.

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F 0580	The facility provided the following credible allegation of immediate jeopardy removal:		
Level of Harm - Immediate jeopardy to resident health or safety	1) Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance		
Residents Affected - Few	Resident #294 no longer resides in the facility. Resident was transferred to the local hospital on [DATE] due to altered mental status. The center recognizes that all residents have the potential to be affected from the noncompliance of notifying the physician as it relates to obtaining a urine sample for residents identified with complaints of burning urination and decreased fluid intake, including signs and symptoms of dehydration as evidenced by the inability to collect urine via an in and out catheter when the resident had a dry brief.		
	A review of Resident #294's electronic medical record revealed an order for UA w/ reflex, Urine Culture and Sensitivity with Diagnosis of Dysuria was ordered on [DATE]. The facility staff attempted to push fluids and obtain urine sample on [DATE] at approximately 5:00 AM and 9:00 PM, [DATE] at approximately 5:30 AM and was unable to collect urine sample. A review of Resident #294 orders indicated resident was prescribed Lasix 20mg daily to be administered daily per physicians' orders.		
	DATE] through [DATE] were audite re urine sample was obtained. Nin in condition that required residents identified as having a sing and Unit Managers to ensure lect urine. No resident was ability to collect urine, therefore		
	Director regarding notifying the phy It was determined through the root	vas completed by the Director of Clinic rsician for Resident #294 when staff we cause analysis that the facility failed to ge in condition as it relates to decrease n urine sample.	ere unable to obtain a urine sample follow policy and procedures to
		pecify the action the entity will take to alter the process or system failure to prevent a serious adverse ome from occurring or recurring, and when the action will be complete	
	residents identified as having a cha Recommendation (SBAR) as it rela [DATE]. The licensed nurse is to as attending physician when there is a and Unit Managers re-educated lice ensure prompt physician notificatio Nurse Assistants) not educated on prior to working the floor. Newly hir Unit Manager on notifying physician	ad Nurse Managers re-educated license ange in condition via Situation, Backgro tes to assessing residents with signs a ssess the resident, including vitals, con a change in the status or condition of th ensed nurses on recognizing signs and n for change in condition on [DATE]. S [DATE], will be educated by the Direct ed staff will be educated during orienta n for residents identified as having a ch signs and symptoms of dehydration.	und, Assessment and and symptoms of dehydration on aplete the SBAR and notify the e resident. The Director of Nursin I symptoms of dehydration to taff (licensed nurses/ Certified or of Nursing and or Unit Manager tion by the Director or Nursing or
	(continued on next page)		

NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         Cary Health and Rehabilitation       STREET ADDRESS, CITY, STATE, ZIP CODE         For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.       (X4) ID PREFIX TAG         SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)       The Director of Clinical Services and Nurse Managers re-educated licensed nurses on notifying physician via change in condition (SBAR) for residents with an order for UA/CSB and unable to obtain urine sample on [DATE]. The licensed nurse is to assess the resident, including vials, complete the SBAR and notify the attending physician when there is a change in the status or condition of the resident.         Residents Affected - Few       The Director of Clinical Services and Nurse Managers re-educated outfied nursing assistants on signs and symptoms of dehydration and immediately report the change in condition of the resident.         Staff (licensed nurses/ Certified Nurse Assistance) not educated on [DATE]. Newly hired staff will be educated during orientation by the Director of Nursing and or Unit Managers Staff (licensed nurses/ Certified Nurse Assistance) not educated on [DATE]. Will be educated by the Director of Nursing and or Unit Manager prior to working the floor.         Date of Immediate Jeopardy Removal [DATE]       On [DATE] the facility's immediate jeopardy removal was validated [TRUNCATED]	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345403	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
(X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)         F 0580       The Director of Clinical Services and Nurse Managers re-educated licensed nurses on notifying physician via change in condition (SBAR) for residents with an order for UA/C&S and unable to obtain urine sample on [DATE]. The licensed nurse is to assess the resident, including vitals, complete the SBAR and notify the attending physician when there is a change in the status or condition of the resident.         Residents Affected - Few       The Director of Clinical Services and Nurse Managers re-educated certified nursing assistants on signs and symptoms of dehydration and immediately report the change in condition to the licensed nurse on [DATE]. Newly hired staff will be educated during orientation by the Director of Clinical Service and or Unit Managers. Staff (licensed nurses/ Certified Nurse Assistance) not educated on [DATE], will be educated by the Director of Nursing and or Unit Manager prior to working the floor.         Date of Immediate Jeopardy Removal [DATE]			6590 Tryon Road	P CODE
(Each deficiency must be preceded by full regulatory or LSC identifying information)F 0580Level of Harm - Immediate jeopardy to resident health or safetyResidents Affected - FewResidents Affected - FewDate of Immediate Jeopardy Removal [DATE]	For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey a	agency.
Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Residents Affected - Few Date of Immediate Jeopardy Removal [DATE]	(X4) ID PREFIX TAG			
	Level of Harm - Immediate jeopardy to resident health or safety	The Director of Clinical Services an change in condition (SBAR) for resi [DATE]. The licensed nurse is to as attending physician when there is a The Director of Clinical Services an symptoms of dehydration and imme Newly hired staff will be educated of Staff (licensed nurses/ Certified Nu of Nursing and or Unit Manager prior Date of Immediate Jeopardy Remo	Id Nurse Managers re-educated license idents with an order for UA/C&S and un seess the resident, including vitals, com a change in the status or condition of th ad Nurse Managers re-educated certifie ediately report the change in condition of luring orientation by the Director of Clir rse Assistance) not educated on [DATE or to working the floor. val [DATE]	ed nurses on notifying physician via nable to obtain urine sample on nplete the SBAR and notify the e resident. ed nursing assistants on signs and to the licensed nurse on [DATE]. nical Service and or Unit Managers. E], will be educated by the Director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345403	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Cary Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZI 6590 Tryon Road Cary, NC 27518	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	 tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0641	Ensure each resident receives an accurate assessment.		
Level of Harm - Minimal harm or potential for actual harm	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38702		
Residents Affected - Few		on, and staff interview, the facility failed area of hypnotics medication for 1 of	
	Findings included:		
	Resident #55 was admitted to the facility on [DATE] with diagnoses including dementia.		
	The annual Minimum Data Set (MDS) dated [DATE] had Resident #55 coded as severely cognitively impaired, and hypnotics were taken during the look back period.		
	The August and September 2024 Medication Administration Records (MAR) did not reveal an order for hypnotics.		
	An interview with the Director of Nursing (DON) was conducted on 11/19/2024 at 2:49 PM. The DON stated she look at MARs as far back as April 2024 for Resident #55 and there had not been a hypnotic ordered. The DON also stated the MDS was coded incorrectly and expected the MDS nurse to code the assessment accurately.		
	An interview with the MDS nurse was conducted on 11/19/2024 at 2:58 PM. The MDS Nurse stated she was the one who completed the MDS for Resident #55. There was a data entry error because Resident #55 was not receiving hypnotics during that time.		
	An interview with the Administrator was conducted on 11/22/2024 at 1:08 PM. The Administrator stated he expected the MDS assessments to be coded correctly.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345403	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Cary Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZI 6590 Tryon Road Cary, NC 27518	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	l tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0684	Provide appropriate treatment and care according to orders, resident's preferences and goals.		
Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on record review, and staff, facility staff failed to recognize the s identify the need for urgent medical decrease in food and fluid intake wi- night shift nurse ([DATE] at 11:00 F urine culture and sensitivity (C & S) made to collect the urine specimen successful. Another nurse attempte [DATE] but was not successful. Re- despite decreased intake. The poor of urine, there was minimal urine nu of [DATE] staff requested PA #1 to condition, altered mental status, de intravenous (IV) fluids for 3 days, b #294 was dehydrated, and she cou IV access. On [DATE] Resident #21 requested the resident be sent to th specimen for the urinalysis had still at the facility at 4:02 PM and the pr was sepsis. The chief complaint wa transferred to the emergency depait critically ill, obtunded (reduced leve extremities, with dilated pupils with identified with altered mental status there is inadequate blood circulatio problems and can lead to life-threat the body's temperature drops below lactic acid and the liver can't metab are a medication that are used to tr life-threatening condition that happi infection) with end organ dysfunctio occurred for 1 of 3 residents (Reside Immediate jeopardy began on [DAT change in condition and obtain nec [DATE] when the facility implement remain out of compliance at a scop	AVE BEEN EDITED TO PROTECT Co family member, Physician Assistant, an seriousness of a significant change in of a tatention to address an emergent situ as observed by staff. Resident #294 re PM through [DATE] at 7:00 AM) and an o was obtained from Physician Assistar for the UA until [DATE] at around 5:00 ad to obtain the urine specimen the even sident #294 was administered his diure r intake continued and by [DATE] Resident evaluate Resident #294 who noted the creased oral intake, and was clinically ut the nurse did not attempt to insert a idd not find a visible vein. The nurse con 94's family member arrived at the facilit he hospital and the facility requested no not been collected and the IV fluids ha imary impression was altered mental s as altered mental status with onset of [I rtment (ED) where the progress note in of alertness and consciousness), brea- out response bilaterally, and no respon s, tachypnea (rapid and shallow breathin n to organs and tissues and can be an tening conditions), hypothermia (a med v 95 F), severe lactic acidosis (occurs v olize it fast enough), and new vasoprei- eat people with low blood pressure mo tens when your blood pressure drops to on. Resident #294 died at 8:26 PM on [ tent #294) reviewed for professional sta rE] when staff failed to recognize the s essary emergent medical attention. Im ed a credible allegation of immediate ju e and severity of D (no actual harm with o ensure education is completed and m	nd Medical Director interviews, the condition, the importance of and ation. On [DATE] a sudden ported burning with urination to the order for a urinalysis (UA) and at #2 on [DATE]. No attempts were AM and the nurse was not oning of [DATE] and the morning of thic daily [DATE] through [DATE] dent #294 had become incontinent staff had to feed him. The morning resident had a change in dehydrated. PA #1 ordered peripheral line because Resident thatcted the vascular team to obtain ty at approximately 3:00 PM and on emergent transport. The ad not been initiated. EMS arrived tatus and secondary impression DATE]. Resident #294 was idicated Resident #294 presented athing on his own, with cold distal se to painful stimuli. He was ng), poor perfusion (occurs when early sign of circulatory or heart lical emergency that occurs when when the body produces too much soor requirements (vasopressors obt consistent with septic shock (at a dangerously low level after an DATE]. This deficient practice andards of care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345403	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Cary Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZI 6590 Tryon Road Cary, NC 27518	P CODE
For information on the nursing home's	nion to correct this deficiency, places con	tact the nursing home or the state survey	20000
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC		
F 0684 Level of Harm - Immediate jeopardy to resident health or safety	Resident #294 was initially admitted to the facility on [DATE] with the last readmission to the facility on [DATE]. His diagnoses included fracture of right femur (thigh bone between hip and knee), dementia, typ diabetes, adult failure to thrive, generalized muscle weakness, chronic kidney disease, and congestive h failure. He was admitted to the facility for rehabilitation therapy services after hospitalization following the femur fracture.		
Residents Affected - Few	A hospital discharge summary dated [DATE] indicated Resident #294 was admitted to the hospital [DATE] to [DATE] due to inability to care for himself at home after he was discharged home from 3 [DATE] and readmitted to the hospital on [DATE]. He had an unwitnessed ground-level fall early n [DATE] at the hospital when he thought he smelled smoke in his room and got up to investigate. F revealed right femoral neck fracture.		
	Resident #294 underwent a right hip hemiarthroplasty on [DATE] and was discharged to SNF on [DATE] with physical and occupational therapy recommendations.		
	reason for admission was debility. as being moderate. The note indica disease and suspected major neuro adult. Resident #294 was admitted was discharged from the hospital o from the SNF to the community on the hospital on [DATE]. He was livit consistently taking his medications. perform other activities of daily livin including unable to bathe himself of prior records, Resident had demon- follow-up for 3 years despite signifit self-discontinuing enalapril (medica color, demonstrating inability to ma indicated Resident #294 had a set require frequent medication change significant risk of worsening medica	SNF) admission note indicated Reside The symptoms had begun 11 weeks ag ated that the resident had a history of ty ocognitive disorder and had presented to the hospital on [DATE] through [DA' n [DATE] and admitted to a skilled nurs [DATE] but he was unable to care for s ing in a trailer without access to running. He was known to only be able to feed og (ADL) or instrumental activities of da r use toilet, often using water jugs as c strated inability to follow-up with medic cant cardiac history) and was paranoid ation used to treat high blood pressure) ke rational decisions regarding his hea of conditions, syndromes and functiona es, other treatment changes and re-eva al (including behavioral) status and was rbidities required intensive management	po and the symptoms were reported repe 2 diabetes, coronary artery to the hospital for failure to thrive TE] for difficulty caring for self. He sing facility and was discharged self at home and was readmitted to water or sewer and likely not and dress himself but not to ily living (IADLs) independently, commodes instead. Per review of al providers (was lost to Cardiolog about medications, such as because he did not trust new pill th. The plan on the admission no al impairments that would likely subations. Resident was at a t significant risk for readmissior
	for fluid deficit related to diuretic us Interventions included: monitor and ordered/per protocol and record; no	sed on [DATE] had a care focus area th e with the goals for Resident to be free I document intake and output as per fa otify physician of significant abnormaliti nydration; obtain and monitor lab/diagn is indicated.	of symptoms of dehydration. cility policy; monitor vital signs as es; monitor/document/report as
	A physician order dated [DATE] ind (continued on next page)	licated full code.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345403	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	PCODE
Cary Health and Rehabilitation		6590 Tryon Road Cary, NC 27518	
For information on the nursing home's	plan to correct this deficiency, please cont	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	IENCIES full regulatory or LSC identifying informati	on)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety	A physician order dated [DATE] indicated give Lasix oral tablet 20 milligram by mouth one time a day for edema (swelling from fluid retention). Lasix is a diuretic used to treat fluid retention that can result from congestive heart failure, kidney disease or other medical conditions. Lasix increases urine output and can lead to dehydration.		
Residents Affected - Few	Resident #294's admission Minimum Data Set (MDS) assessment dated [DATE] coded Resident #294 as cognitively intact. He had no behaviors or rejection of care. He required supervision or touching assistance with toileting. He required setup or clean up assistance with eating. He was coded as frequently incontinent of bowel and bladder and was also coded as taking a diuretic. His weight was 137 pounds, and his height was 68 inches. Resident #294's overall discharge goal was to return to the community. He was not coded for hospice care.		
	A 24-hour facility condition report completed by Nurse #5 dated [DATE] indicated Resident #294 had poor oral intake on day shift (7:00 AM to 7:00 PM). The facility's 24-hour condition report is a form that nurses document the status of all the residents during or at the end of their shift to communicate any pertinent information to the next shift and nursing management.		
	on [DATE] from 7:00 AM to 7:00 PM 25% of his tray food and drinks but	on [DATE] at 2:45 PM, she stated that M. Nurse #5 indicated that normally Re on [DATE] he had eaten and drank les in the 24 hour report and informed the	sident # 294 consumed more than ss than 25% during the three meals
	Vital signs documented on [DATE] oxygen saturations: 96% and tempe	at 1:43 PM by Nurse #5 were blood pr erature: 98 F.	essure (BP): ,d+[DATE], pulse:79,
		vith Nursing Assistant (NA) #3, the NA 0 PM) on [DATE], and were unsucces	
	A 24-hour facility condition report completed by Nurse #4 dated [DATE] indicated Resident #294 was complaining of burning with urination on night shift ([DATE] 11:00 PM to [DATE] 7:00 AM shift).		
	Resident #294 on [DATE] at 7:00 P #5 had informed her and document oral intake with food and drinks. Nu during her shift and she left a note t report and informed the oncoming of and the only concern during her shi	53 PM with Nurse #4, she stated that M to [DATE] at 7:00 AM. Nurse #4 stated in the 24-hour condition report that Irse #4 verbalized that Resident #294 of for the Provider in the physician book, day shift nurse (Nurse #1). Nurse #4 st ift was complaints of burning with urina luids while Resident #294 was awake	ted that during shift change Nurse Resident #294 had a decreased complained of burning with urinatio noted it in the 24-hour condition ated that Resident #294 was stable tion which she noted in the
	Resident #294's medication admini AM by Nurse #1.	stration record indicated Lasix 20 mg v	vas administered on [DATE] at 9:00
		[DATE] at 11:59 AM ordered by Physic ensitivity (C & S) for a diagnosis of dys	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIE Cary Health and Rehabilitation	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345403 NAME OF PROVIDER OR SUPPLIER		(X3) DATE SURVEY COMPLETED 11/22/2024 P CODE
		6590 Tryon Road Cary, NC 27518	
For information on the nursing home's plan to correct this deficiency, please cont		tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES y full regulatory or LSC identifying information)	
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 10:20 AM with Nurse #1, she indicated that she had cared for Resident #294 on [DATE]. Nurse #1 stated that when she came to work on [DATE] at around 7:00 AM she was informed by the off going night shift nurse (Nurse #4) that Resident #294 had complained of pain with urination during the night shift ([DATE] at 7:00 PM to [DATE] at 7:00 AM). Nurse #1 verbalized that a UA/CS to rule out a urinary tract infection was ordered during her shift ([DATE] 7:00 AM- 7:00 PM) but she did not attempt to obtain a urine sample since it would not have been picked up until around 6:00 AM the following morning. She stated that she was pushing fluids and Resident #294's vital signs were stable. Nurse #1 stated she did not obtain urine specimen and put in the refrigerator because it was normally collected on night shift to be sent out in the morning.		
	Vital signs documented on [DATE] saturations: 94% and temperature:	at 3:13 PM by Nurse #1 were BP: ,d+[l 97.5 F.	DATE], pulse:65, oxygen
	A 24-hour facility condition report dated [DATE] on day shift (7:00 AM to 3:00 PM) completed by Nurse and evening shift (3:00 PM to 11:00 PM) completed by Nurse #6 indicated the need for a UA/CS for Re #294 in the morning ([DATE]).		
	An interview was conducted on [DATE] at 1:40 PM with Nurse #6. He stated that he had filled in for four hours and cared for Resident #294 on [DATE] from 7:00 PM to 11:00 PM and he was aware that Resid #294 required a urine sample, but he did not obtain it because it wouldn't have been picked up until arc 6:00 AM in the morning. He notified the third shift nurse (Nurse #2) to collect the urine specimen when took over at 11:00 PM. Nurse #6 explained that the laboratory specimens were picked up by laboratory in the morning at approximately 6:00 AM. Nurse #2 stated that Resident #294 was stable and carried o conversation with him when he went to administer his 9:00 PM medications, he was in no pain and he f his medications with no concerns. Nurse #6 stated he did not collect the urine specimen and refrigerate during his shift since a sample collected by third shift would have been fresher when it was sent out in f morning.		
		ated [DATE] on night shift ([DATE] 11: ift ([DATE] 7:00 AM to 3:00 PM) compl nt #294.	
	on the night shift ([DATE] at 11:00 assignment that night, she was not Resident #294. She indicated that waking him up to give him any fluid she attempted to obtain the urine s unsuccessful and she notified the c incontinence brief was wet during the Resident #294's regular nurse and signs were obtained on day shift, b was in acute distress.	38 PM with Nurse #2, she stated that s PM to [DATE] at 7:00 AM). Nurse #2 st ified by the off going nurse (Nurse #6) when she came on shift Resident # 294 s. Nurse #2 indicated that Resident #2 pecimen via an in and out catheter at a ncoming day shift nurse (Nurse #1). N he in and out catheter attempt. Nurse # she was not familiar with his baseline. ut she would have obtained a set of vit	tated that when she took over the that a urine sample was needed for 4 was asleep and she did not recall 94 slept throughout her shift, and around 5:00 AM on [DATE] but was urse #2 indicated Resident #294's #2 also indicated that she was not She further stated that his vital
	(continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345403	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing STREET ADDRESS, CITY, STATE, ZI	(X3) DATE SURVEY COMPLETED 11/22/2024
Cary Health and Rehabilitation		6590 Tryon Road Cary, NC 27518	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	ICIENCIES y full regulatory or LSC identifying information)	
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on [DATE] at 2:12 PM with NA #2 who had cared for Resident #294 on [DATE] and [DATE] on night shift. NA #2 stated that Resident #294 took only a few sips of water during her shifts and when she changed his incontinence brief there was very little urine. NA #2 stated she worked with Nurse #3 ([DATE] at 11:00 PM through [DATE] at 7:00 AM) and Nurse #3 was aware of Resident's condition from the beginning of her shift when she had told NA #2 to offer and encourage the Resident to drink water when she went to check on him because they needed to obtain urine. NA #2 stated she could not recall if she had reported any information about Resident #294 to Nurse #2 on [DATE] night shift. Resident #294's medication administration record indicated Lasix 20 mg was administered on [DATE] at 9:00 AM by Nurse #1.		
	During an interview on [DATE] at 10:20 AM with Nurse #1, she stated that when she came back to work of [DATE] at around 7:00 AM she was informed by the off going night shift Nurse (Nurse #2) that a urine sample was still needed for Resident #294 since she had not been able to obtain the urine during the night shift. Nurse #1 stated that she did not attempt to obtain the urine sample on [DATE] day shift since it wou wait until the following morning at around 6:00 AM to be picked up. She indicated that Resident #294 was still not at baseline; he was less talkative than usual and not eating/drinking as usual and she continued to push fluids. Nurse #1 stated that Resident #294 normally ate and drank most of what was on his tray, and also drank most of the water she gave him during medication administration, but on [DATE] he took only a with the medication. She further stated that Resident #294 consumed 0 out of 120 milliliters of his med par (nutritional supplementation) on [DATE] at approximately 9:00 AM and 5:00 PM whereas previously he consumed 100 % of the supplementation. Nurse #1 stated she recognized the resident was not at his baseline and was not eating and drinking as he usually did. The UA had been ordered the day before and Nurse #2 had not been able to obtain the specimen the previous shift. Nurse #1 stated she did not think to obtaining the urine during her shift to be sent to the lab and she left it for the next shift so it could be sent the following day because it was normally collected on night shift and sent out in the morning.		
	saturations: 94% and temperature: A 24-hour facility condition report c	ompleted by Nurse #3 dated [DATE] or	n night shift ([DATE] 7:00 PM to
	<ul> <li>[DATE] 7:00 AM) indicated the nurse attempted twice to collect urine unsuccessfully.</li> <li>A late entry nursing progress note written by Nurse #3 dated [DATE] at 6:13 AM indicated report wat to the nurse that a UA/C&amp;S was needed. The nurse attempted to push fluids, however, resident wou take small sips. The first attempt to obtain the UA/CS was around 9:00 PM on [DATE] and she was incollect as not enough urine came out. The writer continued to push fluids throughout the shift, again, getting small sips. The first attempt to collect the urine was reported to the supervisor. The second an obtain the UA/C&amp;S was at 5:33 AM on [DATE] and was again unsuccessful. Oncoming nurse (Nurse the Unit Manager were made aware of the attempts and that patient is still in need of a specimen or medical doctor may need to be called to get further orders.</li> <li>Nursing progress note written by Nurse #3 dated [DATE] at 6:31 AM indicated writer attempted to convert need to convert need to be called to get further orders.</li> </ul>		
	(continued on next page)		

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         345403    NAME OF PROVIDER OR SUPPLIER Cary Health and Rehabilitation For information on the nursing home's plan to correct this deficiency, please cont		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. Building       COMPLETED         B. Wing       11/22/2024         STREET ADDRESS, CITY, STATE, ZIP CODE       6590 Tryon Road         Cary, NC 27518       Complexity	
		`	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	full regulatory or LSC identifying informati	on)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	<ul> <li>#294 on [DATE] at 7:00 PM through off going day shift nurse (Nurse #1) to obtain the specimen at around 92 out catheter both times but was unst thick to be processed. She stated the she was pushing fluids but Resider reported to the oncoming day shift specimen via an in and out catheter shift on [DATE] and were stable. She during her shift and if she did, she was tated that Resident #294 was verb informed the physician to send him</li> <li>During an interview on [DATE] at 33 Resident #294 on [DATE] through [ those 3 days she noticed that Resident #294 was verb incontinent whereas previously here himself, but she had to feed him an usually did. NA #1 also stated that were guite and not shoutin #1 was aware that Resident #294 were getting ready to transfer the R Resident #294's medication admini AM by Nurse #1.</li> <li>A Physician Assistant (PA) progress #294 was seen by PA at the request minimally responsive. This was a nursing/therapy. The roommate rep Nursing attempted to obtain UA/CS note also indicated the resident had was clinically dehydrated. An order fluids) 2 liters for 3 days ([DATE] to for insulins with decreased oral inta</li> </ul>	105 PM with Nursing Assistant (NA) #1 DATE] during the 7:00 AM to 3:00 PM dent #294 was eating and drinking less was using the urinal. She also stated th d offer drinks on [DATE] and [DATE] b when she changed Resident #294's briving Resident #294 a shower on [DATI ing like he would normally do during sho vas not drinking and eating as he norm his fluids and also to give him a shower #294 was not alert and oriented when s	she had received report from the Resident #294 and she attempted y 5:30 AM on [DATE] via an in and parely any urine, and it was too was dry during both attempts, and could not get in much. Nurse #3 successful in obtaining the urine s vital signs were completed on day e had obtained any vital signs ere outside parameters. Nurse #3 distress otherwise she would have she stated that she had cared for shift. NA #1 stated that during than usual, and he had become nat previously he could feed ut he did not eat or drink as he lefs there was minimal urine. NA #1 E] he was not as responsive as owers. She verbalized that Nurse ally did and had told NA #1 to because he kept pulling off his she completed her shift, and they was administered on [DATE] at 9:00 at 11:52 AM indicated Resident no condition. The resident was d and interactive per 294 eat over the past 3 days. were with catheter. The progress status, decreased oral intake, and E] and ordered IVF (intravenous d she confirmed hold parameters (normal range between 70 and 100

NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         Cary Health and Rehabilitation       6590 Tryon Road         For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345403	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES			6590 Tryon Road	P CODE
	For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey a	agency.
(Each deficiency must be preceded by full regulatory or LSC identifying information)				on)
<ul> <li>F 0684</li> <li>Level of Ham - Immediate joe preceded by fuel regulatory of a regulatory of a system #1 (PA #1) she stated that we was notified by Nurse #1 vites she came to the facility at around 10:30 AM on [DATE] that Resident #284 had a change in condition, and they had not been able to obtain a urine sample for a UA and CS. The PA explained that when she went to assess Resident #284, he seemed dehydrated but was responsive to to estain a midline so that they could administer IV fluids. The PA stated she diro tak now Resident #284 had an indicense of harded that view she went to assess Resident #284 had not know Resident #284 had an indice so that they could administer IV fluids. The PA stated she diro tak now Resident #284 had an teal of the facility contracted ther to let her know that they had not obtain peripheral intravenous access.</li> <li>A Physician order dated [DATE] at 10:15 AM ordered by PA #1 indicated to obtain peripheral intravenous (PIV) access (small catheter inserted into a superficial vein [a vein incated close to the surface of the skin].</li> <li>A Physician order dated [DATE] ordered by PA #1 indicated Sodium Chloride Intravenous Solution 0.9 %. Use 2 liters intravenous in the blood stream).</li> <li>A Physician order dated [DATE] ordered by PA #1 indicated Sodium Chloride Intravenous solution 0.9 %. Use 2 liters intravenous in the more or and nake for 3 Days. Administer 2 liters intravenous fulds normal saline at 100 milliters per hour for 3 days. (Sodium Chloride intravenous Solution 0.9 %. Use 2 liters intravenous in the tead of the ask in formed by the of going night shift muse (Nurse #3) that a urine sample was still needd. Nurse #1 stated she ad dministered Resident #294 serveral times that morning and she had administered his norming medications at around 900 AM which he took with 25% of his med pass nutritional supplementation. Nurse #1 stated she had administered Resident #294 states and ordered and lite he she addministered Resident #294 states an</li></ul>	Level of Harm - Immediate jeopardy to resident health or safety	During an interview on [DATE] at 4 notified by Nurse #1 when she cam change in condition, and they had r explained that when she went to as questions. She gave an order to ins to obtain a midline so that they cou baseline since she was not the prin recall if the facility contacted her to A Physician order dated [DATE] at (PIV) access (small catheter inserts unable to obtain, obtain a midline (a fluids or medication into the blood s A Physician order dated [DATE] or Use 2 liters intravenously in the mo normal saline at 100 milliliters per h in the body.) During an interview with Nurse #1 stated s administered his morning medicatio supplementation. Nurse #1 stated s administered his morning medicatio supplementation. Nurse #1 reveale and [DATE] at approximately 9:007 she did not think to hold it or ask th than the previous 2 days, and she r between 10:00 AM and 11:00 AM c and IV fluids. Nurse #1 stated she o dehydrated and she could not find a specialized in inserting intravenous and also called Resident #294's far member did not answer the phone, at around 3:00 PM and the Nurse in midline. Nurse #1 indicated Resident #294 condition and Nurse #1 stated she called emergency medical services	30 PM with Physician Assistant #1 (PA te to the facility at around 10:30 AM on not been able to obtain a urine sample seess Resident #294, he seemed dehyd seess Resident #294, he seemed dehyd seess Resident #294, he seemed dehyd ed administer IV fluids. The PA stated s nary care provider for Resident #294. S let her know that they had not obtained 10:15 AM ordered by PA #1 indicated te ad into a superficial vein [a vein located a long flexible tube that is inserted into stream). dered by PA #1 indicated Sodium Chloo rning for poor oral intake for 3 Days. A nour for 3 days. (Sodium Chloride is use on [DATE] at 10:20 AM, Nurse #1 state is informed by the off going night shift nu he checked on Resident #294 several ons at around 9:00 AM which he took w d that she had administered Resider # AM despite the resident's decreased or e provider about it. She stated Resider notified Physician Assistant (PA) #1 wh on [DATE]. PA #1 went to examine Res did not attempt to insert a peripheral lin a visible vein. She called the vascular t catheters) between 10:00 AM and 11: nily member to obtain consent for the r and she left a message for her. The fa formed her that the vascular team was nt #249 was quieter around 3:00 PM co	A #1) she stated that she was [DATE] that Resident #294 had a for a UA and CS. The PA drated but was responsive to and if unable to obtain PIV access the did not know Resident #294's She also stated that she could not d an IV (intravenous) access. to obtain peripheral intravenous I close to the surface of the skin]). If a vein in the upper arm to deliver ride Intravenous Solution 0.9 %. dminister 2 liters intravenous fluids ed to replenish lost water and salt d that when she came to work on urse (Nurse #3) that a urine sample times that morning and she had vith 25% of his med pass nutritional #294's Lasix on [DATE], [DATE] ral food and fluid intake and that tt #294 seemed more confused leen she came to the facility sident #294 and ordered a midline e because Resident #294 was eam (a contracted entity that is 00 AM to come and insert a midline nidline insertion. The family mily member arrived at the facility s enroute to the facility to insert the compared to earlier in the day. The tment (ED) due to the worsening er and the facility Provider and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. Building	(X3) DATE SURVEY COMPLETED
	345403	B. Wing	11/22/2024
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
Cary Health and Rehabilitation		6590 Tryon Road Cary, NC 27518	
For information on the nursing home's	plan to correct this deficiency, please cont	tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	IENCIES full regulatory or LSC identifying informati	on)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	was notified by Nurse #1 on [DATE the facility to see the resident and w told Nurse #1 to go ahead and send she was not aware if the Provider w condition until [DATE] when the Pro- stated that Resident #294 was bein that wanted the Resident to be sen- intravenous access had been obtai #294's medical records she stated to An interview was conducted with Re 3:02 PM. The family member stated approximately 1:30 PM indicating the update. The family member decided back the facility and was put on hol Resident naked and disoriented, his drank it. The family member stated an intravenous line and she informe because he was in distress and Nu the Resident's vital signs during the oxygen to the Resident after she ch During an interview on [DATE] at 10 vital signs before he was transferre remember was that oxygen saturati Emergency medical services (EMS non-emergent transportation due to impression was altered mental statis mental status with onset of [DATE]. (irregular heart rhythm characterize PM were noted as blood pressure: of consciousness was responds to used to measure patient's level of or IV fluids due to Resident #294 meet to establish IV access. EMS depart hospital of sepsis indication at 5:00 non-verbal with minimal alertness, I were clear with increased respirato	e Unit Manager (UM) on [DATE] at 10: ] at approximately 3:00 PM that Reside vanted him to be sent to the hospital de d the Resident out to the hospital per fa- vas notified about the inability to obtain ovider came to the facility between 10:0 g provided treatment at the facility, but t out. During the interview the UM initia ned and fluids administered but when s that she thought the fluids had been ac esident #294's Emergency Contact #1 d that she received a voice message fm hat Resident #294 was doing okay and d to come to the facility to check what v d. When she arrived at the facility at ar s mouth was dry and crusty, and she a Nurse #1 told her she was waiting for ved Nurse #1 that she wanted the Resid rse #1 called 911. The family member is conversation in the room and Nurse hecked the oxygen saturations. D:20 AM with Nurse #1 she stated that d to the ED but she could not recall wh on was below 90 % and she administe ) report dated [DATE] indicated that EM of family choice. EMS arrived at the facil us and secondary impression was seps An electrocardiogram (ECG) at 4:05 F d by rapid and irregular heartbeat). Viti ,d+[DATE], pulse: 65, respirations: 8, c painful stimulation on the AVPU (alert, consciousness). EMS obtained a teleph ting the criteria for sepsis. IV fluids wer ed facility at 4:39 PM with Resident #2 PM. EMS assessment at 5:05 PM indi he had rapid mouth breathing, his skin ry rate and oxygen saturation readings nt #294 arrived at the ED at 5:41 PM.	ent #294's family member was in ue to altered mental status and she amily request. The UM verbalized the urine sample and change in 00 AM and 11:00 AM. The UM the family member was the one Illy told the surveyor that she further looked in Resident Iministered but they were not. (Family Member) on [DATE] at that she wanted to give her an was going on when she tried to call ound 3:00 PM she found the ttempted to give him a drink and he vascular team to come and insert ent to be sent to the hospital also stated that Nurse #1 checked #1 immediately administered she had checked Resident #294's at they were, all she could red oxygen. <i>MS</i> was contacted at 3:42 PM for a ity at 4:02 PM and primary sis. The chief complaint was altered PM indicated atrial fibrillation al signs obtained by EMS at 4:17 oxygen saturation: 94 % and level voice, pain, unresponsive scale ione order at 4:22 PM to administer re not administered due to inability 94 and notified the receiving cated Resident #294 was lethargic, was cold and dry, lung sounds

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	345403	A. Building B. Wing	11/22/2024
NAME OF PROVIDER OR SUPPLIER         Cary Health and Rehabilitation         For information on the nursing home's plan to correct this deficiency, please contained         (X4) ID PREFIX TAG		STREET ADDRESS, CITY, STATE, ZIP CODE 6590 Tryon Road Cary, NC 27518 act the nursing home or the state survey agency.	
(X4) ID PREFIX TAG F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(Each deficiency must be preceded by Emergency department (ED) progranoted as follows: blood pressure: , c saturation: 33 %, and temperature: Resident #294 presented critically in his own with cold distal extremities stimuli. Facility stated that he had na naked by his family and encourage Resident #294 was found to be in na body). Because of his cold extremit Discussion with family revealed path discussion regarding his goals of his understood that he was critically ill altered mental status, tachypnea (ra inadequate blood circulation to orgation and can lead to life-threatening con- temperature drops below 95 F), seviand the liver can't metabolize it fast medication that are used to treat per life-threatening condition that happer infection) with end organ dysfunction An interview was conducted with the was aware of Resident #294's condor Resident's condition. He indicated to when they could not obtain a urine sent out before the IV access was co- earlier that day on [DATE] the outcome interview that the state is a state of the state of the state and the live can't metabolize it fast medication that are used to treat per life-threatening condition that happer infection (bit endicated to the state of the	<b>TENCIES</b> full regulatory or LSC identifying information ass note dated [DATE] indicated that R I+[DATE], heart rate: 138, and respiration 93.4 degrees Fahrenheit at 6:23 pm. T II, obtunded (reduced level of alertness with dilated pupils without response bill ot been eating or drinking anything for d the nurse to take his vital signs who the netabolic acidosis (a condition in which ies, they were unable to reliably obtain ient had voiced wishes to have everyth s care, family wanted the patient to con at that moment. The ED note indicated apid and shallow breathing), poor perfu- ans and tissues and can be an early sig ditions), hypothermia (a medical emergy ere lactic acidosis (occurs when the bi- enough), and new vasopressor require tople with low blood pressure drops to a on as cause of death. Resident #294 di e facility Medical Director (MD) on [DA dition and the facility did what they were hat when the Resident showed signs of sample, they ordered an IV access for obtained. The MD also stated that if the ome would not have been any different positive for a UTI they would have star	Resident #294's vital signs were ions 29 at 5:45 PM and oxygen The progress note indicated a and consciousness), breathing on laterally and no response to painful 3 days, and today he was found then emergently called for 911. to oo much acid accumulates in the a pulse oximeter reading. hing done to sustain his life. After ntinue to be full code. They that Resident's presentation with usion (occurs when there is gen of circulatory or heart problems gency that occurs when the body's ody produces too much lactic acid ements (vasopressors are a nsistent with septic shock (a a dangerously low level after an ed at 8:26 PM on [DATE]. TE] at 4:37 PM. The MD stated he e supposed to do to manage the of a UTI, a UA was ordered and hydration, but the Resident was a Resident had been sent out t. He also stated that if the UA had

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NAME OF PROVIDER OR SUPPLIER Cary Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZI 6590 Tryon Road Cary, NC 27518	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	ID PREFIX TAG SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by f		on)
F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on record review, and staff, the facility failed to ensure staff rec resident receiving a diuretic (Lasix identified with decreased nutritiona beyond what thirst dictates to avoid symptoms of dehydration on [DATE evidenced by the inability to collect bladder) when the resident had no administer the resident's Lasix (diu dehydration. On [DATE] at 10:15 A inserted into a superficial vein [a vei the resident and staff did not attem can cause veins to be difficult to loo resident be sent to the hospital. Em Resident #294 was transferred to th tachypnea (rapid and shallow breat to organs and tissues and can be a life-threatening conditions), hypothe drops below 95 F), severe lactic ac can't metabolize it fast enough), an used to treat people with low blood that happens when your blood pres dysfunction. Resident #294 died at (Resident #294) reviewed for dehyd Immediate jeopardy began on [DAT of dehydration for Resident #294 w resident had no recent episodes of on [DATE] when the facility implem remain out of compliance at a scop harm that is immediate jeopardy) to and are effective. The findings included: Resident #294 was admitted to the bone between hip and knee), deme weakness, chronic kidney disease,	AVE BEEN EDITED TO PROTECT Con- family member, Physician Assistant (P ognized the seriousness of signs and s 20 mg daily) and who had decreased fi I and fluid intake on [DATE] requiring s I dehydration) through [DATE]. Resider E] at approximately 9:00 PM and [DATE] urine via an in and out catheter (insert recent episodes of urination. During this retic) 20 milligrams once daily at 9:00 A M the PA ordered a peripheral intraver sin located close to the surface of the s pt to insert the PIV due to the inability to cate). That afternoon, Resident #294's nergency Medical Services (EMS) were the emergency room where he was ider thing), poor perfusion (occurs when the ermia (a medical emergency that occur idosis (occurs when the body produces d new vasopressor requirements (vaso pressure) most consistent with septic sure drops to a dangerously low level 8:26 PM on [DATE]. This deficient pra	A), and Medical Director interviews symptoms of dehydration for a luid intake. Resident #294 was first taff to push fluids (deliberately drink nt #294 exhibited signs and E] at approximately 5:30 AM as ing a thin, hollow tube into the is time, nursing staff continued to AM despite signs and symptoms of nous (PIV) access (small catheter kin]) to provide intravenous fluids to to find a visible vein (dehydration family member requested the e contacted at 3:42 PM and ntified with altered mental status, are is inadequate blood circulation olems and can lead to rs when the body's temperature is too much lactic acid and the liver opressors are a medication that are shock (a life-threatening condition after an infection) with end organ ctice occurred for 1 of 3 residents eriousness of signs and symptoms ria an in and out catheter when the mmediate jeopardy was removed te jeopardy removal. The facility will th potential for more than minimal conitoring systems put into place

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NAME OF PROVIDER OR SUPPLIER Cary Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZI 6590 Tryon Road Conv. NC 27548	P CODE
For information on the nursing home's	nian to correct this deficiency, please cont	Cary, NC 27518	202001
	bian to correct this denotency, please com		agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	for fluid deficit related to diuretic us Interventions included: monitor and ordered/per protocol and record; no needed any signs/symptoms of def results to physician and follow up a		e of symptoms of dehydration. cility policy; monitor vital signs as es; monitor/document/report as ostic work as ordered and report
	edema (swelling from fluid retentior congestive heart failure, kidney disc can lead to dehydration.) Resident #294's admission Minimu cognitively intact. He was coded as	licated give Lasix oral tablet 20 milligra n). Lasix is a diuretic used to treat fluid ease or other medical conditions. (Lasi m Data Set (MDS) assessment dated   frequently incontinent of bowel and bl verall discharge goal was to return to t	retention that can result from x increases the flow of urine and [DATE] coded Resident #294 as adder and was also coded as
	for hospice care. A facility 24-hour condition report or oral intake on day shift. The facility' the residents during or at the end o nursing management. During an interview with Nurse #5 o on [DATE] from 7:00 AM to 7:00 PM	ompleted by Nurse #5 dated [DATE] in s 24-hour condition report is a form tha f their shift to communicate any pertine on [DATE] at 2:45 PM, she stated that M. Nurse #5 indicated that normally Re on [DATE] he had eaten and drank les	dicated Resident #294 had poor at nurses document the status of al ent information to the next shift and she had cared for Resident #294 sident # 294 consumed more than
	and dinner and she documented it i # 4). During an interview on [DATE] at 3: Resident #294 on [DATE] at 7:00 P #5 had informed her and document oral intake with food and drinks. Nu her shift was complaints of burning fluids while Resident #294 was awa	53 PM with Nurse #4, she stated that M to [DATE] at 7:00 AM. Nurse #4 stated in the 24-hour condition report that rese #4 stated that Resident #294 was with urination which she noted in the p ake because she thought it was a sign rink much fluids because it was at nigh	oncoming night shift nurse (Nurse she was assigned to care for ted that during shift change Nurse Resident #294 had a decreased stable and the only concern during ohysician's book and she pushed of urinary tract infection. Nurse #4
	A Physician telephone order dated [DATE] at 11:59 AM ordered by Physician Assistant (PA) #2 indicated urinalysis (UA), urine culture and sensitivity (C & S) for a diagnosis of dysuria.		
	Resident #294's medication administration record indicated Lasix 20 mg was administered on [DATE] at 9:00 AM by Nurse #1.		
	#294 on [DATE]. She stated that sh	0:20 AM with Nurse #1, she indicated the was pushing fluids because Resider been a sign of a urinary tract infection. ATE].	nt #294 had complained of burning
	(continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Cary Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZI 6590 Tryon Road Cary, NC 27518	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES / full regulatory or LSC identifying information)	
F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	<ul> <li>During an interview on [DATE] at 3:38 PM with Nurse #2, she stated that she had cared for Resident #29 on night shift ([DATE] at 11:00 PM to [DATE] at 7:00 AM). Nurse #2 stated that when she took over the assignment that night, she was notified by the off going nurse (Nurse #6) that a urine sample was needed Resident #294. She indicated that when she came on shift Resident #294 was asleep and she did not rer waking him up to give him any fluids. Nurse #2 indicated that Resident #294 slept throughout her shift, ar she attempted to obtain the urine specimen via an in and out catheter at around 5:00 AM on [DATE] but vusuccessful and she notified the oncoming day shift nurse (Nurse #1). Nurse #2 indicated Resident #294 incontinence brief was wet during the in and out catheter attempt.</li> <li>An interview was conducted on [DATE] at 2:12 PM with NA #2 who had cared for Resident #294 on [DAT and [DATE] on night shift. NA #2 stated that Resident #294 took only a few sips of water during her shifts and when she changed his incontinence brief there was very little urine. NA #2 stated that Nurse #3 was aware of Resident's condition and had told her to offer and encourage the Resident to drink water when swent to check on him.</li> <li>Resident #294's medication administration record indicated Lasix 20 mg was administered on [DATE] at AM by Nurse #1.</li> </ul>		
	[DATÉ] at around 7:00 AM she was sample was still needed for Reside shift. She indicated that Resident # he was not at his baseline. He was continued to push fluids and he did drank most of what was on his tray administration, but on [DATE] he to consumed 0 out of 120 milliliters of 9:00 AM and 5:00 PM whereas pre A facility 24-hour condition report c [DATE] 7:00 AM) indicated the nurs A late entry nursing progress note of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the	on [DATE] at 10:20 AM, she stated that is informed by the off going night shift N nt #294 since she had not been able to 294 was more like he was the previous less talkative than usual and not eating not drink much. Nurse #1 stated that F , and he also drank most of the water s look only sips with the medication. She f his med pass (nutritional supplementa viously he consumed 100 % of the sup ompleted by Nurse #3 dated [DATE] or se attempted twice to collect urine unsu- written by Nurse #3 dated [DATE] at 6: meded. The nurse attempted to push flui	urse (Nurse #2) that a urine o obtain the urine during the night a day ([DATE]) when she had noted g/drinking as usual and she Resident #294 normally ate and he gave him during medication urther stated that Resident #294 tion) on [DATE] at approximately plementation. In night shift ([DATE] 7:00 PM to accessfully.
	take small sips. The first attempt to to collect as not enough urine came getting small sips. The first attempt obtain the UA/C&S was at 5:33 AM the Unit Manager were made awar the medical doctor may need to be Nursing progress note written by N	obtain the UA/C&S was around 9:00 F e out. The writer continued to push fluic to collect the urine was reported to the I on [DATE] and was again unsuccessfi e of the attempts and that the resident	PM on [DATE] and she was unable is throughout the shift, again, only supervisor. The second attempt to ul. Oncoming nurse (Nurse #1) and was still in need of a specimen or ated writer attempted to collect

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For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES y full regulatory or LSC identifying information)	
F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	<ul> <li>#294 on [DATE] at 7:00 PM throug off going day shift nurse (Nurse #1) to obtain the specimen at around 9 out catheter both times but was unst to be processed. She stated that R was pushing fluids but Resident #2 reported to the oncoming day shift specimen via an in and out cathete in any acute distress otherwise she when she did not obtain the urine s could notify the PA that morning an much, they had not been able to ob During an interview on [DATE] at 3 Resident #294 on [DATE] through   those 3 days she noticed that Resid incontinent whereas previously he himself, but she had to feed him an usually did. NA #1 also stated that further stated that when she was gi usual, he was quiet and not shoutir #1 was aware of Resident #294's c fluids and also to give him a shower Resident #294's medication admini AM by Nurse #1.</li> <li>A Physician order dated [DATE] at obtain, obtain a midline (a long flex medication into the blood stream).</li> <li>A Physician order dated [DATE] or Use 2 liters intravenously in the more set of the state of th</li></ul>	ATE] at 1:54 PM with the Nurse #3 who In [DATE] at 7:00 AM. Nurse #3 stated so that a urine specimen was needed for 100 PM on [DATE] and at approximatel successful. She stated that there was b esident #294's incontinence brief was of 94 was only taking small sips and could nurse (Nurse #1) that she had been un r. Nurse #3 stated that Resident #294 w would have informed the physician to pecimen at 5:30 AM she notified the or d they could probably get an order for a stain the urine sample and he was prob 105 PM with Nursing Assistant (NA) #1 DATE] during the 7:00 AM to 3:00 PM dent #294 was eating and drinking less was using the urinal. She also stated th d offer drinks on [DATE] and [DATE] b when she changed Resident #294's briving resident #294 a shower on [DATE] ng like he would normally do during sho ondition and had told NA #1 to encourant r because he kept pulling off his clother stration record indicated Lasix 20 mg w 10:15 AM ordered by PA #1 indicated of ible tube that is inserted into a vein in the dered by PA #1 indicated Sodium Chloride is used the out of r 3 days. (Sodium Chloride is used and the subscheme is used the out of r 3 days. (Sodium Chloride is used the out of r 3 days. (Sodium Chloride is used the out of r 3 days. (Sodium Chloride is used the out of r 3 days. (Sodium Chloride is used the out of r 3 days. (Sodium Chloride is used the out of r 3 days. (Sodium Chloride is used the out of r 3 days. (Sodium Chloride is used the out of r 3 days. (Sodium Chloride is used the out of r 3 days. (Sodium Chloride is used the out of r 3 days. (Sodium Chloride is used the out of r 3 days. (Sodium Chloride is used the out of r 3 days. (Sodium Chloride is used the out of r 3 days. (Sodium Chloride is used the out of r 3 days. (Sodium Chloride is used the out of r 3 days. (Sodium Chloride is used the out of r 3 days. (Sodium Chloride is used the out of r 3 days. (Sodium Chloride is used the out of r 3 days. (Sodium Chloride is used the out of r 3 days. (Sodium	she had received report from the Resident #294 and she attempted y 5:30 AM on [DATE] via an in and arely any urine and it was too thick fry during both attempts, and she d not get in much. Nurse #3 successful in obtaining the urine was verbal and did not seem to be send him out. She stated that nooming day shift nurse so that she an IV because he was not drinking ably dehydrated. she stated that she had cared for shift. NA #1 stated that during than usual, and he had become that previously he could feed ut he did not eat or drink as he efs there was minimal urine. NA #1 E] he was not as responsive as wers. She verbalized that Nurse age Resident #294 to drink his s. vas administered on [DATE] at 9:00 obtain PIV access and if unable to he upper arm to deliver fluids or

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	345403	B. Wing	11/22/2024
NAME OF PROVIDER OR SUPPLIER Cary Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 6590 Tryon Road	
For information on the nursing home's	plan to correct this deficiency please cont	Cary, NC 27518	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.         (X4) ID PREFIX TAG         SUMMARY STATEMENT OF DEFICIENCIES			
	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE] at around 7:00 AM she was was still needed. She stated that sh the PA know that they had not beer which was probably a sign of dehyd medication administration on [DATE [DATE], [DATE] and [DATE] at app intake and that she did not think to she had administered Lasix when th not drinking much. She stated Resi notified Physician Assistant (PA) #1 [DATE]. PA #1 went to examine Re not attempt to insert a peripheral lin visible vein. She called the vascula catheters) to come and insert a mid the midline insertion. The family me family member arrived at the facility were enroute to the facility to insert Emergency Department (ED) due to the Unit Manager and the facility Pr transfer Resident #294 to the hospi A PA progress note written by PA # the request of nursing for evaluation a noted change from usually being he had not seen Resident #294 eatt provide adequate sample even witt condition, altered mental status, de to obtain a PIV on [DATE] and order indicated staff were unable to obtai During an interview on [DATE] at 4: she came to the facility at around 1 they had not been able to obtain a assess Resident #294, he seemed a peripheral intravenous (PIV) line a administer IV fluids. The PA stated	Adated [DATE] at 11:52 AM indicated in of change in condition. The resident wagitated and interactive per nursing/the over the past 3 days. Nursing attempts a catheter. The progress note also indic creased oral intake, and was clinically ared IVF 2 liters for 3 days ([DATE] to [In UA/C&S given dehydration. 30 PM with PA #1, she stated that she 0:30 AM on [DATE] that Resident #294 urine sample for a UA and C&S. The P dehydrated but was responsive to que and if unable to obtain PIV access to ol she did not know Resident #294's base also stated that she could not recall	urse (Nurse #3) that a urine sample lity that morning and she would let resident was not drinking much alk only sips of water during ninistered Resident #294's Lasix on nt's decreased oral food and fluid se #1 stated she could not say why e specimen and the Resident was in the previous 2 days, and she in 10:00 AM and 11:00 AM on I IV fluids. Nurse #1 stated she did ated and she could not find a ialized in inserting intravenous amily member to obtain consent for he left a message for her. The ormed her that the vascular team ed Resident #294 to be sent to the 1 stated she agreed. She informed services (EMS) who came to Resident #294 was seen by PA at was minimally responsive. This was erapy. The roommate reported that ed to obtain UA/C&S, unable to cated the resident had a change in dehydrated. An order was provided DATE]). The progress note also

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NAME OF PROVIDER OR SUPPLIER Cary Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 6590 Tryon Road Cary, NC 27518	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	<ul> <li>was notified by Nurse #1 on [DATE] the facility to see the resident and we told Nurse #1 to go ahead and serve Resident #294 was being provided the Resident to be sent out. During access had been obtained and fluir records she stated that she though</li> <li>An interview was conducted with R 3:02 PM. The family member stated approximately 1:30 PM indicating the update. The family member decide back the facility and was put on hol Resident naked and disoriented, hi drank it. The family member stated an intravenous line and she informable because he was in distress and Nut the Resident's vital signs during the oxygen to the Resident after she che can be carrived are and secondary impression was segan electrocardiogram (ECG) at 4:0 rapid and irregular heartbeat). Vital d+[DATE], pulse: 65, respirations: 3 painful stimulation on the AVPU (al consciousness). EMS obtained a termeeting the criteria for sepsis. IV fl departed facility at 4:39 PM with RePM. EMS assessment at 5:05 PM i he had rapid mouth breathing, his separation was the formation on the facility at 4:39 PM with RePM. EMS assessment at 5:05 PM i he had rapid mouth breathing, his separation was the facility at 4:39 PM with RePM.</li> </ul>	e Unit Manager (UM) on [DATE] at 10: ] at approximately 3:00 PM that Reside vanted him to be sent to the hospital de d the Resident out to the hospital per fa treatment at the facility but the family r the interview, the UM initially told the s administered but when she further lo t the fluids had been administered but the esident #294's Emergency Contact #1 d that she received a voice message fr hat Resident #294 was doing okay and d to come to the facility to check what vd d. When she arrived at the facility arous s mouth was dry and crusty and she at Nurse #1 told her she was waiting for ed Nurse #1 that she wanted the Resid rse #1 called 911. The family member in conversation in the room and Nurse necked the oxygen saturations. I that EMS was contacted at 3:42 PM fo at the facility at 4:02 PM and primary in sis. The chief complaint was altered m 5 PM indicated atrial fibrillation (irregula signs obtained by EMS at 4:17 PM we 8, oxygen saturation: 94 % and level of ert, voice, pain, unresponsive scale us allephone order at 4:22 PM to administered uids were not administered due to inab esident #294 and notified the receiving ndicated Resident #294 was lethargic, skin was cold and dry, lung sounds wer s were inconsistent due to the resident	ent #294's family member was in ue to altered mental status and she amily request. The UM stated that member was the one that wanted surveyor that an intravenous ooked in Resident #294's medical they were not. (Family Member) on [DATE] at om Nurse #1 on [DATE] at that she wanted to give her an was going on when she tried to call nd 3:00 PM she found the tempted to give him a drink and he vascular team to come and insert ent to be sent to the hospital also stated that Nurse #1 checked #1 immediately administered or a non-emergent transportation npression was altered mental status ental status with onset of [DATE]. ar heart rhythm characterized by re noted as blood pressure: , consciousness was responds to ed to measure patient's level of r IV fluids due to Resident #294 ility to establish an IV access. EMS hospital of sepsis indication at 5:00 non-verbal with minimal alertness, re clear with increased respiratory

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Cary Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 6590 Tryon Road Cary, NC 27518	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	<ul> <li>pressure: ,d+[DATE], heart rate: 13 temperature: 93.4 degrees Fahrenl critically ill, obtunded (reduced level extremities with dilated pupils without that he had not been eating or drinl encouraged the nurse to take his vible in metabolic acidosis (a condition extremities, they were unable to relipatient had voiced wishes to have dhis care, family wanted the patient moment. The ED note indicated that perfusion, hypothermia, severe lack shock with end organ dysfunction at the Resident's condition. He indicated that for hydration, but the Resident was the Resident had been sent out ear asked if the staff should have continurine with no recent episodes of uneverything right.</li> <li>An interview was conducted on [DA if nurses were not able to obtain the because PAs are normally in the budehydration and the resident is not provider in the building. The DON aregarding Lasix administration if Refute 9:00 AM Lasix since the Reside the ordered urine specimen.</li> <li>The Administrator was notified of in The facility provided the following control of the noncompliance</li> <li>Resident #294 no longer resides in to altered mental status. The cente</li> </ul>	Indicated that Resident #294's vital signal and respirations 29 at 5:45 PM and heit at 6:23 pm. The progress note indicated of alertness and consciousness), breat sut response bilaterally and no responsing anything for 3 days, and today here it al signs who then emergently called for in which too much acid accumulates iably obtain a pulse oximeter reading. I everything done to sustain his life. After to continue to be full code. They unders at Resident's presentation with altered residencies, and new vasopressor requises cause of death. Resident #294 died are facility Medical Director (MD) on [DA dition and the facility did what they were that when they could not obtain a urine sent out before the IV access was obtarlier the outcome would not have been nued administering Lasix with decrease nation, the MD did not elaborate and here a seident #294 was not drinking adequate and had complained of burning with uring the allegation of immediate jeopardy on [DATE] at 6:04 For eact that all resident was transferred to recognize start all residents have the cognize significant changes in condition and the facility to suffer, a series that all residents have the cognize significant changes in condition and the facility to suffer a series that all residents have the cognize significant changes in condition and the facility.	oxygen saturation: 33 %, and cated Resident #294 presented athing on his own with cold distal e to painful stimuli. Facility stated was found naked by his family and or 911. Resident #294 was found to in the body). Because of his cold Discussion with family revealed r discussion regarding his goals of stood that he was critically ill at that mental status, tachypnea, poor irements, consistent with septic at 8:26 PM on [DATE]. TE] at 4:37 PM. The MD stated he e supposed to do to manage the sample, they ordered an IV access ained. The MD also stated that if any different. When the MD was ed oral intake and inability to obtain e reiterated that the facility did rsing (DON). The DON stated that <i>A</i> they should have notified the PA urses notice any signs of the on call provider if there is no d a discussion with the provider ely on [DATE] before administering ation and they had not obtained PM. by removal: ious adverse outcome as a result

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIE Cary Health and Rehabilitation		A       (X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. Building       COMPLETED         B. Wing       11/22/2024         STREET ADDRESS, CITY, STATE, ZIP CODE       6590 Tryon Road         Cary, NC 27518       contact the nursing home or the state survey agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Sensitivity with Diagnosis of Dysuri obtain urine sample on [DATE] at a was in a dry brief and staff was una resident was prescribed Lasix 20m A quality review of current resident by the Director of Clinical Services residents were identified as having were identified as having a physicia Nursing and Unit Managers to ensu collect urine. The Director of Nursir vital signs (blood pressure, increas lips, poor skin turgor and or altered signs and symptoms of dehydratior No concerns were identified during On [DATE], a root cause analysis v Director regarding staff failure to re necessary medical services to addi decreased fluid intake and signs or an in out catheter. Nursing staff als dehydration. It was determined thro procedures to recognize the seriou obtain necessary medical services 2) Specify the action the entity will outcome from occurring or recurring. The Director of Clinical Services ar signs and symptoms of dehydratior medications, and notify the physica with emphasis on signs and symptor Staff (licensed nurses/ Certified Nu of Nursing and or Unit Manager pri- orientation by the Director of Clinical Services ar symptoms of dehydration and immo-	vas completed by the Director of Clinica cognize the signs and symptoms of de ress an emergent situation for Residen symptoms of dehydration as evidence o continued to administer resident Lasi bugh the root cause analysis that the fa sness of signs and symptoms of dehyd to address an emergency situation. take to alter the process or system failu g, and when the action will be complete in through assessing the resident, obser an to obtain necessary medical service orns of dehydration and continued adm rse Assistants) not educated on [DATE or to working the floor. Newly hired stat al Services and or Unit Managers. and Nurse Managers re-educated certifice ediately report the change in condition ation by the Director of Clinical Service	staff attempted to push fluids and approximately 5:30 AM the resident of Resident #294 orders indicated visicians' orders. DATE] through [DATE] were audited re a urine sample was obtained. No indicate dehydration. 23 residents re audited by the Director of tion as evidenced by the inability to ent residents to include obtaining grature), observation of dry cracked ure no other residents exhibited icated to the physician on [DATE]. al Services and the Executive hydration and then to provide t #294. The resident had d by the inability to collect urine via ix despite signs and symptoms of icility staff failed to follow policy and lration and notify the physician to ure to prevent a serious adverse exercises an emergent situation inistration of diuretics, on [DATE]. E], will be educated by the Director ff will be educated during

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	D		P CODE
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F 0692	On [DATE] the facility's immediate	jeopardy removal was validated by the	following:
Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	by the Director of Nursing/Director residents with an order for UA/C&S orders for UA/C&S with no other re dehydration. The audits also includ as having a physician order to adm evidenced by the inability to collect include obtaining vital signs (blood observation of dry cracked lips, poo other residents exhibited signs and the physician. The facility provided The education information indicated all licensed nurses on [DATE] on h the resident, observation, and char necessary medical services to addh dehydration and continued adminis re-educated licensed nursing staff a (decreased urination, dry mouth, cr mental status, poor skin turgor). Int orientation by the Director of Clinica	n to support immediate jeopardy remov of Clinical Services and Unit Managers if from [DATE] through [DATE] which was sidents identified as having an issue wi ed all residents with orders for diuretics inister diuretics and to ensure no signs urine. The audits also included assess pressure, increased heart rate, oxygen or skin turgor and or altered mental stat symptoms of dehydration that was not documentation on the education they p d that the Director of Clinical Services a ow to recognize signs and symptoms o t review to include medications, and no ress an emergent situation with empha- tration of diuretics. The Director of Clin and nursing assistants on [DATE] on si acked lips, low blood pressure, increas erviews confirmed that newly hired stat al Service and/or Unit Managers. Interv rmation as indicated in immediate jeopa ate of [DATE] was verified.	The audits included all current as revealed nine (9) residents with ith lab collection that would indicate s and 23 residents were identified and symptoms of dehydration as ments of all current residents to a saturation, temperature), tus and chart review to ensure no a addressed and communicated to provided to include sign-in sheets. and Nurse Managers re-educated of dehydration through assessing tify the physician to obtain sis on signs and symptoms of ical Services and Nurse Managers gns and symptoms of dehydration sed heart rate, sunken eyes, altered ff would be educated during riews with nursing staff verified the

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F 0919	Make sure that a working call system is available in each resident's bathroom and bathing area.		
Level of Harm - Minimal harm or potential for actual harm	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38702		
Residents Affected - Few	Based on observation, record review, and Resident and staff interviews, the facility failed to ensure call were plugged into the wall panel for a dependent resident to allow them to call for assistance if needed. deficient practice was for 1 of 30 residents reviewed for accommodation of needs (Resident #6).		
	Findings included:		
	Resident #6 was admitted to the facility on [DATE].		
	The quarterly Minimum Data Set (MDS) dated [DATE] had Resident #6 coded as moderately cognitively impaired with clear speech, she makes herself understood and can understand others. Resident #6 was always incontinent with bowel and bladder.		
	An observation and interview were conducted with Resident #6 on 11/18/2024 at 10:43 AM. Resident #6 wa in her room, in her bed with head of bed elevated. One end of her call bell wire was placed over the top of the bed and the other end with the red button was tied around the bedrail. The call light panel was not visible from the door. Resident #6 was asked if she could use her call bell and if so to call for assistance. The Resident stated she does use her call bell and pushed the red button. The light outside of the Residents room did not light up. The panel behind the Resident's bed was checked to see if the light was on and it did not come on and the plug for the call light was not plugged in. The call bell was wrapped and tied around the resident's bedrail. Resident #6 stated, she used her call bell regularly. The last time she used the call bell was last evening without any issues. Nurse #7 came to Resident #6's room and found the call bell knotted up and tied to the resident's bedrail, she started to untangle the wires and then plugged the wire into the outlet. The resident was asked to push the call light, and the call light came on.		
	An interview with Nurse #7 was conducted on 11/18/2024 at 11:11 AM. The Nurse stated all residents shoul have their call bells within reach and working. The Nurse also stated the last time she came in to check on the resident was an hour ago and the Nursing Assistant (NA)# 4 was giving care to Resident #6's roommate (Resident #10) and thought she would make sure the call bells were working and within reach for the residents.		
	An interview with NA #4 was conducted on 11/18/2024 at 11:34 AM. The NA stated she usually made sure the call bells were within reach before she left the room, and she looked at the panel to make sure it was plugged in. She did not notice if the call bell was plugged in when she left the room. The NA also stated she did not know how it happened. The call bell wire could have come out when Resident #6 raised the head of her bed.		
	staff are trained to place the call be	ursing (DON) was conducted 11/18/202 Il within reach and make sure they plug staff to make sure the Residents call li r rooms.	g into the panel prior to leaving the