

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345233	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/01/2011
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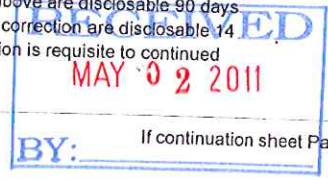
NAME OF PROVIDER OR SUPPLIER SUNRISE REHABILITATION & CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 306 DEER PARK ROAD NEBO, NC 28761
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, family and staff interviews, and medical record review, the facility failed to gain permission from the resident's responsible parties for two (2) of five (5) dependent residents to wear yellow wrist bands designating them at risk for elopement and wandering. (Resident #'s 7 and 10).</p> <p>The findings include:</p> <p>1. Resident #7 was admitted to the facility on 06/04/09 with a diagnosis of anemia, hypertension, Alzheimer's disease and depression. The most recent Minimum Data Set dated 01/12/11 revealed the resident had moderately impaired cognitive skills. He was assessed as having wandering and exit seeking behavior.</p> <p>A review of Resident #7's updated care plan on 04/01/11 revealed a problem of wandering and exit seeking behavior with an approach to place the resident on the yellow alert program to make staff aware of his risk for exiting the facility.</p> <p>On 04/01/11 at 10:15 a.m. Resident #7 was observed wearing a bright yellow bracelet with no writing on it.</p>	F 241	<p>Without admitting or denying the validity or existence of the alleged deficiencies Sunrise Rehabilitation & Care provides the following plan of correction.</p> <p>F 241</p> <p>1. Resident #7 and #10 responsible Parties were contacted and notified of yellow alert program which states that resident is at risk for elopement. Responsible party was asked for permission for resident to wear yellow bracelet and permission was documented by Social Services and placed in the Assessment section of the chart.</p> <p>2. All residents that are identified as at risk for Elopement had their responsible parties contacted and had the yellow alert Program explained to them and permission obtained for resident to wear yellow bracelet and have other yellow identifiers for elopement.</p>	4-13-11
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cynthia J. McConick</i>	TITLE Administrator	(X6) DATE 4-28-11
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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F 241	<p>Continued From page 1</p> <p>An interview was conducted on 03/31/11 at 10:29 a.m. with the Social Services Director. She revealed a risk assessment was done on all residents at the time of admission. She said if a resident was identified as a risk for elopement or wandering then a yellow band was placed on them. Families were notified of residents who have been identified as risks for elopement and told a yellow bracelet had been placed on them to identify them at risk for exiting the facility. The Social Services Director stated she has not gotten families' permission to place the bracelet on the resident and had never considered the need to request permission.</p> <p>An interview was conducted on 04/01/11 12:20 p.m. with marketing and admissions staff. She reported she had informed families that if a resident wanders toward exit doors a yellow alert band had been placed on their wrist or ankle and, if the resident was wheelchair bound, on their wheelchair. The admissions staff stated families were not asked permission to place the bracelet on the resident.</p> <p>An interview was conducted on 04/01/11 at 1:35 p.m. with the Director of Nursing and Administrator. They stated permission to place a yellow bracelet on a resident who has been identified as a risk for elopement should have been requested.</p> <p>An interview on 04/01/11 at 2:52 p.m. was conducted with the responsible party of Resident #7. She stated the facility explained the yellow alert system and they had placed a yellow wrist band on Resident #7 to identify him as an elopement risk. She revealed they had not asked permission to place the yellow band on him.</p>	F 241	<p>3. Nursing staff were in-serviced on 4-13-2011 during nurses meeting the proper steps of placing a resident on yellow alert program. This included gaining responsible parties' permission for resident to wear yellow bracelet.</p> <p>4. ADON/Designee will monitor that yellow alert program guidelines are done correctly for each resident who is placed on program. Will monitor weekly x4, monthly x3 and then quarterly and report findings to the QA committee, monthly x 3 and then quarterly.</p>	4-13-11	

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F 241	<p>Continued From page 2</p> <p>2. Resident #10 was admitted to the facility on 11/01/10 and readmitted on 03/08/11 with a diagnosis of dementia with behaviors, history of wandering, and chronic arthritic pain. The most recent Minimum Data Set dated 03/08/11 revealed the resident had moderate cognitive impairment. He was assessed as having wandering behaviors exhibited one (1) to three (3) days which had worsened compared to previous assessments.</p> <p>A review of Resident #10's care plan, dated 11/01/10 and updated 01/19/11 revealed a problem of a history of wandering with an approach to place the resident on the yellow alert program to make staff aware of his risk for exiting the facility.</p> <p>On 04/01/11 at 10:16 a.m. Resident #10 was observed wearing a bright yellow bracelet with no writing on it.</p> <p>An interview was conducted on 03/31/11 at 10:29 a.m. with the Social Services Director. She revealed a risk assessment had been done on all residents at the time of admission. She said if a resident had been identified as a risk for elopement or wandering then a yellow band had been placed on them. Families were notified of residents who have been identified as risks for elopement and told a yellow bracelet had been placed on them to identify them as a risk for exiting the facility. The Social Services Director stated she had not gotten families' permission to place the bracelet on the resident and had never considered the need to request permission.</p>	F 241			

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F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and	F 323	F 323 1. Resident # 1 is no longer at facility.	4-13-11	

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F 323	<p>Continued From page 4</p> <p>family interviews, the facility failed to prevent one (1) of nine (9) cognitively impaired residents with wandering behaviors from exiting the facility unsupervised. Resident #1 eloped from the facility on 03/26/11 and walked down a hill off of the facility property and across the roadway. Staff located the resident walking up a hill toward a residential dwelling.</p> <p>Immediate Jeopardy began on 03/26/11 when Resident #1 eloped from the facility unsupervised without staff's knowledge. Immediate jeopardy was removed on 04/01/11 at 3:00 p.m. when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put in place and completion of employee education.</p> <p>The findings are:</p> <p>Resident #1 was admitted to the facility on 03/10/11 with diagnoses including dementia. Review of the latest Minimum Data Set (MDS) dated 03/16/11 assessed him as being independent with walking in room and in corridor, having modified independence with cognitive skills for daily decision making and short term memory loss. The MDS further assessed him with exhibiting wandering behaviors which occurred every four to six days, but less than daily and was at risk of wandering to a potentially dangerous place.</p> <p>Review of the Yellow Alert Program dated 02/26/09 which is the facility's policy to address</p>	F 323	<p>2. The Yellow Alert Program dated 02-26-09 which is the policy to identify residents who are at risk for unsafe wandering and or elopement, either per their own choice, or due to impaired cognition/awareness of their actions was reviewed by the facility administration. This policy was updated 4/1/11 to include obtaining permission from the responsible party to utilize the yellow bracelets and dots to identify residents who are at risk for wandering and/or elopement. The Social Worker and MDS Nursing</p> <p>Staff audited all residents and assessed them for risks of elopement on 3/31/11. Care Plans for the residents identified for risk of elopement were updated with the yellow alert program information to alert staff of elopement potential, frequent monitoring to ensure wandering is within safe boundaries of the facility, and monitoring of behaviors which puts a resident at risk for</p>	4-13-11
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F 323	<p>Continued From page 5</p> <p>unsafe wandering and elopement of residents who have been identified to be at risk. Interventions included placement of a bright yellow band on the identified resident's wrist, placement of a yellow dot beside their name on the nameplate of their assigned room and daily monitoring of band placement.</p> <p>Review of the Patient information form (FL-2) completed by Resident #1's physician dated 03/07/11 indicated the resident was constantly disoriented and had wandering behavior.</p> <p>Review of the initial Interdisciplinary Care Plan for Resident #1 dated 03/11/11 did not address the wandering behavior identified on the FL2. The elopement risk score documented on this care plan identified only the resident having dementia and being ambulatory.</p> <p>Review of Nurses Notes written as a late entry on 03/14/11 at 9:00 a.m. indicated Resident #1 was going out the front door of the facility with visitors. Resident #1 was redirected back into the building. Documentation at 1:00 p.m. revealed Resident #1 walked to the end of the South Hall, pulled the fire alarm and exited through the door. A Nursing Assistant (NA) escorted the resident from the outside back into the facility. Documentation at 2:00 p.m. on 03/14/11 revealed Resident #1 walked to the end of the North Hall, pulled the emergency exit and opened the door. Attempts were made by the NA to block the resident from exiting the door and the resident was redirected back into the facility.</p> <p>Review of Nurses Notes dated 03/15/11 at 8:00 a.m. revealed Resident #1 was observed walking to exit doors and attempting to get out. The</p>	F 323	<p>elopement. All current residents' responsible parties were notified on 3-31-11 by telephone or mail to notify nursing staff before assisting any Resident out side. The resident admission packet was updated on 3-31-11 to inform residents and their responsible parties/visitors to check with nursing staff, before assisting any Resident outside.</p>	4-13-11	

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F 323	<p>Continued From page 6</p> <p>resident was also observed trying to get out a window; however a screen was in place to prevent his exiting. Documentation at 7:10 p.m. revealed the Director of Nursing (DON) was notified of Resident #1's attempts to enter the kitchen, increased agitation, and attempts to hit NAs. The Responsible Party (RP) was notified of the resident's behavior. The RP stayed with the resident until he fell asleep the same evening.</p> <p>Review of the Resident Social Progress Note dated 03/16/11 completed by the social worker as a follow up to the admission Social Service History documented, "Resident #1 has been agitated and wanting to leave. He has threatened staff when they try to intervene with him leaving and he has pulled the fire alarm, too"</p> <p>Review of an Elopement Evaluation Screen dated 03/17/11 completed by the MDS coordinator revealed Resident #1 triggered a score of six (6) which placed him at high risk for elopement. Triggers included verbal/non-verbal comments/behaviors, wandering in the last three (3) months, behaviors, independent in ambulation, and diagnoses of dementia. At this time the interim care plan was not updated to reflect the change in assessment.</p> <p>Review of care plan updated and implemented on 03/23/11 identified as a problem, Resident #1 had threatened staff, hit them, pulled the fire alarm and wandered about the facility. Care Plan goals included resident will wander within safe boundaries of facility with interventions to monitor frequently to ensure he wandered within safe boundaries of facility and implementation of "Yellow Alert Program" to alert staff of elopement potential.</p>	F 323	<p>3. All current staff was in-serviced by the QA nurse and/or DON, by 4/1/11. Education included a review of the Elopement and Wandering Program. All new staff will have education on the Elopement and Wandering Program as part of their orientation.</p> <p>4. ADON/Designee will monitor weekly x4, monthly x3 and quarterly to ensure staff aware of exiting behaviors and what yellow alert program is. Also audit will include monitoring risk assessments to ensure if residents are identified at risk for elopement, have they been placed on the yellow alert program, do they need to be on the program, and is the program being followed correctly. Findings will be reported at the QA meeting, monthly x 3 months and the quarterly x 3.</p>	4-13-11	

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F 323	<p>Continued From page 7</p> <p>Review of Nurses Notes dated 03/23/11 at 2:00 a.m. revealed Resident #1 wandering in hallways, pointing to doors and asking if that is the way out. Resident #1 was redirected back to his room.</p> <p>Review of Nurses Notes dated 03/26/11 revealed Resident #1 was medicated a second time for wandering and increased agitation at 12:00 p.m. with Haldol 0.5 milligrams (mg) by mouth. At 12:45 p.m. Licensed Nurse (LN) # 1 documented she was notified that Resident #1 was found across the road going up the driveway of a private residence. The resident was directed back to the facility, the on-call physician and the responsible party was notified.</p> <p>On 03/30/11 at 12:10 p.m. Resident #1's responsible party was interviewed. She stated the resident was admitted to the facility because he had tried to leave the residence four times since moving in with her in December, 2010 and had actually left the house on one occasion and was found 10 minutes away from home. She stated she made the facility aware of his behaviors at the time of his admission.</p> <p>On 03/30/11 at 12:30 p.m. an interview with LN # 1 revealed she medicated Resident #1 at 12:00 p.m. with an as needed (PRN) dose of Haldol 0.5 mg for wandering and agitation. LN#1 also revealed LN #2 and LN #3 notified her at 12:40 p.m. on 3/26/11 Resident #1 had eloped from the facility and was being brought back into the building. LN #1 further revealed prior to the elopement on 03/26/11, Resident #1 would push on a door and if unable to get out would try another door. She stated she would consider these actions to be exit seeking. LN #1 was</p>	F 323			

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F 323	<p>Continued From page 8</p> <p>uncertain when the yellow bracelet was placed on Resident #1.</p> <p>On 03/30/11 at 1:05 p.m. NA#3 was interviewed and indicated the yellow bracelet on a resident's arm is for fall precaution.</p> <p>An interview with NA #4 on 03/30/11 at 3:30 p.m. revealed she was unsure what a yellow alert program meant.</p> <p>An interview with the DON on 03/30/11 at 2:40 p.m. revealed the facility did not provide staff education related to elopement after Resident #1 eloped. The DON stated staff from all shifts was informed of the elopement of Resident #1 and to "monitor him."</p> <p>An interview on 03/30/11 at 2:44 p.m. with NA#1 assigned to Resident #1 on 03/26/11 revealed he looked for the resident to take him to the dining room for lunch. When he was unable to locate the resident he notified the nurse and started searching. NA#1 stated he went out to the back parking lot and saw the resident on an embankment in front of a big house across the road from the facility. NA #1 stated the weather was a little cool, foggy and drizzling rain. He acknowledged the resident was wearing a light weight jacket. Resident #1 was assisted back into the facility, vital signs were taken and "evening staff kept a close eye on him." NA#1 further revealed the yellow wrist band meant fall risk.</p> <p>On 03/30/11 at 3:10 p.m. an interview with NA#2 revealed on 3/26/11 prior to Resident #1 leaving the facility, she noticed the resident packing his things, saying he was going to leave and asking for the directions to Black Mountain.</p>	F 323			

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F 323	Continued From page 9 An interview with LN #2 on 03/31/11 at 10:15 a.m. revealed a visitor walked by her while she was at the medication cart on the 100 hall and said "I think one of your residents has gone out the door and looks like he is going to the house across the road". LN# 2 called for assistance to bring Resident #1 back into the building. Following the interview an observation was made with LN#2 from the door where the resident was presumed to have exited to the area where Resident #1 was found. The distance from the facility was approximately 370 paces. The resident crossed the road near a blind curve, walked up the driveway of a residential dwelling, and was found behind the dwelling. On 03/31/11 at 10:37 a.m. an interview with the MDS Coordinator, revealed on admission resident information was obtained from the medical record, FL2 form and family to complete the initial interdisciplinary care plan. The MDS coordinator also revealed a second elopement screen was completed on 03/17/11 as part of the MDS completion and Resident #1 scored six (6) which placed him at high risk for elopement. Resident #1's care plan was updated on 03/23/11 to include Yellow Alert Program. The Administrator was notified of the Immediate Jeopardy on 03/31/11 at 10:53 a.m. The facility provided a credible allegation of compliance on 04/01/11 at 3:00 p.m. The following interventions were put into place by the facility to remove the Immediate Jeopardy: Resident #1 was returned to the facility	F 323			

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F 323	<p>Continued From page 10</p> <p>accompanied by staff at 12:40 p.m. A head to toe assessment was completed on Resident #1 by a Licensed Nurse on return to the facility at 12:40 p.m. on 03/26/11. The assessment included vital signs, skin assessment and assessment of extremities for fractures. The findings included stable vital signs, no bruising, skin tears or fractures. A visual checklist and one on one observation of the resident was implemented on 03/26/11 at 12:40 p.m. to monitor Resident #1's whereabouts and activities. Visual checks were done and documented every thirty minutes beginning 03/26/11 at 12:40 p.m. and ending 03/27/11 at 11:30 a.m. Resident #1's on call physician was notified at 12:45 p.m. on 03/26/11. Resident #1's Responsible Party was notified at 12:50 p.m. on 03/26/11 and she came to the facility at 4:00 p.m. and sat with him until 5:30 p.m. Beginning 03/27/11 at 12:30 p.m., and ending 03/30/11 at 3:00 p.m., hourly visual checks which included the resident's whereabouts and activities were performed. Resident #1 was discharged to a facility with a secured unit on 03/30/11 at 3:00 p.m.</p> <p>Additional corrective actions taken by the facility included:</p> <ul style="list-style-type: none"> On 30/28/11 at 7:00 a.m., a sign located next to the key pad by the front entrance door requesting visitors to see a nursing staff member before letting a resident out the door was removed and placed directly on the door. The sign was revised which included an increase in front size and bold print for easier visualization. The revised signs were placed on all visitor entry doors on 03/31/11 at 3:30 p.m. 	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345233	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/01/2011
NAME OF PROVIDER OR SUPPLIER SUNRISE REHABILITATION & CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 306 DEER PARK ROAD NEBO, NC 28761		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	Continued From page 11 <ul style="list-style-type: none"> The Yellow Alert Program dated 02/26/09 which is the policy to identify residents who are at risk for unsafe wandering and/or elopement, either per their own choice or due to impaired cognition/awareness of their actions was reviewed by the facility administration on 04/01/11. This policy will be updated to include obtaining permission from the responsible party to utilize the yellow bracelets and placement of yellow dots on the resident's door to identify residents who are at risk for wandering and/or elopement. On 03/31/11 the Social Worker and MDS Nursing Staff audited all residents and assessed them for risks of elopement. The audit revealed two residents that were no longer at risk for elopement. One resident triggered one positive response but this did not put him at risk. Residents that are currently on the Yellow Alert Program which entails placement of a yellow bracelet on resident, picture in yellow alert notebook along with the policy on yellow alert. Notebooks are located at each nursing station and in the front office for staff access. A yellow dot is placed beside the resident's name on the name plate outside of the resident's room which identifies the resident is at risk for unsafe wandering and/or elopement. Care Plans for the residents identified for risk of elopement were updated with the Yellow Alert Program information to alert staff of elopement potential, frequent monitoring to ensure wandering is within safe boundaries of the facility and monitoring of behaviors which puts a resident at risk for elopement. Care Plans updated and revised on 03/31/11. 	F 323			

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NAME OF PROVIDER OR SUPPLIER SUNRISE REHABILITATION & CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 306 DEER PARK ROAD NEBO, NC 28761		
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F 323	<p>Continued From page 12</p> <ul style="list-style-type: none"> All current staff will be in-serviced by the QA nurse and/or DON by 04/01/11. For any staff members unable to complete the education by 04/01/11 will be required to complete the education prior to returning to work. Education will include a review of the Elopement and Wandering Program. Key points of the education module include assessment of residents behaviors associated with wandering and/or elopement, process to report behaviors and implementation of interventions to help prevent chances of elopement. Interventions include a photo in a notebook, yellow bracelet placed on resident, yellow dot on name plate and information placed inside the resident's closet doors. All new staff will have education on the Elopement and Wandering Program as part of their orientation beginning 04/01/11. All current residents' responsible parties were notified on 03/31/11 by telephone or mail to notify nursing staff before assisting any resident outside. The resident admission packet was updated on 03/31/11 to inform residents and their responsible parties/visitors to check with nursing staff before assisting any resident outside. <p>On 04/01/11, staff which included nursing, housekeeping, and dietary from all shifts were interviewed and confirmed they had received in-service training on the Yellow Alert Program, the use of yellow bracelet, on residents who were at risk for exit seeking behaviors and on procedures to implement if a resident eloped from the facility. Visual confirmation was made on 04/01/11 that a sign was placed on all entry doors requesting visitors to check with nursing staff before letting a resident out. Visual confirmation was made on other residents identified to be at</p>	F 323			

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F 323	Continued From page 13 risk for elopement for update of care plan, placement of yellow bracelet, yellow dot on resident's door name plate and information documented in the notebooks. Medical record review revealed all residents had been assessed with the elopement risk assessment tool and the facility had identified one resident with one positive response, which did not put the resident at risk. The audit further revealed two residents that were no longer at risk for elopement. A sample of Responsible Parties of the residents identified to be at risk for elopement were interviewed and confirmed the facility had notified them of their family member's risk assessment and implementation of the Yellow Alert Program.	F 323			