PRINTED: 04/07/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345077	B. WING _	 		03/09/2017
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZI 25 SUNNYBROOK ROAD RALEIGH, NC 27610	•	
(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 (EACH CORRECTIVE A CROSS-REFERENCED 1 DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 272 SS=E			F 2	772		3/31/17
	(1) Resident Assessimust make a compre resident's needs, stre preferences, using the instrument (RAI) speciassessment must incomplete (ii) Identification and (ii) Customary routin (iii) Cognitive pattern (iv) Communication. (v) Vision. (vi) Mood and behave (vii) Psychological were (viii) Physical fun problems. (ix) Continence. (x) Disease diagnos (xi) Dental and nutrit (xii) Skin Conditions. (xiii) Activity purs (xiv) Medications (xv) Special treatment (xvi) Discharge proposed (xvii) Documentating (xvii) Documentating (xviii) Documentating (xviii) Documentating (xviiii) Documentating (xviiiiii) Documentating (xviiiiiiiii) Documentating (xviiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	ment Instrument. A facility hensive assessment of a engths, goals, life history and e resident assessment cified by CMS. The lude at least the following: d demographic information ne. ns. rior patterns. ell-being. retioning and structural is and health conditions. ional status. suit this and procedures. lanning. tion of summary information nal assessment performed triggered by the completion				
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUF	PE	TITLE		(X6) DATE

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

03/30/2017

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.

Electronically Signed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345077				03/09/2017	
	ROVIDER OR SUPPLIER	ON CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 25 SUNNYBROOK ROAD RALEIGH, NC 27610	•		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 272	on all shifts. The assessment probservation and coas well as communicating sormal shifts. This REQUIREME by: Based on record of facility failed to consummaries which it risk factors, and fare developing individual for 10 of 13 sample #22, #63, #100, #1 and #229) with consumeries which it risk factors, and fare developing individual for 10 of 13 sample #22, #63, #100, #1 and #229) with consumeries included the findings included the findings included the findings of the communicating sormal factors are sampled there was completed and the section did not indigathered, the under the section and communication in the section did not indigathered, the under the section and communication in the section did not indigathered, the under the section did not indigathered, the under the section did not indigathered.	rocess must include direct ommunication with the resident, nication with licensed and a care staff members on all NT is not met as evidenced eview and staff interviews, the included underlying causes, ctors to be considered in interventions ed residents (Residents #6, 62, #165, #183, #209, #224 inprehensive assessments. Ided: I was admitted to the facility on gnoses included expressive and diabetes mellitus. I with the resident had difficulty with me thoughts, had a ed, therapeutic diet, and had a	F 2	F272 1. Corrective action for the raffected by the alleged deficinew comprehensive assess completed by the MDS Cooresidents 6,22,63,100,162,165,183,20 229 using the newly added Comprehensive Assessmen provided in Point Click Carefacility's Electronic Medical Isoftware. The CAA tool bein reflective of appendix C in the manual. No negative outcon identified from the alleged dipractice. 2. Corrective action taken for residents having the potential affected by the alleged defining the potential affected by the alleged defining the potential interdisciplinary team meresponsible for completing the assessment (Members inclusive Coordinators, Social Worket Director, and the Dietician.) 3. Systemic measure implering the potential affected by the alleged defining the potential affected by the alleged defining the potential assessment (Members inclusive Coordinators, Social Worket Director, and the Dietician.)	cient practice: ciment will be rdinator for 09,224, and at Tool (CAA) c (PCC) the Records ng utilized is he RAI mes were deficient or those al to be cient practice: eing utilized by embers the MDS ude the MDS r, Activities		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING				(X3) DATE SURVEY COMPLETED	
				0	3/09/2017		
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	•		
		051155		25 SUNNYBROOK ROAD			
SUNNYBR	ROOK REHABILITATION	CENTER		RALEIGH, NC 27610			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 272	Continued From pag	e 2	F 27	72			
F 2/2	1a. The Communica 02/02/17) stated, "Re needs known simply identifying objects. Owhen it was in her haunderstood that she ask for assistance. Fnoted that resident is illness." The MDS Coordinate #1) was interviewed regarding the lack of guiding the review of Coordinator/Supervisassessment tool in the 1b. The Nutrition CA stated, "[Resident #2 Mass Index) due to rexceeding caloric exbe desirable. Receiv diagnosis DM (diabe mechanically altered The Registered Dieti 03/09/17 at 9:50 AM assessment tool for Nutrition for resident stated "I answer bas indicated that after retriggered the Nutritio to writing her analysi should be included in	tion CAA Analysis (dated esident is able to make her but has noted confusion in could not identify call light and, but knew and needs to use the call light to amily states that they have a more confused than prior to or/Supervisor (MDS Nurse on 03/09/17 at 9:40 AM an assessment tool for a triggered areas. The MDS for stated there wasn't an ine facility's current software. A Analysis dated 01/28/17 and (history) caloric intake penditure, weight loss would ing therapeutic diet due to tes mellitus) and diet due to dysphagia."	F 21	ensure alleged deficient pra reoccur: CAA tool was adde users are required to compl tool along with the MDS ass members of the Interdiscipli have who are responsible for the CAA have been in-servi 3/10/2017 by the Regional I using the tool for MDS accuprocess compliance. These members include both MDS the Social Worker, the Dieti Activities Director. 4. Monitoring to ensure the deficient practice does not recoordinator will use CAA CAUGIT Form to verify the use tool in completion of all resicomprehensive assessmen will be performed for all con assessments X 4 weeks, 10 assessments weekly X 4 were 10 random assessments meyear. All results will be reported Quality Assurance Committed continued monitoring and in 5. Compliance Date: 3/31/2	ed to PCC and lete the CAA sessments. All inary Team or completing ded on MDS Nurse for uracy and RAI team S Coordinators, cian, and the alleged reoccur: MDS completion of the CAA dents' ts The audit inprehensive or random eeks and then conthly X one wred to the ee for inprovement.		
	Administrator indicat tool was an oversigh	ed the lack of an assessment t and that corrective action ne corporation. She stated it					

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345077	B. WING		0	3/09/2017	
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 25 SUNNYBROOK ROAD RALEIGH, NC 27610			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 272	2. Resident #224 wa 02/05/17. The diagn behaviors, symbolic failure (CHF), cerebracute renal failure and The admission Minin 02/12/17, indicated to repleasure in doing therapeutic diet. Review of the Care Arevealed there was recompleted and then section did not indicagathered, the underly necessary referrals results. The Psychosocial (dated 02/14/17) starshort-term rehab and activities due to focults.	that staff use a CAA te the assessment process. Is admitted to the facility on toses included dementia with dysfunction, congestive heart ral vascular accident (CVA), and Vitamin D deficiency. Inum Data Set (MDS) dated the resident had little interest things, and received and Area Assessments (CAA) to assessment tool arrative in the Analysis ate how the information was aying causes, risk factors or regarding care for Resident al Well Being CAA Analysis ted, "Resident is here for d is not interested right now in	F 21				
	at 9:32 AM, regardin tool for guiding the re Being for this resider she would click on the went straight to writing she never had training worksheet.	g the lack of an assessment eview of Psychosocial Well of the North Social Worker said the worksheet tab but then ong the analysis. She stated on anything else, like a A Analysis dated 02/07/17					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345077	B. WING _			03/09/2017	
	ROVIDER OR SUPPLIER	CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 25 SUNNYBROOK ROAD RALEIGH, NC 27610	Ē		
(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 COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 272	Continued From pag	e 4	F 2	72			
	fibrillation, CHF." The Registered Dieti 03/09/17 at 9:50 AM assessment tool for g Nutrition for residents stated "I answer bas- indicated that after re- triggered the Nutritio to writing her analysi should be included in During an interview of Administrator indicate tool was an oversigh had been taken by th was her expectation worksheet to comple	s. The Registered Dietician ed on what triggered." She eviewing the item that had in CAA, she would go directly is and had no training in what in the Care Area assessment. on 03/09/17 at 4:04 PM, the ed the lack of an assessment it and that corrective action ne corporation. She stated it					
	vascular disease (P\ (ESRD), and diabete	oses included peripheral /D), end-stage renal disease is mellitus (DM). the knee amputation (AKA), a seessment was completed.					
	The Significant Char 01/24/17, indicated to	ge assessment dated he resident had a body mass eiving a therapeutic diet and					
	stated, "[Resident #2 (history) caloric intak expenditure, s/p (stat loss would be desirated diet due to diagnose:	tus post) left AKA, weight ble. Receiving therapeutic					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		345077	B. WING _		_	03/0	9/2017
	ROVIDER OR SUPPLIER	CENTER	·	STREET ADDRESS, CITY, ST/ 25 SUNNYBROOK ROAD RALEIGH, NC 27610	ATE, ZIP CODE		
(X4) ID PREFIX TAG			ID PREFIX TAG	((EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 272	Continued From page	ə 5	F 2	272			
	dysphagia reported, regular consistency."	patient stated consuming					
	03/09/17 at 9:50 AM, assessment tool for g Nutrition for residents stated "I answer base indicated that after re triggered the Nutrition to writing her analysis should be included in During an interview of Administrator indicated tool was an oversight had been taken by the worksheet to complet 4a. Resident #63 was 10/24/16 and had a disymbolic dysfunction. The Admission Minimal Assessment dated 10 had moderate cognition.	is. The Registered Dietician and on what triggered." She eviewing the item that had in CAA, she would go directly and had no training in what in the Care Area assessment. In 03/09/17 at 4:04 PM, the end the lack of an assessment and that corrective action are corporation. She stated it that staff use a CAA are the assessment process. It is admitted to the facility on the liagnosis of dementia and (communication problem). In Data Set (MDS) 10/31/16 noted the resident we impairment.					
	Loss/Dementia dated scored lower than no for Mental Status test did not list the resider causes, contributing to CAA was signed as continuous contributions of the causes	issment (CAA) for Cognitive I 11/9/16 noted the resident rmal on the Brief Interview to due to confusion. The CAA int's diagnoses, underlying factors or risk factors. The completed by MDS Nurse #2. Inducted on 3/9/17 at 9:46 AM who stated the social worker initive loss/dementia.					
		ated in an interview on at she did the resident ' s					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		345077	B. WING _			03/09/2017
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, S 25 SUNNYBROOK ROAD RALEIGH, NC 27610	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	(EACH CORRE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIAT DEFICIENCY)	
F 272	Worker further stated	e 6 ss/dementia. The Social d she had not received rite a care area assessment.	F2	272		
	an interview it was haccurate and the car	M the Administrator stated in er expectation the MDS be e area assessments reflect s. The Administrator further ded more training.				
	10/24/16 and had a d symbolic dysfunction and urinary tract infe The Admission Minin Assessment dated 1 had moderate cognit	num Data Set (MDS) 0/31/16 noted the resident ive impairment, required for toileting and was				
	Incontinence dated of received care with all staff and was inconting daily. The CAA further become more independent of the rapy. The CA diagnoses, underlying factors or risk factors	In the session of the				
	9:46 AM, the MDS N aware of a tool to be The MDS Nurse stat just showed the trigg triggered and then w	MDS Nurse #2 on 3/9/17 at lurse stated she was not used to complete the CAAs. ed their computer program lers at the top and then why it e go to the analysis of the lurse stated she had been ints for 4 months.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345077	B. WING			3/09/2017	
	ROVIDER OR SUPPLIER	N CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 25 SUNNYBROOK ROAD RALEIGH, NC 27610	•		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 272	an interview it was haccurate and the cathe resident 's statuthey had a turnover needed more training. 5a. Resident #100 will 1/12/17 and had a contract infection and not tract infection and not assessment dated assessment dated assevere cognitive implies Cognitive Loss/Demonstrate for more training and the complete for the complete for more training and the complete for the complete for more training and the complete for the complete f	M the Administrator stated in her expectation the MDS be re area assessments reflect its. The Administrator stated in staff and their MDS staffing. It was admitted to the facility on diagnosis of dementia, urinary eurogenic bladder. In the MDS staffing is admitted to the facility on diagnosis of dementia, urinary eurogenic bladder. In the MDS is admitted to the facility on diagnosis of dementia, urinary eurogenic bladder. In the MDS is admitted to the facility on diagnosis of dementia, urinary eurogenic bladder. In the MDS is admitted to the facility on diagnosis of dementia, urinary eurogenic bladder. In the MDS is admitted to the facility on diagnosis of dementia, urinary eurogenic bladder. In the MDS is admitted to the facility on diagnosis of dementia, urinary eurogenic bladder. In the MDS is admitted to the facility on diagnosis of dementia, urinary eurogenic bladder. In the MDS is admitted to the facility on diagnosis of dementia, urinary eurogenic bladder. In the MDS is admitted to the facility on diagnosis of dementia, urinary eurogenic bladder. In the MDS is admitted to the facility on diagnosis of dementia, urinary eurogenic bladder. In the MDS is admitted to the facility on diagnosis of dementia, urinary eurogenic bladder.	F 2'				
	On 3/9/17 at 1:52 P an interview it was h accurate and the ca the resident 's statu	M the Administrator stated in her expectation the MDS be re area assessments reflect is. The Administrator stated in staff and their MDS staff					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345077	B. WING		03/09/2017		
	ROVIDER OR SUPPLIER	N CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 25 SUNNYBROOK ROAD RALEIGH, NC 27610			
(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 SHOUL) CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE COMPLETION		
F 272	1/12/17 and had a contract infection and not tract infection and not tract infection and not a urinary catheter and assistance for toiletic. The Care Area Assessistance for Urinary Incontine admitted to the facily hospital for altered not indwelling urinary catract infections. The sidiagnoses, under factors or risk factor. In an interview with 9:46 AM, the MDS Now aware of a tool to be the MDS Now aware of a tool to be the MDS Now at the trighting and then with the findings. The MDS I doing the MDS assessing the man and the man	was admitted to the facility on diagnosis of dementia, urinary leurogenic bladder. mum Data Set (MDS) 1/12/17 noted the resident had not required extensive ing and personal hygiene. essment (CAA) dated 1/19/17 ence noted the resident was ity after admission to the mental status and had an atheter with a history of urinary e CAA did not list the resident ' ying causes, contributing as of the urinary catheter. MDS Nurse #2 on 3/9/17 at Nurse stated she was not e used to complete the CAAs. Ited their computer program gers at the top and then why it we go to the analysis of the Nurse stated she had been essments for 4 months.	F 272	, , , , , , , , , , , , , , , , , , ,			
	an interview it was haccurate and the cathe resident 's statuthey had a turnover needed more training. 6. Resident #162 was	M the Administrator stated in the mer expectation the MDS be are area assessments reflect us. The Administrator stated in staff and their MDS staffing. as admitted to the facility on diagnosis of cerebrovascular					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SU IDENTIFICATIO		IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345077	B. WING		03/09/2017
NAME OF PROVIDER SUNNYBROOK F		N CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 25 SUNNYBROOK ROAD RALEIGH, NC 27610	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
The A Asse was antipe days The O Psych reside medical diagration of the residence of the r	Admission Minit sement dated 2 cognitively intact sychotic and arrof the 7 day as Care Area Assent of the CA coses, underlying or risk factor awas no informaking an antips and cation had interview with AM, the MDS Nurse state of a tool to be MDS Nurse state and the triggered and then vigs. The MDS Note of a tool to be MDS assent of the MDS assent	mum Data Set (MDS) 2/28/17 revealed the resident ct and received an ntidepressant medication for 7 seessment period. Passessment period. Passessment (CAA) for Use dated 3/2/17 noted the an antidepressant A did not list the resident 's ng causes, contributing Is of psychotropic drugs. Ination in the CAA the resident Is sychotic medication or why Is been ordered for the resident. MDS Nurse #2 on 3/9/17 at Is stated she was not at used to complete the CAAs. It is their computer program Is gers at the top and then why it Is go to the analysis of the Is syments for 4 months. M the Administrator stated in Inter expectation the MDS be are area assessments reflect Is. The Administrator stated in staff and their MDS staff	F 27	2	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	' '	(X3) DATE SURVEY COMPLETED	
		345077	B. WING _			03/09/2017
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 25 SUNNYBROOK ROAD RALEIGH, NC 27610	•	
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 272	F 272 Continued From page 10		F 2	72		
	dated 3/6/17 noted the pressure ulcer to the relieving device for the would receive weekly not list the resident 'causes, contributing pressure ulcer. The Admission Minin Assessment that was resident was cognitive extensive assistance and toileting. The Micoccasionally incontinincontinent of bowel. resident was admitte III pressure ulcer. In an interview with Micocasion and the micontinent of bowel.	s in progress noted the rely intact and required with bed mobility, transfers DS revealed the resident was ent of urine and frequently. The assessment noted the d to the facility with a stage. MDS Nurse #2 on 3/9/17 at urse stated she was not				
	The MDS Nurse state just showed the trigg triggered and then w findings. The MDS N	used to complete the CAAs. ed their computer program ers at the top and then why it e go to the analysis of the urse stated she had been essments for 4 months.				
	an interview it was he accurate and the car the resident's status	If the Administrator stated in the expectation the MDS be area assessments reflect in the Administrator stated in staff and their MDS staff it.				
		s admitted to the facility on gnosis of peripheral vascular gia.				

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345077	B. WING _		,	03/09/2017	
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 25 SUNNYBROOK ROAD RALEIGH, NC 27610			
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 272	Continued From pag	e 11	F 2	72			
	An admission nurse PM read: "Missing al	s note dated 6/9/16 at 8:41 upper teeth."					
	resident had any der trigger the dental car therefore a dental ca completed. On 3/9/17 at 1:52 PN interview the MDS w no longer worked at stated the MDS shou resident had missing	/30/16 did not indicate the stal problems and did not e area assessment, re assessment was not //, MDS Nurse #2 stated in an as completed by a nurse that the facility. The MDS Nurse					
	an interview it was haccurate and the car the resident 's status 9. Resident #183 wa 10/14/16 and re-adm diagnosis including I The Admission Minin 10/21/16 revealed th	s admitted to the facility on litted on 2/10/17 with Depressive disorder. num Data Set (MDS) dated e resident was cognitively					
	The Care Area Asses Psychotropic Drug U resident was taking a medication. The CAA diagnoses, underlyin factors or risk factors	n antidepressant medication ay assessment period. ssment (CAA) Summary for se dated 10/21/16 noted the an antidepressant A did not list the resident's g causes, contributing of anti-depressant drugs, sons or referrals to other					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		345077	B. WING _			03/09/2017	
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 25 SUNNYBROOK ROAD RALEIGH, NC 27610	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 272	Continued From pag	e 12	F 2	72			
	-	lan reveled Resident #183 ant medication related to a sion.					
	9:46 AM, the MDS N aware of a tool to be The MDS Nurse statijust showed the trigg triggered and then w findings. The MDS N doing the MDS assess. On 3/9/17 at 1:52 PN an interview it was he accurate and the car	MDS Nurse #2 on 3/9/17 at urse stated she was not used to complete the CAAs. ed their computer program ers at the top and then why it e go to the analysis of the urse stated she had been esments for 4 months. If the Administrator stated in er expectation the MDS be e area assessments reflect is. The Administrator stated					
	needed more training 10. Resident #6 was 7/6/16 and re-admitte	admitted to the facility on ed on 12/29/16 with Schizoaffective disorder and					
	8/10/16 revealed the intact and received a	n Data Set (MDS) dated resident was cognitively n antidepressant medication by assessment period.					
	Psychotropic Drug U resident was taking a medication. The CAA diagnoses, underlyin factors or risk factors	esment (CAA) Summary for se dated 8/10/16 noted the an antidepressant A did not list the resident's g causes, contributing of anti-depressant drugs, ons or referrals to other					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345077	B. WING			03/	09/2017
	ROVIDER OR SUPPLIER	CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 5 SUNNYBROOK ROAD RALEIGH, NC 27610	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 272	Continued From page		F	272			
F 278 SS=D	an antidepressant mediagnosis of Depress In an interview with M 9:46 AM, the MDS No aware of a tool to be The MDS Nurse state just showed the trigger triggered and then we findings. The MDS No doing the MDS assess On 3/9/17 at 1:52 PM an interview it was he accurate and the care the resident 's status they had a turnover in needed more training 483.20(g)-(j) ASSESS ACCURACY/COORD (g) Accuracy of Assess must accurately reflect (h) Coordination A registered nurse meach assessment with participation of health (i) Certification (1) A registered nurse the assessment is could be accurated to the coordination (2) Each individual with the state of the coordination (3) A registered nurse the assessment is could be accurated to the coordination (4) A registered nurse the assessment is could be accurated to the coordination (5) Certification (6) Certification (7) A registered nurse the assessment is could be accurated to the coordination (1) A registered nurse the assessment is could be accurated to the coordination (1) A registered nurse the assessment is could be accurated to the coordination (1) A registered nurse the assessment is could be accurated to the coordination (2) Each individual with the coordination (3) A registered nurse the accurated to the coordination (4) A registered nurse the coordination (5) A registered nurse the coordination (6) A registered nurse the coordination (7) A registered nurse the coordination (7) A registered nurse the coordination (8) A	ion. IDS Nurse #2 on 3/9/17 at urse stated she was not used to complete the CAAs. and their computer program ers at the top and then why it ago to the analysis of the urse stated she had been sments for 4 months. I the Administrator stated in the expectation the MDS be a area assessments reflect a staff and their MDS staff. IMATION/CERTIFIED ISSMENT INATION/CERTIFIED INATION/CERTIFIED ISSMENT INATION/CERTIFIED INATION/CERTIFIED	F	278			3/31/17

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345077	B. WING		03/09/2017	
	ROVIDER OR SUPPLIER	N CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 25 SUNNYBROOK ROAD RALEIGH, NC 27610		1 00.00.20	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 278	Continued From pa	ge 14	F 278	3		
	(j) Penalty for Falsifi (1) Under Medicare who willfully and kno	and Medicaid, an individual				
	resident assessmen	al and false statement in a t is subject to a civil money than \$1,000 for each				
	and false statement	individual to certify a material in a resident assessment is ney penalty or not more than essment.				
	material and false so This REQUIREMEN by:	T is not met as evidenced		F278		
	facility failed to accu Data Set (MDS) in the (Resident #162), an	views and record review, the rately code the Minimum ne areas of active diagnoses d dental status (Resident impled residents reviewed for		1. Corrective action for the residents affected by the alleged deficient pract Resident #162 was discharged from the facility on 3/21/2017. A correction was done to the resident's MDS assessment.	the s	
		s admitted to the facility on		to include the diagnosis of Bipolar Disorder. Resident #165 MDS Assessment was reviewed by the MD	os e	
	The hospital dischart Seroquel (antipsych every night at bedtir Remeron (antidepressedtime for depress	iagnosis of Bi-Polar Disorder. rge medications included otic) 300mg (milligrams) ne for bi-polar disorder and ssant) 45mg every night at ion. These orders were rebruary 2017 Medication ord in the facility.		2. Corrective action taken for those residents having the potential to be affected by the alleged deficient pract The MDS Coordinator will cross check residents assessment for accuracy be transmission. Every resident assessment will be cross checked for accuracy us the Accuracy Tool for 4 weeks, then a	tice: ck the efore nent sing	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345077	B. WING _			03/	09/2017
	ROVIDER OR SUPPLIER	CENTER		25	TREET ADDRESS, CITY, STATE, ZIP CODE 5 SUNNYBROOK ROAD ALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	revealed the resident and an antipsychotic the 7 day assessmer Section I of the MDS had any psychiatric portion of the MDS had any psychiatric portion of the MDS had any psychiatric portion of the MDS nurse #2 with MDS nurse stated should be section I of the MDS o	num Data Set (MDS) (28/17 under section N (28/17 under esident medicate the resident medication for 7 days during the following of the section of the s	F	2278	random sample of 10 residents x 4 weeks, then 10 random assessments monthly X one year. Both MDS Coordinators were in-serviced by the the Regional MDS Nurse on 3/10/2017 concerning the importance of accurate completion of the residents' assessment and RAI process compliance. 3. Systemic measure implemented to ensure alleged deferment practice doe not reoccur: The MDS Coordinator will cross check the residents assessment accuracy before transmission. Every resident assessment will be cross checked for accuracy using the Accuration for 4 weeks, then a random sample of 10 residents x 4 weeks, then 10 random assessments monthly X one year. 4. Monitoring to ensure the alleged deficient practice does not reoccur: The Resident Care Director will use the MDAccuracy Audit Form on 10 random assessments weekly X 4 weeks and the monthly X one year. All results will be reported to the Quality Assurance Committee for continued monitoring an improvement. 5. Compliance Date: 3/31/2017	nts s for cy le	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345077	B. WING		03/09/2017		
	ROVIDER OR SUPPLIER ROOK REHABILITATION	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 25 SUNNYBROOK ROAD RALEIGH, NC 27610			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE COMPLETION		
F 279 SS=D	483.20 (d) Use. A facility must assessments complements in the resider results of the assess and revise the resider plan. 483.21 (b) Comprehensive Comprehensive perseach resident, consiste the resident, consister forth at §483.10(includes measurable to meet a resident's and psychosocial necomprehensive assecare plan must describe and psychosocial necomprehensive assecare plan must describe in the resident or maintain the resident of the resident o	care Plans Care Plans Care Plans Care Plans develop and implement a con-centered care plan for stent with the resident rights c)(2) and §483.10(c)(3), that objectives and timeframes medical, nursing, and mental eds that are identified in the ssment. The comprehensive ribe the following - are to be furnished to attain ent's highest practicable of psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ding the right to refuse 3.10(c)(6).	F 27	9	3/31/17		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345077	B. WING		03/09/2017	
	ROVIDER OR SUPPLIER	I CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 25 SUNNYBROOK ROAD RALEIGH, NC 27610		, 33,33,201	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 279	Continued From pag	e 17 .RR, it must indicate its	F 2	79		
	_	ent's medical record.				
	(iv)In consultation with the resident and the resident's representative (s)-					
	(A) The resident's go desired outcomes.	oals for admission and				
	future discharge. Far whether the resident community was asse	reference and potential for cilities must document is desire to return to the essed and any referrals to es and/or other appropriate ose.				
	plan, as appropriate requirements set for section. This REQUIREMEN	in the comprehensive care in accordance with the th in paragraph (c) of this T is not met as evidenced				
	facility failed to inclu- indwelling urinary ca comprehensive care	view and staff interviews the de the care of a resident 's theter in the resident 's plan for 1 of 2 residents catheters (Resident #100).		1. Corrective action for the reside affected by the alleged deficient president #100 was discharged from 1/16/2017, therefore the standard No.	practice: rom the le care	
	1/12/17 and had diag dementia, urinary tra	admitted to the facility on gnoses that included act infection (UTI), and with chronic use of an theter.		plan could not be updated. No ne outcomes were identified from th deficient practice. 2. Corrective action taken for the residents having the potential to affected by the alleged deficient.	e alleged se be	
	1/16/17 noted the re for signs and sympto	nprehensive Care Plan dated sident continued to be at risk oms of recurrent UTIs. The taff to assist with peri-care		affected by the alleged deficient The MDS Coordinator reviewed a updated all care plans for the res with Foley catheters on 3/8/2017 plans are current and appropriate	and sidents . All care	

AND BLAN OF CORRECTION INTEREST INCIDENTIFICATION NUMBERS		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345077	B. WING _			03	/09/2017
NAME OF P	ROVIDER OR SUPPLIER		•		DDRESS, CITY, STATE, ZIP CODE	•	
SUNNYBR	OOK REHABILITATION	CENTER			BROOK ROAD I, NC 27610		
04004	CLIMMADY	FATEMENT OF DEFICIENCIES		KALEIGH,	·	ON	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 279	Continued From pag	e 18	F 2	79			
		vel incontinence. There was Care Plan that the resident		update	ed.		
	had an indwelling uri of a urinary catheter.	nary catheter or of the care		ensure	stemic measure implemented to be alleged deferment practice of coccur: All residents with Foley	loes	
		num Data Set (MDS)			ters will be reviewed and the c		
		/19/17 revealed the resident			updated appropriately in week	kly	
		impairment, was not extensive assistance for		locus	meetings X one year.		
	toileting and personal hygiene, was incontinent of			4. Mor	nitoring to ensure the alleged		
	bowel and had an inc	dwelling urinary catheter.		deficie	ent practice does not reoccur:	Foley	
				I	ter care plans for all residents		
	The Care Area Asses				catheters will be reviewed and	d	
		ing Urinary Catheter dated sident had an indwelling			ted to the Quality Assurance mittee quarterly for one year fo	r	
		a history of UTIs. The		I	nued monitoring and improvem		
		d the urinary catheter would					
	be care planned.			5. Cor	mpliance Date: 3/31/2017		
		onal information added to the					
	indwelling urinary ca	n regarding the care for an theter.					
	with MDS Nurse #2 v the assessment and #100. The MDS Nurs was overlooked on the Nurse further stated nursing assistants was	are Plan and did not include					
F 520	an interview she exp to be care planned a assessments comple Assessment Instrum	, ·	F 5	20			3/31/17

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345077	B. WING _			03/09/2017	
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 25 SUNNYBROOK ROAD RALEIGH, NC 27610			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 520	Continued From page	e 19	F 5	20			
SS=E	COMMITTEE-MEMB QUARTERLY/PLANS						
	(g) Quality assessme	nt and assurance.					
	(1) A facility must ma and assurance comm minimum of:	intain a quality assessment nittee consisting at a					
	(i) The director of nur	sing services;					
	(ii) The Medical Direc	etor or his/her designee;					
	staff, at least one of v administrator, owner, individual in a leaders	a board member or other ship role; and					
	(g)(2) The quality ass committee must :	essment and assurance					
	coordinate and evalu	n respect to which quality					
		ement appropriate plans of tified quality deficiencies;					
	Secretary may not re records of such comr such disclosure is rel	rmation. A State or the quire disclosure of the nittee except in so far as ated to the compliance of the requirements of this					
	(i) Sanctions. Good fa	aith attempts by the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		E SURVEY IPLETED
		345077	B. WING	·····	0;	3/09/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE	
				25 SUNNYBROOK ROAD		
SUNNYBR	OOK REHABILITATION	CENTER		RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 520	Continued From page	e 20	F 52	20		
	committee to identify					
	_	be used as a basis for				
	sanctions.	ve used as a basis for				
		Γ is not met as evidenced				
		ons, staff interviews and		F520		
		cility's Quality Assessment		1 320		
		mittee failed to maintain		Corrective action for the re	esidents	
	implemented proced			affected by the alleged defici		
		nmittee put into place in May,		new comprehensive assess		
		eficiencies which were cited		completed by the MDS Coor		
	during the facility's re			residents		
	_	2016 and recited during the		6,22,63,100,162,165,183,209	9,224, and	
		survey. The deficiencies		229 using the newly added	, ,	
		omprehensive assessment		Comprehensive Assessment	Tool (CAA)	
		uracy. In addition, the facility		provided in Point Click Care	· ·	
		in the area of assessment		facility's Electronic Medical F	Records	
	accuracy during a re-	certification survey		software. The CAA tool being	g utilized is	
	conducted on 07/31/	The continued failure of		reflective of appendix C in the	e RAI	
		ee federal surveys of record		manual.		
		facility's inability to sustain				
	an effective Quality A	ssurance Program.		Resident #162 was disc		
				the facility on 3/21/2017. A c		
	Findings included:			done to the resident's MDS		
				to include the diagnosis of Bi	•	
	This tag is cross refe	rred to:		Disorder. Resident #165		
				Assessment was reviewed b	-	
	•	nsive Assessment: Based on		Coordinator and the Director	•	
		aff interviews, the facility		No negative outcomes were		
	failed to complete Ca			from the alleged deficient pra	actice.	
		luded underlying causes,		2. Compative action tale 6	. th	
		ors to be considered in		2. Corrective action taken for		
		ized care plan interventions		residents having the potentia		
		residents (Residents #6,		affected by the alleged defic	•	
		2, #165, #183, #209, #224		Newly added CAA Tool is be		
	and #229) with comp	rehensive assessments.		all interdisciplinary team mer		
	Duning the energy CC	tion our co. of 05/40/0040		responsible for completing th		
	_	tion survey of 05/19/2016,		assessment (Members included Coordinators Co		
	the facility was cited	rziz iorialiure to	1	Coordinators, Social Worker,	. ACIIVI(IES	1 I

PRINTED: 04/07/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345077	B. WING			03/	09/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2011
				2	5 SUNNYBROOK ROAD		
SUNNYBR	ROOK REHABILITATION	CENTER		R	RALEIGH, NC 27610		
(X4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 520	Continued From page	e 21	F	520			
		ess a resident in the area of			Director, and the Dietician.) The MDS		
		3 residents (Resident #14)			Coordinator will cross check the reside	nts	
	reviewed.	(,			assessment for accuracy before		
					transmission. Every resident assessme	ent	
	The Administrator wa	s interviewed on 03/09/17 at			will be cross checked for accuracy usir		
		e Care Area Assessments			the Accuracy Tool for 4 weeks, then a		
	(CAA). The Administr				random sample of 10 residents x 4		
		ne facility software, Point			weeks, then 10 random assessments		
	,	ve the CAA Worksheet tool.			monthly X one year. The MDS		
	We have already got	that in place as of today."			Coordinator was in-serviced by the		
					Administrator on 3/28/2017 concerning		
	2 E279 Assessment	Accuracy: Based on staff			the importance of accurate completion the residents' assessments	Oī	
		review, the facility failed to			the residents assessments		
		Minimum Data Set (MDS)			3. Systemic measure implemented to		
	•	eas of active diagnoses			ensure alleged deferment practice doe	s	
		dental status (Resident			not reoccur: CAA tool was added to PC		
		npled residents reviewed for			and users are required to complete the	!	
	MDS accuracy.				CAA tool along with the MDS		
					assessments All members of the		
		tion survey of 05/19/2016,			Interdisciplinary Team have who are		
		F278 for failure to accurately			responsible for completing the CAA ha	ve	
		ata Set (MDS) assessment			been unserviced on using the tool for		
	in the areas of active	~			MDS accuracy and completion. These		
		Resident #39 and #122)			team members include both MDS		
	reviewed for medicat				Coordinators, the Social Worker, the	20	
	_	tion survey of 07/31/2015, F278 for failure to accurately			Dietician, and the Activities Director. The Resident Care Director will attend the	IC	
	-	ata Set (MDS) assessment			state sponsored MDS training.		
		sidents (Resident #41) with			cate openioned maning.		
		on Screening and Resident			4. Monitoring to ensure the alleged		
	Review.	ŭ			deficient practice does not reoccur: The	е	
					Resident Care Director will review at le		
		s interviewed on 03/09/17 at			5 full comprehensive assessments for		
		e accuracy of assessments			MDS accuracy and RAI process		
		recertification surveys. The			compliance quarterly for one year and		
		ed the facility's Quality			submit findings to the Quality Assurance	е	
		e met monthly and the two			committee for review.		
	MDS nurses had bee	n in their positions less than					

Facility ID: 923270

	DF DEFICIENCIES CORRECTION			((X3) DATE SURVEY COMPLETED	
		345077	B. WING _			03/09/2017
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 25 SUNNYBROOK ROAD RALEIGH, NC 27610	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIAT	(X5) COMPLETION DATE
F 520	6 months. The Admir	nistrator said, "We had a onnel. Both of our MDS	F	520 5. Compliance Date: 3/31/20	<u> </u>	