STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345077	A. BUILDING _____ B. WING _____	03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK REHABILITATION CENTER	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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and	F 272		3/31/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/30/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345077	A. BUILDING _____ B. WING _____	03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 272	Continued From page 1 non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete Care Area Assessment summaries which included underlying causes, risk factors, and factors to be considered in developing individualized care plan interventions for 10 of 13 sampled residents (Residents #6, #22, #63, #100, #162, #165, #183, #209, #224 and #229) with comprehensive assessments. The findings included: 1. Resident #209 was admitted to the facility on 01/24/17. The diagnoses included expressive language disorder and diabetes mellitus. The admission Minimum Data Set (MDS) dated 01/31/17, indicated the resident had difficulty with communicating some thoughts, had a mechanically altered, therapeutic diet, and had a Stage 3 pressure ulcer at admission. Review of the Care Area Assessments (CAA) revealed there was no assessment tool completed and the narrative in the Analysis section did not indicate how the information was gathered, the underlying causes, risk factors or necessary referrals regarding care for Resident #209.	F 272	F272 1. Corrective action for the residents affected by the alleged deficient practice: new comprehensive assessment will be completed by the MDS Coordinator for residents 6,22,63,100,162,165,183,209,224, and 229 using the newly added Comprehensive Assessment Tool (CAA) provided in Point Click Care (PCC) the facility's Electronic Medical Records software. The CAA tool being utilized is reflective of appendix C in the RAI manual. No negative outcomes were identified from the alleged deficient practice. 2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice: Newly added CAA Tool is being utilized by all interdisciplinary team members responsible for completing the MDS assessment (Members include the MDS Coordinators, Social Worker, Activities Director, and the Dietician.) 3. Systemic measure implemented to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345077	A. BUILDING _____ B. WING _____	03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 272	Continued From page 2 1a. The Communication CAA Analysis (dated 02/02/17) stated, "Resident is able to make her needs known simply but has noted confusion in identifying objects. Could not identify call light when it was in her hand, but knew and understood that she needs to use the call light to ask for assistance. Family states that they have noted that resident is more confused than prior to illness." The MDS Coordinator/Supervisor (MDS Nurse #1) was interviewed on 03/09/17 at 9:40 AM regarding the lack of an assessment tool for guiding the review of triggered areas. The MDS Coordinator/Supervisor stated there wasn't an assessment tool in the facility's current software. 1b. The Nutrition CAA Analysis dated 01/28/17 stated, "[Resident #209] with high BMI (Body Mass Index) due to hx (history) caloric intake exceeding caloric expenditure, weight loss would be desirable. Receiving therapeutic diet due to diagnosis DM (diabetes mellitus) and mechanically altered diet due to dysphagia." The Registered Dietician was interviewed on 03/09/17 at 9:50 AM, regarding the lack of an assessment tool for guiding the review of Nutrition for residents. The Registered Dietician stated "I answer based on what triggered." She indicated that after reviewing the item that had triggered the Nutrition CAA, she would go directly to writing her analysis and had no training in what should be included in the Care Area assessment. During an interview on 03/09/17 at 4:04 PM, the Administrator indicated the lack of an assessment tool was an oversight and that corrective action had been taken by the corporation. She stated it	F 272	ensure alleged deficient practice does not reoccur: CAA tool was added to PCC and users are required to complete the CAA tool along with the MDS assessments. All members of the Interdisciplinary Team have who are responsible for completing the CAA have been in-serviced on 3/10/2017 by the Regional MDS Nurse for using the tool for MDS accuracy and RAI process compliance. These team members include both MDS Coordinators, the Social Worker, the Dietician, and the Activities Director. 4. Monitoring to ensure the alleged deficient practice does not reoccur: MDS Coordinator will use CAA Completion Audit Form to verify the use of the CAA tool in completion of all residents' comprehensive assessments The audit will be performed for all comprehensive assessments X 4 weeks, 10 random assessments weekly X 4 weeks and then 10 random assessments monthly X one year. All results will be reported to the Quality Assurance Committee for continued monitoring and improvement. 5. Compliance Date: 3/31/2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345077	A. BUILDING _____ B. WING _____	03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 272	Continued From page 3	F 272		

was her expectation that staff use a CAA worksheet to complete the assessment process.

2. Resident #224 was admitted to the facility on 02/05/17. The diagnoses included dementia with behaviors, symbolic dysfunction, congestive heart failure (CHF), cerebral vascular accident (CVA), acute renal failure and Vitamin D deficiency.

The admission Minimum Data Set (MDS) dated 02/12/17, indicated the resident had little interest or pleasure in doing things, and received and therapeutic diet.

Review of the Care Area Assessments (CAA) revealed there was no assessment tool completed and the narrative in the Analysis section did not indicate how the information was gathered, the underlying causes, risk factors or necessary referrals regarding care for Resident #224.

2a. The Psychosocial Well Being CAA Analysis (dated 02/14/17) stated, "Resident is here for short-term rehab and is not interested right now in activities due to focusing on therapy."

The Social Worker was interviewed on 03/09/17 at 9:32 AM, regarding the lack of an assessment tool for guiding the review of Psychosocial Well Being for this resident. The Social Worker said she would click on the worksheet tab but then went straight to writing the analysis. She stated she never had training on anything else, like a worksheet.

2b. The Nutrition CAA Analysis dated 02/07/17 stated, "[Resident #224] is receiving therapeutic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345077	A. BUILDING _____ B. WING _____	03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
F 272	Continued From page 4	F 272		

diet due to diagnoses: CVA, persistent atrial fibrillation, CHF."
The Registered Dietician was interviewed on 03/09/17 at 9:50 AM, regarding the lack of an assessment tool for guiding the review of Nutrition for residents. The Registered Dietician stated "I answer based on what triggered." She indicated that after reviewing the item that had triggered the Nutrition CAA, she would go directly to writing her analysis and had no training in what should be included in the Care Area assessment.

During an interview on 03/09/17 at 4:04 PM, the Administrator indicated the lack of an assessment tool was an oversight and that corrective action had been taken by the corporation. She stated it was her expectation that staff use a CAA worksheet to complete the assessment process.

3. Resident #22 was admitted to the facility on 12/08/16. The diagnoses included peripheral vascular disease (PVD), end-stage renal disease (ESRD), and diabetes mellitus (DM).

Following an above the knee amputation (AKA), a significant change assessment was completed. The Significant Change assessment dated 01/24/17, indicated the resident had a body mass index of 39, was receiving a therapeutic diet and had one or more unhealed wounds.

The Nutrition CAA Analysis (dated 01/29/17) stated, "[Resident #22] with high BMI due to hx (history) caloric intake exceeding caloric expenditure, s/p (status post) left AKA, weight loss would be desirable. Receiving therapeutic diet due to diagnoses ESRD on HD (hemodialysis), DM (diabetes mellitus). No

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345077	A. BUILDING _____ B. WING _____	03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 272	Continued From page 5	F 272		

dysphagia reported, patient stated consuming regular consistency."

The Registered Dietician was interviewed on 03/09/17 at 9:50 AM, regarding the lack of an assessment tool for guiding the review of Nutrition for residents. The Registered Dietician stated "I answer based on what triggered." She indicated that after reviewing the item that had triggered the Nutrition CAA, she would go directly to writing her analysis and had no training in what should be included in the Care Area assessment.

During an interview on 03/09/17 at 4:04 PM, the Administrator indicated the lack of an assessment tool was an oversight and that corrective action had been taken by the corporation. She stated it was her expectation that staff use a CAA worksheet to complete the assessment process.
4a. Resident #63 was admitted to the facility on 10/24/16 and had a diagnosis of dementia and symbolic dysfunction (communication problem). The Admission Minimum Data Set (MDS) Assessment dated 10/31/16 noted the resident had moderate cognitive impairment.

The Care Area Assessment (CAA) for Cognitive Loss/Dementia dated 11/9/16 noted the resident scored lower than normal on the Brief Interview for Mental Status test due to confusion. The CAA did not list the resident ' s diagnoses, underlying causes, contributing factors or risk factors. The CAA was signed as completed by MDS Nurse #2. An interview was conducted on 3/9/17 at 9:46 AM with MDS Nurse #2 who stated the social worker did the CAAs for cognitive loss/dementia.

The Social Worker stated in an interview on 3/9/17 at 1:49 PM that she did the resident ' s

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345077	A. BUILDING _____ B. WING _____	03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK REHABILITATION CENTER	25 SUNNYBROOK ROAD RALEIGH, NC 27610

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F 272	Continued From page 6	F 272		

CAA for cognitive loss/dementia. The Social Worker further stated she had not received training on how to write a care area assessment.

On 3/9/17 at 1:52 PM the Administrator stated in an interview it was her expectation the MDS be accurate and the care area assessments reflect the resident ' s status. The Administrator further stated their staff needed more training.

4b. Resident #63 was admitted to the facility on 10/24/16 and had a diagnosis of dementia, other symbolic dysfunctions (communication problem) and urinary tract infection.
The Admission Minimum Data Set (MDS) Assessment dated 10/31/16 noted the resident had moderate cognitive impairment, required extensive assistance for toileting and was frequently incontinent of urine.

The Care Area Assessment (CAA) for Urinary Incontinence dated 11/9/16 noted the resident received care with all activities of daily living from staff and was incontinent of bowel and bladder daily. The CAA further noted the resident could become more independent with care with help from therapy. The CAA did not list the resident ' s diagnoses, underlying causes, contributing factors or risk factors of urinary incontinence. The CAA was signed as completed by MDS Nurse #2.

In an interview with MDS Nurse #2 on 3/9/17 at 9:46 AM, the MDS Nurse stated she was not aware of a tool to be used to complete the CAAs. The MDS Nurse stated their computer program just showed the triggers at the top and then why it triggered and then we go to the analysis of the findings. The MDS Nurse stated she had been doing the assessments for 4 months.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345077	A. BUILDING _____ B. WING _____	03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
F 272	Continued From page 7 On 3/9/17 at 1:52 PM the Administrator stated in an interview it was her expectation the MDS be accurate and the care area assessments reflect the resident ' s status. The Administrator stated they had a turnover in staff and their MDS staff needed more training. 5a. Resident #100 was admitted to the facility on 1/12/17 and had a diagnosis of dementia, urinary tract infection and neurogenic bladder. The Admission Minimum Data Set (MDS) Assessment dated 1/12/17 noted the resident had severe cognitive impairment which triggered the Cognitive Loss/Dementia Care Area Assessment. The Care Area Assessment (CAA) for Cognitive Loss/Dementia dated 1/19/17 revealed during the brief interview for mental status the resident could not answer questions and only stated: "Yes." The CAA did not list the resident ' s diagnoses, underlying causes, contributing factors or risk factors of cognitive loss/dementia. In an interview with MDS Nurse #2 on 3/9/17 at 9:46 AM, the MDS Nurse stated she was not aware of a tool to be used to complete the CAAs. The MDS Nurse stated their computer program just showed the triggers at the top and then why it triggered and then we go to the analysis of the findings. The MDS Nurse stated she had been doing the MDS assessments for 4 months. On 3/9/17 at 1:52 PM the Administrator stated in an interview it was her expectation the MDS be accurate and the care area assessments reflect the resident ' s status. The Administrator stated they had a turnover in staff and their MDS staff	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345077	A. BUILDING _____ B. WING _____	03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
F 272	Continued From page 8	F 272		

needed more training.

5b. Resident #100 was admitted to the facility on 1/12/17 and had a diagnosis of dementia, urinary tract infection and neurogenic bladder.

The Admission Minimum Data Set (MDS) Assessment dated 1/12/17 noted the resident had a urinary catheter and required extensive assistance for toileting and personal hygiene.

The Care Area Assessment (CAA) dated 1/19/17 for Urinary Incontinence noted the resident was admitted to the facility after admission to the hospital for altered mental status and had an indwelling urinary catheter with a history of urinary tract infections. The CAA did not list the resident ' s diagnoses, underlying causes, contributing factors or risk factors of the urinary catheter.

In an interview with MDS Nurse #2 on 3/9/17 at 9:46 AM, the MDS Nurse stated she was not aware of a tool to be used to complete the CAAs. The MDS Nurse stated their computer program just showed the triggers at the top and then why it triggered and then we go to the analysis of the findings. The MDS Nurse stated she had been doing the MDS assessments for 4 months.

On 3/9/17 at 1:52 PM the Administrator stated in an interview it was her expectation the MDS be accurate and the care area assessments reflect the resident ' s status. The Administrator stated they had a turnover in staff and their MDS staff needed more training.

6. Resident #162 was admitted to the facility on 2/21/17 and had a diagnosis of cerebrovascular accident (Stroke), depression and bi-polar

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345077	A. BUILDING _____ B. WING _____	03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
F 272	Continued From page 9	F 272		

disorder.

The Admission Minimum Data Set (MDS) Assessment dated 2/28/17 revealed the resident was cognitively intact and received an antipsychotic and antidepressant medication for 7 days of the 7 day assessment period.

The Care Area Assessment (CAA) for Psychotropic Drug Use dated 3/2/17 noted the resident was taking an antidepressant medication. The CAA did not list the resident ' s diagnoses, underlying causes, contributing factors or risk factors of psychotropic drugs. There was no information in the CAA the resident was taking an antipsychotic medication or why the medication had been ordered for the resident.

In an interview with MDS Nurse #2 on 3/9/17 at 9:46 AM, the MDS Nurse stated she was not aware of a tool to be used to complete the CAAs. The MDS Nurse stated their computer program just showed the triggers at the top and then why it triggered and then we go to the analysis of the findings. The MDS Nurse stated she had been doing the MDS assessments for 4 months.

On 3/9/17 at 1:52 PM the Administrator stated in an interview it was her expectation the MDS be accurate and the care area assessments reflect the resident ' s status. The Administrator stated they had a turnover in staff and their MDS staff needed more training.

7. Resident #229 was admitted to the facility on 2/23/17 and had a diagnosis of anemia, chronic obstructive pulmonary disease (COPD), lung cancer, diabetes, chronic ischemic heart disease and pressure ulcer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345077	A. BUILDING _____ B. WING _____	03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK REHABILITATION CENTER	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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 10	F 272		

The Care Area Assessment for Pressure Ulcer dated 3/6/17 noted the resident had a stage III pressure ulcer to the sacrum, had a pressure relieving device for the bed and wheelchair and would receive weekly skin checks. The CAA did not list the resident ' s diagnoses, underlying causes, contributing factors or risk factors for the pressure ulcer.

The Admission Minimum Data Set (MDS) Assessment that was in progress noted the resident was cognitively intact and required extensive assistance with bed mobility, transfers and toileting. The MDS revealed the resident was occasionally incontinent of urine and frequently incontinent of bowel. The assessment noted the resident was admitted to the facility with a stage III pressure ulcer.

In an interview with MDS Nurse #2 on 3/9/17 at 9:46 AM, the MDS Nurse stated she was not aware of a tool to be used to complete the CAAs. The MDS Nurse stated their computer program just showed the triggers at the top and then why it triggered and then we go to the analysis of the findings. The MDS Nurse stated she had been doing the MDS assessments for 4 months.

On 3/9/17 at 1:52 PM the Administrator stated in an interview it was her expectation the MDS be accurate and the care area assessments reflect the resident ' s status. The Administrator stated they had a turnover in staff and their MDS staff needed more training.

8. Resident #165 was admitted to the facility on 6/9/16 and had a diagnosis of peripheral vascular disease and dysphagia.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345077	A. BUILDING _____ B. WING _____	03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK REHABILITATION CENTER	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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 11	F 272		

An admission nurse ' s note dated 6/9/16 at 8:41 PM read: "Missing all upper teeth."

The Admission Minimum Data Set (MDS) Assessment dated 6/30/16 did not indicate the resident had any dental problems and did not trigger the dental care area assessment, therefore a dental care assessment was not completed.
On 3/9/17 at 1:52 PM, MDS Nurse #2 stated in an interview the MDS was completed by a nurse that no longer worked at the facility. The MDS Nurse stated the MDS should have reflected the resident had missing teeth and this would have triggered the dental care area assessment to be completed.

On 3/9/17 at 1:52 PM the Administrator stated in an interview it was her expectation the MDS be accurate and the care area assessments reflect the resident ' s status.
9. Resident #183 was admitted to the facility on 10/14/16 and re-admitted on 2/10/17 with diagnosis including Depressive disorder.

The Admission Minimum Data Set (MDS) dated 10/21/16 revealed the resident was cognitively intact and received an antidepressant medication for 7 days of the 7 day assessment period.

The Care Area Assessment (CAA) Summary for Psychotropic Drug Use dated 10/21/16 noted the resident was taking an antidepressant medication. The CAA did not list the resident's diagnoses, underlying causes, contributing factors or risk factors of anti-depressant drugs, care plan considerations or referrals to other disciplines.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345077	A. BUILDING _____ B. WING _____	03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK REHABILITATION CENTER	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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 12	F 272		

Review of the care plan reveled Resident #183 used an antidepressant medication related to a diagnosis of Depression.

In an interview with MDS Nurse #2 on 3/9/17 at 9:46 AM, the MDS Nurse stated she was not aware of a tool to be used to complete the CAAs. The MDS Nurse stated their computer program just showed the triggers at the top and then why it triggered and then we go to the analysis of the findings. The MDS Nurse stated she had been doing the MDS assessments for 4 months.

On 3/9/17 at 1:52 PM the Administrator stated in an interview it was her expectation the MDS be accurate and the care area assessments reflect the resident ' s status. The Administrator stated they had a turnover in staff and their MDS staff needed more training.

10. Resident #6 was admitted to the facility on 7/6/16 and re-admitted on 12/29/16 with diagnosis including Schizoaffective disorder and Depressive disorder.

The Annual Minimum Data Set (MDS) dated 8/10/16 revealed the resident was cognitively intact and received an antidepressant medication for 7 days of the 7 day assessment period.

The Care Area Assessment (CAA) Summary for Psychotropic Drug Use dated 8/10/16 noted the resident was taking an antidepressant medication. The CAA did not list the resident's diagnoses, underlying causes, contributing factors or risk factors of anti-depressant drugs, care plan considerations or referrals to other disciplines.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345077	A. BUILDING _____ B. WING _____	03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK REHABILITATION CENTER	25 SUNNYBROOK ROAD RALEIGH, NC 27610

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F 272	Continued From page 13 Review of the care plan reveled Resident #6 used an antidepressant medication related to a diagnosis of Depression. In an interview with MDS Nurse #2 on 3/9/17 at 9:46 AM, the MDS Nurse stated she was not aware of a tool to be used to complete the CAAs. The MDS Nurse stated their computer program just showed the triggers at the top and then why it triggered and then we go to the analysis of the findings. The MDS Nurse stated she had been doing the MDS assessments for 4 months. On 3/9/17 at 1:52 PM the Administrator stated in an interview it was her expectation the MDS be accurate and the care area assessments reflect the resident ' s status. The Administrator stated they had a turnover in staff and their MDS staff needed more training.	F 272		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278		3/31/17

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F 278	Continued From page 14 (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to accurately code the Minimum Data Set (MDS) in the areas of active diagnoses (Resident #162), and dental status (Resident #165), for 2 of 13 sampled residents reviewed for MDS accuracy. Findings included: 1 Resident #162 was admitted to the facility on 2/21/17 and had a diagnosis of Bi-Polar Disorder. The hospital discharge medications included Seroquel (antipsychotic) 300mg (milligrams) every night at bedtime for bi-polar disorder and Remeron (antidepressant) 45mg every night at bedtime for depression. These orders were carried over to the February 2017 Medication Administration Record in the facility.	F 278	F278 1. Corrective action for the residents affected by the alleged deficient practice: Resident #162 was discharged from the facility on 3/21/2017. A correction was done to the resident's MDS assessment to include the diagnosis of Bipolar Disorder. Resident #165 MDS Assessment was reviewed by the MDS Coordinator and the Director of Nursing. 2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice: The MDS Coordinator will cross check the residents assessment for accuracy before transmission. Every resident assessment will be cross checked for accuracy using the Accuracy Tool for 4 weeks, then a	

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F 278	Continued From page 15 The Admission Minimum Data Set (MDS) Assessment dated 2/28/17 under section N revealed the resident received an antidepressant and an antipsychotic medication for 7 days during the 7 day assessment period. Section I of the MDS did not indicate the resident had any psychiatric problems. On 3/9/17 at 1:33 PM an interview was conducted with MDS Nurse #2 who stated she completed the MDS assessment for Resident #162. The MDS Nurse stated she had included the billing code for bi-polar disorder at the bottom of the form but did not check the diagnosis under Section I of the MDS. On 3/9/17 at 1:52 PM the Administrator stated in an interview it was her expectation that the MDS be coded accurately. 2. Resident #165 was admitted to the facility on 6/9/16 and had a diagnosis of dysphagia (difficulty swallowing). An admission nurse's note dated 6/9/16 at 8:41 PM read: "Missing all upper teeth." The Admission Minimum Data Set (MDS) Assessment dated 6/30/16 did not indicate the resident had any missing teeth or dental problems. On 3/9/17 at 10:00 AM MDS Nurse #2 stated in an interview the MDS nurse that completed the Admission MDS for Resident #165 no longer worked at the facility. On 3/9/17 at 1:52 PM the Administrator stated in an interview it was her expectation that the MDS assessments be coded accurately.	F 278	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' assessments and RAI process compliance. 3. Systemic measure implemented to ensure alleged deferment practice does not reoccur: The MDS Coordinator will cross check the residents assessment for accuracy before transmission. Every resident assessment will be cross checked for accuracy using the Accuracy Tool 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 MDS Accuracy Audit Form on 10 random assessments weekly X 4 weeks and then monthly X one year. All results will be reported to the Quality Assurance Committee for continued monitoring and improvement. 5. Compliance Date: 3/31/2017	

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	345077	A. BUILDING _____ B. WING _____	03/09/2017

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F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 279		3/31/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 17 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to include the care of a resident ' s indwelling urinary catheter in the resident ' s comprehensive care plan for 1 of 2 residents reviewed for urinary catheters (Resident #100). The findings included: Resident #100 was admitted to the facility on 1/12/17 and had diagnoses that included dementia, urinary tract infection (UTI), and neurogenic bladder with chronic use of an indwelling urinary catheter. The resident ' s Comprehensive Care Plan dated 1/16/17 noted the resident continued to be at risk for signs and symptoms of recurrent UTIs. The Care Plan directed staff to assist with peri-care	F 279	F279 1. Corrective action for the residents affected by the alleged deficient practice: Resident #100 was discharged from the facility on 2/16/2017, therefore the care plan could not be updated. No negative outcomes were identified from the alleged deficient practice. 2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice: The MDS Coordinator reviewed and updated all care plans for the residents with Foley catheters on 3/8/2017. All care plans are current and appropriately	

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F 279	Continued From page 18 after incidents of bowel incontinence. There was no information in the Care Plan that the resident had an indwelling urinary catheter or of the care of a urinary catheter. The Admission Minimum Data Set (MDS) Assessment dated 1/19/17 revealed the resident had severe cognitive impairment, was not ambulatory, required extensive assistance for toileting and personal hygiene, was incontinent of bowel and had an indwelling urinary catheter. The Care Area Assessment for Urinary Incontinence/Indwelling Urinary Catheter dated 1/19/17 noted the resident had an indwelling urinary catheter with a history of UTIs. The assessment revealed the urinary catheter would be care planned. There was no additional information added to the resident ' s Care Plan regarding the care for an indwelling urinary catheter. On 3/9/17 at 9:46 AM an interview was conducted with MDS Nurse #2 who stated she completed the assessment and Care Plan for Resident #100. The MDS Nurse stated the urinary catheter was overlooked on the Care Plan. The MDS Nurse further stated the Care Guide for the nursing assistants was generated by the computer from the Care Plan and did not include care for the urinary catheter. On 3/9/17 at 2:08 PM the Administrator stated in an interview she expected the resident ' s needs to be care planned according to the care area assessments completed during the RAI (Resident Assessment Instrument) process.	F 279	updated. 3. Systemic measure implemented to ensure alleged deferment practice does not reoccur: All residents with Foley catheters will be reviewed and the care plans updated appropriately in weekly focus meetings X one year. 4. Monitoring to ensure the alleged deficient practice does not reoccur: Foley catheter care plans for all residents with Foley catheters will be reviewed and reported to the Quality Assurance Committee quarterly for one year for continued monitoring and improvement. 5. Compliance Date: 3/31/2017	
F 520	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA	F 520		3/31/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 520 SS=E	Continued From page 19	F 520		

COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS

(g) Quality assessment and assurance.

(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:

(i) The director of nursing services;

(ii) The Medical Director or his/her designee;

(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and

(g)(2) The quality assessment and assurance committee must :

(i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;

(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.

(i) Sanctions. Good faith attempts by the

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F 520	Continued From page 20 committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions the committee put into place in May, 2016. This was for deficiencies which were cited during the facility's recertification survey completed on 05/19/2016 and recited during the current recertification survey. The deficiencies were in the area of comprehensive assessment and assessment accuracy. In addition, the facility received a deficiency in the area of assessment accuracy during a recertification survey conducted on 07/31/15. The continued failure of the facility during three federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: 1. F 272 Comprehensive Assessment: Based on record review and staff interviews, the facility failed to complete Care Area Assessment summaries which included underlying causes, risk factors, and factors to be considered in developing individualized care plan interventions for 10 of 13 sampled residents (Residents #6, #22, #63, #100, #162, #165, #183, #209, #224 and #229) with comprehensive assessments. During the recertification survey of 05/19/2016, the facility was cited F272 for failure to	F 520	F520 1. Corrective action for the residents affected by the alleged deficient practice: new comprehensive assessment will be completed by the MDS Coordinator for residents 6,22,63,100,162,165,183,209,224, and 229 using the newly added Comprehensive Assessment Tool (CAA) provided in Point Click Care (PCC) the facility's Electronic Medical Records software. The CAA tool being utilized is reflective of appendix C in the RAI manual. Resident #162 was discharged from the facility on 3/21/2017. A correction was done to the resident's MDS assessment to include the diagnosis of Bipolar Disorder. Resident #165 MDS Assessment was reviewed by the MDS Coordinator and the Director of Nursing. No negative outcomes were identified from the alleged deficient practice. 2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice: Newly added CAA Tool is being utilized by all interdisciplinary team members responsible for completing the MDS assessment (Members include the MDS Coordinators, Social Worker, Activities	

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F 520	Continued From page 21 comprehensively assess a resident in the area of mental status for 1 of 3 residents (Resident #14) reviewed. The Administrator was interviewed on 03/09/17 at 3:02 PM regarding the Care Area Assessments (CAA). The Administrator said, "We were unaware that PCC (the facility software, Point Click Care) didn't have the CAA Worksheet tool. We have already got that in place as of today." 2. F278 Assessment Accuracy: Based on staff interviews and record review, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of active diagnoses (Resident #162), and dental status (Resident #165), for 2 of 13 sampled residents reviewed for MDS accuracy. During the recertification survey of 05/19/2016, the facility was cited F278 for failure to accurately code the Minimum Data Set (MDS) assessment in the areas of active diagnoses for 2 of 5 sampled residents (Resident #39 and #122) reviewed for medications. During the recertification survey of 07/31/2015, the facility was cited F278 for failure to accurately code the Minimum Data Set (MDS) assessment for 1 of 2 sampled residents (Resident #41) with a Level II Preadmission Screening and Resident Review. The Administrator was interviewed on 03/09/17 at 3:12 PM regarding the accuracy of assessments cited on the two prior recertification surveys. The Administrator indicated the facility's Quality Assurance Committee met monthly and the two MDS nurses had been in their positions less than	F 520	Director, and the Dietician.) The MDS Coordinator will cross check the residents assessment for accuracy before transmission. Every resident assessment will be cross checked for accuracy using the Accuracy Tool for 4 weeks, then a random sample of 10 residents x 4 weeks, then 10 random assessments monthly X one year. The MDS Coordinator was in-serviced by the Administrator on 3/28/2017 concerning the importance of accurate completion of the residents' assessments 3. Systemic measure implemented to ensure alleged deferment practice does not reoccur: CAA tool was added to PCC and users are required to complete the CAA tool along with the MDS assessments All members of the Interdisciplinary Team have who are responsible for completing the CAA have been unserviced on using the tool for MDS accuracy and completion. These team members include both MDS Coordinators, the Social Worker, the Dietician, and the Activities Director. The Resident Care Director will attend the state sponsored MDS training. 4. Monitoring to ensure the alleged deficient practice does not reoccur: The Resident Care Director will review at least 5 full comprehensive assessments for MDS accuracy and RAI process compliance quarterly for one year and submit findings to the Quality Assurance committee for review.	

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F 520	Continued From page 22 6 months. The Administrator said, "We had a change-over in personnel. Both of our MDS people need some more training."	F 520	5. Compliance Date: 3/31/2017	