PRINTED: 04/10/2017 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345077	B. WING _			03	/09/2017
	ROVIDER OR SUPPLIER	I CENTER		25 S	EET ADDRESS, CITY, STATE, ZIP CODE UNNYBROOK ROAD LEIGH, NC 27610	, 33	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 272 SS=E	483.20(b)(1) COMPF ASSESSMENTS	REHENSIVE	F 2	272			3/31/17
	(b) Comprehensive A	Assessments					
	must make a compreresident's needs, str preferences, using the instrument (RAI) speciassessment must incomplete (iv) Identification and (ii) Customary routification (v) Communication (v) Vision. (vi) Mood and behad (vii) Psychological work (viii) Physical full problems. (ix) Continence. (x) Disease diagnorification (xii) Skin Conditions (xiii) Activity pure (xiv) Medications (xv) Special treatme (xvi) Discharge problems. (xvi) Discharge provide (xvii) Documentate (xvii) Documentate (xviii) Documentate (xviiii) Documentate (xviii) Documentate (xviii) Documentate (xviii) Documentate (xviiii) Documentate (xviiiii) Documentate (xviiiii) Documentate (xviiiiii) Documentate (xviiiiiiiii) Documentate (xviiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	d demographic information ine. ins. vior patterns. vell-being. inctioning and structural sis and health conditions. itional status. suit. s. ints and procedures. colanning. ition of summary information inal assessment performed					
	licensed and	as sommanioadon with					
ABORATORY	L DIRECTOR'S OR PROVIDER	/SUPPLIER REPRESENTATIVE'S SIGNATU	RE		TITLE		(X6) DATE

LABORATORY 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:	` '	JILTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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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 impler	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		

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	345077	B. WING	·····		3/09/2017	
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SUNNYBROOK REHABILITATION	ON CENTER		RALEIGH, NC 27610			
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F 272 Continued From page 1	age 2	F 27	72			
1a. The Communic 02/02/17) stated, "needs known simplified it was in her understood that shask for assistance noted that residentillness." The MDS Coordination will was interviewed regarding the lack guiding the review Coordinator/Super assessment tool in 1b. The Nutrition Of stated, "[Resident Mass Index) due to exceeding caloric be desirable. Receding caloric be desirable and the distribution for reside stated." I answer be indicated that after triggered the Nutrit to writing her analyshould be included.	cation CAA Analysis (dated Resident is able to make her ally but has noted confusion in Could not identify call light hand, but knew and the needs to use the call light to Family states that they have it is more confused than prior to ator/Supervisor (MDS Nurse and on 03/09/17 at 9:40 AM of an assessment tool for of triggered areas. The MDS visor stated there wasn't and the facility's current software. CAA Analysis dated 01/28/17 #209] with high BMI (Body on hx (history) caloric intake expenditure, weight loss would siving therapeutic diet due to	F 21	ensure alleged deficient practice reoccur: CAA tool was added users are required to comple tool along with the MDS assessmembers of the Interdisciplin have who are responsible for the CAA have been in-service 3/10/2017 by the Regional M using the tool for MDS accura process compliance. These to members include both MDS of the Social Worker, the Dieticial Activities Director. 4. Monitoring to ensure the adeficient practice does not recoordinator will use CAA Conduction for the use of tool in completion of all reside comprehensive assessments will be performed for all compassessments X 4 weeks, 10 assessments weekly X 4 weeks 10 random assessments more year. All results will be report Quality Assurance Committee continued monitoring and imposition of the process	d to PCC and te the CAA essments. All early Team recompleting ed on IDS Nurse for acy and RAI early Team Coordinators, ian, and the Illeged eoccur: MDS mpletion of the CAA ents' a The audit prehensive random eks and then onthly X one ted to the e for provement.		

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F 272	2. Resident #224 wa 02/05/17. The diagn behaviors, symbolic failure (CHF), cerebracute renal failure ar The admission Minin 02/12/17, indicated to r pleasure in doing therapeutic diet. Review of the Care Arevealed there was recompleted and then section did not indicagathered, the underly necessary referrals researched with the respective of the care Arevealed there was recompleted and then section did not indicagathered, the underly necessary referrals researched with the care Arevealed there was recompleted and then section did not indicagathered, the underly necessary referrals researched with the care Arevealed there was recompleted and then section did not indicagathered. The care Arevealed the care Arevealed there was recompleted and the necessary referrals researched with the care Arevealed th	that staff use a CAA te the assessment process. Is admitted to the facility on loses 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 27	72			
	at 9:32 AM, regardin tool for guiding the re Being for this resider she would click on the went straight to writin	vas interviewed on 03/09/17 g the lack of an assessment eview of Psychosocial Well nt. The Social Worker said ne worksheet tab but then ng the analysis. She stated ng on anything else, like a					
		A Analysis dated 02/07/17					

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F 272	fibrillation, CHF." The Registered Die 03/09/17 at 9:50 AN assessment tool for Nutrition for resider stated "I answer ba indicated that after triggered the Nutriti to writing her analys should be included During an interview Administrator indicated was an oversig had been taken by was her expectation worksheet to comple 3. Resident #22 wa 12/08/16. The diag vascular disease (F (ESRD), and diabeted	tician was interviewed on M, regarding the lack of an guiding the review of the sed on what triggered." She reviewing the item that had on CAA, she would go directly sis and had no training in what in the Care Area assessment. on 03/09/17 at 4:04 PM, the ated the lack of an assessment that had that corrective action the corporation. She stated it in that staff use a CAA ete the assessment process. s admitted to the facility on moses included peripheral PVD), end-stage renal disease the mellitus (DM).	F 27				
	significant change at The Significant Charles 101/24/17, indicated index of 39, was rechad one or more under the Nutrition CAA stated, "[Resident # (history) caloric intate expenditure, s/p (stated) to see would be desired to diagnostic the significant to the significant change at the significant to the significant to the significant change at the significant change at the significant change at the significant to the significan	Analysis (dated 01/29/17) 22] with high BMI due to hx ke exceeding caloric atus post) left AKA, weight able. Receiving therapeutic					

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F 272	The Registered D 03/09/17 at 9:50 A assessment tool for Nutrition for reside stated "I answer be indicated that after triggered the Nutrowiting her analyshould be included. During an interviee Administrator indicated tool was an overshad been taken be was her expectation worksheet to com 4a. Resident #63 10/24/16 and had symbolic dysfunct. The Admission Michassessment dated had moderate cool. The Care Area As Loss/Dementia dascored lower than for Mental Status did not list the rescauses, contribution CAA was signed a An interview was with MDS Nurse and the CAAs for the Social Worker The Social Worker CAA was for the Care Area As CAA was signed a CAA was signed	d, patient stated consuming	F 2	72			

03/09/2017
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RECTION (X5) HOULD BE COMPLETION PPROPRIATE DATE

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 272	Continued From pag	ge 7	F 2	72			
	an interview it was haccurate and the care the resident 's statu they had a turnover needed more trainin. 5a. Resident #100 w 1/12/17 and had a d tract infection and not receive the control of the Admission Minir Assessment dated 1 severe cognitive impropersion. The Care Area Asse Loss/Dementia date brief interview for more than the complete the complet	vas admitted to the facility on iagnosis of dementia, urinary eurogenic bladder. mum Data Set (MDS) /12/17 noted the resident had pairment which triggered the entia Care Area Assessment. ssment (CAA) for Cognitive d 1/19/17 revealed during the ental status the resident could a and only stated: "Yes." The resident 's diagnoses, contributing factors or risk					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	CENTER	2	TREET ADDRESS, CITY, STATE, ZIP CODE 5 SUNNYBROOK ROAD RALEIGH, NC 27610	
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F 272	1/12/17 and had a di tract infection and ne The Admission Minin Assessment dated 1 a urinary catheter an assistance for toiletin. The Care Area Asses for Urinary Incontine admitted to the facilit hospital for altered mindwelling urinary catract infections. The s diagnoses, underly factors or risk factors. In an interview with M9:46 AM, the MDS Naware of a tool to be The MDS Nurse stat just showed the trigg triggered and then who findings. The MDS National the MDS asses. On 3/9/17 at 1:52 PN an interview it was haccurate and the carthe resident 's status.	as admitted to the facility on agnosis of dementia, urinary eurogenic bladder. num Data Set (MDS) /12/17 noted the resident had d required extensive ag and personal hygiene. ssment (CAA) dated 1/19/17 note noted the resident was sy after admission to the nental status and had an theter with a history of urinary CAA did not list the resident 'ing causes, contributing of the urinary catheter. 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 lurse stated she had been ssments for 4 months. M the Administrator stated in er expectation the MDS be e area assessments reflect is. The Administrator stated in staff and their MDS staff	F 272		
	2/21/17 and had a di	s admitted to the facility on agnosis of cerebrovascular pression and bi-polar			

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F 272	Assessment dated 2 was cognitively intact antipsychotic and ard days of the 7 day as The Care Area Asse Psychotropic Drug Uresident was taking medication. The CAdiagnoses, underlying factors or risk factors. There was no inform was taking an antipsyche medication had In an interview with 19:46 AM, the MDS Naware of a tool to be The MDS Nurse statigust showed the trigg triggered and then we findings. The MDS Naware of a tool to be The MDS naware of a tool to be The MDS Nurse statigust showed the trigg triggered and then we findings. The MDS Naware of a tool to be The MDS naware of a tool tool to be The MDS naware of a tool tool to be The MDS naware of a tool tool to be The MDS naware of a tool tool to be The MDS naware of a tool tool to be The MDS naware of a tool tool tool tool tool to be The M	mum Data Set (MDS) 2/28/17 revealed the resident ct and received an ntidepressant medication for 7 resessment period. Resement (CAA) for Use dated 3/2/17 noted the an antidepressant A did not list the resident 's ng causes, contributing s of psychotropic drugs. nation in the CAA the resident respectation or why been ordered for the resident. MDS Nurse #2 on 3/9/17 at resulting stated she was not resulting used to complete the CAAs. The determinant the top and then why it respectation the modern sessments for 4 months. M the Administrator stated in rerespectation the MDS be re area assessments reflect s. The Administrator stated in staff and their MDS staff g. as admitted to the facility on iagnosis of anemia, chronic	F 27	2		
	9:46 AM, the MDS Naware of a tool to be The MDS Nurse start just showed the trigg triggered and then with findings. The MDS National the MDS asset on 3/9/17 at 1:52 Pl an interview it was haccurate and the carther esident 's statuthey had a turnover needed more trainin 7. Resident #229 wa 2/23/17 and had a dobstructive pulmona	Aurse stated she was not a 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. M the Administrator stated in the expectation the MDS be the area assessments reflect so the Administrator stated in staff and their MDS staff go.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
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F 272	Continued From pag	e 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.					

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F 272	Continued From page	<u> 11</u>	F	272			
	An admission nurse ' PM read: "Missing all	s note dated 6/9/16 at 8:41 upper teeth."					
	resident had any dent trigger the dental care therefore a dental care completed. On 3/9/17 at 1:52 PM interview the MDS wano longer worked at the stated the MDS should resident had missing triggered the dental completed. On 3/9/17 at 1:52 PM an interview it was he accurate and the care the resident #183 was 10/14/16 and re-admit diagnosis including D The Admission Minim 10/21/16 revealed the	30/16 did not indicate the tal problems and did not e area assessment, re assessment was not as completed by a nurse that the facility. The MDS Nurse did have reflected the teeth and this would have are area assessment to be a the Administrator stated in the expectation the MDS be a area assessments reflect admitted to the facility on tited on 2/10/17 with epressive disorder.					
	Psychotropic Drug Us resident was taking a medication. The CAA diagnoses, underlying factors or risk factors	did not list the resident's					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		ATE SURVEY OMPLETED
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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				

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	OOK REHABILITATION	CENTER		25	REET ADDRESS, CITY, STATE, ZIP CODE SUNNYBROOK ROAD ALEIGH, NC 27610		
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F 272	an antidepressant me diagnosis of Depressi In an interview with M 9:46 AM, the MDS Nu aware of a tool to be	an reveled Resident #6 used edication related to a son. IDS Nurse #2 on 3/9/17 at surse stated she was not used to complete the CAAs.	F 2	272			
F 278 SS=D	just showed the trigger triggered and then we findings. The MDS No doing the MDS asses 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 Asses must accurately reflect (h) Coordination A registered nurse more each assessment with	the Administrator stated in a expectation the MDS be area assessments reflect. The Administrator stated a staff and their MDS staff. SMENT SINATION/CERTIFIED assents. The assessment of the resident's status.	F2	2278			3/31/17
	the assessment is con (2) Each individual wh	e must sign and certify that mpleted. no completes a portion of the n and certify the accuracy of					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED
		345077	B. WING _	· · · · · · · · · · · · · · · · · · ·	0	3/09/2017
NAME OF PROVIDER OR SUPPLIER SUNNYBROOK REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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						
PREFIX	(EACH DEFICI	ENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	Continued From p (j) Penalty for Fals (1) Under Medicar who willfully and k (i) Certifies a mate resident assessme penalty of not mor assessment; or (ii) Causes anothe and false stateme subject to a civil m \$5,000 for each as (2) Clinical disagre material and false This REQUIREME by: Based on staff int facility failed to ac Data Set (MDS) ir (Resident #162), a #165), for 2 of 13 MDS accuracy. Findings included: 1 Resident #162 v	age 14 dification re and Medicaid, an individual remain and false statement in a rent is subject to a civil money re than \$1,000 for each er individual to certify a material remain in a resident assessment is rement does not constitute a restatement. ENT is not met as evidenced reviews and record review, the curately code the Minimum remain the areas of active diagnoses and dental status (Resident remains admitted to the facility on		F278 1. Corrective action for the raffected by the alleged defice Resident #162 was discharge facility on 3/21/2017. A corredone to the resident's MDS to include the diagnosis of B Disorder. Resident #165 MD Assessment was reviewed by	esidents ient practice: ged from the ection was assessment sipolar oS by the MDS	
	The hospital disch Seroquel (antipsydevery night at bed Remeron (antidep bedtime for depres	arge medications included chotic) 300mg (milligrams) time for bi-polar disorder and ressant) 45mg every night at ssion. These orders were February 2017 Medication cord in the facility.		2. Corrective action taken for residents having the potential affected by the alleged deficing The MDS Coordinator will corresidents assessment for action transmission. Every resident will be cross checked for action the Accuracy Tool for 4 weel	or those all to be sient practice: coss check the couracy before t assessment curacy using	

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(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	, 3335
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 278	revealed the resident and an antipsychotic the 7 day assessmer Section I of the MDS had any psychiatric p. On 3/9/17 at 1:33 PM with MDS Nurse #2 with MDS Nurse stated shoode for bi-polar discording but did not check Section I of the MDS. On 3/9/17 at 1:52 PM an interview it was help be coded accurately. 2. Resident #165 was 6/9/16 and had a diack (difficulty swallowing An admission nurse's PM read: "Missing al The Admission Minim Assessment dated 6/1 resident had any mis problems. On 3/9/17 at 10:00 A an interview the MDS.	num Data Set (MDS) /28/17 under section N treceived an antidepressant medication for 7 days during int period. did not indicate the resident problems. If an interview was conducted who stated she completed to for Resident #162. The me had included the billing proder at the bottom of the set the diagnosis under If the Administrator stated in mer expectation that the MDS If admitted to the facility on gnosis of dysphagia If upper teeth." Inum Data Set (MDS) /30/16 did not indicate the sing teeth or dental If MMDS Nurse #2 stated in If anurse that completed the Resident #165 no longer	F 278	random sample of 10 residents x weeks, then 10 random assessm monthly X one year. Both MDS Coordinators were in-serviced by Regional MDS Nurse on 3/10/20 concerning the importance of acc completion of the residents' asse and RAI process compliance. 3. Systemic measure implemente ensure alleged deferment practic not reoccur: The MDS Coordinate cross check the residents assess accuracy before transmission. Everesident assessment will be cross checked for accuracy using the ATool for 4 weeks, then a random of 10 residents x 4 weeks, then 1 random assessments monthly X year. 4. Monitoring to ensure the alleged deficient practice does not reoccur Resident Care Director will use the Accuracy Audit Form on 10 random assessments weekly X 4 weeks a monthly X one year. All results we reported to the Quality Assurance Committee for continued monitor improvement. 5. Compliance Date: 3/31/2017	the the 17 curate ssments ed to e does or will sment for very s cccuracy sample 0 one ed ur: The ne MDS om and then ill be e
		If the Administrator stated in er expectation that the MDS ed accurately.			

Facility ID: 923270

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(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	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 279 SS=D	COMPREHENSIVE 483.20 (d) Use. A facility in assessments components in the residence and revise the residence and revise the residence. 483.21 (b) Comprehensive (1) The facility must comprehensive per each resident, consist forth at §483.10 includes measurable to meet a resident's and psychosocial in comprehensive assecare plan must design of the components of the com	nust maintain all resident leted within the previous 15 ent's active record and use the sments to develop, review lent's comprehensive care Care Plans It develop and implement a son-centered care plan for sistent with the resident rights (c)(2) and §483.10(c)(3), that e objectives and timeframes is medical, nursing, and mental eeds that are identified in the essment. The comprehensive cribe the following - It are to be furnished to attain dent's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and att would otherwise be required 13.25 or §483.40 but are not resident's exercise of rights uding the right to refuse 83.10(c)(6).	F 2	79	3/31/17
	provide as a result recommendations.	of PASARR If a facility disagrees with the			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(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	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 279	Continued From page		F 279		
	findings of the PASAI rationale in the reside	RR, it must indicate its ent's medical record.			
	(iv)In consultation wit resident's representa	h the resident and the tive (s)-			
	(A) The resident's go desired outcomes.	als for admission and			
	future discharge. Fac whether the resident' community was asse	eference and potential for illities must document s desire to return to the ssed and any referrals to s and/or other appropriate			
	entities, for this purpo				
	requirements set forti section. This REQUIREMENT	in accordance with the h in paragraph (c) of this			
		iew and staff interviews the le the care of a resident 's		F279	
	indwelling urinary cat comprehensive care	heter in the resident ' s plan for 1 of 2 residents catheters (Resident #100).		Corrective action for the residents affected by the alleged deficient practic Resident #100 was discharged from the facility on 2/16/2017, therefore the care plan could not be updated. No negative	e e
	1/12/17 and had diag dementia, urinary tra-	ct infection (UTI), and		outcomes were identified from the alleg deficient practice.	
	neurogenic bladder v indwelling urinary cat			Corrective action taken for those residents having the potential to be affected by the alleged deficient practice.	e:
	1/16/17 noted the res	prehensive Care Plan dated sident continued to be at risk ms of recurrent UTIs. The aft to assist with peri-care		The MDS Coordinator reviewed and updated all care plans for the residents with Foley catheters on 3/8/2017. All caplans are current and appropriately	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRU			E SURVEY PLETED
		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.		
		Il 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:	t 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) MULTIP A. BUILDING	LE CONSTRUCTION	(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 DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPOLICIENCY)	D BE COMPLETION	
F 520	1 3		F 52	0		
SS=E	COMMITTEE-MEMB QUARTERLY/PLANS	-				
	(g) Quality assessme	nt and assurance.				
	(1) A facility must mai and assurance comm minimum of:	ntain a quality assessment ittee consisting at a				
	(i) The director of nurs	sing services;				
	(ii) The Medical Direc	tor or his/her designee;				
	staff, at least one of w	a board member or other				
	(g)(2) The quality ass committee must :	essment and assurance				
	coordinate and evalua	respect to which quality				
		ement appropriate plans of ified quality deficiencies;				
	Secretary may not rec records of such comm such disclosure is rela	mation. 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 CO	•	
				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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE 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 us a basis for				
		Γ is not met as evidenced				
		ons, staff interviews and		F520		
		cility's Quality Assessment		1 320		
		mittee failed to maintain		1. Corrective action for the re	esidents	
	implemented procedu			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		6,22,63,100,162,165,183,20	9,224, and	
		survey. The deficiencies		229 using the newly added	. ,	
		omprehensive assessment		Comprehensive Assessment	t 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 red	certification survey		software. The CAA tool being	g utilized is	
	conducted on 07/31/	The continued failure of		reflective of appendix C in th	ie 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 B	•	
	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. Corrective action tales for	r than	
		ors to be considered in		Corrective action taken for residents beginning the petention		
		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		
	Demine at the second	tion		responsible for completing the		
	_	tion survey of 05/19/2016,		assessment (Members inclu		
	the facility was cited	rziz iorialiure to	1	Coordinators, Social Worker	. ACIIVITIES	1 I

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345077	B. WING _			03/09/2017	
NAME OF P	ROVIDER OR SUPPLIER	-		STREET ADDRESS,	CITY, STATE, ZIP CODE	•	
				25 SUNNYBROOK	ROAD		
SUNNYBE	ROOK REHABILITATIO	N CENTER		RALEIGH, NC 2	7610		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTION I CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRI DEFICIENCY)		ON
F 520	mental status for 1 reviewed. The Administrator v 3:02 PM regarding (CAA). The Adminisunaware that PCC Click Care) didn't h We have already g 2. F278 Assessmen interviews and reconstructed accurately code the assessment in the (Resident #162), at #165), for 2 of 13 s MDS accuracy. During the recertification the facility was cited the Minimum in the areas of actives ampled residents reviewed for medic During the recertification the facility was cited to the Minimum for 1 of 2 sampled a Level II Preadmis Review. The Administrator v 3:12 PM regarding cited on the two pring cited on the two prince contents and contents are c	vas interviewed on 03/09/17 at the Care Area Assessments strator said, "We were (the facility software, Point ave the CAA Worksheet tool. of that in place as of today." Int Accuracy: Based on staff ord review, the facility failed to be Minimum Data Set (MDS) areas of active diagnoses and dental status (Resident ampled residents reviewed for cation survey of 05/19/2016, d F278 for failure to accurately Data Set (MDS) assessment asset (MDS) asset	F	Coordinator assessment transmission will be cross the Accuracy random sam weeks, then monthly X of Coordinator Administrate the importan the residents 3. Systemic ensure alleg not reoccur: and users all CAA tool ald assessment Interdisciplin responsible been unserv MDS accurateam memb Coordinators Dietician, an Resident Ca state sponso 4. Monitoring deficient pra Resident Ca 5 full compre MDS accurate compliance	d the Dietician.) The MDS will cross check the reside for accuracy before in. Every resident assessments of the control of the	ent ng g of scCC e ve	
	Assurance Commit	tee met monthly and the two		committee for	or review.		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 25 SUNNYBROOK ROAD RALEIGH, NC 27610 ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 520 5. Compliance Date: 3/31/2017		(X3) DATE COMP	SURVEY LETED	
		345077	B. WING			03/	09/2017
	ROVIDER OR SUPPLIER	CENTER		25	S SUNNYBROOK ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI	X	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
F 520		istrator said, "We had a nnel. Both of our MDS	F	520	·		