DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	IO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY IPLETED
		345233	B. WING		04	C 4/21/2017
NAME OF PI	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
	REHABILITATION & CAI	25		306 DEER PARK ROAD		
JUNKIJE		XE		NEBO, NC 28761		
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	5	F OC	00		
		e cited as a result of the on Event ID # KLLX11.				
		SUPPLIER REPRESENTATIVE'S SIGNATU		TITLE		(X6) DATE

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.

	MENT OF HEALTH AN	ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MULT			(X3) DATE	
	CORRECTION	IDENTIFICATION NUMBER:					PLETED
				_		R	-C
		345233	B. WING				21/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	REET ADDRESS, CITY, STATE, ZIP CODE		
				30	06 DEER PARK ROAD		
SUNRISE	REHABILITATION & CAP	KE		Ν	EBO, NC 28761		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		COMPLETION DATE
IAG					DEFICIENCY)		
F 333	483.45(f)(2) RESIDE	NTS FREE OF	F3	333			5/15/17
SS=D							
	483.45(f) Medication	Errors.					
	The facility must ensu	are that its-					
	(f)(2) Residents are fr	ree of any significant					
	medication errors.						
	This REQUIREMENT	is not met as evidenced					
	by:						
		cord review and interviews			Resident #173□s PT/INR lab was		
	with staff, nurse pract				completed on 4-20-2017. Resident and		
		cility failed to maintain a			physician were notified of any lab result	S	
		oumadin (a blood thinner)			by the nurse on 4-20-2017 with new		
		g the PT/INR (prothrombin			orders received and initiated per order.	_	
		malized ratio, a test used to le physician to use for			MD identified the next date for PT/INR to		
		1 of 3 sampled residents on			be drawn, order given and date written of MAR.	JII	
	Coumadin. (Resident	-					
					This had the potential to affect three oth	er	
	The findings included	:			residents on Coumadin in April 2017.		
					Charts and MARs reviewed for those		
	Resident #173 was a	dmitted to the facility			three residents and no errors were foun	d	
		alization 03/05/17-03/24/17			in Coumadin medication administration.		
	-	included endocarditis,					
		and rheumatic mitral			Licensed staff was in-serviced by Nurse		
		nospital records revealed			Administration on updated center policy		
	replacement April of 2	e prosthetic heart valve			and procedures for Coumadin administration on 4-24-2017. Licensed		
					staff were re-educated on 4-24-2017 by		
	The admission Minim	um Data Set dated 03/31/17			Nurse Administration regarding proper		
		sessed her with no cognitive			procedures for Coumadin Labs. The DC	N	
		nistered an anticoagulant			or Designee will include lab procedures		
	-	days. The care plan for			the orientation of newly hired licensed		
	Resident #173 include	ed a problem area dated			staff.		
	-	nticoagulant use, related to					
		lacement. Approaches to			The DON or designee will audit Couma		
	-	luded give Coumadin (an			medication administration to include: lab)	
	anticoagulant) per ph	ysician order, have labs			order, Coumadin order, order		
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURI	=		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGN

Electronically Signed

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.

05/11/2017

	-	ID HUMAN SERVICES				FORM	APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	
AND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING _			PLETED
		345233	B. WING				-C 21/2017
NAME OF P	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 345233 B. WING F PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SE REHABILITATION & CARE 306 DEER PARK ROAD NEBO, NC 28761 Methods SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) 33 Continued From page 1 drawn for PT/INR (prothrombin time/international normalized ratio, a test used to dose Coumadin) per physician order, observe for signs/symptoms of unusual bleeding and teach resident potential complications of anticoagulant therapy. F 333						
SUNRISE	REHABILITATION & CAF	RE					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	ЗE	(X5) COMPLETION DATE
F 333	drawn for PT/INR (pro- normalized ratio, a tes- per physician order, co- of unusual bleeding a complications of antico Review of admission Resident #173 was to Coumadin daily due to valve as well as Love anticoagulant) 100 mi Located on the Medico (MAR) for Resident # Coumadin/PT/INR flo INR range listed for m 2.5-3.5. Physician/nurse practor physician orders, revi- lab results in the med included the following -03/29/17-Resident # physician for an initial Physician progress no #173 was being admi (intravenous) antibioti stenosis with endocar mechanical heart valv with anticoagulation. -03/31/17-PT/INR res -04/03/17-A physiciar change Coumadin to	othrombin time/international st used to dose Coumadin) observe for signs/symptoms ind teach resident potential coagulant therapy. orders dated 03/24/17 noted to take 7.5 milligrams of o the mechanical mitral nox (an injectable illigrams every 12 hours. eation Administration Record 173 was a wsheet which indicated the nechanical heart valve was titioner progress notes, ew of the MAR and PT/INR ical record of Resident #173 r: 173 was seen by the 1 visit, history and physical. otes indicated Resident tted to the facility for IV ics due to rheumatic mitral rditis and noted a ve present and to continue ults were 17.3/1.4 n's order was written to 10 milligrams every day. 173 was seen by the nurse	F	333	transcription, Lab Logs, lab results, Coumadin MAR updated, and timely M notifications through direct observation and record review for residents with Coumadin orders weekly for six weeks then monthly x3 months. Results of th audits will be taken to the monthly QA Committee for review and to ensure	n s, ese	

	-	ID HUMAN SERVICES				FORM	/ APPROVED
					E CONSTRUCTION		0.0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		ECONSTRUCTION	(X3) DATE COMP	LETED
						R	-C
		345233	B. WING			04/	21/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SUNRISE	REHABILITATION & CAP	RE			306 DEER PARK ROAD		
				1	NEBO, NC 28761		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 333		omplaints of abdominal x shots, had a history of lacement and was on	F	333			
	Coumadin. The nurs recent INR was subth	e practitioner noted the most erapeutic and Coumadin reased to 10 milligrams					
	-04/05/17-PT/INR res	ults were 51.8/4.32					
		173 was seen by the ated INR. The physician hold Coumadin for 2 days					
	-04/05/17-A physiciar Coumadin and do a F	n's order was written to hold PT/INR on 04/07/17.					
	-04/07/17-PT/INR res	ults were 19.5/1.63					
	-04/07/17-A physiciar discontinue Lovenox.	n's order was written to					
	Coumadin was not ac 04/08/17 and 04/09/1	7. Review of physician ere no orders for Coumadin					
	practitioner and progr 04/07/17 INR result of bilateral ankles. The Resident #173 had a replacement and had since. The nurse pra #173 reported her ho						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG .			-C
		345233	B. WING				21/2017
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SUNRISE	REHABILITATION & CAF	E			306 DEER PARK ROAD NEBO, NC 28761		
(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 APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 333	every 3 days. The nu Resident #173 report how she was able to a prior to this regimen s subtherapeutic (an IN supratherapeutic (an IN supratherapeutic (an -04/10/17-A physician Lovenox 100 milligrar was 2.5, check INR o Coumadin 10 milligrar next day then 5 milligr -04/11/17-A physician written for 10 milligrar 7.5 milligrams of Coumad PT/INR on 04/13/17. -04/12/17-Resident # physician and progres #173 had increased to physician noted he we 20 milligrams, for 5 da -04/13/17-PT/INR res -04/13/17-Resident # practitioner and progr Resident #173 was as and hematocrit and so nurse practitioner not Resident #173's hem extremely low the bloo blood drawn from the central catheter) line.	uation of the same regimen rse practitioner indicated ed the home regimen was remain therapeutic and that he was always R less than 2.5) or INR greater than 3.5). 's order was written for ns every 12 hours until INR n 04/13/17 and to start ms one day, 7.5 milligrams rams then start over. 's clarification order was ns of Coumadin 04/10/17, madin 04/11/17, 5 lin on 04/12/17 and recheck 173 was seen by the ss notes indicated Resident ower extremity edema. The buld start Lasix (a diuretic), ays. ults were 14.0/1.16. 173 was seen by the nurse ess notes indicated sessed for low hemoglobin ubtherapeutic INR. The ed in the past when atocrit and hemoglobin were od sample was diluted from PICC (peripherally inserted	F	333			
	-04/13/17-A physiciar	's order was written to take					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>·</i>		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C	
		345233	B. WING				-C /21/2017
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0.	•
SUNRISE	REHABILITATION & CAR	RE			306 DEER PARK ROAD NEBO, NC 28761		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 333	04/14/17 and report r was written to not use stick for PT/INR and c count). -04/14/17-PT/INR res -Review of the April 2 noted Coumadin was 04/15/17 and 04/16/1 orders noted there we (to administer or to he -04/17/17-Resident # practitioner and progres subtherapeutic INR fr -04/17/17-A physiciar Coumadin 8.5 milligra on 04/20/17. -04/19/17-Resident # physician and progres #173 had concerns a abdomen from the Lo physician noted Resid heart valve and was of continue with anticoa bleeding. Located in the April 2 Administration Recorn was a Coumadin/PT/ on this flowsheet inclu- per resident. Comple PT/INR is drawn. File medical record under	 madin and redraw INR on esult to provider. An order e PICC line for lab, use fresh CBC (complete blood sults were 14.4/1.19 2017 MAR for Resident #173 ont given 04/14/17, 7. Review of physician ere no orders for Coumadin old) on these dates. 173 was seen by the nurse ress notes noted a rom 04/14/17. n's order was written to start ams every day and draw INR 173 was seen by the ss notes indicated Resident bout bruising in her ovenox injections. The dent #173 had a mechanical on Coumadin and to gulation and monitor for any 017 Medication d (MAR) for Resident #173 INR flowsheet. Directions uded, "Use one flowsheet ete an entry every time a e completed form in the 	F	333			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/15/2017 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	
		345233	B. WING				-C 21/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SUNRISE	REHABILITATION & CAP	RE			306 DEER PARK ROAD		
	1				NEBO, NC 28761		
(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 APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 333	order must be written Coumadin or change listed on the flowshee was 2.5-3.5. The flow Date/Time, INR Resu Coumadin Dose, MD Dose Change, Next F Signature. Documented entries of Resident #173 were: 04/05/17, INR=4.32, F Dose=10 milligrams, I Change=hold X 2 day 04/07/17 04/13/17, INR=1.16, F Dose=10/7.5/5 alterna Change=10 milligram 04/14/17 Date=blank on entry, C Dose=blank on entry, C D	to continue same dose of dose." The INR range et for mechanical heart valve vsheet included entries for lts, PT Results, Current (Medical Doctor) Notified, PT/INR Date and Nurse's on the flowsheet for PT=51.8, Current Coumadin MD notified=yes, Dose vs, Next PT/INR date PT=14, Current Coumadin ating, MD notified=yes, Dose s, Next PT/INR date INR=blank on entry, urrent Coumadin MD notified=yes, Dose ns, Next PT/INR date sident #173 did not include /17 or 04/14/17 PT/INR AM Resident #173 reported oumadin for several days sident #173 stated phone k/14/17 and thought that d to the issue.	F	333	3		

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 05/15/2017 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION		3) DATE COMP	SURVEY LETED
		345233	B. WING					-C 21/2017
NAME OF P	ROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE	•	-	-
SUNRISE	REHABILITATION & CAP	RE			306 DEER PARK ROAD NEBO, NC 28761			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
F 333	will inform her of any Nurse #6 stated she of anything specific beir Resident #173 but kn usually came back du -On 04/21/17 at 11:30 worked on 04/07/17 ft the unit Resident #17 she did not receive re- worked 04/07/17 from PT/INR results. Nurs- recall was thinking the #173 was still on hold typically first shift wou and did not recall see through during her sh- signed PT/INR results 04/07/17 noted result Nurse #7 stated she I available to immediat Coumadin orders. Ne worked the remainde from 7:00 PM-11:00 F Attempts to contact N 04/21/17 were unsucc Interviews with staff tt #173 on 04/14/17-04/ -On 04/20/17 at 2:00 coordinator over the of stated she worked wi 04/14/17 from 6:30 A stated the PT/INR was of 04/14/17 (during the	t nurse that reports to her pending PT/INR results. could not remember ng reported to her about new that PT/INR results uring first shift. DAM Nurse #7 reported she from 3:00 PM-7:00 PM on '3 resided. Nurse #7 stated eport from Nurse #6 (that n 7:30 AM-2:30 PM) about se #7 stated all she could e Coumadin for Resident d. Nurse #7 stated that uld receive PT/INR results eing PT/INR results come nift. (The Fax stamp on the s for Resident #173 from is were sent at 3:36 PM). knew if PT/INR results were tely call the physician for urse #7 stated Nurse #8 r of her shift on 04/07/17 PM. lurse #8 by phone on cessful. hat worked with Resident (15/17 included the following: PM Nurse #1 (unit unit Resident #173 resided)	F	333	3			

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		10. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	, í	3	· · ·	MPLETED
						R-C
		345233	B. WING			4/21/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
				306 DEER PARK ROAD		
SUNRISE	REHABILITATION & CA	RE		NEBO, NC 28761		
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIOI DATE
F 333	Continued From pag	o 7	Гаа	2		
1 333			F 33	.3		
	(that worked 04/14/1	d she reported to Nurse #2 7 from 11:00 AM-2:30 PM) Its from 04/14/17 had not				
	Come back.					
		PM Nurse #2 stated she				
		from 11:00 AM-2:30 PM with				
	Resident #173. Nurs					
		report that the PT/INR #173 were pending. Nurse				
		R results for Resident #173				
		hile she was on duty and this				
		oncoming nurse, Nurse #3.				
		PM Nurse #3 stated she				
		it #173 on 04/14/17 from 2:30				
		e #3 stated labs were usually				
		AM-4:00 AM and typically around noon or at some				
		t. Nurse #3 stated she did				
		results had not come back				
		nd did not recall being told				
		urse #2 at the start of the				
	shift on 04/14/17. No	urse #3 stated she attempted				
		results around 5:00 PM and,				
		the facility phone lines were				
		#3 stated she attempted to he end of her shift and was				
		he lab for results because the				
		ot working. Nurse #3 stated				
		personal phone available to				
		lurse #3 stated she typically				
		din during her shift but, she				
	-	in to Resident #173 on				
		e lab results were not back.				
		n the PT/INR results were				
		an would be notified so ined. Nurse #3 stated at the				
	oracio coula de obla	π σ σ π σ	1			1

Facility ID: 923334

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/15/2013 FORM APPROVEI OMB NO. 0938-039
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED R-C
		345233	B. WING		04/21/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	
SUNRISE	REHABILITATION & CAP	RE		306 DEER PARK ROAD	
				NEBO, NC 28761	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5) E ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 333	Continued From page	e 8	F 3	33	
		sed that information on to			
	worked with Resident 10:30 PM until 04/15/ stated she recalled th her shift and thought 1:00 AM on 04/15/17 not recall hearing any Coumadin during rep beginning of her shift typically would not ge PT/INR results, notify results or administerin night shift. Nurse #4	AM Nurse #4 stated she t #173 on 04/14/17 from /17 at 6:30 AM. Nurse #4 he phones were out part of service was restored around . Nurse #4 stated she did /thing about the PT/INR or ort from Nurse #3 at the . Nurse #4 stated she et involved in receiving ring the physician of PT/INR ng Coumadin during her stated her involvement with requisition slips for the lab			
	worked with Resident AM-2:30 PM. Nurses there had been proble it was not an issue du stated when she rece (that worked 04/14/17 AM) the only concern results were back and call the on call provid called the on call provid called the on call provid called the on call provid results that were draw #173. Nurse #5 docu results the response to which was to begin F supplement) every da and hematocrit on 04 did not see PT/INR res	PM Nurse #5 stated she t #173 on 04/15/17 from 6:30 #5 stated she had heard ems with phone service but uring her shift. Nurse #5 sived report from Nurse #4 7 10:30 PM- 04/15/17 6:30 or reported was the CBC d she/Nurse #5 offered to er. Nurse #5 stated she vider to report the CBC wn 04/14/17 for Resident umented on the 04/14/17 lab from the on call provider errous Sulfate (an iron ay and recheck hemoglobin /17/17. Nurse #5 stated she esults (which were also 4/17 lab results along with			

Facility ID: 923334

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/15/2017 MAPPROVED O. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION) ́сом	E SURVEY IPLETED R-C
		345233	B. WING				≺-C I/21/2017
NAME OF P	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE		
SUNDISE	REHABILITATION & CAP	DE			306 DEER PARK ROAD		
	REHABIEITATION & OAI				NEBO, NC 28761		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 333	during her shift. Nurs reported to the on call #173 had complaints stated the on call pro- the headache and Re- it saying she had alwa Ibuprofen when on a stated Resident #173 about her Coumadin that typically it was ac nursing staff. -On 04/21/17 at 10:12 with Nurse #1 (unit co Resident #173 reside expectation was for th received the PT/INR of physician/nurse pract immediately of the re- dosing of Coumadin of stated it was expected PT/INR results would Coumadin/PT/INR Fla and include all inform physician's order wou new orders for Coum- next PT/INR was due PT/INR was done Co without a physician's as the unit coordinato the Coumadin/PT/INF nothing was missed. typically reviewed the and the PT/INR's that physician for Residen Fridays. Nurse #1 sta weren't back on 04/14	adin for Resident #173 be #5 stated she also Il provider that Resident of a headache. Nurse #5 vider ordered Ibuprofen for esident #173 refused to take ays heard not to take blood thinner. Nurse #5 of did not report any concerns during her shift and noted dministered by second shift 2 AM in a follow-up interview bordinator over the unit of) she stated the ne nurse on duty that results to notify the ditioner/on call practitioner sults so new orders for could be obtained. Nurse #1 d the nurse that received the log them on the individual pwsheet located on the MAR ation. Nurse #1 stated a uld be written to include the adin as well as when the c. Nurse #1 stated after a umadin would not be given order. Nurse #1 stated that or she usually tried to look at R Flowsheets to ensure Nurse #1 stated she e flow sheets Monday-Friday t were not called in to the	F	333	3		

Facility ID: 923334

If continuation sheet Page 10 of 36

	S FOR MEDICARE &					O. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		· · · ·	E SURVEY
			A. BUILDING	<u> </u>		R-C
		345233	B. WING			
	ROVIDER OR SUPPLIER	040200		STREET ADDRESS, CITY, STATE, ZIP CO		4/21/2017
NAME OF FI	CONDER OR SUFFLIER			306 DEER PARK ROAD	DE	
SUNRISE	REHABILITATION & CA	RE		NEBO, NC 28761		
0(0)15		TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF C		(1/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIOI DATE
F 333	Continued From pag	e 10	F 33	33		
		Nurse #2 that took over the				
		2:30 PM. Nurse #1 stated				
		e was still waiting to hear the				
		esident #173 and also told				
		system was not working.				
		was in the facility until				
		PM on 04/14/17 and the				
		till not operational when she				
		I nursing staff were using s for any calls that needed to				
		stated the PT/INR was				
		arly in the morning and the				
		e back on first shift. Nurse				
	#1 stated second shi					
		1 stated third shift nurses				
	wrote the requisition	for the labwork and would				
		nurse to look for the lab				
		ated lab work drawn by the				
		t via Fax but was also				
		Nurse #1 stated because the				
		ot working the lab results				
		e sent via Fax and staff would o access on line. Nurse #1				
		ve to call the lab to obtain				
		1 stated the actual 04/14/17				
		or Resident #173 came via				
	Fax on 04/15/17 at 2	:45 AM. Nurse #1 stated				
	Nurse #4 (that worke	ed 04/14/17 from 10:30				
	PM-04/15/17 at 6:30	AM) should have called for				
		nt #173 did not receive				
		Nurse #1 stated she saw				
		vorked 04/15/17 from 6:30				
	-	the on call provider with the				
		n't understand why she didn't IR results. Nurse #1 stated				
	-	ed of the PT/INR results for				
		rse #2. Nurse #1 stated				
	Nurse #2 should hav	e reported the need for the				

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	H AND HUMAN SERVICES RE & MEDICAID SERVICES			PRINTED: 05/15/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345233	B. WING		R-C 04/21/2017
NAME OF PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE,	ZIP CODE
SUNRISE REHABILITATION &	& CARE		306 DEER PARK ROAD	
			NEBO, NC 28761	
PREFIX (EACH DEFI	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	IX (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5) EACTION SHOULD BE COMPLETION D TO THE APPROPRIATE DATE CIENCY)
the need for the to Nurse #4. Nu have reported th Resident #173 to call provider was PT/INR results of Nurse #1 stated and are given to responsible for ti stated the result: then placed in th practitioner. Nur explain exactly w Resident #173 n 04/14/17-04/16/' aware (until the Resident #173 h 04/07/17-04/09/' and Nurse #7 as when lab results #1 stated she mi in the Coumadin #173 on 04/07/1 On 04/21/17 at 9 involved with can interviewed. The began working a present in the fa nurse practitione with Resident #1 Coumadin dosin therapeutic rang mechanical hear stated she and ti staff to inform th possible to dose	Nurse #3 should have reported PT/INR results for Resident #173 rse #1 stated Nurse #4 should e need for the PT/INR results for o Nurse #5 so that when the on a called about the CBC results the ould also have been reported. lab results typically came via Fax the nurse that is on duty and he care of the resident. Nurse #1 is are addressed (if needed) and he box of the physician/nurse rse #1 stated she could not what happened which resulted in ot receiving Coumadin 17. Nurse #1 stated she was not time of the interview) that ad not received Coumadin 17. Nurse #1 identified Nurse #6 is the nurses on duty 04/07/17 would have come back. Nurse issed seeing the entries were not /PT/INR Flowsheets for Resident	F	333	

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		ID HUMAN SERVICES MEDICAID SERVICES					INTED: 05/15/2017 FORM APPROVED IB NO. 0938-0391	
STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION					LE CONSTRUCTION	(X3	B) DATE SURVEY COMPLETED	
		345233	B. WING			R-C 04/21/2017		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
SUNRISE	REHABILITATION & CAP	2E			306 DEER PARK ROAD			
CONTROL					NEBO, NC 28761			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 333	duty to address any r nurse practitioner stat Lovenox while at the Coumadin) until INR I therapeutic range. Pl 2017 MAR and Courr #173 were reviewed of The nurse practitioner until the time of the in had missed dosing of 04/07/17-04/09/17 be results had not been practitioner noted the high so the Coumadin 04/06/17 and the PT/ The nurse practitioner facility 04/10/17 and a PT/INR results for Re them with other labwo practitioner stated wh subtherapeutic for Re 10 milligrams of Courr as restarted Lovenox ha 04/07/17 because of #173 had been refusi because of discomfor stated she spoke to F and Resident #173 di received Coumadin for practitioner stated Re how Coumadin had b hospitalization (an alt the alternating dose f	lways an on call provider on needs of residents. The ted Resident #173 was on facility (in addition to the evels were within hysician orders, the April hadin Flowsheet for Resident with the nurse practitioner. r stated she didn't realize, terview, that Resident #173 Coumadin from cause the 04/07/17 PT/INR reported. The nurse INR level on 04/05/17 was n was held 04/05/17 and INR was done 04/07/17. r stated she came to the addressed the 04/07/17 sident #173 when she found ork in "her box". The nurse en she saw the INR was esident #173 she ordered the madin on 04/10/17 as well . The nurse practitioner ad been discontinued the high INR and Resident ng injections of Lovenox t. The nurse practitioner Resident #173 shared with her een dosed prior to ernating dose) and that with her INR levels were able to range. The nurse	F	333				
	04/13/17. The nurse	e ordered the next INR practitioner stated the ere still subtherapeutic in						

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STREEMENT OF DEPICENCIES (X) INCOMPENSION NUMBER (X) INCOMPENSION NUMBER </th <th></th> <th></th> <th>ID HUMAN SERVICES MEDICAID SERVICES</th> <th></th> <th></th> <th></th> <th>FOR</th> <th>D: 05/15/2017 MAPPROVED D. 0938-0391</th>			ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/15/2017 MAPPROVED D. 0938-0391	
345233 B. WING 04/21/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE 300 DEER PARK ROAD SUNRISE REHABILITATION & CARE STREET ADDRESS, CITY, STATE, ZP CODE OWING OF ADDRESS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION COMPLETOR OWING OF ADDRESS PLAN OF CORRECTION FEGULATORY OR LSC. DENTRYING INFORMATION) PRETX, PRECIN, CARE OF ADDRESS, CITY, STATE, ZP CODE COMPLETOR OF ADDRESS, CITY, STATE, ZP CODE OWING OF ADDRESS PLAN OF CORRECTION FEGULATORY OR LSC. DENTRYING INFORMATION) PRETX, PRECINCATORY OR LSC. DENTRY INFORMATION (PRECINCATORY OR LSC. DENTRY INFORMATION)	STATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				COMPLETED		
SUNRISE REHABILITATION & CARE 306 DEER PARK ROAD NEDO, NC 28761 PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) D D PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH ODER(STIVE ACTION SHOULD BE CROSS-REFINENCE) TO THE APPROPRIATE DEFICIENCY COMMETTION DEFICIENCY			345233	B. WING					
SUMMARY STATEMENT OF DEFICIENCIES PREEK TAG NEBO, NC 28761 PAUTO TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST REPRECIPED BY TULL REQUIDENCY OR LSC DENTEYING INFORMATION) D PAGEX TAG PROVDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST REPRECIPED BY TULL REQUIDENCY OR LSC DENTEYING INFORMATION) D PAGEX TAG PROVDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST REPRECIPED BY TULL REQUIDENCY OR LSC DENTEYING INFORMATION) D PAGEX TAG PROVDER'S PLAN OF CORRECTION (EACH OPENCED TO THE APPROPRIATE DEFICIENCY) OWE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY OWE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCE OWE CROSS-REFERENCED TO T	NAME OF PF	ROVIDER OR SUPPLIER	•	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
No. 10 PREFX TX0 SUMMARY STREMENT OF DEFICIENCIES (e.CAC) DEFICIENCY MUST HE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) Deficit PREFX TX0 PROVIDER'S FLAN OF CORRECTION (e.CAC) DEFICIENCY AND THE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) Deficit PREFX TX0 PROVIDER'S FLAN OF CORRECTION (e.CAC) DEFICIENCY COMPLETION DEFICIENCY F 333 Spite of being on Counsain for 3 days and she was concerned the bload drawn from the PICC line might have been olluted (as happened early in the stay of Resident #173). The nurse practitioner stated as a precationary measure she asked to have a repeat INR on 04/14/17 and to do a fresh stick, not from the PICC line. The nurse practitioner stated she knew the physician was on call 04/14/17-04/16/17 and knew he would be addressing the 7T/INR results from 04/17/17 the nurse practitioner stated she was curious to see how the new attemating regimen was working for Resident #173. The nurse practitioner stated when she came to the facility on 04/17/17. The nurse practitioner stated she was suprised to see the results were still subthrapeutic and went to talk to Resident #173. The nurse practitioner stated she was suprised to see the results were still subthrapeutic and went to talk to Resident #173. The nurse practitioner stated she was also an anticcagulant. The nurse practitioner stated she was very upset Resident #173 missed the Counsel the counse which worth how at also an onticcagulant. The nurse practitioner stated she count on the real Which nurses. The nurse practitioner stated she at told the phone lines were at which contributed to the problem. The nurse practitioner stated she did not feel the missed Counse on the covenox						306 DEER PARK ROAD			
PRETRY TAG (EACH DEFICIENCY MUST BE RECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRETRY TAG CICACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCES TO THE APPROPRIATE DEFICIENCY) F 333 Continued From page 13 spile of being on Cournadin for 3 days and she was concerned the blood drawn from the PICC line might have been diluted (as happened early in the stay of Resident #173). The nurse practitioner stated as a precautionary measure she asked to have a repeat INR on 04/14/17 and to do a fresh stick, not from the PICC line. nurse practitioner stated she knew the physician was on call 04/14/17-04/16/17 and knew he would be addressing the PTI/INR results from 04/14/17. The nurse practitioner stated she was curious to see how the new alternating regimen was working for Resident #173. The nurse practitioner stated she came to the facility on 04/17/17 she found the PTI/INR lab results from 04/14/17. The nurse practitioner stated she was suprised to see the results were still subtherapeutic and went to talk to Resident #173. The nurse practitioner stated she was date and mot to talk to Resident #173. The nurse practitioner stated she was suprised to see the results were still subtherapeutic and went to talk to Resident #173. The nurse practitioner stated she was suprised to see the results were still subtherapeutic and went to talk to Resident #173. The nurse practitioner stated she was also an anticoaquiant. The nurse practitioner stated she assured Resident #173 miseed the Councadin doses on 04/14/17-04/16/17 and discussed the counce nithich markes; though hes stated she counce not which contributed to the problem. The nurse practitioner stated she was on the lovenon x which contributed to the problem. The nurse practitioner stated she did not feel the missed Councadin harmed Resident #173 because she was on the Lovenox	SUNRISE	REHABILITATION & CAP	KE			NEBO, NC 28761			
spite of being on Cournadin for 3 days and she was concerned the blood drawn from the PICC line might have been diluted (as happened early in the stay of Resident #173). The nurse practitioner stated as a precautionary measure she asked to have a repeat INR on 04/14/17 and to do a fresh stick, not from the PICC line. The nurse practitioner stated she knew the physician was on call 04/14/17-04/16/17 and knew he would be addressing the PT/INR results from 04/14/17. The nurse practitioner stated she was curious to see how the new alternating regimen was working for Resident #173. The nurse practitioner stated when she came to the facility on 04/17/17 she found the PT/INR lab results from 04/14/17, in "her box" with other paperwork for her review. The nurse practitioner stated she was suprised to see the results were still subtherapeutic and went to talk to Resident #173. The nurse practitioner stated Resident #173. The nurse practitioner stated Resident #173 reported to her she did not receive her Cournadin 04/14/17.04/16/17. The nurse practitioner stated she was very upset Resident #173 missed the Cournadin doses on 04/14/17-04/16/17 and discussed the concern with several nurses; though she stated she could not recall which nurses. The nurse practitioner stated she did not feel the missed Cournadin hared Resident #173 because she was on the Lovenox	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF) BE	COMPLETION	
practitioner stated the half life of Coumadin would also lessen the problem when doses were missed 04/07/17-04/09/17. The nurse	F 333	spite of being on Cou was concerned the bl line might have been in the stay of Resider practitioner stated as she asked to have a r to do a fresh stick, no nurse practitioner stat was on call 04/14/17- would be addressing 04/14/17. The nurse curious to see how th was working for Resid practitioner stated wh on 04/17/17 she foun from 04/14/17 in "her for her review. The n was surprised to see subtherapeutic and w The nurse practitioner reported to her she di 04/14/17-04/16/17. T she assured Residen because she had bee also an anticoagulant stated she was very u the Coumadin doses discussed the concer though she stated she nurses. The nurse pr told the phone lines w the problem. The nur did not feel the misse Resident #173 becau which was also an an practitioner stated the also lessen the proble	madin for 3 days and she ood drawn from the PICC diluted (as happened early at #173). The nurse a precautionary measure repeat INR on 04/14/17 and t from the PICC line. The ted she knew the physician 04/16/17 and knew he the PT/INR results from practitioner stated she was e new alternating regimen dent #173. The nurse en she came to the facility d the PT/INR lab results box" with other paperwork urse practitioner stated she the results were still rent to talk to Resident #173. r stated Resident #173 id not receive her Coumadin The nurse practitioner stated t #173 she was "safe" en on Lovenox which was the nurse practitioner upset Resident #173 missed on 04/14/17-04/16/17 and n with several nurses; e could not recall which ractitioner stated she was vere out which contributed to rse practitioner stated she d Coumadin harmed se she was on the Lovenox ticoagulant. The nurse e half life of Coumadin would em when doses were	F	333				

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/15/2017 M APPROVED O. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION					E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED	
		345233	B. WING			R-C 04/21/2017		
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
SUNRISE	REHABILITATION & CAI	RE		3	306 DEER PARK ROAD			
		-		N	NEBO, NC 28761			
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 333	Continued From page	e 14	F	333				
		sician should have been IR results and she would ır again.						
	interview on 04/21/17 of Resident #173 was of Resident #173 stat missed doses of Cou until 04/21/17. The p nurse practitioner we with PT/INR results a received so orders co Coumadin dosing. T concerning that Resid Coumadin when leve physician stated since receiving Lovenox he had been harmed. T days Resident #173 r or Coumadin (04/07/ caused harm becaus and Lovenox and also	build be received for the physician stated it was dent #173 did not receive the Is were subtherapeutic. The e Resident #173 was e did not feel Resident #173 the physician stated the few received neither the Lovenox 17-04/09/17) would not have e of the half life of Coumadin to because it was such a cating there was only a						
	Nursing stated the nu- look for PT/INR result individual residents' Mout on the MAR when review of the individu Coumadin/PT/INR Fluthe nurse that had be hour communication lab book to see what Assistant Director of explain why the PT/IM	PM the Assistant Director of urse on duty should know to ts through review of the MAR (because it is blocked in the test was done), from al resident's owsheet, from report from een on duty, the nurses 24 sheet and from review of the labs had been drawn. The Nursing stated she could not NR results from 04/07/17 and t #173 were not called to the						

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		D HUMAN SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345233	B. WING				R-C /21/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SUNRISE	REHABILITATION & CAR	RE			806 DEER PARK ROAD NEBO, NC 28761		
(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 APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 333 {F 431} SS=D	physician when they were avaiting PT/INR Nursing stated PT/INR than all entries on the PT/INR than a stated PT/INR Nursing stated PT/INR Nursing stated PT/INR the expected second results. The Director was told the phone sets the directed staff to u until coverage was reads a state directed staff to u until coverage was reads a state (b)(2)(3)(g)(h) LABEL/STORE DRUC The facility must providrugs and biologicals them under an agreer §483.70(g) of this par unlicensed personnel law permits, but only usupervision of a license (a) Procedures. A face pharmaceutical service that assure the accurated dispensing, and admiting the provision of the that assure the accurate that assure the accurated the provision of a license that assure the accurated that assure the accurated that assure the accurated that assure the accurated the provision of the the accurated the provision accurated the accurated the provision accurated the provision accurated the accurated the provision accurated the accurated the provision accurated the provisio	were received. PM the Director of Nursing explain why the PT/INR and 04/14/17 for Resident tly reported to the physician. Ing stated she expected the o be recorded on the MAR Coumadin/PT/INR isident to be completed. Ing stated she expected een nursing shifts when they R results. The Director of R results typically came if they were not received shift staff to call about the of Nursing stated when she ervice was out on 04/14/17 se their personal phones stored. DRUG RECORDS, GS & BIOLOGICALS ide routine and emergency to its residents, or obtain ment described in t. The facility may permit to administer drugs if State under the general sed nurse. clilty must provide the needs of each resident.	F 4	333			5/15/17

Facility ID: 923334

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/15/2017 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		(X3) DATE SUR COMPLETE R-C		
		345233	B. WING				-C 21/2017
NAME OF PI	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CIT	TY, STATE, ZIP CODE		
SUNRISE	REHABILITATION & CAR	RE		306 DEER PARK ROA NEBO, NC 28761	ND		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVI (EACH CC	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD B FERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 431}	 employ or obtain the pharmacist who (2) Establishes a syst disposition of all control detail to enable an active of the enable and period (g) Labeling of Drugs Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the enable of th	tem of records of receipt and rolled drugs in sufficient courate reconciliation; and rug records are in order and controlled drugs is dically reconciled. and Biologicals. s used in the facility must be e with currently accepted s, and include the y and cautionary expiration date when and Biologicals. h State and Federal laws, all drugs and biologicals in s under proper temperature only authorized personnel to eys. provide separately locked, compartments for storage of d in Schedule II of the Abuse Prevention and nd other drugs subject to the facility uses single unit ution systems in which the imal and a missing dose can	{F 43	31}			
	by: Based on observatio	 is not met as evidenced ns and staff interviews the ve 1 medication which was 			oms and medication carl pected and audited on	s	

Facility ID: 923334

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/15/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345233	B. WING		R-C 04/21/2017
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	
				306 DEER PARK ROAD	
SUNKISE	REHABILITATION & CAI	KE		NEBO, NC 28761	
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
{F 431}	Continued From page	e 17	F 43	113	
(· ·)	10	on 1 of 3 medication carts.	1 10	4-21-2017 for medication of	compliance of
				expired or improperly label	
	The findings included	i:		Prescription medications. A	
				improperly labeled medicat	tion was
		AM 8 individual foil packed		removed.	
) milligrams were observed ient of the Seafoam Hall		This had the potential to af	foot all
	-	drawer. The Remeron was		residents who receive med	
		ner from the pharmacy.			
				Licensed staff was in-servi	ced by Nursing
	-	vith Nurse # 2 on 4/20/17 at		Administration, which was	•
		that medications such as		4/24/17, related to facility	
		rom the pharmacy in small		procedures regarding the c	
		els which included resident's tions, and expiration date.		safe delivery of all medicat prescription or over the cou	
	-	to locate the bag for the		included:	
	Remeron.			The removal of expired or i	improperly
				labeled medications.	
		ducted on 4/20/17 with the		Rotating of house stock me	
		that the medication carts		Checking medication expir	
		e hall nurses as well as the nembers. Nurse # 1 also		prior to dispensing of medi Checking medication room	
	-	ations except the over the		medication carts for expire	
		should have pharmacy		well as Prescription medica	
		esident, dosing information,		The DON or Designee will	-
	and expiration date.			delivery of medications in t	
		• • • •		of newly hired licensed sta	ff.
	On 4/20/17 at 5:27 P				roviow and
		irector of Nursing (DON) expected that medications		The DON or Designee will audit all medication carts a	
		labels prepared by the		rooms five times for the first	
	pharmacy.	- r - r - ,		weekly for three months fo	
				medications & Prescription	medication
				expiration dates. Results o	
				will be taken to the monthly	
				Committee for review with action plan developed and	-
				as indicated to ensure ong	-
				compliance.	

Event ID: 7Q1212

Facility ID: 923334

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/15/2017 MAPPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345233	B. WING				-C 21/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SUNRISE	REHABILITATION & CAR	RE			06 DEER PARK ROAD EBO, NC 28761		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 505 SS=D		IPTLY NOTIFY PHYSICIAN	F5	505			5/15/17
	(2) The facility must-						
	nurse specialist of lab outside of clinical refe with facility policies ar notification of a practi physician's orders.	urse practitioner, or clinical oratory results that fall rence ranges in accordance					
	with staff, nurse pract Resident #173 the fac therapeutic dose of C by not timely reporting time/international nor dose Coumadin) to th	cility failed to maintain a oumadin (a blood thinner) g the PT/INR (prothrombin malized ratio, a test used to e physician to use for 1 of 3 sampled residents on			Resident #173 s PT/INR lab was completed on 4-20-2017. Resident and physician were notified of any lab result by the nurse on 4-20-2017 with new orders received and initiated per order. MD identified the next date for PT/INR t be drawn, order given and date written MAR.	ts to on	
	with diagnoses which prosthetic heart valve	dmitted to the facility lization 03/05/17-03/24/17 included endocarditis,			This had the potential to affect three oth residents on Coumadin in April 2017. Charts and MARs reviewed for those three residents and no errors were four in Coumadin medication administration. Licensed staff was in-serviced by Nurse Administration on updated center policy	nd Ə	
	Resident #173 had th replacement April of 2 The admission Minim for Resident #173 ass impairment and admin	e prosthetic heart valve			and procedures for Coumadin administration on 4-24-2017. Licensed staff were re-educated on 4-24-2017 by Nurse Administration regarding proper procedures for Coumadin Labs. The DC or Designee will include lab procedures the orientation of newly hired licensed	/ ON	

Facility ID: 923334

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE		
			A. BUILDI	NG _			-C	
		345233	B. WING 04/21/2					
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
SUNRISE	REHABILITATION & CAR	RE			06 DEER PARK ROAD IEBO, NC 28761			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 505	Resident #173 include 04/13/17, long term a mechanical valve repl this problem area incl anticoagulant) per phy drawn for PT/INR (pro normalized ratio, a tes per physician order, o of unusual bleeding a complications of antic Review of admission of Resident #173 was to Coumadin daily due to valve as well as Love anticoagulant) 100 mi Located on the Medic (MAR) for Resident # Coumadin/PT/INR flor INR range listed for m 2.5-3.5. Physician/nurse pract physician orders, revii lab results in the med included the following -03/29/17-Resident #* physician for an initial Physician progress no #173 was being admir (intravenous) antibioti stenosis with endocar	ed a problem area dated nticoagulant use, related to lacement. Approaches to uded give Coumadin (an ysician order, have labs othrombin time/international st used to dose Coumadin) observe for signs/symptoms nd teach resident potential loagulant therapy. orders dated 03/24/17 noted take 7.5 milligrams of take 7.5 milligrams of the mechanical mitral nox (an injectable lligrams every 12 hours. ration Administration Record 173 was a wsheet which indicated the nechanical heart valve was itioner progress notes, ew of the MAR and PT/INR ical record of Resident #173 : 173 was seen by the visit, history and physical. otes indicated Resident tted to the facility for IV res due to rheumatic mitral rditis and noted a ve present and to continue	F	505	staff. The DON or designee will audit Coura medication administration to include: la order, Couradin order, order transcription, Lab Logs, lab results, Couradin MAR updated, and timely M notifications through direct observation and record review for residents with Couradin orders weekly for six weeks then monthly x3 months. Results of the audits will be taken to the monthly QAF Committee for review and to ensure ongoing substantial compliance.	b D se		

Facility ID: 923334

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/15/2017 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			LETED -C
		345233	B. WING				-0 21/2017
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SUNRISE	REHABILITATION & CAP	RE			306 DEER PARK ROAD NEBO, NC 28761		
(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 505	-04/03/17-A physiciar change Coumadin to -04/04/17-Resident # practitioner and progr Resident #173 had co bruising from Lovenon mechanical valve rep Lovenox subcutaneou Coumadin. The nurse recent INR was subth had been recently inc daily with the next INF -04/05/17-PT/INR res -04/05/17-Resident # physician due to eleva noted the plan was to and repeat an INR. -04/05/17-A physician Coumadin and do a F -04/07/17-PT/INR res -04/07/17-PT/INR res -04/07/17-A physician discontinue Lovenox. -Review of the April M Coumadin was not ac 04/08/17 and 04/09/1 orders noted there we (to administer or to ho -04/10/17-Resident # practitioner and progr 04/07/17 INR result o	I's order was written to 10 milligrams every day. 173 was seen by the nurse ess notes indicated omplaints of abdominal x shots, had a history of lacement and was on us until bridged to e practitioner noted the most erapeutic and Coumadin reased to 10 milligrams R due 04/05/17. ults were 51.8/4.32 173 was seen by the ated INR. The physician hold Coumadin for 2 days I's order was written to hold PT/INR on 04/07/17. ults were 19.5/1.63 I's order was written to NAR for Resident #173 noted Iministered 04/07/17, 7. Review of physician ere no orders for Coumadin old) on these dates. 173 was seen by the nurse ess notes noted the f 1.63 and edema to	F	505			
	practitioner and progr 04/07/17 INR result o	ess notes noted the					

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If continuation sheet Page 21 of 36

		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/15/2017 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATE	
		345233	B. WING				-C 21/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SUNRISE	REHABILITATION & CAR	RE			306 DEER PARK ROAD NEBO, NC 28761		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 505	Resident #173 had a replacement and had since. The nurse prace #173 reported her how was 10 milligrams, the milligrams with contin every 3 days. The nur Resident #173 reported how she was able to reprior to this regimen s subtherapeutic (an IN supratherapeutic (an IN supratherapeutic (an IN supratherapeutic (an -04/10/17-A physician Lovenox 100 milligram was 2.5, check INR o Coumadin 10 milligram next day then 5 milligr -04/11/17-A physician written for 10 milligram r.5 milligrams of Coumad PT/INR on 04/13/17. -04/12/17-Resident #* physician and progress #173 had increased lo physician noted he wo 20 milligrams, for 5 da -04/13/17-PT/INR ress -04/13/17-Resident #* practitioner and progress and hematocrit and so nurse practitioner noted here	history of mechanical valve been on Coumadin therapy citioner noted Resident me regimen of Coumadin en 7.5 milligrams, then 5 uation of the same regimen urse practitioner indicated ed the home regimen was remain therapeutic and that she was always R less than 2.5) or INR greater than 3.5). I's order was written for ns every 12 hours until INR n 04/13/17 and to start ms one day, 7.5 milligrams rams then start over. I's clarification order was ns of Coumadin 04/10/17, madin 04/11/17, 5 lin on 04/12/17 and recheck 173 was seen by the ss notes indicated Resident ower extremity edema. The ould start Lasix (a diuretic), ays. ults were 14.0/1.16. 173 was seen by the nurse ess notes indicated ssessed for low hemoglobin ubtherapeutic INR. The	F	505	5		

Facility ID: 923334

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						FORM	D: 05/15/2017 APPROVED
	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING		COMF	LETED
		345233	B. WING				-C 21/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	04/	21/2017
SUNDISE	REHABILITATION & CAP	DE			306 DEER PARK ROAD		
JUNKISE	REHABILITATION & CAP				NEBO, NC 28761		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 505	Continued From page	22	F	505	5		
		od sample was diluted from					
	-	PICC (peripherally inserted					
	 -04/13/17-A physiciar	n's order was written to take					
	10 milligrams of Cour	madin and redraw INR on					
		esult to provider. An order PICC line for lab, use fresh					
	stick for PT/INR and (-					
	count).						
	-04/14/17-PT/INR res	sults were 14.4/1.19					
		017 MAR for Resident #173					
	noted Coumadin was	-					
		7. Review of physician ere no orders for Coumadin					
	(to administer or to he						
	-04/17/17-Resident #	173 was seen by the nurse					
	practitioner and progr	ress notes noted a					
	subtherapeutic INR fr	rom 04/14/17.					
	-04/17/17-A physiciar	n's order was written to start					
	-	ams every day and draw INR					
	on 04/20/17.						
	-04/19/17-Resident #						
		ss notes indicated Resident					
	#173 had concerns al abdomen from the Lo	ovenox injections. The					
	physician noted Resid	dent #173 had a mechanical					
	heart valve and was o						
	bleeding.	gulation and monitor for any					
	Located in the April 2	017 Medication					
	Located in the April 2 Administration Record	d (MAR) for Resident #173					
		INR flowsheet. Directions					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING			
		345233	B. WING				-C 21/2017
NAME OF PI	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		-
SUNRISE	REHABILITATION & CAP	RE			306 DEER PARK ROAD NEBO, NC 28761		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	T BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			COMPLETION DATE	
F 505	Continued From page	23	F	505	5		
		uded, "Use one flowsheet					
		te an entry every time a e completed form in the					
	medical record under	•					
		INR results. A physicians					
		to continue same dose of dose." The INR range					
	listed on the flowshee	et for mechanical heart valve					
		vsheet included entries for Its, PT Results, Current					
		(Medical Doctor) Notified,					
	-	PT/INR Date and Nurse's					
	Signature. Documented entries of	on the flowsheet for					
	Resident #173 were:						
		PT=51.8, Current Coumadin MD notified=yes, Dose					
	Change=hold X 2 day						
	04/07/17 04/13/17 INR=1 16 I	PT=14, Current Coumadin					
	Dose=10/7.5/5 alterna	ating, MD notified=yes, Dose					
	Change=10 milligram 04/14/17						
	Date=blank on entry, PT=blank on entry, C						
	Dose=blank on entry,	MD notified=yes, Dose					
	Change=8.5 milligram 04/20/17	ns, Next PT/INR date					
		sident #173 did not include					
	results.	/17 or 04/14/17 PT/INR					
		AM Resident #173 reported					
		oumadin for several days sident #173 stated phone					
	-	k/14/17 and thought that					
	might have contribute	•					
	Interviews with staff th	nat worked with Resident					

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING .			-C
		345233	B. WING				-0 21/2017
NAME OF PF	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
SUNRISE	REHABILITATION & CAF	RE			306 DEER PARK ROAD NEBO, NC 28761		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 505	worked from 6:30 AM the unit Resident #17 typically the third shift will inform her of any Nurse #6 stated she of anything specific bein Resident #173 but kn usually came back du -On 04/21/17 at 11:30 worked on 04/07/17 ft the unit Resident #17 she did not receive re worked 04/07/17 from PT/INR results. Nurs recall was thinking the #173 was still on hold typically first shift wou and did not recall see through during her sh signed PT/INR results 04/07/17 noted result Nurse #7 stated she H available to immediate Coumadin orders. Nu worked the remainded from 7:00 PM-11:00 F Attempts to contact N 04/21/17 were unsuce	uded the following: PM Nurse #6 stated she -2:30 PM on 04/07/17 on 3 resided. Nurse #6 stated inurse that reports to her pending PT/INR results. could not remember g reported to her about ew that PT/INR results iring first shift. 0 AM Nurse #7 reported she rom 3:00 PM-7:00 PM on 3 resided. Nurse #7 stated port from Nurse #6 (that 1 7:30 AM-2:30 PM) about e #7 stated all she could e Coumadin for Resident . Nurse #7 stated that ild receive PT/INR results ing PT/INR results come ift. (The Fax stamp on the s for Resident #173 from s were sent at 3:36 PM). cnew if PT/INR results were ely call the physician for urse #7 stated Nurse #8 r of her shift on 04/07/17 PM. urse #8 by phone on cessful. hat worked with Resident 15/17 included the following:	F	508			
		unit Resident #173 resided)					

Facility ID: 923334

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	MENT OF HEALTH AN	D HUMAN SERVICES				FORM): 05/15/2017 APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE	
		345233	B. WING				-C
	ROVIDER OR SUPPLIER	040200		STREET ADDRESS, CITY, STA		04/.	21/2017
				BIRLET ADDIREGO, ON 1, OTA			
SUNRISE	REHABILITATION & CAP	RE		NEBO, NC 28761			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 505	stated she worked wii 04/14/17 from 6:30 Al stated the PT/INR wa of 04/14/17 (during th not come back when AM. Nurse #1 stated (that worked 04/14/17 that the PT/INR result come back. -On 04/21/17 at 5:00 worked on 04/14/17 fr Resident #173. Nurse remembered getting r results for Resident # #2 stated the PT/INR did not come back wh was reported to the of -On 04/20/17 at 3:00 worked with Resident PM-10:30 PM. Nurse drawn between 2:00 / came (via Fax) back a point during first shift. not know the PT/INR for Resident #173 and that in report from Nu shift on 04/14/17. Nu to call the lab for the r at that time, realized the not working. Nurse # call the lab through the not able to contact the phone service was no she did not have her use to call the lab. Nu administered Coumad	th Resident #173 on M-11:00 AM. Nurse #1 s drawn early the morning ird shift) but the results had she gave report at 11:00 she reported to Nurse #2 7 from 11:00 AM-2:30 PM) ts from 04/14/17 had not PM Nurse #2 stated she rom 11:00 AM-2:30 PM with e #2 stated she	F 505				

Facility ID: 923334

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	APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SU	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLET	TED
R-C	;
345233 B. WING 04/21	/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
SUNRISE REHABILITATION & CARE 306 DEER PARK ROAD	
NEBO, NC 28761	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE 0 TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE 0	COMPLETION DATE
DEFICIENCY)	
F 505 Continued From page 26 F 505	
04/14/17 because the lab results were not back.	
Nurse #3 stated when the PT/INR results were	
available the physician would be notified so	
orders could be obtained. Nurse #3 stated at the	
end of her shift the phone lines were still not	
working and she passed that information on to	
Nurse #4.	
-On 04/21/17 at 6:00 AM Nurse #4 stated she	
worked with Resident #173 on 04/14/17 from	
10:30 PM until 04/15/17 at 6:30 AM. Nurse #4	
stated she recalled the phones were out part of	
her shift and thought service was restored around	
1:00 AM on 04/15/17. Nurse #4 stated she did	
not recall hearing anything about the PT/INR or	
Coumadin during report from Nurse #3 at the	
beginning of her shift. Nurse #4 stated she	
typically would not get involved in receiving PT/INR results, notifying the physician of PT/INR	
results or administering Coumadin during her	
night shift. Nurse #4 stated her involvement with	
labs was writing the requisition slips for the lab	
service.	
-On 04/20/17 at 5:45 PM Nurse #5 stated she	
worked with Resident #173 on 04/15/17 from 6:30	
AM-2:30 PM. Nurse #5 stated she had heard there had been problems with phone service but	
it was not an issue during her shift. Nurse #5	
stated when she received report from Nurse #4	
(that worked 04/14/17 10:30 PM- 04/15/17 6:30	
AM) the only concern reported was the CBC	
results were back and she/Nurse #5 offered to	
call the on call provider. Nurse #5 stated she	
called the on call provider to report the CBC	
results that were drawn 04/14/17 for Resident	
#173. Nurse #5 documented on the 04/14/17 lab	
results the response from the on call provider which was to begin Ferrous Sulfate (an iron	

Facility ID: 923334

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345233	B. WING				R-C / 21/2017
NAME OF P	ROVIDER OR SUPPLIER		-		STREET ADDRESS, CITY, STATE, ZIP CODE		
SUNRISE	REHABILITATION & CAP	RE			306 DEER PARK ROAD NEBO, NC 28761		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 505	supplement) every da and hematocrit on 04. did not see PT/INR re- included on the 04/14 the CBC) and wasn't the PT/INR or Couma during her shift. Nurs reported to the on cal #173 had complaints stated the on call pro- the headache and Re- it saying she had alwa Ibuprofen when on a stated Resident #173 about her Coumadin that typically it was ac nursing staff. -On 04/21/17 at 10:12 with Nurse #1 (unit co Resident #173 reside expectation was for the received the PT/INR of physician/nurse pract immediately of the resident stated it was expected PT/INR results would Coumadin/PT/INR Flo and include all inform physician's order wou new orders for Couma next PT/INR was due PT/INR was done Co without a physician's as the unit coordinato the Coumadin/PT/INF nothing was missed.	ay and recheck hemoglobin (17/17. Nurse #5 stated she esults (which were also (17 lab results along with aware of any concerns with adin for Resident #173 as #5 stated she also I provider that Resident of a headache. Nurse #5 vider ordered Ibuprofen for esident #173 refused to take ays heard not to take blood thinner. Nurse #5 did not report any concerns during her shift and noted dministered by second shift 2 AM in a follow-up interview bordinator over the unit d) she stated the ne nurse on duty that results to notify the itioner/on call practitioner sults so new orders for could be obtained. Nurse #1 d the nurse that received the log them on the individual pwsheet located on the MAR ation. Nurse #1 stated a lld be written to include the adin as well as when the . Nurse #1 stated after a umadin would not be given order. Nurse #1 stated that or she usually tried to look at R Flowsheets to ensure	F	50			

Facility ID: 923334

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/15/2017 MAPPROVED D. 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345233	B. WING				R-C / 21/2017
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
				:	306 DEER PARK ROAD		
SUNRISE	REHABILITATION & CAF	RE		1	NEBO, NC 28761		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 505	physician for Residen Fridays. Nurse #1 sta weren't back on 04/14 was working with Res had been reported to cart from 11:00 AM-2 she told Nurse #2 she PT/INR results for Re Nurse #2 the phone s Nurse #1 stated she approximately 5:30 P phone system was sti left. Nurse #1 stated their personal phones be made. Nurse #1 stated cournadin. Nurse #1 wrote the requisition f inform the oncoming results. Nurse #1 stated contract lab was sent accessible on line. N phone system was not would not have been not have been able to stated staff would hav the results. Nurse #1 PT/INR lab results for Fax on 04/15/17 at 6:30 p orders since Residen Coumadin 04/14/17. that Nurse #5 (that worked AM-2:30 PM) called to	t were not called in to the at #173 were both on ated she knew the results #17 at 11:00 AM when she sident #173. She stated this Nurse #2 that took over the :30 PM. Nurse #1 stated e was still waiting to hear the sident #173 and also told system was not working. was in the facility until M on 04/14/17 and the ill not operational when she nursing staff were using of or any calls that needed to stated the PT/INR was arly in the morning and the e back on first shift. Nurse it typically gave the stated third shift nurses for the labwork and would nurse to look for the lab ted lab work drawn by the via Fax but was also urse #1 stated because the of working the lab results sent via Fax and staff would o access on line. Nurse #1 ve to call the lab to obtain stated the actual 04/14/17 r Resident #173 came via 45 AM. Nurse #1 stated d 04/14/17 from 10:30 AM) should have called for t #173 did not receive Nurse #1 stated she saw orked 04/15/17 from 6:30 he on call provider with the	F	505			
	CBC results and didn	't understand why she didn't					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE SURVEY COMPLETED R-C		
		345233	B. WING				-C 21/2017	
	ROVIDER OR SUPPLIER	RE	I		STREET ADDRESS, CITY, STATE, ZIP CODE 306 DEER PARK ROAD NEBO, NC 28761			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)					(X5) COMPLETION DATE	
F 505	also report the PT/INI she reported the need Resident #173 to Nur Nurse #2 should have PT/INR results for Re Nurse #1 stated Nurs the need for the PT/IN to Nurse #4. Nurse # have reported the need Resident #173 to Nur call provider was calle PT/INR results could Nurse #1 stated lab re and are given to the r responsible for the ca stated the results are then placed in the box practitioner. Nurse # explain exactly what H Resident #173 not read 04/14/17-04/16/17. N aware (until the time of Resident #173 had no 04/07/17-04/09/17. N and Nurse #7 as the no when lab results woul #1 stated she missed in the Coumadin/PT/I #173 on 04/07/17 at 9:13 A involved with care for interviewed. The nur- began working at the present in the facility	R results. Nurse #1 stated d of the PT/INR results for se #2. Nurse #1 stated e reported the need for the sident #173 to Nurse #3. e #3 should have reported NR results for Resident #173 f1 stated Nurse #4 should ed for the PT/INR results for se #5 so that when the on ed about the CBC results the also have been reported. esults typically came via Fax nurse that is on duty and are of the resident. Nurse #1 addressed (if needed) and k of the physician/nurse 1 stated she could not nappened which resulted in ceiving Coumadin Jurse #1 stated she was not of the interview) that of received Coumadin Jurse #1 identified Nurse #6 nurses on duty 04/07/17 d have come back. Nurse seeing the entries were not NR Flowsheets for Resident d 04/14/17. AM the nurse practitioner Resident #173 was se practitioner stated she facility 01/30/17 and was four days a week. The ted she was very involved nd was working on keep INR's within the	F	504	5			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/15/2017 M APPROVED D. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		E CONSTRUCTION	(X3) DATE COME	TE SURVEY MPLETED R-C	
		345233	B. WING				/21/2017	
NAME OF P	ROVIDER OR SUPPLIER	I		5	STREET ADDRESS, CITY, STATE, ZIP CODE			
				3	306 DEER PARK ROAD			
JUNKIJE	REHABILITATION & CAP	χε.		1	NEBO, NC 28761			
(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 SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 505	stated she and the pr staff to inform them of possible to dose Cou The nurse practitione available there was a duty to address any r nurse practitioner stat Lovenox while at the Coumadin) until INR I therapeutic range. Pl 2017 MAR and Courr #173 were reviewed of The nurse practitione until the time of the in had missed dosing of 04/07/17-04/09/17 be results had not been practitioner noted the high so the Coumadin 04/06/17 and the PT/ The nurse practitione facility 04/10/17 and a PT/INR results for Re them with other labwo practitioner stated wh subtherapeutic for Re 10 milligrams of Cour as restarted Lovenox ha 04/07/17 because of #173 had been refusi because of discomfor stated she spoke to F and Resident #173 di received Coumadin for practitioner stated Re how Coumadin had b	ve. The nurse practitioner hysician were dependent on f the INR results as soon as madin based on the results. r stated if they were not lways an on call provider on needs of residents. The ted Resident #173 was on facility (in addition to the levels were within hysician orders, the April hadin Flowsheet for Resident with the nurse practitioner. r stated she didn't realize, terview, that Resident #173 coumadin from ecause the 04/07/17 PT/INR reported. The nurse INR level on 04/05/17 was n was held 04/05/17 and INR was done 04/07/17. r stated she came to the addressed the 04/07/17 esident #173 when she found ork in "her box". The nurse uen she saw the INR was esident #173 she ordered the madin on 04/10/17 as well . The nurse practitioner ad been discontinued the high INR and Resident ng injections of Lovenox t. The nurse practitioner Resident #173 on 04/10/17 id not indicate she had not or 3 days. The nurse esident #173 shared with her	F	505				

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STATEMENT O AND PLAN OF	F DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345233	· /	TIPLE			D. 0938-0391
NAME OF PR	OVIDER OR SUPPLIER	245022	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PR	OVIDER OR SUPPLIER	345255	B. WING				-C 21/2017
		•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				30	06 DEER PARK ROAD		
SUNRISE F	REHABILITATION & CAP	RE		N	IEBO, NC 28761		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
	be within therapeutic practitioner stated sho 04/13/17. The nurse results on 04/13/17 w spite of being on Cou was concerned the bl line might have been in the stay of Resider practitioner stated as she asked to have a r to do a fresh stick, no nurse practitioner stat was on call 04/14/17- would be addressing 04/14/17. The nurse curious to see how th was working for Resid practitioner stated wh on 04/17/17 she foun from 04/14/17 in "her for her review. The n was surprised to see subtherapeutic and w The nurse practitioner reported to her she di 04/14/17-04/16/17. T she assured Residen because she had bee also an anticoagulant stated she was very u the Coumadin doses	her INR levels were able to range. The nurse e ordered the next INR practitioner stated the rere still subtherapeutic in madin for 3 days and she ood drawn from the PICC diluted (as happened early th #173). The nurse a precautionary measure repeat INR on 04/14/17 and the PICC line. The ted she knew the physician 04/16/17 and knew he the PT/INR results from practitioner stated she was e new alternating regimen dent #173. The nurse en she came to the facility d the PT/INR lab results box" with other paperwork urse practitioner stated she the results were still rent to talk to Resident #173. r stated Resident #173 id not receive her Coumadin The nurse practitioner stated	F	505	DEFICIENCY)		
	told the phone lines w the problem. The nur did not feel the misse	actitioner stated she was vere out which contributed to rse practitioner stated she d Coumadin harmed se she was on the Lovenox					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP		
		345233	B. WING				-0 21/2017	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>•</u>	-	
SUNRISE	REHABILITATION & CAP	RE			306 DEER PARK ROAD NEBO, NC 28761			
(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 BE CC CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 505	which was also an an practitioner stated the also lessen the proble missed 04/07/17-04/0 practitioner stated it w either she or the physi informed of the PT/IN ensure it did not occur On 04/21/17 at 12:25 interview on 04/21/17 of Resident #173 was of Resident #173 was of Resident #173 stat missed doses of Cour until 04/21/17. The p nurse practitioner wer with PT/INR results a received so orders co Cournadin dosing. Th concerning that Resid Cournadin when level physician stated since receiving Lovenox he had been harmed. Th days Resident #173 r or Cournadin (04/07/1 caused harm because and Lovenox and also short time frame; india slight possibility of a s On 04/21/17 at 1:30 F Nursing stated the nu look for PT/INR result individual residents' N out on the MAR wher review of the individual Cournadin/PT/INR Flo	ticoagulant. The nurse e half life of Coumadin would em when doses were 09/17. The nurse vas not good practice and sician should have been R results and she would r again. PM and in a follow-up at 12:53 PM the physician e he was not aware of the madin for Resident #173 hysician stated he and the re dependent on staff to call s soon as they were ould be received for ne physician stated it was dent #173 did not receive the ls were subtherapeutic. The e Resident #173 was did not feel Resident #173 ne physician stated the few eceived neither the Lovenox 17-04/09/17) would not have e of the half life of Coumadin o because it was such a cating there was only a stroke. PM the Assistant Director of rse on duty should know to its through review of the MAR (because it is blocked in the test was done), from	F	505				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	O. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCT		(X3) DATE SURVEY COMPLETED	
		345233	B. WING _				R-C 1/21/2017
NAME OF PI	ROVIDER OR SUPPLIER		_ _		ESS, CITY, STATE, ZIP CODE	•	
SUNRISE	REHABILITATION & CAF	RE		306 DEER PAR NEBO, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC ACH CORRECTIVE ACTION SHO DSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 505 {F 520} SS=D	hour communication s lab book to see what Assistant Director of M explain why the PT/IN 04/14/17 for Resident physician when they v On 04/21/17 at 2:24 F stated she could not e results from 04/07/17 #173 were not promp The Director of Nursin need for the PT/INR t and all entries on the Flowsheet for each re The Director of Nursin communication betwe were awaiting PT/INF Nursing stated PT/INF Nursing stated PT/INF Nursing stated PT/INF back on first shift but she expected second results. The Director was told the phone se she directed staff to u until coverage was re 483.75(g)(1)(i)-(iii)(2)(COMMITTEE-MEMBI QUARTERLY/PLANS (g) Quality assessme (1) A facility must mai and assurance comm minimum of: (i) The director of nursi	sheet and from review of the labs had been drawn. The Nursing stated she could not IR results from 04/07/17 and #173 were not called to the were received. PM the Director of Nursing explain why the PT/INR and 04/14/17 for Resident tly reported to the physician. ng stated she expected the o be recorded on the MAR Coumadin/PT/INR esident to be completed. ng stated she expected een nursing shifts when they R results. The Director of R results typically came if they were not received shift staff to call about the of Nursing stated when she ervice was out on 04/14/17 se their personal phones stored. (i)(ii)(h)(i) QAA ERS/MEET ant and assurance.	F 5				5/15/17

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/15/2017 (IAPPROVED): 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION	(X3) DATE	
		345233	B. WING _				-C 21/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
SUNRISE	REHABILITATION & CAP	3E			06 DEER PARK ROAD		
				N	EBO, NC 28761		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 520}	Continued From page	34	{F 5:	20}			
	staff, at least one of w	a board member or other					
	(g)(2) The quality ass committee must :	essment and assurance					
	coordinate and evaluate	respect to which quality					
		ement appropriate plans of ified quality deficiencies;					
	Secretary may not rec records of such comn 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 committee to identify deficiencies will not be sanctions. This REQUIREMENT by: 	and correct quality					
	Based on observation facility's Quality Asses Committee failed to m procedures and moni- committee put into pla was for one recited de originally cited in Mar	tor interventions the ace in March of 2017. This eficiency which was			The facility will ensure the QAPI committee maintains an effective plant monitor continued compliance of deficiencies identified to include F431. This has the potential to affect all residents.	0	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED R-C 04/21/2017	
		345233					
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
SUNRISE REHABILITATION & CARE				306 DEER PARK ROAD			
				N	EBO, NC 28761		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPI DEFICIENCY)			(X5) COMPLETION DATE
{F 520}	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		{F 5	520}	Facility Quality Assurance Performanc Improvement committee members wer re-educated by the Director of Clinical Operations on 5/12/17 regarding the G process. This includes: Facility will identify areas of continuous quality monitoring and the monitoring to to be used. Monitoring activities should focus on th process that effect resident outcomes most significantly to include survey deficiencies. Ongoing monitoring is used to establis the facility s baseline and predictabilit various outcomes. The QAPI Committee will continue to meet on a monthly basis to continue monitoring identified areas of improvement, to include survey deficiencies for compliance. The QAPI Committee will address the identified areas, examine and improve the identi need through improvement (action) pla and monitoring the effectiveness of su plans. The Director of Clinical Operatio or Designee will review the facility QAF Committee meeting minutes for six months or until substantial compliance achieved.	fied ans ch ons pri	

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