AMENDED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/Supplier/CMS/CLIA IDENTIFICATION NUMBER:

345233

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

(X3) DATE SURVEY COMPLETED

12/02/2011

NAME OF PROVIDER OR SUPPLIER

SUNRISE REHABILITATION & CARE

STREET ADDRESS, CITY, STATE, ZIP CODE

306 DEER PARK ROAD

NEBO, NC 28761

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 225 SS-D

483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge that it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

F 225

Plan of Correction

12/11/11

Without admitting or denying the validity of existence of the alleged deficiencies, Sunrise Rehab and Care provides the following plan of correction.

F 225-SS-D Failure to investigate allegations

1. Immediate and 5 day report has been submitted to the State agency for resident #160. NA #1 has been counseled and re-educated on proper positioning of residents. LN #8 and LN #2 have been re-inserviced on abuse reporting.

2. Occurrence reports for the last six months have been re-reviewed to ensure there were no other potential abuse/lack of investigation issues and none were identified.

LABORATORY DIRECTORS OR PROVIDER/Supplier REPRESENTATIVE'S SIGNATURE

ADMINISTRATOR

1/21/11

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 recordable a 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 recordable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction will be a condition for continued program participation.

Received

Dec 22 2011

BY:________________________
F 225 Continued From page 1

This REQUIREMENT is not met as evidenced by:

Based on review of facility records and staff and resident interviews the facility failed to report an incident of alleged abuse by a nurse aide within 24 hours and complete an investigative report within five days and submit it to the state agency for one (1) of three (3) residents (Resident # 160)

The findings are:

Resident #160 was admitted to the facility with diagnoses of Cerebrovascular Accident (CVA) with left hemiparesis, general weakness, gait difficulty, chronic back pain, arthritis and fibromyalgia. A review of the latest Minimum Data Set (MDS) assessment of 10/14/2011 revealed the resident was cognitively intact and required extensive to total assistance of two staff with daily care, bed mobility and transfer.

On 11/29/2011 at 10:44 a.m. during an initial interview Resident # 160 revealed a few weeks ago Nursing Assistant #1 (NA) turned her onto her "bad arm" (left) while putting her on the bedpan. Resident # 160 further stated she told NA # 1 the whole time her arm hurt and NA #1 just looked at her and did not stop. A follow-up interview with Resident #160 on 11/30/2011 at 2:00 p.m. revealed when she reported the incident to the 7:00 a.m. to 3:00 p.m. nurse on 10/28/2011, LN # 8, the nurse told her she would take care of things. Resident # 160 reported she told her family that same evening and they talked to the 3:00 p.m. to 11:00 p.m. nurse identified as LN #2.

3. All staff were inserviced by the administrator on the requirement of reporting any suspicions or actual event of abuse to the administrator immediately.

4. Nursing supervisors/charge nurse will check reports each day for allegations. The review committee meets each day to review the occurrences and follow up if needed, if any allegations found. MDS nurse will audit occurrence log weekly X4, monthly X3 then quarterly to ensure that any allegations have been investigated by the administrator with committee documentation. Results will be given to QA committee monthly.

12/30/11
**NAME OF PROVIDER OR SUPPLIER**

**SUNRISE REHABILITATION & CARE**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

306 DEER PARK ROAD
NEBO, NC 28761

**DATE SURVEY COMPLETED**

12/02/2011

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<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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On 11/30/2011 at 4:10 p.m. LN# 2 was interviewed and the "Resident Occurrence Report" reviewed. LN # 2 confirmed he filled out the "Resident Occurrence Report" on 10/26/2011 at 9:00 p.m. and placed it on the nurses station for that unit. LN#2 documented the following: "Resident said: "NA #1 was putting me on the bedpan and I told her she was hurting my arm". LN #2 confirmed when he assessed Resident # 160 the bruise was already in evidence.

Interview with the Director of Nurses (DON) on 11/30/2011 at 4:25 p.m. revealed she expected her staff to report immediately any alleged abuse occurrences to her or the facility Assistant Director of Nurses (ADON). In addition the DON confirmed there was no date by her signature to indicate when she had reviewed it.

On 11/30/2011 at 5:15 p.m. the Administrator was interviewed and confirmed the date by her signature as 11/10/2011 which was when she received and reviewed the report. When asked about the possibility of this occurrence being abuse the Administrator revealed staff must not have regarded it as abuse and she would have taken it as a transfer accident and not abuse. Continued interview revealed the Administrator indicated it should have been brought to her attention within 24 hours so she could follow facility procedure especially since an x-ray was done.

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<tr>
<td>F 253</td>
<td>483.15(h)(2) HOUSEKEEPING &amp;</td>
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F 253 SS-B

1. Room #65 has been painted and doors repaired. Room # 61 has been painted. Doors leading into 300 hall have been repaired. Doors entering 100 hall dinning room have been repaired.

2. All resident rooms and equipment will be checked by Administrator and Maintenance Director for any needed painting/repairs/replacements.
3. Staff has been re-inserviced by DON on the process for notifying maintenance of any needed repairs.

4. QA nurse will audit rooms and equipment weekly X4, monthly X3 and quarterly after that... Results will be reported to QA committee monthly.
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<td>F 253</td>
<td>Continued From page 5 plastic covering. c. Observations on 12/01/11 at 11:23 a.m. and at 4:50 p.m. in the facility's 200 hall dining room revealed two (2) mechanical lifts and a geri chair were stored along a dining room wall. Closer inspection of these pieces of equipment revealed that the two (2) lifts were very unclean with accumulated dried substances and the material on both of the geri chair's arm rests was torn in multiple places. On 12/01/11 at 4:50 p.m. an Interview was conducted with the facility's Maintenance Director. The Maintenance Director stated that he was unaware of any resident care equipment, including geri chairs, wheel chairs, side rail pads and mechanical lifts, that needed to be repaired or cleaned. When the Maintenance Director was shown the two (2) unclean mechanical lifts and the torn arm rests on the geri chair in the facility's 200 hallway dining room he confirmed the need for both of the lifts to be cleaned and for the geri chair's arm rests to be repaired. The Maintenance Director stated that he relied on the staff to inform him of any issues regarding resident care equipment, so that he could resolve these issues as soon as possible. On 12/02/11 at 10:15 a.m. an interview was conducted with the facility's Administrator. The Administrator stated that mechanical lifts should be deep cleaned at least every three (3) months or as needed and staff were expected to inform the facility's Maintenance Director of any resident care equipment, including wheel chairs and geri chairs, that were in need of any repairs.</td>
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<td>F 322</td>
<td>483.25(g)(2) NG TREATMENT/SERVICES</td>
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F 322 SS-D

1. The expired cans were removed from the cabinets and discarded.

2. All supply cabinets have been checked for any other expired supplements. A new log sheet has been started to document date placed on shelf and current expiration date.

3. All nursing and stock personnel were instructed and in-serviced by the DON on the importance of checking product expiration dates prior to administration of tube feedings. QA nurse and stocking personnel were instructed and in-serviced by the administrator on the use of new forms and rotation of stock. Stock is checked daily by the stock person.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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problem/need: "Receives a regular ground meat diet & eats 80% of most all meals. G-Tube feedings if less than 50% of meals are consumed."

Review of Resident #24's November 2011 Medication Administration Record (MAR) revealed the resident had received and consumed multiple cans of Jevity 1.5 during the month of November.

Observations of the facility's two hundred (200) hall pantry room on 12/01/11 at 10:51 a.m. and on 12/02/11 at 9:30 a.m. revealed fifty-five (55) of fifty-five (55) eight ounce cans of Jevity 1.5, that were stored in this room, had expired expiration dates of 11/01/11.

Interview with Licensed Nurse (LN) #7 on 12/02/11 at 9:39 a.m. revealed that Resident #24 was the only resident who received Jevity 1.5 on the facility's 200 hallway. LN #7 specified that Resident #24 had an order to receive a can of Jevity 1.5 by his gastrosotmy tube when he consumed less than half of his meals and that staff would obtain this product from the facility's 200 hallway pantry room when it was needed for Resident #24. LN #7 reviewed the resident's December 2011 MAR and stated that he had not received any Jevity 1.5 on either 12/01/11 or 12/02/11. LN #7 further stated that she was unsure what staff was responsible for checking the expiration dates on the enteral products stored in the facility's 200 hall pantry area.

On 12/02/11 at 10:10 a.m. the facility's administrator was interviewed. The Administrator stated that the facility's Quality Assurance staff

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4. QA nurse is to check cabinet weekly X4, monthly x3, then quarterly. Results will be reported to QA committee monthly.
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLIANCE DATE</th>
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<td>F 322</td>
<td>Continued From page 8 and dietary staff were responsible for checking expiration dates of products stored in pantry cabinets on at least a weekly basis. The administrator stated that staff should have realized the fifty-five (55) cans of Jevity 1.5 had expiration dates of 11/01/11 and should have removed all of these cans on or before 11/01/11. The Administrator confirmed that Resident #24 had received Jevity 1.5 on multiple occasions during the month of November 2011.</td>
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