PRINTED: 04/03/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Fig. 50.00		CONSTRUCTION	(X3) DATE COMPI	
	2		34.	-	9	(
		345233	B. WNG			03/2	20/2014
NAME OF	PROVIDER OR SUPPLIER	*	# #	S	FREET ADDRESS, CITY, STATE, ZIP CODE		10
SHABIS	E REHABILITATION & CA	RF		30	06 DEER PARK ROAD	•	
50111/151	L KENADIENATION & OA	NE .		N	EBO, NC 28761		2.
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	5550	(X5) COMPLETION DATE
F 156 SS=0	The facility must inform and in writing in a lar understands of his or regulations governing responsibilities during facility must also promotice (if any) of the §1919(e)(6) of the Admade prior to or upon resident's stay. Received	83.10(b)(1) NOTICE OF ERVICES, CHARGES In the resident both orally aguage that the resident her rights and all rules and gresident conduct and gresident conduct and gresident with the stay in the facility. The wide the resident with the State developed under ct. Such notification must be a admission and during the eipt of such information, and it, must be acknowledged in	F	156	This Plan of Correction is the center's compilance. Preparation and/or execution of this plan constitute admission or agreement by the the facts alleged or conclusions set forth i deficiencies. The plan of correction is presolely because it is required by the provision. F- 156 1.) How corrective action will be accomplished for the residents affer the Survey Results Notebook is cl	of correction of correction of the staten ippared and ions of fede	on does not the truth of nent of or executed
j	writing. The facility must info entitled to Medicaid to fadmission to the note in the note items and services the facility services under which the resident mother items and services and for which the resident mother items and services the amount of charge inform each resident	rm each resident who is benefits, in writing, at the time cursing facility or, when the gible for Medicaid of the nat are included in nursing or the State plan and for ay not be charged; those ices that the facility offers sident may be charged, and when changes are made to see specified in paragraphs (5)			labeled and located in the front lot the facility. Its location is clearly identified on the residents' inform bulletin board. The State Compla phone number is posted clearly on bulletin board. The name and phonumber for the Ombudsman is retand posted in large enough font for residents to clearly read it and it is at a height for wheelchair viewing. 2.) How corrective action will be accomplished for those residents in the potential to be affected:	ation ation int Line the one yped r located)
ŧ	at the time of admiss the resident's stay, of facility and of charge including any charge under Medicare or but The facility must furn legal rights which ind A description of the	es for services not covered y the facility's per diem rate. hish a written description of cludes:			All residents have the potential of affected. No negative outcomes id	Belack / Builliob R 15 21 by:	1

Administrator

4.11.14

Any deficiency statement ending with an asterisk ("Idenotes 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.

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	0.00	MULTIPLE JILDING _	CONSTRUCTION	(X3) DATE S COMPL	
		345233	B. W.	1NG	2	03/2	0/2014
	(EACH DEFICIENC	RE ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	(E)	30	TREET ADDRESS, CITY, STATE, ZIP CODE 16 DEER PARK ROAD EBO, NC 28761 PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(25) COMPLETION DATE
F 156	personal funds, under section; A description of the representation of the restablishing eligible the right to request a 1924(c) which deternon-exempt resource institutionalization are spouse an equitable cannot be considered toward the cost of the medical care in his ordinary down to Medicaid eligible. A posting of names, numbers of all perting groups such as the sagency, the State lict ombudsman program advocacy network, a unit, and a statement complaint with the Sagency concerning remisappropriation of the restablishment of the section.	equirements and procedures stility for Medicaid, including in assessment under section innes the extent of a couple's es at the time of indicate at the indica	C (C)	F 156	3.) What measures will be put in systemic changes made to ensure correction: The Social Worker is identified responsible for compliance on the information bulletin board. The Administrator or designee will of weekly audits for four weeks an audits for three months to ensure compliance with all information to be posted for residents. The Resident will be educate corrections made and location of complaint line and Ombudsman numbers as well the location of the Notebook. The Administrator waddress the Resident Council and they are made aware of all chands. How the facility plans to more performance to make that solutions under the quarterly Quality Assurance Committee Meeting The Administrator was presented to the compliance will be resulted.	as le resident e onduct d monthly e required Resident led on the f phone the Survey fill d cusure ges, hitor its cons are the dewed for sistrator is	
	name, specialty, and physician responsible. The facility must prowritten information, applicants for admissinformation about he Medicare and Medicare	minently display in the facility and provide to residents and				# 1	,

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X4) PROVIDER/SUPPLIER/CLIA (X4) PROVIDER/SUPPLIER/CLIA (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) PROVIDER/SUPPLIER/CLIA (X6) PROVIDER/SUPPLIER/SU					1	LETED	
981		345233	B. WNG		g 30	1	20/2014
	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			306 NE	1 50		
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156	N 5965	e 2	F	156	è		R ·
	by: Based on observation interviews the facility results, post the state number, and failed to Ombudsman's phone low enough to be view	ons, and staff and resident failed to label the survey e complaint line phone oprint and place the anumber large enough and				e e	
	Observations were method the survey hall near the dining reinformation for reside was the name and plombudsman in small standing at the board	nade on 03/18/14 and by of a bulletin board in the born which contained ents. On this bulletin board hone number of the I regular type at eye level if I. Furthermore the number		-	**************************************	ike *	
	was a note indicating could be found on a the building. This not markings indicating v. An interview was cor AM with the Residen stated she was unaw was or where her nur further explained she state complaint line pwhere the results of the state of the	the survey results notebook table near the front door of ebook was observed with no what it was.					
is.	, could,					2 4	

CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	8 5		CONSTRUCTION	COMPL	SURVEY .ETED
			200		C	
	345233	B. WNG			03/2	20/2014
ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
TO MAKE BEHAVIOLEN AN ANALYSIS WARRING TO SEE THE SERVICE OF THE S	West		30	6 DEER PARK ROAD		
REHABILITATION & CA	RE		NE	EBO, NC 28761		
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
An interview was con AM with the Adminis stated it was her exp name would be post to read it. She further survey results to be	nducted on 03/20/14 at 11:30 trator. The Administrator pectation the Ombudsman ed where residents were able or stated she expected the labeled and the state	F	156	compliance. Preparation and/or execution of this plan of constitute admission or agreement by the prothe facts alleged or conclusions set forth in the facts alleged. The plan of correction is prepared to the facts of correction in the facts alleged.	correction d ovider of the he statement red and/or e	oes not truth of of executed
483.13(a) RIGHT TO	BE FREE FROM	F	221	1.) How corrective action will be accomplished for the residents aff	ected:	4.17.14
physical restraints in discipline or conven treat the resident's resident's resident's resident's resident's resident's resident's resident's resident's resident res	nposed for purposes of lence, and not required to nedical symptoms. T is not met as evidenced on, record review and staff failed to release a lap buddy			to release Resident #16 lap buddy restraint. Res. #16 restraint is bei released during meals. Res #16 cand Pictorial reviewed and update necessary. 2.) How corrective action will be	ng ire plan ed as	,
The findings included Resident #16 was a 08/12/06 with diagnost disease, hypertension most recent Minimu 12/18/13 noted the impaired cognition of during the assessm required extensive to transfers and was a prevented rising less observation period.	dmitted to the facility on oses including Alzheimer's on and seizure disorder. The m Data Set (MDS) dated Resident #16 had severely with continuous inattention ent period. Resident #16 wo person assistance for ssessed as using a chair that is than daily during the)	identified as potentially being affer Audit conducted by the DON or do to ensure all identified residents we restraints are being released during meals. No negative outcomes identified to the systemic changes made to ensure correction: The Staff Development Coordinated designed re-educated the nursing regarding proper releasing of residenting resident meals. The MDS	cted, esignee; ith ig ctified. clace or	de su
	SUMMARY S' (EACH DEFICIENC REGULATORY OR Continued From pag An interview was con AM with the Adminis stated it was her exp name would be post to read it. She furthe survey results to be complaints line num 483.13(a) RIGHT TO PHYSICAL RESTRA The resident has the physical restraints in discipline or conveni treat the resident's in This REQUIREMEN by: Based on observati interview, the facility during meals for 1 o (Resident #16). The findings include Resident #16 was a 08/12/06 with diagnor disease, hypertension most recent Minimu 12/18/13 noted the impaired cognition v during the assessmirequired extensive t transfers and was a prevented rising les observation period.	REHABILITATION & CARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 An interview was conducted on 03/20/14 at 11:30 AM with the Administrator. The Administrator stated it was her expectation the Ombudsman name would be posted where residents were able to read it. She further stated she expected the survey results to be labeled and the state complaints line number to be posted. 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to release a lap buddy during meals for 1 of 1 resident with restraints (Resident #16). The findings included: Resident #16 was admitted to the facility on 08/12/06 with diagnoses including Alzheimer's disease, hypertension and seizure disorder. The most recent Minimum Data Set (MDS) dated 12/18/13 noted the Resident #16 had severely impaired cognition with continuous inattention during the assessment period. Resident #16 required extensive two person assistance for transfers and was assessed as using a chair that prevented rising less than daily during the	ROVIDER OR SUPPLIER REHABILITATION & CARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 An interview was conducted on 03/20/14 at 11:30 AM with the Administrator. The Administrator stated it was her expectation the Ombudsman name would be posted where residents were able to read it. 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Resident #16 required extensive two person assistance for transfers and was assessed as using a chair that prevented rising less than dally during the observation period.	ROMDER OR SUPPLIER REHABILITATION & CARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 An interview was conducted on 03/20/14 at 11:30 AM with the Administrator. The Administrator stated it was her expectation the Ombudsman name would be posted where residents were able to read it. She further stated she expected the survey results to be labeled and the state complaints line number to be posted. 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. 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Resident #16 required release with resortion of the residents and the state of the potential to be affected: The Gare Area Assessment (CAA) for physical three continuous period. The Gare Area Assessment (CAA) for physical three continuous period. The Gare Area Assessment (CAA) for physical during resident manifer manifer to the potential of the strain of the potential reviewed and the strain of the potential reviewed and the sace of the potential reviewed and update necessary. 2.) How corrective action will be accomplished for the residents of the potential reviewed and update necessary. 2.) How corrective action will be accomplished for those residents of the potential to be affected: 3.) What measures will be put in province and the state of the potential reviewed and the sace of the potential reviewed and the sace of	REHABILITATION & CARE SUMMARY STATEMENT OF DEFICIENCES (EACH DEPICIENCY MUST BE PRECUEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 An interview was conducted on 03/20/14 at 11:30 AM with the Administrator steed it was her expectation the Ombudsman name would be posted where residents were able to read it. She further stated she expected the survey results to be labeled and the state compliants in number to be posted. 483.13(a) RIGHT TO BE FREE FROM Physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. 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SUMMARY STATEMENT OF DEFICIENCY MINE AND PROPRIED TO CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS RETREMED TO THE PROPROPART EMERGENCY EXCELLENCE TO THE PROPRIED TO CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS RETREMED TO THE PROPROPART EMERGENCY EXCELLENCE TO THE PROPROPART EMERCIAL CONTINUES and the summer definition or ongreenest by the provisions of factor of the facility on the provision of the plane of correction is the center's credible allege constituted by the provisions of factor of the facility on the provision of the provisions of factor of the facility on the provisions of factor of the plane of correction is the center's credible allege constituted by the provisions of factor of the facility on the provision of correction is the center's credible allege complaints or the provisions of factor of the facility of the provisions of factor of the factor of the factor of the factor of the factor of

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C			
		345233	B. WNG		03/20/2014			
	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF		22	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		
F 221	falls due to trying to go balance, medication The CAA summary frexperienced 3 falls we previous assessment tolerated in a wheeld restraint. His care plan was last included the problem lap buddy restraint wan appropriate intervaddress releasing the 1:1 care. Review of the Reside Nurse Aides (NAs) to had "Lap Cushion" or instructions for released A review of Resident revealed a restraint of which indicated he let toward the floor whill lap buddy to prevent causing injury. On 03/17/14 from 11 Resident #16 was of room being fed by Nonn-self release padd between the resident armrests of the wheel on 03/19/14 from 11 Resident #16 was of room being fed by Nonn-self release padd between the resident armrests of the wheel on 03/19/14 from 11 Resident #16 was of room being fed by Nonn-self release padd between the resident armrests of the wheel on 03/19/14 from 11 Resident #16 was of room being fed by Nonn-self release padd between the resident #16 was of room being fed by Nonn-self release padd between the resident #16 was of room being fed by Nonn-self release padd between the resident #16 was of room being fed by Nonn-self release padd between the resident #16 was of room being fed by Nonn-self release padd between the resident #16 was of room being fed by Nonn-self release padd between the resident #16 was of room being fed by Nonn-self release padd by Nonn-self release padd between the resident #16 was of room being fed by Nonn-self release padd by Non	desident #16 was at risk of get up unassisted, impaired side effects and recent falls. Further indicated he had without injury since the tand was out of bed daily as hair with a lap buddy st reviewed on 12/18/13 and of risk for falls with use of then in wheelchair noted as ention. The care plan did not be restraint during meals or ent Care Guide used by direct the resident's care incled but did not indicate any sing the restraint. #16's medical record evaluation dated 09/18/13 caned forward with his head at falls from the wheelchair :45 AM until 12:40 PM oserved in the north wing day urse Aide (NA) #5. A ded lap buddy was in place t's abdomen and the	F 22	Pictorials for those with restraint updates them as necessary reflect releasing for meals. DON or dest conduct documented QA Audits monitor restraint release during through direct random observation record review audits 2x weekly for weeks, then once weekly for four and monthly x3 months for compliance with the fact restraint policy. The SDC will in provisions for restraint policy amprocedure during orientation of mursing personnel. 4.) How the facility plans to monit performance to make that solution ensured: Audit results will be reviewed an analyzed monthly by the DON or for three months, and then quart the Quality Assurance Committed Meeting with subsequent plan of developed and implemented as in by the QA Committee. The Direct Nursing is responsible for overall restraint compliance,	Ing gnee will co meals on and or 4 weeks lianceserviced ility clude d new tor its ons are d designee erly at e action dicated etor of			

Facility ID: 923334

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		18 6	NG	COMP	COMPLETED		
		345233	B. WNG			1	20/2014
	ROVIDER OR SUPPLIER REHABILITATION & C	ARE		306 E	ET ADDRESS, CITY, STATE, ZIP CO DEER PARK ROAD O, NC 28761	DE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 221	wheelchair. On 03/20/14 at 10: interviewed about the releasing of restated the facility powere to be released hours during toileting knew they were exevery 2 hours, she covered in periodic on 03/20/14 at 11: about what she way with restraints during was trained to released why some strained to release to the covered in periodic on 03/20/14, she state facility a few weeks facility policy was as on 03/20/14 at 11: Coordinator was in does orientation of restraint usage durinstructs the NAs of that they should be the resident is toile of NA # 5's oriental restraints was covered on 03/20/14 at 3:4 interviewed about of restraints. The Assignment of the control of the covered about of restraints. The Assignment of the covered about of restraints. The Assignment of the covered about of restraints.	and the armrests of the 33 AM the MDS nurse was the care plan not addressing straints and the MDS nurse to the colicy specified that restraints during meals and every 2 the color when asked how the NAs pected to release the restraint stated the expectation was	F	221			
		s to be released whenever the tly supervised and during				ı	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	9 12 15		CONSTRUCTION	(X3) DATE S COMPL	ETED
		345233	B. WNG				20/2014
	ROVIDER OR SUPPLIER	ARE .		30	TREET ADDRESS, CITY, STATE, ZIP CODE 06 DEER PARK ROAD EBO, NC 28761		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 221	Nursing (ADON) was expectation for the report of the resident and resident record review the faresidents reviewed and and and resident and and resident and resid	is PM the Assistant Director of as interviewed about her release of restraints. The expected restraints to be als and when residents were are. When asked about buddy, she stated it should be als. AND RESPECT OF comote care for residents in a environment that maintains or ident's dignity and respect in sor her individuality. NT is not met as evidenced and staff interviews and acility failed to ensure ted with dignity for 2 of 4 for dignity. (Residents #19		221	This Plan of Correction is the center's or compliance. Preparation and/or execution of this plan of constitute admission or agreement by the prothe facts alleged or conclusions set forth in the factor of the provision law. F-241 1.) How corrective action will be accomplished for the residents afted and results reported pregulatory guidelines. A complete investigated completed and results reported pregulatory guidelines. Both residents in the facility and report in negative outcomes. 2.) How corrective action will be accomplished for those residents the potential to be affected: All residents are potentially affect Audit conducted by the Administ designee ensuring all residents' dand respect (resident rights) are lamintained by interviewing all with designated as interviewable. For resident's identified as un-intervistaff observations during Guardi rounds and random interviews with Responsible Parties will be compensure those residents dignity and resure the residents dignity and results reported by the provision of the prov	fected: and #22 a state ion was er ents no having ted. rator or ignity being ho are those ewable, an Angel ith leted to	loes not iruth of tof tof executed and state
	conducted with Re	6 PM an interview was sident #19. Resident #19 t remember who it was but she)	V	residents rights are maintained. I negative outcomes identified. 3.) What measures will be put in systemic changes made to ensure	place or	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	8 9	PLE CONSTRUCTION	(X3) DATE COMP	
771 ₂₀		* *				
1	*	345233	B. WING _		03/	20/2014
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE		
{; •		(8)		306 DEER PARK ROAD		
SUNRISE	REHABILITATION & CA	RE		NEBO, NC 28761	¥	.]
2/11/15	SUMMARY ST	ATEMENT OF DEFICIENCIES .	ID	PROVIDER'S PLAN OF CORF	RECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		SHOULD BE	COMPLETION DATE
	}			86		1
F 241	Continued From page	e 7 ·	F 2	41 correction:		
	was going to make hi	m do something. He stated				
	he did not tell anyone	because they would just	·	The Staff Development Coo		
	laugh at him.			designee re-educated all fac	ility staff	
	53ec			regarding proper understan		
		PM during an interview with		residents' rights to upholding		
	■ 197 - MANAGORO (1971), M. AND AND D. (2011) (2011)	ed someone did take his		dignity and respect. Reside	_	
	No. 100 100 100 100 100 100 100 100 100 10	he could not remember who		education included custome		HS W
	had done this.			dignity and respect, grievan		
ě.	0.004044.15.054	DN4 !-4 !		abuse protocols. Guardian		i i
	On 03/18/14 at 5:05 l	THE CONTROL OF THE PROPERTY OF		and procedures reviewed w		p.
		ocial Worker (SW). She spoken to Resident #19 in a		by the Administrator. Adm		
	 In a specific programmer and an expensive form of the control of the	nner and jerked something		designee will conduct docum		1
		SW stated she had reported		Audits of interviewable resi		
	this to the Administra			responsible parties of un-in		
	uno to uno riarrimiona			resident to monitor resident		i. I
	A telephone interview	was conducted on 03/20/14		regarding dignity and respe		
		Administrative Assistant (AA)		two weeks for 4 weeks and i		
		Admission Coordinator. She		months for compliance. Th		III'
	stated she had witnes	ssed the incident which		include provisions for reside		
	occurred 01/20/14 wi	th Resident #19. The AA		during orientation of new fa	icility	
		gone to the doctor and left		personnel. ,		% 1
1	The second of th	he front door which was		4.) How the facility plans to	monitor its	0.3
	The same and the same and the same	A stated Resident #19 had		performance to make that s		۲.,
2.		of the building near her		ensured:	orations are	
	office as he frequenti	y did using his rolling walker.		chisured.		
		#19 had sat in the empty		Audit results will be review	ed and	
	E.	he AA then told Resident air belonged to a resident		analyzed monthly by the So		
		to need it. The AA stated		for three months, and then		72
5:		etting up when the DON		the Quality Assurance Com		
		e and told him to get out of		Meeting with subsequent pl		
		DON then opened the		developed and implemented		,
		dent #19's rolling walker and		by the QA Committee. The		
		hcloths he had stored there.		Administrator is responsibl	e for overall	
		ent #19 used the washcloths		resident rights compliance.	3	
	because he drooled.	The AA stated Resident #19		=:		
	grabbed the washclo	ths and a tug of war ensued.	*	ý.		
1	Sho stated the DON	started to twist the				

PRINTED: 04/03/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO, 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES. (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING_ C B. WNG 345233 03/20/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 306 DEER PARK ROAD SUNRISE REHABILITATION & CARE NEBO, NC 28761 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) F 241 Continued From page 8 F 241 washcloths which was also twisting Resident #19's arm. Resident #19 then fell backward into the wheelchair. The AA stated the DON could have hurt Resident #19's arm as his arm and hand were being twisted. She stated this was reported to the previous Administrator by the SW. 2. Resident #22 was admitted to the facility on 06/28/3 with diagnoses which included depression and Parkinson's disease. Resident #22's most recent Quarterly MDS dated 12/26/14 assessed him as being cognitively intact. An interview was conducted on 03/18/14 with Resident #22. Resident #22 reported the Director of Nursing (DON) yelled and hollered at him. He stated she got to talking real loud and he did not want other people to hear it. He told her he did . not think she should be working there and that she needed to be gentle and quiet. He stated it was just himself and the DON in her office. He stated it was a matter of heavy scolding and her voice was very harsh and bitter. On 03/18/14 at 5:05 PM an interview was conducted with the Social Worker (SW). She stated had heard the DON velling at Resident #22. The SW stated she heard the DON speak down to Resident #22. The SW stated she reported the incident to the Administrator. On 03/18/14 at 5:45 PM an interview was

conducted with Resident #22 with the

Administrator present. Resident #22 stated when the DON spoke to him the way she did it made him feel terrible. He stated he wondered if it was going to be that way all the time. Resident #22 then stated since then she just glared at me and does not speak. He stated he had been feeling

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIEF/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI A BUILDING COMPLET				
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NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
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SUNRISE	REHABILITATION & CAI	RE		NEBO, NC 28761			
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F 241 F 242 SS=D	incident happened he cry. 483.15(b) SELF-DET MAKE CHOICES The resident has the schedules, and health her interests, assessinteract with member inside and outside the about aspects of his are significant to the This REQUIREMENT by: Based on medical reand staff interviews the and honor the choice of 3 residents review #34 and Resident #7 The findings included 1. Resident #34 was with diagnosis which diabetes, hypertensic disease. Resident #34 was with diagnosis which diabetes, hypertensic disease. Resident #34 was cognition and needin person with bathing. MDS indicated no reg.	ing in the facility but after this is just wanted to sit down and its instruction of the property of the community both a facility; and make choices or her life in the facility that resident. This not met as evidenced excord reviews and resident for bathing frequency for 2 and for choices. (Resident 6). The resident of the facility that resident for bathing frequency for 2 and for choices. (Resident 6). The resident of the facility that resident for bathing frequency for 2 and for choices. (Resident 6). The resident of the facility that resident for bathing frequency for 2 and for choices. (Resident 6). The resident of the facility that resident for bathing frequency for 2 and for choices. (Resident 6). The resident for the facility that resident for bathing frequency for 2 and for choices. (Resident 6). The resident for the facility that resident for bathing frequency for 2 and for choices. (Resident 6).	F 24	Preparation and/or execution of this plan of constitute admission or agreement by the provide facts alleged or conclusions set forth in the deficiencies. The plan of correction is prepared solely because it is required by the provisions law. F- 242 1.) How corrective action will be accomplished for the residents affer Resident #34 and #76 shower choice obtained by direct interviews and such schedules updated to reflect their of Staff re-educated by the DON/designes #34 and #76 shower schedules. #34 and #76 care plan and Pictoria reviewed and updated by the MDS Coordinator as necessary to reflect resident choices. 2.) How corrective action will be accomplished for those residents he potential to be affected: All residents are identified as potential to be affected. Audits and assessing conducted by the DON or designeed resident shower choices are obtain. Those residents who could not be interviewed, preference information obtained from the Responsible Parawhere applicable or through staff knowledge of resident, when Responsible dentified.	prrection doss not ider of the truth of statement of ed and/or executed of federal and state Lacted: Les were shower choices. I are aving aving		
		assistance with activities of Resident #34's medical	1	What measures will be put in p systemic changes made to ensure	lace or		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A BUILDIN	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 242	with bathing and was On 03/19/14 at 9:12 / conducted with Resic gets two showers per a shower every day. During an interview w #1 on 03/19/14 at 2:2 shower schedule set determined by reside stated residents get t NA#1 stated if reside showers a week they additional showers. It did not resist care. On 03/19/14 at 4:13 if conducted with the A (ADON) she explaine a week and if they wa to request additional On 03/20/14 at 11:52 conducted with the A stated during the adn were asked how they and if they preferred evening shower. The allows for each reside week. The AD stated than two showers a v resident's family wou to the nursing staff so	ing assistance of 1 person not resistive to care. AM an interview was lent #34. She stated she week but would like to have with Nursing Assistant (NA) 19 revealed there was a up by the nurses which was nt's room number. She wo showers per week. In the word of the wood have to request NA #1 stated Resident #34 PM an interview was sesistant Director of Nursing and residents get two showers anted more they would have	F 2	Admission Assessments by nursing staff will include to "Bathing Preference Sheet new resident what their share. When applicable, MI or designee will contact the Parties for residents identified interviewable. The Staff Decordinator or designee residents identified to choice the resident in the choice of the c	atilizing the "asking each ower choices OS Coordinator e Responsible fied as un- evelopment e-educated the the resident's ower day and asked for their dated by MDS uarterly care g Preference by the resident. w Care Plans apdates them as lent choices and for those un- reference binder in MDS "Bathing miated e will conduct monitor the lirect random view audits 2x nce weekly for 3 months for employees will mpliance with The SDC will dent rights to
		ents upon admission how ek they would like to have.		personnel. 4) How the facility plans t	o monitor its

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A BUILD		CONSTRUCTION	(X3) DATE S	
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	er.	345233	B. WING			03/2	0/2014
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F 242	conducted with the A were not being asse number of showers the each week. The AD expectation that resist admission about the many times a week. 2. Resident #76 where on 03/11/14 with diangeneration of the chronic kidney diseased beindeness, hypopsychosis. Resident Minimum Data Set (assessed her as beindependent with bases.	a follow-up interview was ADON, she stated residents ssed for preferences on the they would like to receive ON stated it was her dents be assessed upon ir preferences specific to how they wanted to bathe/shower. The sas re-admitted to the facility ignoses which included ase, diabetes mellitus, edema, ertension, depression and it #76's most recent quarterly MDS) dated 12/24/13 ing cognitively intact, withing, and needing transfer DS indicated no rejection of	F	242	performance to make that solution ensured: Audit results will be reviewed and analyzed monthly by the DON or for three months, and then quarte the Quality Assurance Committee with subsequent plan of actions do and implemented as indicated by Committee. The Director of Nurs responsible for overall shower sch compliance.	designee orly at meeting eveloped the QA ing is	
	she was independed (ADL's). On 03/19/14 at 9:21 conducted with Res gets two showers proshowers three times. Wednesday, and Frobeen asked by facil week she would like. On 03/19/14 at 2:52 conducted with Nurstated there was a	AM an interview was ident #76. She stated she er week but would like to have a week on Monday, iday. She stated she had not ity staff the number of times a er to bathe/shower. 2 PM an interview was sing Assistant (NA) #2. NA #2 shower schedule set up by the determined by resident's room					
2	number. If a reside	ent wants more than two ey or their families had to	w w		160		3

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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F 242		PM an interview was	F	This Plan of Correction is the center compliance. Preparation and/or execution of this placoustitute admission or agreement by the the facts alleged or conclusions set forthe deficiencies. The plan of correction is particular to the plan of correction is particular.		of correction royidar of the	n does not he iruth of an of
e 34	(ADON) she explain	Assistant Director of Nursing ed residents get two showers ranted more they would have showers.			deficiencies. The plan of correction is prej solely because it is required by the provision	pared and/oi ons of federd	r executed
	conducted with the A stated during the ad were asked how the and if they preferred evening shower. The allows for each residence. The AD state than 2 showers a we resident's family wor to the nursing staff's accommodated. The specifically ask resident's accommodated asked to the state of th	2 AM an interview was Activity Director (AD), she mission process residents y preferred to bathe/shower a morning, afternoon, or a current shower schedule dent to have 2 showers a aid if a resident wanted more each the resident or the full have to communicate this so their preferences could be a AD stated she did not dents upon admission how ek they would like to have.					e e
w.	conducted with the were not being assenumber of showers each week. The AD expectation that resadmission about the	A follow-up interview was ADON, she stated residents essed for preferences on the they would like to receive DON stated it was her idents be assessed upon eir preferences specific to how they wanted to bathe/shower.					1
F 279	483.20(d), 483.20(k	(1) DEVELOP	F	279	F- 279		1/4
SS=D	COMPREHENSIVE	CARE PLANS			1,) How corrective action will be	1	4.17.14
	•				accomplished for the residents ass	ected:	1 1 1 1
		he results of the assessment			Decident #10 generales to us 3 ct 3	. 1	
Y.C.		and revise the resident's			Resident #19 care plan is updated		
	comprehensive plan	rorcare,			reflect accurate dependency and c interventions which address assist		
	The facility must de	velop a comprehensive care			required for specific ADL's,	ance	
	I The racinty must de	rolop a comprehensive care	- 1		reduit en for specific VDP.2.		I.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 279	plan for each residen objectives and timeta medical, nursing, and needs that are identificassessment. The care plan must do to be furnished to attachighest practicable pleasychosocial well-being \$483.25; and any serbe required under \$4 due to the resident's \$483.10, including the under \$483.10 (b)(4). This REQUIREMENT by: Based on record revifacility failed to developlan for activities of dwas dependent for careviewed for activities #19) The findings included Resident #19 was ad 11/09/12 with diagnon Parkinson's disease. Quarterly Minimum Double 1/14/14 assessed hone cognitive impairment him as needing externand personal hygiene Review of Resident #19.	that includes measurable bles to meet a resident's I mental and psychosocial ided in the comprehensive escribe the services that are ain or maintain the resident's hysical, mental, and ang as required under vices that would otherwise 83.25 but are not provided exercise of rights under e right to refuse treatment This is not met as evidenced item and staff interviews the op a comprehensive care aily living for a resident who are for 1 of 4 residents, is of daily living. (Resident included Resident #19's most recent that Set (MDS) dated im as having moderate. The MDS further assessed asive assistance with toileting extensions.	F 27.9	2.) How corrective action will be accomplished for those residents in the potential to be affected: Dependent residents needing assis with ADL's are identified. Care Felctorial audits completed by the Coordinators for all dependent reto assure compliance. Updates to Plans or Pictorials completed. No negative outcomes identified. 3.) What measures will be put in a systemic changes made to ensure correction: The Administrator or designee recoducated the MDS Coordinators regarding proper individualized of Plan documentation required for dependent residents for ADL's to individualized interventions and the amount of assistance required. A staff re-educated on accurately	tance . Plan and MDS sidents Care cinclude; he	
à.	dated 01/14/14 revea	aled he required limited to		<i>a</i> 3		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 279	(ADL). The goal of the Resident #19 will confolling walker through interventions which a what assistance was Review of the Care Adated 10/16/14 reveatinger for activities of CAA read: "Resident times. Becomes easi refuses care at times. On 03/20/14 at 2:42 conducted with Nursinurse and wrote Resistated activities of daily living. She stated what that meant. She assistance to limited daily living. She stated what that meant. She assistants use the Rhow they know what On 03/20/14 at 3:11 conducted with Nursicare plan for Reside understand the need of daily living care. Sneeds to be prompted can do himself and stemmember.	most activities of daily living e care plan was that attinue to ambulate with his in next review. There were no addressed specific ADL or needed. Area Assessment (CAA) aled Resident #19 he did if daily living function. The is alert and confused at lly agitated and resists and it." PM an interview was a #5 who was the MDS ident #19's care plan. She ally living were considered. Nurse #5 stated the care #19 needed extensive assistance with activities of ad everyone would know a stated the nursing esident Care Card which is to do for a resident. PM an interview was a #4. Nurse #4 stated the nut #19. did not help her to its of the resident's activities who stated Resident #19 and regarding the things he cometimes he could not	F 279	11 13	will to cation con and ns and cly for 4 weeks ching ADL taff will nee with include e Plans cition of litor its ons are ad r designee terly at ce f action indicated cetor of	
# E	PM with Nurse #3, the stated residents' car	nducted on 03/20/14 at 3:16 ne unit coordinator. Nurse #3 e plans were what the nurses at the resident's needs were.	a 2			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED		
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F 279	Continued From page She stated the care page Resident #19's person be more specific.	olan did not relate to nal care needs and should	F	279	This Plan of Correction is the center's or compliance. Preparation and/or execution of this plan of constitute admission or agreement by the prothe facts alleged or conclusions set forth in the deficiencies. The plan of correction is preparately because it is required by the provision law.	correction a ovider of the he statement ared and/or e	loes not truth of t of sxecuted	
F 312 SS=E	conducted with the A Administrator stated not address his ADL stated this was a wor was working on maki tell the story of the re 483.25(a)(3) ADL CA DEPENDENT RESID A resident who is una daily living receives t	dministrator. The Resident #19's care plan did issues. The Administrator k in progress and the facility ng care plans that actually sident's and their needs. RE PROVIDED FOR	F	312	F- 312 1.) How corrective action will be accomplished for the residents affice Resident #9 nails were trimmed a cleaned. Residents #9, #13, #19 reappropriate mouth care. Res #9 hair was trimmed. Nursing staff serviced on policy and procedures ADL care provided dependent reby the Staff Development Coordinate.) How corrective action will be accomplished for those residents.	nd eccived facial in- s for sidents nator.	4.17.14	
	by: Based on observation interviews and record provide mouth care f (Residents #9, #13 a care and trim facial h reviewed for activitie The findings included	nd #19) and to provide nail lair for 1 of 4 residents s of daily living (Resident #9).			the potential to be affected: Dependent residents needing assist with ADL's are identified. Nail compute care, and facial hair groom audits completed by the DON or designee for all dependent resident assure compliance. Documented Angel round observations will incresident personal hygiene checks reported during daily manageme meetings. LNHA will maintain the Consider Angel observations.	are, ning DON nts to Guardian clude and be nt		
,	06/27/12 with diagnor dementia, diabetes a most recent Quarter dated 12/09/13 asse				Guardian Angel observations. No negative outcomes identified. 3.) What measures will be put in systemic changes made to ensure correction:	place or		

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	}				The DON or designee re-educated	the	
F 312	Continued From page	e 16	F		nursing staff regarding proper nai		
	40 Vo 11 Omilio (6)	ng extensive assistance with			nursing staff regarding proper nat	rare,	
	personal hygiene.	rig exterior of deciclarities man	3		mouth care and facial hair groomi	ng. The	
	porsonar rrygione.				DON or designee will conduct		1
	Raview of Resident #	9's care plan dated 03/05/14			documented QA Audits to monitor		
	revealed she needed				resident ADL care through direct		
	The contract of the contract o				observation and record review and		
	assistance for most a	ctivities of daily living.			5 residents 2x weekly for 4 weeks,		*
	An abaanistian	nade on 03/19/14 at 10:15			once weekly for four weeks and me	onthly	
	AM of Resident #9 si				x3 months for ongoing ADL care a	nd	
	1,000				resident personal hygiene complian	nce. As	
		#9 was observed to have			necessary employees will be in-ser		
		ner fingernails on both			assure compliance with the facility		
	Character production in the figure of the control o	numerous white facial hairs			The SDC will include provisions of		
	A CONTROL OF THE CONT	her neck. The white hairs			care, mouth care and facial hair gi		
	were approx 3/8 of ar				during the orientation of new nurs		
		#9 was further observed to			during the orientation of new nurs	Angel	
		on her teeth which was very			personnel. Documented Guardian	Angel	
		ine and her gums were red			round observations will include re		
	and inflamed.				personal hygiene checks and be re		
	An interview was con	ducted on 03/19/14 at 10:15			during daily management meeting	S.	
		. She stated sometimes they			4.) How the facility plans to monit	or its	
į.	The Committee of the Co	im her chin hairs on shower	8		performance to make that solution		
1	Sept. Sept. 1 (1997)	III TIET CHIII Hall'S OH SHOWEI	125		ensured:		1
	days.				onsar ou.		
1	On 03/19/14 at 2:48	PM an interview was			Audit results will be reviewed and		
		ing Assistant (NA) #3. NA #3	17		analyzed monthly by the DON or	designee	
		ras unable to do for herself.			for three months, and then quarte		
20		not tried to provide care for			the Quality Assurance Committee		
360							
		#3 further stated she should a care and cleaned her			Meeting with subsequent plan of a		
					developed and implemented as inc		
		d not notice it. She stated			by the QA Committee. The Direct		
	sne should also have	e trimmed her chin hairs.	(8)		Nursing is responsible for overall	ADL	
		1			compliance.	, 1	
		nducted with Nurse #4 who			(America)	E	
		ith Resident #9. She stated			-0 = =		
		hould be cleaned if they are				8	
- 5		nould be brushed twice per					
		ed chin hairs should be					
	trimmed on Sundays	s as needed.			0.00		

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CENTER	S FOR MEDICARE & MEDICA	ID SERVICES						. 0938-0391
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F 312	Continued From page 17		F	312				*
v	An interview was conducted of PM with Nurse #3 who was the She stated the nursing assistation mouth care after meals and affurther stated chin hairs should needed.	e unit coordinator. ants should provide t bedtime. Nurse #3	e			8		x 5
t.	An interview was conducted we Director of Nursing (ADON) or PM. The ADON stated her expands should be cleaned and conducted with care should be performed to the performance of the perf	n 03/19/14 at 4:38 pectation was that thin hairs shaven on The ADON stated	*			(4) E		,
	2. Resident #13 was admitted 11/02/09 with diagnoses which depression, diabetes and conjoints. Resident #13's most remaining Data Set (MDS) data revealed she was cognitively of the MDS revealed she was for taileting and personal by a	h included tractures in multiple cent Quarterly ed 01/27/14 intact, further review totally dependent			in the state of th			

surgically extracted.

daily living.

Resident #13's care plan revealed she needed extensive to total assistance with all activities of

An interview was conducted on 03/17/14 at 3:13 PM with Resident #13. Resident #13 stated staff had not offered to brush her teeth in several years. She went on to say that she had a top denture which she wipes off herself with a tissue. She stated since she had been admitted to the facility several of her bottom teeth had rotted below the gum line. She stated she had seen a dentist who told her they would have to be

DEPARTMENT OF HEALTH AND HUMAN SERVICES

GENTERS FOR MEDICARE & MEDICAID SERVICES

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE S COMPL		
31-4	٠	345233	B. WNG		. C	0/2014	
	ROVIDER OR SUPPLIER	9		STREET ADDRESS, CITY, STATE, ZIP CODE 306 DEER PARK ROAD NEBO, NC 28761	1 0372	012014	8
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION # DATE	
F 312		e 18 erview on 03/19/14 at 10:41 conducted again with	F 31	12			
	provide mouth care of the time they were pr	ated staff had not offered to or denture care for her during oviding her ADL care.			æ		
	PM with Nursing Ass mouth care should be morning care. NA #3	ducted on 03/19/14 at 2:30 istant (NA) #3 who stated a performed daily as part of further stated she had never outh-care for Resident #13			3 % 4 4	na de care	1 12
	because she was ab do her own nails. NA Resident #13 did not brush her own teeth. water and something	le to comb her own hair and #3 then went on to say have access to water to She stated she would need to spit in. She then stated in doing mouth care for all		•		ā	
5	PM with Nurse #4. N	nducted on 03/19/14 at 2:48 urse #4 stated Resident ave been brushed and her d cleaned daily.		9			
r	PM with Nurse #3, the stated Resident #13' removed and placed in denture cleanser a	nducted on 03/19/14 at 3:49 the unit coordinator. She is dentures should have been in a denture cup and soaked at night. She further stated the preformed after meals and			g)	51	к
φ. γ	PM with the Assistar (ADON). She stated Resident #13's teeth	nducted on 03/19/14 at 4:29 at Director of Nursing it was her expectation for to be brushed twice per day be soaked and cleaned daily.		4		an a	
	3. Resident #19 was	admitted to the facility on	les es				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND FLAN OF CORRECTION IDENTIFICATION NUMBER:		1 * *	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345233	B. WNG_		9 1		C /20/2014	
NAME OF PE	ROVIDER OR SUPPLIER	<u> </u>		S	TREET ADDRESS, CITY, STATE, ZIP CODE			-
SUNRISE	REHABILITATION & CA	RE .	s)	306 DEER PARK ROAD NEBO, NC 28761			2) (0)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES . Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 312	Resident #19's most Data Set (MDS) asse moderate cognitive in the MDS revealed he assistance with person	es which included and hypertension. Review of recent Quarterly Minimum essed him as having mpairment. Further review of e needed extensive onal hygiene. The MDS seen no resistance to care nt period.	F	312	o de la compansa de l	eq -	al so to the	£, 55,55
	required limited to exactivities of daily living. An observation was of Resident #19. His yellow film and he had debris in his teeth ald in his lower teeth. An interview was cored per with Resident #1 cleaned his teeth one if there is a special of teeth. An interview and observed was considered to the special of the	the stated of the stated coasion they will clean his				3		
	had offered to brush would like it if some teeth continued to co covered with a yellow. On 03/19/14 at 10:30 observation was con Resident #19 stated teeth. When asked if stated it would not de	his teeth. He stated he one would brush his teeth. His ontain food debris and were		1500		u	i.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE COMP	SURVEY	
4		345233	B. WNG_		ā)	C 20/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT 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 CORRECTI CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 312	state there had been had been resistive to	v film. PM an interview was ing Assistant (NA) #3. She times when Resident #19 care. NA #3 stated she had nouth care for Resident #19	F 3	12 Preparation and/or exe constitute admission or the facts alleged or con deficiencies. The plan	ction is the center's credible alle compliance. ccullon of this plan of correction agreement by the provider of the actusions set forth in the stateme of correction is prepared and/o ulred by the provisions of federa	n does not he truth of ent of r executed
ı	conducted with Nurse the hall where Reside stated her expectation performed after each	PM an interview was e #4 who was the nurse for ent #19 lived. Nurse #4 on was for mouth care to be n meal. She stated at the ould be performed every ight.				
	PM with Nurse #3 wl She stated the nursin mouth care after me	\$ 6 6 W \$60 W				
F 356 SS=C	Director of Nursing (A PM. The ADON state mouth care should b 483.30(e) POSTED	nducted with the Assistant ADON) on 03/19/14 at 4:38 ed her expectation was be performed twice per day. NÜRSE STAFFING	F 3	F- 356 I.) How corrective:	action will be ne residents affected:	4.17.14
	a daily basis: o Facility name. o The current date. o The total number a by the following cate			Facility Staffing Shall required compoincluding; facility national hours worked by Restaffing is posted d	eet is revised to ensure nents are included name, date, total actual N, LPN, and CNA. aily and in the lobby cessible to residents,	j.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	DANCES DANCE CHEST OF	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	· ·	345233	B. WNG		03/	C 20/2014	
NAME OF PI	ROVIDER OR SUPPLIER	3	s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 001	10/2017	
CHADICE	DELLA DULITATION & CA	DE.	3	06 DEER PARK ROAD			
SURKISE	REHABILITATION & CA	ARE .	1	IEBO, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 356	Licensed practivocational nurses (a - Certified nurse or Resident census. The facility must posspecified above on a of each shift. Data ro Clear and readable or line and residents and visitor. The facility must, up make nurse staffing for review at a cost of standard. The facility must may staffing data for a more required by State law. This REQUIREMENT by: Based on observatifacility failed to post a place readily acceevisitors for four (4) of the findings included observations on 03.	cal nurses or licensed is defined under State law), aides. In the nurse staffing data is daily basis at the beginning must be posted as follows: it format. It is cereadily accessible to is. In on oral or written request, data available to the public mot to exceed the community intain the posted daily nurse in immum of 18 months, or as in w, whichever is greater. This not met as evidenced ones and staff interviews the nurse staffing information in its is is to residents and onsecutive days.	F 356	2.) How corrective action will be accomplished for those residents the potential to be affected: No residents have the potential to adversely affected. No negative of identified. 3.) What measures will be put in systemic changes made to ensure correction: The Staff Development Coordination identified as responsible for postistaffing sheet. SDC is educated administrator on all requirement posting the staffing information. DON and a designated back-up are educated on all posting requirement The Administrator or designee we conduct documented QA Audits monitor posted staffing through or andom observation and record a audits of staffing sheets 2x weekly weeks, then once weekly for four and monthly x3 months compliant. 4.) How the facility plans to monit performance to make that solution ensured:	place or tor is ng this ny the ts for The re ents. ill io direct review y for 4 weeks icc, tor its		
	10:03 AM revealed information anywhe	no posting for nursing staffing re in the facility. on 03/20/14 at 1:45 PM with	p		10 47		
		ent Coordinator (SDC), ed daily nursing assignments		g ##			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
88 384 4 186		345233	B. WNG	# g = #1	03/20/2014
	ROVIDER OR SUPPLIER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 06 DEER PARK ROAD IEBO, NC 28761	1 CONTROLL
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID - PREFIX TAG -	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 356	did not know nurse st posted daily in a visib visitors. The SDC fur know the nurse staffir facility name, current total number and actu	oins. The SDC stated she affing information had to be le location for residents and ther explained she did not an information included date, resident census, and leal hours worked by the nurses, licensed practical.	F 356	Audit results will be reviewed and analyzed monthly by the DON or for three months, and then quarte the Quality Assurance Committee Meeting with subsequent plan of a developed and implemented as incompleted by the QA Committee. The Direc Nursing is responsible for overall compliance.	designeed rly at action dicated
F 412 SS=D	During an interview of Assistant Director of explained she did not information was not be expectation to have reposted daily within 30 shift and visible for the	n 03/20/14 at 1:47 PM the Nursing (ADON), she realize the nurse staffing eing posted and it was her urse staffing information minutes of the start of first	F 412	This Plan of Correction is the center's creample compliance. Preparation and/or execution of this plan of constitute admission or agreement by the prothe facts alleged or conclusions set forth in a deficiencies. The plan of correction is preparable by the provision law. F- 412 1.) How corrective action will be accomplished for the residents a	correction does not ovider of the truth of the statement of ared ond/or executed as of federal and state
	an outside resource, §4§3.75(h) of this par covered under the St dental services to me resident; must, if nec making appointments transportation to and must promptly refer r darnaged dentures to	t, routine (to the extent ate plan); and emergency et the needs of each essary, assist the resident in s; and by arranging for from the dentist's office; and esidents with lost or		Facility's dental referral follow-continues to search for a dental able to extract the resident #13's hospital setting per RP request. on a waiting list for physician in while facility explores other opti-#13 care plan and Pictorial revieupdated as necessary for current oral/dental condition. 2.) How corrective action will be accomplished for those residents	up provider teeth in a Resident Charlotte ons. Res wed and
B (6)	by: Based on resident, f and record review the through with the den	amily and staff interviews e facility failed to follow tist's recommendation for eth for 1 of 2 residents	- 12 - 12	the potential to be affected:	naving

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A BUILDING_	C .	
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	ROVIDER OR SUPPLIER	RE.	. 30	TREET ADDRESS, CITY, STATE, ZIP CODE 06 DEER PARK ROAD EBO, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 412	reviewed for dental of The findings included Resident #13 was act 11/02/09 with diagnod depression, diabetes joints. Resident #13's Minimum Data Set (I revealed she was coof the MDS revealed for toileting and pers assessment of her te MDS. A dental referral date required - hospital or A Dentist's note date "Multiple decayed te the extractions unde appointments." The Annual Minimum assessment dated 1 having no natural terms a progress note date Nurse Practitioner restressed a bit by her dentist." An interview was coopen with Resident #1 teeth had rotted belobeen admitted to the seen by the dentist.	dritted to the facility on ses which included and contractures in multiple smost recent Quarterly MDS) dated 01/27/14 gnitively intact, further review she was totally dependent onal hygiene. There was no eeth noted on the Quarterly ed 09/03/13 read, "extractions dental office."	F 412	Residents with dental issues are in as potentially being affected. 100 conducted by the DON or designed ensure all identified residents with issues are assessed to determine in for a dental consult. No negative outcomes identified. 3.) What measures will be put in systemic changes made to ensure correction: The Staff Development Coordinates designed re-educated the nursing regarding proper oral assessment determine status for referrals to a The MDS Coordinator reviews C Plans for those with oral / dental and updates them as necessary. It designed will conduct documented Audits to monitor oral assessment dental referrals through direct rangemental referrals through direct rangemental referrals through direct rangemental referrals through direct rangemental reserviced to assure computed to assure computed to assure computed to the facility's oral assessment policy and procedure orientation of new licensed nursing personnel. 4.) How the facility plans to monity performance to make that solution ensured:	% audit se to h dental secessity place or tor or staff s to d dentist. are issues DON or d QA ts or andom dits 2x ekly for hs for d nurses bliance t policy. for during ag sitor its

(BESTER) (1980년 1980년	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONS ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING		CONSTRUCTION	SURVEY .			
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SUNRISE	REHABILITATION & CAI	RE		И	EBO, NC 28761		
6/// 15	SLIMMARY ST.	ATEMENT OF DEFICIENCIES	ID	1	PROVIDER'S PLAN OF CORRECTION		(X5)
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					, DEFICIENCY)	,	
	1		1		2		
F 412	Continued From page	24	F.	412	Audit results will be reviewed and	l	
	Continuos riom pag				analyzed monthly by the DON or		
	0- 034044 -+ 11:03	AM as istonious yes		- 1	for three months, and then quarte	erly at	
× .		AM an interview was			the Quality Assurance Committee) iii	
		e #3, the unit coordinator.			the Quanty Assurance Committee	nation	
		referral should have been			Meeting with subsequent plan of	action 3:4-3	1
		e stated then they would let			developed and implemented as in	dicated	1
		he would have given an			by the QA Committee. The Direc	tor of	12
27	order to follow the de	ntist's recommendation.			Nursing is responsible for overall	nurse	= 1
					assessment and referral tracking		
	On 03/19/14 at 1:13 /				compliance.	a. ¹⁷ ,	
		ransporter for the facility.			10000		
İ		ed she transported the			2		
4	Resident #13 to the o	oral surgeon (October of					
		nt's Responsible Party (RP)			 		
İ		Transporter stated there		- 8			
I		regarding the resident					
1		to be done in the hospital					
7	and the oral surgeon	could only do it in his office.					
1		PROF 1925/177 of 1925/17 (1926)					
1	The second design of the second secon	nducted on 03/19/14 at 12:20					
		3's RP. The RP stated she					
		ent #13 to the oral surgeon's					
		ne surgery in his office. She				3	
	stated Resident #13				77 es -		•
		ach time she had surgery.					
		dent #13 wanted to have the					
	surgery done in a ho	spital. The RP stated the	1				
		vould find another doctor to					
ţ.	have the surgery dor	ne. The RP stated she came					
	to the care plan mee	ting in late January or early					
	February of 2014 and	d this was discussed. The					
	RP stated it was imp	ortant for Resident #13 as					
	she enjoys eating an	d it was one of the few			7	,	
		still enjoy. The RP stated					
	sometimes she will b	oring the foods Resident #13			9		(a)
		e complains she could not	2.5	,			-
	chew them.	···					
					3**		
	An interview was co	nducted on 03/09/14 at 3:05					
	pm with Nurse #7 th	e unit manager who attended				12	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1 2	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PE	ROVIDER OR SUPPLIER	E.			STF	REET ADDRESS, CITY, STATE, ZIP CODE		1
SUNRISE REHABILITATION & CARE				306 DEER PARK ROAD				
SUNKISE	REHABILITATION & CA	NE .			NE	EBO, NC 28761		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 412	F 412 Continued From page 25 the care plan meeting for Resident #13. She stated she could not remember what was discussed in the care plan meeting other than the resident's wound. She stated she could not find notes regarding the care plan meeting. She stated the Social Worker (SW) should have made notes about what was discussed in the care plan meeting. A telephone interview was conducted with the SW on 03/19/14 at 3:29 PM. She stated she did remember the discussion regarding Resident #13's the dental referral. The SW stated the RP wanted Resident #13 to have the surgery at the hospital. The SW stated she did not know whose responsibility it was to follow-up on an outside appointment.		f	F 412		This Plan of Correction is the center's cred compliance, Preparation and/or execution of this plan of co constitute admission or agreement by the provisite facts alleged or conclusions set forth in the deficiencies. The plan of correction is prepare solety because it is required by the provisions of law.		does not e truth of nt of executed
F 441 SS=D	PM with Nurse #3 w Nurse #3 explained the care plan meetir her place. Nurse #3 should have followe appointment for Res An interview was cop PM with the Assista (ADON). The ADON been a follow up do see a dentist who coto have her teeth ex 483.65 INFECTION SPREAD, LINENS	nducted on 03/19/14 at 4:36 Int Director of Nursing I stated there should have the to get Resident #13 in to build admit her to the hospital stracted. CONTROL, PREVENT Itablish and maintain an		F	441	F- 441 1,) How corrective action will be accomplished for the residents aff	`ected:	4.17.14
2002	Infection Control Prosafe, sanitary and control	ogram designed to provide a comfortable environment and				1.	s:	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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resources appropriate to	MENT OF TIEART				OMB NO. (938-0391
	S FOR MEDICARE OF DEFICIENCIES	& MEDICAID SERVICES (C1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	RVEY
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ä	4 5	345233	B, WNG		03/20	/2014
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		•				
F 441	Continued From p	page 26	F 441	No negative outcomes identified	for any	4
1 771		ne development and transmission		Resident, Licensed nursing staff		S
#)	of disease and in	tection		serviced on proper cleaning and		
	or discase and in	iconori.	#0	disinfecting techniques for gluco.	se	5
	(a) Infection Conf	rol Program	-	monitors. The two identified glu		
		establish an Infection Control	*	monitors are properly cleaned as		
	Program under w			sanitized according to manufactor	irer's	
	(1) Investigates,	controls, and prevents infections		instructions.		
	in the facility;			parameters of the second secon	11-	
36	(2) Decides what	procedures, such as isolation,		2.) How corrective action will be	il	
	should be applied	d to an individual resident; and		accomplished for those residents	having	
		ecord of incidents and corrective		the potential to be affected:		
	actions related to	infections.			il	
				Residents with diabetes requirin		
	(b) Preventing Sp		1	monitoring are potentially affect	ed.	
	(1) When the Inte	ection Control Program	¥0	Sweep of all residents with diabo	etes	
	determines that a	resident needs isolation to		conducted by the DON or design	ce to	
	isolate the reside	ad of infection, the facility must		ensure all glucose monitors are o	clean and	
0	(2) The facility m	ust prohibit employees with a		disinfected. Diabetic residents a		
	(2) The facility in	isease or infected skin lesions	8	designated individual glucose me		
	from direct conta	ct with residents or their food, if		their individual use only. Prope		
		I transmit the disease.		materials per manufacturer's cle		
		ust require staff to wash their		instructions ordered, stocked an		
	hands after each	direct resident contact for which		available to licensed nursing sta		
		indicated by accepted		Procedure for storage of monito		
	professional prac			sanitized manner are established	1, !	
	• contrate escape de la contrate de			-100	W1000 233	
	(c) Linens			3.) What measures will be put in	hisce or	
	Personnel must	handle, store, process and		#		
	70	so as to prevent the spread of			128	
	infection.	· · · · · · · · · · · · · · · · · · ·				
		31			13.0	
	This DECUIDES	MENT is not met as evidenced		•5		
3	1.00	MEIAL 12 HOT HIEL 92 EAIGEHCEA		88		
	by:	vations, record review, and staff		S (98)		
	Dased off obser	valions, record review, and stall		E	1	

interviews the facility failed to ensure blood glucose meters (glucometers) were

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	N 50	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FOUND CORRECTION		IDENTIFICATION TO THE MISSISSISSISSISSISSISSISSISSISSISSISSISS	A BUILDING				
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SUNRISE	REHABILITATION & CA	RE .		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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE :	(X5) COMPLETION DATE	
			-				
	· *			systemic changes made to ensure			
F 441	Continued From page	e 27	F 44	1 correction:			
	disinfected/sanitized	by the manufacturer's		I toward awade a staff in assessed of	an		
1	instructions during 2	of 2 observations of a		Licensed nursing staff in-serviced of	J11		
	glucometer being dis	infected.		center policy for infection control	4	# N	
				procedures of glucose monitors and		i	
	The findings included	d :		manufacturer's disinfecting instruc	Stions		
0				by the DON or designee,	44 15		
		ed Cleaning and Disinfection		The DON or designee will re-educa			
	of Blood Glucose Mo			licensed nursing staff regarding pr			
		ow manufacturer's label	1	infection control techniques accord	itug to		
		ectant must remain in	1	center policy and procedure and	70).	2	
	contact with meter (v	risibly wet) for effectiveness."		manufacturer cleaning instructions			
				DON or designee will monitor for p	proper		
	A review of the instru	uctions provided by the		infection control techniques with			
		germicidal disposable wipe		emphasis on glucose monitor	,		
		was conducted. The		manufacturer cleaning instructions			
		o accomplish disinfection of ed surface must remain		proper storage of monitors. This C			
		ed surface must remain ! minutes. Use additional		will document through direct obser			
		ssure continuous 2 minute		for 5 residents 2x weekly for 4 wee	ics, then		
	wet contact time. Let			monthly x3 months for ongoing	[]		
	Wet contact time. Let	tan diy.		compliance. As necessary employe			
	An observation was	conducted on 03/18/14 at		be given additional in-servicing to			
		obtaining a finger stick		compliance with the facility policy.	The		
		Nurse #1 was observed		SDC will include infection control			
		55's room and following		provisions for glucose monitor clea			
		obtaining a FSBS. Upon		the orientation of new licensed nur	sing		
		1 returned to the medication	i	personnel.	i		
	cart, wiped the gluco	ose meter (glucometer) with a		() TT	!/.	8	
	germicidal wipe, toss	sed the wipe into the trash		4.) How the facility plans to monito		**	
	bin, and placed the g	glucometer in the medication		performance to make that solution	2 916		
1		servation of the glucometer		ensured;			
		appeared dry in less than 30		Audit results will be reviewed and	. 1		
		lid not ensure the glucometer		analyzed monthly for three months	eand		
		ermicidal solution for a full 2	14	then quarterly at the Quality Assu			
	minutes.		W	Committee Meeting with subseque			
				of action developed and implement			
	Fig. 144 of Table Control of Cont	conducted on 03/18/14 at		indicated. The Director of Nursing		380	
		2 obtaining a finger stick		responsible for overall compliance			
1	blood sugar (FSBS). Nurse #2 was observed		18	It eshousible tot, over an combusince	,01	1	

	OT OTT MEDION IN LEG	WEDIO III GETTTIGES				
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A BUILDING	CONSTRUCTION		E SURVEY PLETED
	5 KW - 6	345233	B. WING	*		C 1
	ROVIDER OR SUPPLIER	,	30	REET ADDRESS, CITY, STATE, Z 6 DEER PARK ROAD EBO, NC 28761		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
		- X		*	7.5	
F 441		e 28 52's room and following robtaining a FSBS. Upon	F 441	glucose monitors.	,	2
	completion, Nurse # cart, wiped the gluco germicidal wipe, tos	2 returned to the medication ose meter (glucometer) with a sed the wipe into the trash glucometer on top of the	# a		×	82
*	medication cart. Cor glucometer revealed less than 30 second	ntinuous observation of the I the surface appeared dry in s. Nurse #2 did not ensure ained wet with germicidal	×			
	PM revealed it was utilizing a glucometedown with a germicion of the glucometer with confirmed the glucon the full 2 minutes an instructed that the gwet for 2 full minutes instructions on the cand stated she was ensure the glucome	facility procedure after er to wipe the glucometer dal wipe. During visualization ith Nurse 1, Nurse #1 meter did not remain wet for d stated she had not been lucometer needed to remain s. Nurse #1 then read the container of germicidal wipes unaware of the need to ter remained wet with for 2 minutes to complete the	•	e		a a
	PM revealed it was utilizing a glucometed down with a germici of the glucometer was confirmed the glucothe full 2 minutes bushe was trained to a she was unaware of glucometer remained.	facility procedure after er to wipe the glucometer dal wipe. During visualization ith Nurse #2, Nurse #2 meter did not remain wet for at stated she was doing what do. Nurse #2 further revealed if the need to ensure the end wet with germicidal solution inplete the disinfecting			•	g ¹⁶¹

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA- AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE A BUILDING COMP			SURVEY LETED	
	-39	25 G			C		
		345233	B. WNG		.03/20/20	14	
NAME OF PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	14		
£		5e	3	06 DEER PARK ROAD			
SUNRISE	REHABILITATION & CA	KE .	. 1	IEBO, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COM	(XS) MPLETION DATE	
					¥ ·		
· F 441	Continued From page	e 29	F 441	2 00			
•	Director of Nursing (I expectation was for or DON stated she had long and referred to stated she expected policy which stated sinfect glucometers according to manufaresident use for blood DON was unaware of glucometer remained for 2 minutes to comprocess. The DON or disinfecting the glucon guidelines.	on 03/18/14 at 5:21 PM the DON) was asked what her cleaning of glucometers. The not been at the facility very the facility's policy then the nurses to follow the taff were to sanitize and s with a germicidal wipe cturer's directions between diglucose monitoring. The of the need to ensure the digneral were the digneral with germicidal solution plete the disinfecting onfirmed the nurses were not ometers per manufacturer.	E 530	P. 520			
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEME QUARTERLY/PLAN		F 520	1.) How corrective action will be accomplished for the residents affe	cted:	.17.14	
27	assurance committe nursing services; a p facility; and at least of facility's staff.			Facility has put in place a QA Tool Bathing Preference Tool designed determine resident choices for freq of showers upon admission. Furth Audit Tool for Showers is in place monitor compliance with shower classics.	to vency er, the		
	issues with respect to and assurance active develops and impler action to correct identification and the Secretary of the Secretary of the recommendation of the recommendation of the recommendation of the secretary of the secre	least quarterly to identify to which quality assessment ities are necessary; and nents appropriate plans of ntified quality deficiencies. etary may not require cords of such committee ch disclosure is related to the	,	2.) How corrective action will be accomplished for those residents had the potential to be affected: All residents are identified as potential affected. Audit conducted by DON or designed to ensure all residence choices are obtained and won the shower schedule. No negatioutcomes identified,	ntially y the dent pdated	* *	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIFLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
245222		B. WNG	·	, с		
. 345233				TREET ADDRESS CITY STATE. 710 CODE	03/2	20/2014
NAME OF PROVIDER OR SUPPLIER SUNRISE REHABILITATION & CARE			1	TREET ADDRESS, CITY, STATE; ZIP CODE 06 DEER PARK ROAD		
3000002	KENABIENATION & OA	N <u>S</u>	N	EBO, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD 8 CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
		1 .		2	80	
F 520	Continued From page	e 30	F 520	3.) What measures will be put in pla	ice of	
	compliance of such c			systemic changes made to ensure	ĺ	
	requirements of this s	section.	2	correction;		
Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.		,	Facility schedules and conducts a m QA Committee meeting. All QA monitoring audit tools are reviewed effectiveness of outcomes and analy information collected to include cho	for sls of		
	by: Based on medical re and staff interviews the Assurance process for monitoring practices	r is not met as evidenced ecord reviews and resident he facility's Quality ailed to maintain effective to address residents ' hing frequency (Resident		bathing frequency. In addition the Committee reviews the status of eac of Correction created in response to survey citations. The Administrato ensures compliance is met according the Plan of Correction at each QA Committee meeting, and that QA mare recorded to document compliance.	QA In Plan r g to inutes	
		ased on medical record and staff interviews the		4.) How the facility plans to monitor performance to make that solutions ensured;	r its are	3
	facility failed to assess bathing frequency for for choices (Residen	es and honor the choice for 2 of 3 residents reviewed t #34 and #76).		PoC audit results will be reviewed analyzed monthly for three months then quarterly at the Quality Assur Committee meeting with subsequen	ance	
p.	interview the Adminis Quality Assessment committee met on a market herself, the Medical I Nursing, and all depans QA monitoring to choice for bathing freduring the interview.	aducted with the 20/14 at 6:00 PM. During the strator stated the facility's and Assurance (QA) monthly basis and included Director, the Director of artment heads. There were ols regarding residents' equency available for review. The Administrator stated into the beassessed for ency of showers/bathing on		of actions developed and implement indicated by the QA Committee. The Administrator is responsible for oxide facility QA Committee compliance, Senior Director of Clinical Services designee will monitor QA meeting a minimum of quarterly to ensure thems have been resolved or follower.	ted as he erall The or minutes QA	