	-	ID HUMAN SERVICES				M APPROVED
		MEDICAID SERVICES				<u>0. 0938-0391</u> I
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>			E SURVEY PLETED
		345077	B. WING		09	C / <b>09/2015</b>
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	• •	
SUNNYBR	OOK REHABILITATION	CENTER		25 SUNNYBROOK ROAD		
				RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 00	0		
F 157 SS=J	(DHSR), Nursing Hor Certification Section s investigation survey of facility on 08/20/2015 information at the Stat team decided that ad needed to rule out that substandard quality of reentered the facility of the additional informat that the facility had pro- of care at the Immedia extended survey was the survey team exite The survey team exite The survey team nee- telephone interview of determined to be the Immediate Jeopardy removed on 9/3/2015 483.10(b)(11) NOTIF (INJURY/DECLINE/R A facility must immed consult with the resid known, notify the resi or an interested famil accident involving the injury and has the pot intervention; a signific physical, mental, or p deterioration in health status in either life thr clinical complications significantly (i.e., a ne- existing form of treatr consequences, or to a	started a complaint on 8/18/2015 and exited the 5. Upon review of the survey ditional information was at the facility provided of care. The survey team on 9/2/2015 and collected ation needed to determine rovided substandard quality ate Jeopardy level. A partial conducted on 9/2/2015 and do the facility on 09/03/2015. ded to conduct an additional in 9/9/2015 which was exit date of the survey. The began on 8/3/2015 and was 5. Y OF CHANGES 200M, ETC) iately inform the resident; ent's physician; and if dent's legal representative y member when there is an e resident which results in tential for requiring physician cant change in the resident's sychosocial status (i.e., a n, mental, or psychosocial reatening conditions or ); a need to alter treatment eed to discontinue an nent due to adverse commence a new form of	F 15			9/22/15
		SUPPLIER REPRESENTATIVE'S SIGNATURE	Ē	TITLE		(X6) DATE
Electroni	cally Signed					09/23/2015

**Electronically Signed** 

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		ID HUMAN SERVICES MEDICAID SERVICES				RINTED: 09/28/2015 FORM APPROVED JB NO. 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X	3) DATE SURVEY COMPLETED
		345077	B. WING _			C 09/09/2015
NAME OF PF	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	
	OOK REHABILITATION	CENTER		25 SUNNYBROOK ROAD		
SUNNIBR	OOK REHABILITATION	CENTER		RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 157	the resident from the §483.12(a). The facility must also and, if known, the res or interested family m change in room or roo specified in §483.15( resident rights under regulations as specifi this section. The facility must reco the address and phor legal representative of	ion to transfer or discharge facility as specified in promptly notify the resident sident's legal representative nember when there is a ommate assignment as	F 1	57		
	by: Based on record revi physician interview and staff interviews, the fa physician of a positive knees on 8/3/15 which femur for 1 of 3 reside in delayed medical the resulted in Resident # on 8/8/15 to bilateral The Immediate Jeopa Resident #1 had an x and the positive resul physician. The Imme removed on 9/3/15. credible allegation of	iews, staff interviews, nd the x-ray company ' s acility failed to notify the e x-ray result of the bilateral th revealed a fractured right ents (Resident #1) resulting eatment. The outcome #1 having orthopedic surgery fractured femurs. ardy began on 8/3/15 when t-ray to the bilateral knees lts were not reported to the ediate Jeopardy was The facility provided a compliance.		The statements incluadmission and do no agreement with the a herein. The plan of c completed in the con federal regulations as in compliance with al regulations the center take the actions set f plan of correction. Th correction constitutes allegation of complia deficiencies cited hav completed by the dat	alleged deficiencies orrection is npliance of state and s outlined. To remain Il federal and state er has taken or will forth in the following ne following plan of s the center's nce. All alleged ve been or will be	
		n out of compliance at a f no actual harm with the		a) Resident # 1	is currently	

Facility ID: 923270

If continuation sheet Page 2 of 31

					PLICTION	1	D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF			1 Y /	SURVEY PLETED
			A. BUILDING				<u>_</u>
		345077	B. WING				C
	ROVIDER OR SUPPLIER	343017			ADDRESS, CITY, STATE, ZIP CODE	09	/09/2015
NAME OF F	ROVIDER OR SUFFLIER				YBROOK ROAD		
SUNNYBR	ROOK REHABILITATION	CENTER			H, NC 27610		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	COMPLETION
F 157	Continued From page	e 2	F 15	57			
		in minimal that is not an			harged from the facility on 08/06/1	5	
	immediate jeopardy (	D). The facility was in the neutation and monitoring			did not return to the facility.	0	
		n. The facility needs to			b) Individual verbal re-education	on	
	include the nurse aide	-		accu	urately interpreting and		
	measures.				municating results of diagnostic		
					ies to MD and family		
	Findings included:				esentative/resident was provided l	•	
	Posidont #1 was adm	nitted on 10/13/13 with			Regional Clinical Director to Emplo ctly involved with incident on 08/10		
	diagnoses of difficulty			uned	city involved with incident on 08/10	5/15.	
		ritis, osteoporosis, gout,		2.	Interventions for residents identified	ed	
		s, glaucoma, peripheral			aving the potential to be affected:		
	vascular disease and	cerebrovascular disease.					
					3/10/15, a physician order recap		
		e Minimum Data Set (MDS)			ew of all new physician orders for	_	
	significant change of			ious 4 weeks was performed utiliz			
		esident #1 was moderately dependent for transfers with			'order recap review" and utilizing t		
		ive assist with one assist			<pre>/diagnostic audit tool" to ensure pr w-up including MD/RP notification</pre>		
		tensive assist with assist of			nge in condition (medication chang		
		giene, eating, dressing and			nostic results etc) This audit was	-	
		the unit and dependent			ormed by facility Unit Manager (UI		
	with one assist with to	oileting. Resident #1 used a		and	Director of Nursing (DON) on curr	ent	
	wheelchair and was a and bladder.	always incontinent of bowel		facili	ity residents.		
					08/10/15, all Licensed Nurses (acr	oss	
		nurse ' s note written on			hifts including weekend and as		
		evealed Nurse #1 heard			ded scheduled) were educated by	the	
		or help. The nurse found the			and DON on facility notification		
		e floor next to her bed. The t position. The resident			ess related to change in condition promptly communicating changes		
		al knee pain. The resident			MD/RP.		
		n to the nurse how the fall		vvitii			
		e reported she notified the		New	ly hired Licensed Nurses will be		
		s well as the responsible			cated by the Staff Development		
	party on 8/3/15 at app	-		Coo	rdinator (SDC) during their orienta		
				on fa	acility notification process related t	to	
	A record review of a r	nurse ' s note written on		char	nge in condition including ensuring	1	

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						10.0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		TE SURVEY MPLETED
			A. BUILDING			С
		345077	B. WING		0	9/09/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
0.000				25 SUNNYBROOK ROAD		
SUNNTBR	ROOK REHABILITATION	CENTER		RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 157	Continued From page	e 3	F 15	7		
	_	evealed a urine sample was		x-ray results are promptly comr	nunicated	
	collected from Reside	ent #1 for a urine analysis.		with MD/RP.		
		e also ordered an x-ray for				
		ue to the swelling the nurse		On 08/10/15, all Licensed Nurs		
		reased pain the resident was		all shifts including weekend and needed) were educated on imp		
	having.			Licensed Nurses utilizing facility		
	A record review of a r	radiology report dated 8/3/15		Click Care (PCC) dashboard to		
		dent #1 revealed the resident		communicate change of conditi		
		fracture involving the right		between shifts.		
		lerate displacement. The				
		no fracture or dislocation and		Newly hired Licensed Nurses w		
	showed modest oster	oarthritis.		educated by the SDC during th		
	A report review of a l	nurse ' s note written on		orientation period on importance		
		ritten by Nurse #2 revealed		Licensed Nurses utilizing facility dashboard to communicate cha		
		nunication from the weekend		condition between shifts.		
		t Resident #1 fell and woke				
	up in pain this mornir	ng to her bilateral knees.		All Licensed Nurses were re-ec	lucated on	
	The nurse noted ther			the notification phone call from		
		he nurse ordered a bilateral		(X-ray Provider) when an x-ray		
		se reviewed the x-ray and		and the new notification proced		
	found the result to be	e negative.		effective 10/1/15 which will incl "positive" watermark across the		
	A record review of a r	nurse ' s note written on		x-ray result page for all positive		
	8/6/15 by Nurse #2 a			x ruy roour page for an poolire		
		tinuing to complain of pain to		All Certified Nursing Assistants	(CNA)	
	her left knee. A phys	ician 's order was written on		were educated by the DON on		
		an to x-ray the left femur due		necessity of completing the Inte	•	
	to increased pain.			and Watch tool on their Point C		
	A record review of -	radialagy report data d 0/0/1/5		input screens when they notice of condition of the resident. Th		
		radiology report dated 8/6/15 I Resident #1 had a recent		information automatically show		
	displaced spiral left fe			Point Click Care Clinical Alert D		
				for the nurses to see. (All Licen		
	A record review of a r	nurse ' s note written on		Nurses were re-educated by th		
	-	vealed Resident #1 had a		9/02/15).		
		revealing a fracture to the				
	left femur. The docto	or assessed the resident and		<ol><li>Systematic Change:</li></ol>		

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If continuation sheet Page 4 of 31

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION	(X3) DATE SU	938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLET	
					с	
		345077	B. WING		09/09/	2015
NAME OF P	ROVIDER OR SUPPLIER		<b>_</b>	STREET ADDRESS, CITY, STATE, ZIP CODE	00/00/	2010
				25 SUNNYBROOK ROAD		
SUNNYB	ROOK REHABILITATION	CENTER		RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE C	(X5) COMPLETIOI DATE
F 157	Continued From page	e 4	F 15	7		
	ordered the resident	to be sent to the hospital.				
	The resident was trar	nsported to the hospital via		Change in Facility Notification Pro	tocol:	
	stretcher on 8/6/15.	The responsible party was		08/10/15 and ongoing		
	made aware of the tra	ansfer.				
				a) Lab/Diagnostic results are		
	A phone interview on	8/19/15 at 3:15 pm was		communicated to Physician (MD),		
	conducted with Nurse	e #1 who noted the fall on		Resident or Legal Guardian/Intere		
	8/3/15 at 12:27 am.	The nurse reported that she		Family Member promptly after res	ults are	
		and left a message regarding		received. Follow-up with x - ray/la		
	the fall at approximat	ely 1:00 am. The nurse		Company will occur if results are i	not	
		essage for the physician that		received timely.		
	there was no injury a	nd the range of motion did				
	not change for the re	sident. The nurse also		b) All change of condition, or	der	
	revealed she called t	he responsible party and left		changes or events will be noted o		
	-	se reported the resident		dashboard by Licensed Nurse to e	ensure	
	complained of pain to	o her knees but she had		shift to shift communication.		
	chronic pain to her kr	nees due to osteoporosis.				
	Nurse #1 reported sh	e was medicated with two		c) If Licensed Nurses are una	able to	
	tablets of pain medic	ation at 4:40 am for		contact MD or Legal Guardian/Inte	erested	
	increased pain. The	nurse reported she told		Family Member, document attempt		
	Nurse #2 at the chan	ge of shift that she might		contact with the reason and time i	n	
	need an x-ray due to	the increased pain.		medical record and on PCC dash	board.	
				Also notify oncoming nurse of nee	ed for	
	During an interview of	on 8/19/15 at 2:15 pm, with		follow-up.		
		revealed she ordered an				
		o the increased pain and		An audit is being performed utilizing	ng the	
		had to her knees. The		"Daily 24 Recap" form and		
		ray at 9:15 am on 8/3/15 per		"Lab/Diagnostic" audit tool on all r		
		he physician 's order. The		physician orders during clinical ro		
		ooked at the results quick		daily (including weekends) to ensu		
		axed it to the doctor, but she		change in condition notification of		
		he nurse further added that		Legal Guardian/Interested Family		
		Its to the physician on 8/6/15		is evident. The audit has been per		
		vas at the facility. The nurse		by the DON and UM since 08/10/		
		was complaining of pain in		will continue daily including week		
		physician ordered an x-ray		four (4) weeks, twice weekly for (4)	F)	
		eg. The nurse was asked		weeks, weekly for (4) weeks.		
		s when you order an x-ray				
	I from the x-ray compa	any. The nurse reported that		4. Monitoring of the change to s	ustain	

Facility ID: 923270

			0.00			8-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE SURVE COMPLETED	
			A. BUILDING	G	с	
		345077	B. WING		09/09/20	15
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		15
				25 SUNNYBROOK ROAD	CODE	
SUNNYBR	OOK REHABILITATION	CENTER		RALEIGH, NC 27610		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMP THE APPROPRIATE D	PLETION
F 157	Continued From page	e 5	F 15	57		
	first, you order the x-	ray by phone. The x-ray		system compliance ongoi	ng:	
		the facility and do the x-ray.			-	
		vill fax the results to the		Monthly for a minimum of		
		ported the nurse is to go to		the DON will report audit		
		get the results or they are		Quality Assurance and Pe		
	delivered to the nurse	e 's station by the The nurse was asked why		Improvement Committee. Assurance and Performa	-	
		sults until after 10:00 pm		Improvement Committee		
		om the x-ray company to the		audits to make recommer		
	facility at 12:57 pm.			ensure compliance is sus		
	•	s do not have time; the fax		and determine the need for		
	machine is on the oth	ner end of the room.		auditing beyond the three	months.	
	An interview with Nu	rse #3 at 3:17 pm on 9/2/15				
		ceived a shift change report				
		e #2 reported to Nurse #3				
	Resident #1 had a fa	Il on the morning of 8/3/15				
	and had an x-ray, but					
		d not receive in report the				
	-	any pain nor did she see the				
		orted on the night of 8/4/15				
		sident when the NA came to				
		esident was in pain. The NA				
	-	he resident and was doing the resident was calling out				
		ied the nurse. The nurse				
	•	be in pain and medicated				
		Norco 5/325. The nurse				
		eassessed the resident, she				
		urse reported that her				
		have any increased swelling.				
		e process when a nurse				
		call the x-ray company.				
	-	facility to do the x-ray and				
		the facility. Nurse #3 also				
		It is positive or there is an x-ray company would call to				
		If it is negative, the x-ray				

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			0.00			<u>10. 0938-039</u>
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	TE SURVEY MPLETED
			A. BUILDING	G		С
		345077	B. WING			9/09/2015
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		9/09/2015
				25 SUNNYBROOK ROAD		
SUNNYBR	OOK REHABILITATION	CENTER		RALEIGH, NC 27610		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	E APPROPRIATE	COMPLETION
F 157	Continued From page	<u>e</u> 6	F 15	57		
		the fax machine for results				
		ne does not see them, she				
	•	pany to see if they resulted.				
		esults are positive she would				
		e responsible party with the				
		are negative, she faxes the				
	result to the doctor.					
	An interview with Nur	se #4 on 9/2/15 at 10:35 am				
		had no complaints of pain				
		night shift on 8/3/15, 8/4/15,				
	and 8/5/15. The nurs	e reported the resident slept				
		nurse reported she saw no				
		her knees but the resident				
		o her knees down to her feet				
		ical medicated patches for porosis. The nurse reported				
		e put on her knees at 8:00				
		:00 am. Nurse #4 was told				
	by Nurse #2 that she	had a fall and an x-ray was				
		the results were negative.				
		the x-ray results. Nurse #4				
		when getting an x ray is to				
		one. The x-ray company In faxes the results to the				
		e results are negative, the				
		t to the doctor. If the results				
	are positive, the nurse	e calls the physician for				
		e #4 revealed she did not				
		from the x-ray company				
	-	f the positive result of the				
	x-ray.					
	A phone interview wa	s conducted with a				
	-	-ray company at 11:33 am				
		he results of Resident #1 ' s				
	-	hnician reported the x-ray				
		2:15 pm and resulted at other the facility at this time.				

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &					FORM	D: 09/28/2015 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
	345077	B. WING				C 109/2015
NAME OF PROVIDER OR SUPPLIER	•	•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SUNNYBROOK REHABILITATION	CENTED		2	25 SUNNYBROOK ROAD		
SUNNTBROOK REHABILITATION	CENTER		F	RALEIGH, NC 27610		
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	ЗE	(X5) COMPLETION DATE
the x-ray center, repo into (Nurse #4) on 8/ supervisor further ad courtesy call the x-ra Sometimes they are it right away but the for on the call back scree contacts the facility. x-ray company would for positive or abnorn An interview with Nu revealed Nurse #4 re x-ray company on 8/ the results for reside asked Nurse #2 if we Nurse #2 said, yes. did not inquire about company called. Nu company did not say just asked if the x-ray con results were received positive? Nurse #4 r negative and positive? At 1:50 pm on 9/2/15 the x-ray company a Manager reviewed th 8/6 and reported she done by the compan review the x-ray films Account Manager als company only makes when the results are the facility when the	call center supervisor from orted the result was phoned 5/15. The call center ded that the phone call is a y company does. very busy and cannot get to name of the facility stays up en until the x-ray company The supervisor reported the d only make this courtesy call nal results. rse #4 on 9/2/15 at 3:00 pm eceived a phone call from the 5/15 asking if we received nt. Nurse #4 reported she e received the results and Nurse #4 was asked why she the x-ray when the x-ray rse #4 reported that the x-ray it was a positive result, they he results. Nurse #4 was mpany is calling to verify d, doesn ' t it mean they were eported that they call us with	F	157			

Facility ID: 923270

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	-	D HUMAN SERVICES MEDICAID SERVICES			FOR	D: 09/28/2015 MAPPROVED O. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE COM	E SURVEY PLETED
		345077	B. WING			C / <b>09/2015</b>
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
			2	5 SUNNYBROOK ROAD		
SUNNYBF		CENTER		RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 157	of the x-ray result on a added that if she had fracture to the right fe ordered the facility to hospital right away. T at the facility on 8/6/1. was having knee pain she ordered an x-ray showed a left fracture reported she was sho 8/3/15 on 8/6/15 by N asked why she was n result and Nurse #2 re part of the result and physician reported he is to report any abnor value immediately to the An interview with the 9/2/15 at 12:30 pm. T the condition worsene having the resident ev x-ray on 8/3/15. The maybe the radiologist displacement in the fr reported that if it was could be hard to see. that with any kind of re resident with osteopo The physician recomm radiologist to get furth on 8/3/15. A record re form by the company 9/2/15 revealed the et 8/3/15 were reviewed shown on 8/6 was not prior study. The reviewed	evealed she was not aware B/3/15. The physician known about the acute mur she would have send the resident to the 'he physician recalled being 5 and being told the resident . The physician reported for the resident and it d femur. The physician wn the x-ray result from urse #2. The physician ot told about the 8/3/15 eported, she read the upper missed the lower part. The r expectation of the nurses mal diagnostic test or lab the doctor via phone or fax. physician was conducted on 'he physician was asked if ed to Resident #1 due to not valuated as a result of the physician suggested that missed it if there was no acture. The physician not displaced, the fracture In addition, she reported epositioning or lifting with a rosis a fracture could occur. nended speaking to the er clarification of the x-ray eview of the case review ' s radiology facility on	F 157			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345077	B. WING				C / <b>09/2015</b>
NAME OF P	ROVIDER OR SUPPLIER	L			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
SUNNYB	ROOK REHABILITATION	CENTER			25 SUNNYBROOK ROAD RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	exam is not visible or 8/3/15. The physician sent to the hospital w on both her legs and hospital. On 8/8/15, f surgery to her fracture not return to the facili admitted to another n On 8/20/15 at 10:45 a Director of Nursing (E expectation of the nur immediately when the lab result via fax or a reported her expectat follow up to be sure the phone call or the fax orders from the physi added that her expect the nurse ordered the should check the fax the result. The Administrator wa jeopardy on 9/2/15 at The facility provided a allegation on 9/3/15 at Resident # 1 had a fa evaluated the resider injuries, range of mot complaint of bilateral completed on 8/3/15 right fractured femur. as negative and did m resident had increase second x-ray was ord 8/6/15. The results w	a images of the left knee on a revealed the resident was here she had splints placed was transported to another the resident had bilateral ed femurs. Resident #1 did ty. The resident was ursing home. am, an interview with the DON) revealed the rses is to notify the physician ere is a positive diagnostic or phone call. The DON tion is that the nurses also he physician received the to see if there are further cian. The DON further tation of the nurse is that if e lab or diagnostic test, they room thru out their shift for s notified of the immediate 12:00 pm. an acceptable credible tt 12:30 pm II on 8/3/15. The nurse tt post fall; finding no	F	157	7		

Facility ID: 923270

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345077	B. WING				/09/2015
NAME OF P	ROVIDER OR SUPPLIER			ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE		
SUNNYBR	ROOK REHABILITATION	CENTER			25 SUNNYBROOK ROAD RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	ambulance and was I hospital where orthop to bilateral femurs to resident did not return surgery. The residen nursing home facility. On 8/10/15 the " lab implemented and incl room number, test typ responsible party noti was notified. The " o which consists of tract the previous 24 hours initiated. Individual verbal re-ea interpreting and comm diagnostic studies to resident was provided Director to the employ On 8/10/15, a ph all new physician orde was performed utilizin and utilizing the " lab ensure proper follow- responsible party (ME in condition (medicati results etc.). This au facility Unit Manager Nursing (DON) on cu On 08/10/15, All shifts including weeke scheduled) were educ on facility notification condition and prompt with MD/RP.	ater admitted to another redic surgery was performed repair the fractures. The n to the facility after the t was admitted to another diagnostic tool " was udes the resident name, be and date, date fied and dated the physician order recap audit tool " king all new orders within s per nurse station was also ducation on accurately nunicating results of physician, family and d by the Regional Clinical yee involved on 8/10/15. ysician order recap review of ers for previous 4 weeks ng the " order recap review " /diagnostic audit tool " to up including physician and D/RP) notifications of change on changes, diagnostic idit was performed by the (UM) and Director of rrent facility residents. Licensed Nurses (across all	F	157			

If continuation sheet Page 11 of 31

		ID HUMAN SERVICES MEDICAID SERVICES					INTED: 09/28/201 FORM APPROVE IB NO. 0938-039
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		DNSTRUCTION		) DATE SURVEY COMPLETED
		345077	B. WING				C 09/09/2015
NAME OF P	ROVIDER OR SUPPLIER		•	STR	EET ADDRESS, CITY, STATE, ZIP COD	DE	
SUNNYBF	ROOK REHABILITATION	CENTER			UNNYBROOK ROAD _EIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 157	<ul> <li>(SDC) during their orinotification process raincluding ensuring x-recommunicated with M.</li> <li>On 08/10/15, All shifts including weekeeducated on important utilizing facility Point to communicate char shifts.</li> <li>On 8/10/15, new be educated by the S period on importance facility PCC dashboa of condition between. An audit is being Daily 24 Recap " forraudit tool on all new period on all new period on all new period and proceed and tool on all new period and tool on all new period and tool on all new period on the audit is and UM since 08/10/1 including weekends fi weekly for (4) weeks, Change in Facility Norand ongoing</li> <li>Ø Lab/Diagnostic racommunicated to PhyLegal Guardian/Interest promptly after results x - ray/lab Company preceived timely.</li> <li>Ø All change of communicate of communicatest of company for the section of th</li></ul>	<ul> <li>Development Coordinator ientation on facility</li> <li>elated to change in condition ray results are promptly</li> <li>ID/RP.</li> <li>Licensed Nurses (across all end and as needed) were nee of Licensed Nurses</li> <li>Click Care (PCC) dashboard ge of condition between</li> <li>Ily hired Licensed Nurses will</li> <li>DC during their orientation of Licensed Nurses utilizing rd to communicate change shifts.</li> <li>performed utilizing the " m and " Lab/Diagnostic " ohysician orders during including weekends) to ndition notification of MD and ested Family Member is being performed by the DON 15 and will continue daily or four (4) weeks, twice weekly for (4) weeks.</li> <li>http://dlick.com/</li></ul>	F	157			

Facility ID: 923270

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 09/28/2015 MAPPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345077	B. WING				C / <b>09/2015</b>
NAME OF PF	ROVIDER OR SUPPLIER		-	:	STREET ADDRESS, CITY, STATE, ZIP CODE		
SUNNYBR	OOK REHABILITATION	CENTER			25 SUNNYBROOK ROAD		
					RALEIGH, NC 27610		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	Legal Guardian/Intered document attempt to time in medical record Also, notify oncoming All other residents we hour report, chart revior order recap review ar tool to ensure proper physician and respon change in condition. and the DON on 8/10 Validation on 9/3/15 a credible allegation wa direct nursing staff reli interpreting and comm diagnostic studies to to order recap review to tool, and the Point Cli communicate change	es unable to contact MD or ested Family Member, contact with the reason and d and on PCC dashboard. nurse of need for follow-up. ere assessed utilizing the 24 iews, staff interviews, the d the lab/diagnostic audit follow-up including sible party notifications of This was done by the (UM) /15. at 12:30 pm verified the as evidenced by interviews of lated to education on nunicating results of the physician by utilizing the ol, the lab/diagnostic audit ck Care dashboard to of condition between shifts.	F	157			
F 309 SS=J	Recap form and the L all new physician orde twice weekly for 4 we 483.25 PROVIDE CA HIGHEST WELL BEIL Each resident must re provide the necessary		F	309			9/22/15
	mental, and psychoso						

Facility ID: 923270

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES			FORM	): 09/28/2015 / APPROVED ). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>·</i>	PLE CONSTRUCTION G		LETED
		345077	B. WING			C 09/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
		CENTER		25 SUNNYBROOK ROAD		
SUNNTER		CENTER		RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309	Continued From page	13	F 3	09		
	by: Based on record revi physician interviews, a interviews, the facility for a medical interven (Resident #1) with a s condition of increased bilateral knees after s The Immediate Jeopa the resident develope fall. The resident had right fractured femur a medical attention until jeopardy was remove provided a credible al The facility will remain scope and severity of potential for more that immediate jeopardy (I process of full implem their corrective action Findings Included: Resident #1 had diag muscle weakness, os gout, urinary tract infe peripheral vascular di disease. A record review of the significant change of s 6/3/2015 revealed Re cognitively impaired, of	and x-ray facility staff failed to identify the need tion for 1 of 3 residents ignificant change of I pain and swelling to ustaining a fall. rdy began on 8/3/15 when d pain and swelling after a a positive x-ray result of a and she did not receive 8/6/15. The immediate d on 9/3/15 when the facility legation of compliance. n out of compliance at a no actual harm with the n minimal that is not an D). The facility was in the ientation and monitoring		The statements included are not an admission and do not constitute agreement with the alleged deficience herein. The plan of correction is completed in the compliance of state federal regulations as outlined. To rein compliance with all federal and st regulations the center has taken or take the actions set forth in the following plan of correction. The following plan correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.	cies e and emain ate vill ving n of be nt: n to ified d: irector s and	

Facility ID: 923270

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED
			A. BUILDING		с
		345077	B. WING		09/09/2015
NAME OF PE	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	09/09/2013
				25 SUNNYBROOK ROAD	
SUNNYBR	OOK REHABILITATION	CENTER		RALEIGH, NC 27610	
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION (X5
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLE
F 309	Continued From pag	e 14	F 30	9	
	5	tensive assist with assist of giene, eating, dressing and		address any injuries, and residen	t safety.
	locomotion off and or	n the unit and dependent		b) Evaluate resident for any	
		oileting. Resident #1 used a		additional injury which would requ	
		always incontinent of bowel		medical intervention. Evaluation	includes
	and bladder.	re plane undeted on E/20/1E		but is not limited to:	
		are plans updated on 5/20/15 was in place for risk for falls.		*Vital Signs *Skin Evaluation	
		d getting resident out of bed		*Musculoskeletal asse	ssment
		aking in the morning if she		*Change of Condition	Someric
		ety awareness, encourage		*Pain Assessment	
		, keep call light within reach,		*Neurological assessm	ent as
		right side of bed while in bed.		indicated	
		red cognitive function related			
		lace with interventions to		c) Thoroughly document cl	inical
	-	ent and require approaches ement in daily decision. A		findings in medical record.	
	care plan for weakne	ess related to decrease		d) Interview resident and s	taff to
	functional mobility an	nd falls was in place.		determine if cause of fall can be	
		d offering assistance with		determined.	
	÷ ·	person assist with sit to			
		d from wheelchair. A care		e) Notify MD in person or b	,
	plan for potential for			telephone of all falls, assessment	
		as in place. Interventions		and document notification in med	ICAI
		escorting as needed to medication for pain to knees		record.	
	•	tor effectiveness. The		f) Notify family (responsibl	e nartv)
	resident participated			and document notification in med	
		e physician 's orders		record.	
		1 had an order written on			
		cal pain patches to bilateral		g) Complete post fall asses	ssment
		daily. The resident also had		and formulate interventions based	
		written on 3/3/15 for a		evaluated clinical information.	
		tion, one tablet by mouth			
		eeded for moderate pain, and		h) Communicate established	
	-	every six hours as needed		interventions to the care giving st	aff.
	for severe pain.				
	A record review of th Administration Record	e Electronic Medication		i) Document post fall every shi	IT TOP /2

Facility ID: 923270

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TATEMENT (	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DAT	O. 0938-03 E SURVEY PLETED	
			A. BUILD	ING			С	
		345077	B. WING			09/09/2015		
NAME OF PI	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				25	5 SUNNYBROOK ROAD			
SUNNYBR	ROOK REHABILITATION	CENTER		R	ALEIGH, NC 27610			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 309	Continued From page	e 15	Í -	309				
1 000				309				
	July revealed the dai	it had no pain during the			All Cartified Nursing Assistants (CNI)	• •		
	month of July. Additi			All Certified Nursing Assistants (CNA were educated by the DON on ability	,			
	received any pain me			necessity of completing the Interact				
	July.				and Watch tool on their Point Of Car			
	•	nurse ' s note written on			input screens when they notice a cha			
	8/3/15 at 12:27 am re	evealed that Nurse #1 heard			of condition of the resident. This	0		
	resident #1 calling fo	r help. The nurse found the			information automatically shows up of	on the		
	resident sitting on the	e floor next to the bed. The			Point Click Care Clinical Alert Dashb	oard		
		t position. The resident			for the nurses to see (Nurses in-serv	viced		
		al knee pain. The resident			by the DON on 9/02/15).			
	-	n to the nurse how the fall						
		e reported she notified the			All newly hired Licensed Nurses will	be		
		is well as the responsible			educated by the Staff Development			
	party on 8/3/15 at ap				Coordinator (SDC) on post fall			
		nurse ' s note written on Nurse # 1 revealed the			assessment and documentation duri their orientation period.	ng		
	nurse administered to				their orientation period.			
	medication for severe	•			All newly hired CNAs will be educate	hv		
		nurse ' s note written on			the SDC during their orientation period			
		y Nurse # 2 revealed a urine			ability and necessity of completing th			
		from Resident # 1 for a			Interact Stop and Watch tool on their			
	-	e #2 reported she also			Point Of Care input screens when th			
		the bilateral knees due to the			notice a change of condition of the			
	-	served and the increased			resident.			
	pain the resident was	•						
		radiology report dated 8/3/15			3. Systematic Change:			
	-	dent #1 revealed the resident						
	-	fracture involving the right			The DON and the Unit Managers are			
		derate displacement. The			responsible for the implementation a			
		no fracture or dislocation and			monitoring of the Falls Management			
	showed modest oste	oartnritis. nurse ' s note written on			Program. All fall occurrences will be	iday)		
	8/3/15 at 8:21 pm rev				reviewed ongoing daily (Monday- Fri at stand up meeting, weekly in Quali			
		lets of pain medication			Assurance Risk Management meeting			
	(Norco 5/325 milligra				the DON/Unit Managers and the	.9 ~7		
		nurse 's note written on			Week-end Supervisor/On Call			
		evealed Nurse #2 received			Administrative Registered Nurse on			
		the weekend nurse (Nurse			Saturday and Sunday.			

Facility ID: 923270

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	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT		NSTRUCTION	(X3) DAT	E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,			· /	IPLETED
							С
		345077	B. WING			09	0/09/2015
NAME OF PF	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1	
				25 SU	JNNYBROOK ROAD		
SUNNYBR	OOK REHABILITATION	CENTER		RALE	EIGH, NC 27610		
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 309	Continued From page	a 16		309			
1 000				509			
		fell and woke up in pain this ral knees. Nurse #2 noted		P	Beginning 09/02/15, all residents will	he	
	-	the resident 's knees. The			ssessed post fall within 24 hours by		
		eral knee x-ray. The nurse			acility Unit Manager (UM), Director o		
		nd found the result to be			Iursing (DON) or Nurse Supervisor.		
	negative.				9/02/15, the Facility Regional Clinica		
		nurse ' s note written on			Director educated UM, DON and Nurs		
	8/4/15 revealed Resid	dent # 1 received pain			Supervisor on expectation of assessi		
	medication on 8/4/15	at 5:00 pm. At 9:45 pm on		re	esidents post fall and documenting	-	
	8/4/15, the resident re	eceived one tablet of pain		a	ssessment findings in medical record	d.	
	medication for moder						
	received one tablet of	-			acility DON, UM or Nurse Superviso		
	moderate pain on 8/5			erform "mock" fall drills twice monthl	•		
		nurse 's note written on			across all shifts) for three (3) months		
	8/6/15 by Nurse #2 a	-			nsure proper Licensed Nurse evalua		
		tinuing to complain of pain to			otification, and follow-up of residents		
		ician 's order was written on			ost fall. Licensed Nurse will be requi		
		an to x-ray the left femur due record review of a radiology			o perform a head to toe evaluation at		
	report dated 8/6/15 a			liscuss findings of assessment with F valuator.	KIN		
	femur fracture.	cent displaced spiral left		4	. Monitoring of the change to susta	ain	
		nurse ' s note written on			ystem compliance ongoing:	a111	
		vealed Resident #1 had a			Jotem compliance ongoing.		
		revealing a fracture to the		M	Nonthly for a minimum of three month	ns.	
		or assessed the resident and			ne DON will report "mock" fall drill au		
		to be sent to the hospital.			esults to the Quality Assurance and	-	
		nsported to the hospital via			Performance Improvement Committee	e.	
		The responsible party was			he Quality Assurance and Performa		
	made aware of the tra	ansfer.			mprovement Committee will review the	ne	
		8/19/15 at 3:15 pm was		-	udits to make recommendations to		
		e #1 who noted the fall on			nsure compliance is sustained ongo	ing;	
		The nurse reported that she			nd determine the need for further		
		and left a message regarding		a	uditing beyond the three months.		
		ely 1:00 am. The nurse					
		essage for the physician that					
		nd the range of motion did sident. The nurse also					
I	LIOU COADOR TOUTOR TRA		1				

Facility ID: 923270

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 09/28/2015 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345077	B. WING				C / <b>09/2015</b>
NAME OF PI	ROVIDER OR SUPPLIER	·		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
0.000				2	5 SUNNYBROOK ROAD		
SUNNYBR	OOK REHABILITATION	CENTER		F	RALEIGH, NC 27610		
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	complained of pain to chronic pain to her kn The nurse added the to her bilateral knees # 1 reported she was of pain medication (N 4:40 am for increased she told Nurse #2 that due to the increased there was no increased there was no increased she administered the During an interview o Nurse #2, the nurse r x-ray on 8/3/15 due to swelling the resident nurse ordered this x-r the record review of t nurse reported she to and she thinks she fai could not remember. that she showed the re pain in the left knee ai x-ray on 8/6/15 of the asked what the proce x-ray with the x-ray con that first, you order th x-ray company will co x-ray. The x-ray com the facility. The nurse to the fax machine an delivered to the nurse administrative staff.	se reported the resident of her knees but she had nees due to osteoporosis. resident wears pain patches for the chronic pain. Nurse medicated with two tablets for to 5/325 milligrams) at d pain. The nurse reported at she might need an x-ray pain. Nurse # 1 reported ed swelling noted at the time pain medication. n 8/19/15 at 2:15 pm, with evealed she ordered an to the increased pain and had to her knees. The ray at 9:15 am on 8/3/15 per he physician 's order. The build not remember if she sults in to the doctor. The looked at the results quick xed it to the doctor, but she The nurse further added results to the physician on sician was at the facility. The sident was complaining of and the physician ordered an eleft leg. The nurse was ress was when you order an oppany. The nurse reported the x-ray by phone, and the ome to facility and do the pany will fax the results to e reported the nurse is to go and get the results or they are e 's station by the The nurse was asked why	F	309			
	she did not get the re	sults until after 10:00 pm m the x-ray company to the					

Facility ID: 923270

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						O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · · ·	E SURVEY IPLETED
			A. BOILDING			С
		345077	B. WING		09	9/09/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
				25 SUNNYBROOK ROAD		
SUNNYBR	OOK REHABILITATION	CENTER		RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 309	Continued From page	<b>-</b> 18	F 30	no		
	facility at 12:57 pm.		1 30			
		s do not have time; the fax				
	machine is on the other end of the room.					
	An interview with Nursing Assistant (NA) #1 at 9:35 am on 9/2/15 revealed the NA recalled					
		plained about pain after the				
		reported it was getting				
	harder to assist her.					
	-	h transfers and was only a				
	•	he time with activities of daily				
		ter her fall, she needed two at all times. The NA noticed				
		g and reported it to the				
		stayed in bed on the day				
		e resident refused to get out				
		n. When the resident				
		he NA told the Nurse #2.				
		was medicated with pain reported the resident had a				
		g repositioned. Prior to the				
		Id sit at the edge of the bed				
	and bath the upper pa	art of her body. She would				
		day after breakfast and go to				
		ent liked to be up and out of				
	had any pain prior to	lid not recall if the resident the fall.				
		#2 at 4:27 pm on 9/2/15 A arrived to her shift at 3:00				
		and in her wheelchair. NA				
	-	there the night the resident				
	fell. NA #2 reported t	the resident slid out of bed.				
		was in the lowest position				
	-	by the bed. The resident				
		in but NA #2 could not The NA could not tell if she				
		fall, but before the fall she				

Facility ID: 923270

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 09/28/2015 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		345077	B. WING		_		C 09/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
SUNNYBR	OOK REHABILITATION	CENTER		25 SUNNYBROOK ROAD RALEIGH, NC 27610			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	e 19	F 309				
	the resident fell after s	shift change. NA # and					
	Nurse #1 assisted the	e resident back to bed. The					
	•	ent had no complaints of					
		he could recall. The NA					
	reported that Residen	have any complaints of pain					
		/15. The NA reported the					
	•	as to stay up until after					
		or so depending on her					
	-	o bed. The resident ate					
		he resident utilized a sit to					
		ith an assist of two NAs. have any complaints of pain					
		rior to the fall. The resident					
	÷ .	after her fall during the					
	transfers. The interve	entions that were in place					
		in the lowest position and a					
		her right side while in bed.					
		plaining of pain on Tuesday ports she made Nurse #3					
	aware. The resident						
		nesday and Thursday, she					
		NA started the shift at 3:00					
	pm.						
	A phone interview with	h NA #3 on 9/2/15 at 12: 15					
	-	t #1 got up every day using					
		The NA reported she had					
		and the resident always					
	wanted to get up and						
	and then got ready to	nt had breakfast in her room					
	• •	he dining room. The NA					
		fall, she did refuse to get					
		ticed the resident had					
	swelling to her knees.	The NA reported she told					
		id the resident had arthritis					
		knees ached, but she wore					
	the patches to help w	ith that.					

If continuation sheet Page 20 of 31

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM	D: 09/28/2015 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		345077	B. WING					C 109/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
				2	5 SUNNYBROOK ROAD			
SUNNYBR		CENTER		R	RALEIGH, NC 27610			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREF	IX		PLAN OF CORRECTION TIVE ACTION SHOULD BI	E	(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG			CED TO THE APPROPRIA EFICIENCY)	ΛΤΕ	DATE
F 309	Continued From page	20	F	309				
	A phone interview with	h NA #4 on 9/2/15 at 1:08						
	pm revealed Residen	t #1 had a lot of pain after						
		vant to be moved or have						
		s. The NA reported she told						
		ain and the swelling which e NA reported she does not						
		did, but she knows the						
	nurse went in to see t							
		was resting quietly in bed						
		u moved the resident, that						
	she said she had pair	to her legs.						
	An interview with Nur	se #3 at 3:17 pm on 9/2/15						
		11 shift) received change of						
		e #2 (7-3 shift) on 8/4/15.						
	Nurse #2 reported Re	sident #1 had a fall on the						
		l had an x-ray, but it was						
		Nurse #3 did not receive						
	-	was having any pain nor did						
		urse #3 reported on the night ed the resident when the NA						
		her the resident was in pain.						
		ferred the resident and was						
	•	e and the resident was						
	-	ne NA notified the nurse.						
	The nurse found the r	esident to be in pain and						
		ne tablet of Norco 5/325.						
	-	hen she reassessed the						
		eping. The nurse reported						
	-	did not have any increased eported the process when a						
	nurse orders an x-ray							
		company will come to the						
		. The x-ray company will						
	fax the results to the f	acility. Nurse #3 also						
		t is positive or there is an						
		-ray company would call to						
	speak to the nurse.	f it is negative, the x-ray						

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		MEDICAID SERVICES				IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	TE SURVEY MPLETED
			A. BUILDING	;		С
		345077	B. WING			9/09/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
				25 SUNNYBROOK ROAD		
SUNNYBR	ROOK REHABILITATION	CENTER		RALEIGH, NC 27610		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	DATE
F 309	Continued From page	e 21	F 30	9		
		ax only. Nurse #3 said she				
	would check the fax machine for results during					
		s not see them, she will call see if they resulted. Nurse				
		are positive she would call				
		sponsible party with the				
		are negative, she faxes the				
	result to the doctor.					
	An interview with Nu	rse #4 on 9/2/15 at 10:35 am				
		t had no complaints of pain				
		e night shift on 8/3/15, 8/4/15,				
		se reported the resident slept				
		e nurse reported she saw no				
	-	her knees but the resident to her knees down to her feet				
		bical medicated patches for				
	-	porosis. The nurse reported				
		out on at 8:00 pm and taken				
		se #4 was told by Nurse #2				
		id an x-ray was done on 8/3 vere negative. Nurse #4 did				
		ults. Nurse #4 reported the				
		g an x ray is to order the				
		x-ray company performs the				
		esults. The faxes go to a fax				
		e's station. If the results are				
	-	fax the result to the doctor. itive, the nurse calls the				
		orders. Nurse #4 revealed				
	she did not receive a	phone call from the x-ray				
	company informing the nurse of the positive re					
	of the x-ray.					
	A phone interview wa	as conducted with an				
		-ray company at 11:33 am on				
		results of Resident #1 's				
		nployee reported the x-ray				
	was done on 8/3 at 1	Z to pm and resulted at	1			1

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	e survey IPleted
		345077	B. WING			09	C 9/09/2015
NAME OF P	ROVIDER OR SUPPLIER		<b>I</b>		STREET ADDRESS, CITY, STATE, ZIP CODE		
SUNNYBR	ROOK REHABILITATION	CENTER			25 SUNNYBROOK ROAD RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309	12:57 pm and faxed t An interview with the the x-ray company, re phoned into (Nurse # supervisor further add courtesy call that the Sometimes they are v it right away but the n on the call back scree contacts the facility. that the x-ray compar- calls for positive or at On 9/2/15 at 1:50 pm the x-ray company ar account manager rev 8/3 and 8/6 and repor- review done by the x- facility to review the x. The account manage company only makes when the results are p the facility when the r On 8/20/15 at 10:45 a Director of Nursing (D expectation of the nur- immediately when the lab result via fax or a reported her expect follow up to be sure the phone call or the fax the orders from the physi- added that her expect the nurse ordered the should check the fax the result. The DON licensed nurses on al	o the facility at this time. call center supervisor from eported the result was 4) on 8/5/15. The ded that the phone call is a x-ray company does. very busy and cannot get to ame of the facility stays up en until the x-ray company The supervisor reported by would only make courtesy phormal results. , the account manager from rived at the facility. The iewed the x-ray results from ted she would have a case ray company 's radiology -ray films again from 8/3/15. ger also confirmed the x-ray courtesy calls to the facility positive. They do not call esult is negative or normal.	F	309	9		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345077	B. WING				C / <b>09/2015</b>
NAME OF PI	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
SUNNYRE		CENTER		:	25 SUNNYBROOK ROAD		
SOUNTER	CON RELIABLE TATION	GENTER			RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 309	injuries and resident s 2. Evaluate resider which would require r includes: >Vital Signs >Skin Evaluation >Musculoskeletal ass >Change of condition >Pain Assessment >Neurological assess 3. Thoroughly of medical record 4. Interview res if cause of fall can be 5. Notify MD in falls, assessment find medical record 6. Notify family medical record 7. Complete por formulate intervention clinical information. 8. Communicat to the care giving staf 9. Document p hours. During an interview w Administrator, The DO 9/2/15 that when the p process is for them to The x-ray company p results are faxed to th secretary will check th morning and deliver a they are sent to their	ons: ate care to address any safety nt for any additional injury medical intervention which essment ment as indicated document clinical findings in sident and staff to determine determined person or by telephone of all lings and document in the and document notification in ost fall assessment and as based off evaluated te established interventions f ost fall every shift for 72 with the DON and the DN reported at 12:00 pm on nurses order an x-ray the o call the x-ray company. erforms the x-ray; the ne facility. The DON or the	F	309			

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CENTER STATEMENT ( AND PLAN OF		D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345077	A. BUILDING	E CONSTRUCTION	_	FORM OMB NO (X3) DATE COMP	LETED
SUNNYBF	ROOK REHABILITATION	CENTER		5 SUNNYBROOK ROAD RALEIGH, NC 27610			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	would call the facility a they have a positive re During an interview of the physician, it was r of the x-ray result on a added that if she had fracture to the right fe ordered the facility to hospital right away. T at the facility on 8/6/1 was having knee pain she ordered an x-ray showed a left fracture reported she was sho 8/3/15 on 8/6/15 by N asked why she was n result and Nurse #2 re part of the result and physician reported he is to report any abnor value immediately to An interview with the 9/2/15 at 12:30 pm. T the condition worsene having the resident ex x-ray on 8/3/15. The maybe the radiologist displacement in the fr reported that if it was could be hard to see. that with any kind of re resident with osteopo The physician recomm radiologist to get furth on 8/3/15. A record re	ded the x-ray company and speak to the nurse if esult. n 8/19/15 at 3:00 pm, with evealed she was not aware 8/3/15. The physician known about the acute mur she would have send the resident to the The physician recalled being 5 and being told the resident i. The physician reported	F 309				

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345077	B. WING				09/2015
NAME OF P	ROVIDER OR SUPPLIER		<b>I</b>	Ś	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
SUNNYBF	ROOK REHABILITATION	CENTER			25 SUNNYBROOK ROAD RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	9/2/15 revealed the e 8/3/15 were reviewed shown on 8/6 was no prior study. The revie left femur spiral fractu exam is not visible on 8/3/15 The physician reveal the hospital where sh her legs and was trans on 8/7/15 where the r to her fractured femur A phone interview wa 10:40 am with the race results on 8/3/15 of the knee. The radiologist 8/3/15 were accurate fracture to the distal for reported the 8/3/15 x- another radiologist. The confirmed the 8/3/15 A phone interview wa 11:14 am with the rade result on 8/6/15 of the reported that the fract no signs of healing. The fracture happened with The administrator was jeopardy on 9/2/15 at The facility provided a allegation on 9/3/15 and Resident # 1 was four bed on 8/3/15. The no	xams from 8/6/15 and to determine if the fracture t visible or present on the ew comment revealed the irre described on 8/6/15 images of the left knee on ed the resident was sent to e had splints placed on both isported to another hospital esident had bilateral surgery rs on 8/8/15. s conducted on 9/9/15 at liologist who read the x-ray re right knee and the left treported that the results on . He could not see a emur. The radiologist ray was also read by The other radiologist results were accurate. s conducted on 9/9/15 at liologist who read the x-ray e left femur. The radiologist tresults were accurate. s conducted on 9/9/15 at liologist who read the x-ray e left femur. The radiologist ture looks new as it shows The radiologist felt that the thin one week. s notified of the immediate 12:00 pm. an acceptable credible	F	309			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 09/28/2015 / APPROVED ). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		LETED
		345077	B. WING			( 09/	C 09/2015
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
SUNNYBR		CENTER			25 SUNNYBROOK ROAD RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	An x-ray was complet right fractured femur. as negative and did n Resident had increase second x-ray was ord 8/6/15. The results w fracture. The residen ambulance and was la hospital where orthop to bilateral femurs to a resident did not return surgery. The residen nursing home facility. All NAs will be educat necessity of completin watch tool on their Point of Care in notice a change of co 9/2/15. This information automatic Click Care Clinical Ale to see. All nurses were educat positive confirmation company until the cha 10/1/15. The new pro positive " watermark all positive results. All newly hired license by the Staff Developm assessments and doo orientation period. The DON and the Uni for the implementation Management Program	ted on 8/3/15 resulting in a The nurse read the results ot notify the physician. ed pain and swelling and a ered and performed on rere positive for a left femur t was sent to the hospital via ater admitted to another edic surgery was performed repair the fractures. The n to the facility after the t was admitted to another ted on the ability and ng the interact stop and put screens when they ndition of the resident on cally shows up on the Point ert dashboard for the nurses ated on 9/2/15 of the phone call from the x-ray ange in procedure occurs on	F	309			

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		ID HUMAN SERVICES MEDICAID SERVICES	-			FC	red: 09/28/20 DRM APPROVE NO. 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· , ,		DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345077	B. WING				C 09/09/2015
NAME OF PF	ROVIDER OR SUPPLIER		•		EET ADDRESS, CITY, STATE, ZIP CODE		
SUNNYBR	OOK REHABILITATION	CENTER			UNNYBROOK ROAD .EIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 309 F 520 SS=D	Risk Management me Managers and the Wa Administrative Regist Sunday. Beginning 9/2/15 all r post fall within 24 hou Manager, Director of Supervisor. All other residents we hour report, chart rev resident observations a result of a fall on 9/ Validation on 9/3/15 a credible allegation wa direct nursing staff re reading and reporting the physician as well and implementing inte In-services to NAs an completing accurate a implemented on 8/10 Manager verified they residents within 24 ho on 9/2/15. 483.75(o)(1) QAA COMMITTEE-MEMB QUARTERLY/PLANS A facility must mainta assurance committee nursing services; a pl	eekly in Quality Assurance eeting by the DON/Unit eek-end Supervisor/On Call eered Nurse on Saturday and residents will be assessed urs by the facility Unit Nursing or Nurse ere assessed utilizing the 24 iews, staff interviews and a for changes in condition as 3/15 by the DON. at 12:30 pm verified the as evidenced by interviews of lated to education on g positive x-rays results to as accurate assessments erventions post fall. ad nurses related to falls and assessments were /15. The DON and Unit y will assess post fall burs which was implemented ERS/MEET		520	DEFICIENCY)		9/22/15
	facility's staff. The quality assessme committee meets at le	ent and assurance east quarterly to identify					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOI	ED: 09/28/2015 RM APPROVED NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345077	B. WING			0	C 9/09/2015
NAME OF PI	ROVIDER OR SUPPLIER		<b>I</b>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SUNNYBR	OOK REHABILITATION	CENTER			5 SUNNYBROOK ROAD ALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 520	and assurance activit develops and implem action to correct ident A State or the Secret disclosure of the reco except insofar as suc compliance of such correquirements of this s Good faith attempts b and correct quality de a basis for sanctions. This REQUIREMENT by: Based on record revi interviews the facilitie Assurance Committee implemented procedu interventions that the July of 2015. This way which was originally of yearly recertification s in the area of notificat the facility since the la pattern of the facilities effective Quality Assu Findings Included: This tag is cross-refer	<ul> <li>which quality assessment ies are necessary; and ents appropriate plans of tified quality deficiencies.</li> <li>ary may not require rds of such committee h disclosure is related to the ommittee with the section.</li> <li>by the committee to identify ficiencies will not be used as</li> <li>is not met as evidenced</li> <li>wand staff and resident s ' Quality Assessment and e failed to maintain ures and monitor the committee put into place in as for a recited deficiency, cited in July of 2015 on a survey. The deficiency was tion. The continued failure of ast survey of record show a s ' inability to sustain an irance Program.</li> </ul>	F	520	The statements included are not a admission and do not constitute agreement with the alleged deficier herein. The plan of correction is completed in the compliance of sta federal regulations as outlined. To in compliance with all federal and s regulations the center has taken or take the actions set forth in the folk plan of correction. The following pla correction constitutes the center a allegation of compliance. All alleger deficiencies cited have been or will completed by the dates indicated.	ncies te and remain tate will owing an of	
	reviews, staff interview the x-ray company ' s	to Notify: Based on record ws, physician interview and staff interviews, the facility vsician of a positive x-ray			1. Interventions for affected resid An additional Quality Assessment a		
	7(02-99) Previous Versions Obs	olete Event ID: V8Q	0.11	_	cility ID: 923270		eet Page 29 of 3

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DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE &				FORM	): 09/28/2015 1 APPROVED ). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	345077	B. WING			C 09/2015
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
			25 SUNNYBROOK ROAD		
SUNNYBROOK REHABILITATION	ICENTER		RALEIGH, NC 27610		
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
revealed a fractured residents (Resident a medical treatment. Resident #1 having o to bilateral fractured During an interview o Administrator, Regio the Director of Nursi assurance and perfor was initiated on 8/10 incident). The DON the committee. Aud committee will make compliance is maintar results will be review	knees on 8/3/15 which right femur for 1 of 3 #1) resulting in delayed The outcome resulted in orthopedic surgery on 8/8/15	F 52	<ul> <li>Assurance Committee (QA&amp;A was held on 9/5/15 to review findings related to Notification in Condition. Director of Nursi presented audits thus far to th for review. No issues were ide Resident # 1 was discharged facility on 8/6/15 and has not</li> <li>Interventions for resident as having the potential to be a Re-education was provided to Quality Assessment and Assu Committee (QA&amp;A Committee Regional Clinical Director. Ec included importance of mainta effective QA&amp;A Committee. E emphasized ensuring the QA Committee oversees and ider efforts that improve the quality the facility by monitoring performeasures, directing improvem by correcting and sustaining of and evaluating the effective management activities.</li> <li>Systematic Change:</li> <li>The facility QA&amp;A Committee twice monthly for a minimum months to ensure facility QA p Change in Condition Notificat reviewed thoroughly and recommendations of quality in sustained ongoing.</li> </ul>	all audit of Change ing ne committee entified. from the returned. s identified affected: b the facility urance b) by the ducation aining an iducation &A ntifies all y of care in ormance nent actions compliance ess of quality will meet of three processes for ion are	

Facility ID: 923270

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	-	ID HUMAN SERVICES MEDICAID SERVICES				F	ITED: 09/28/2015 ORM APPROVED NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) [	DATE SURVEY OMPLETED
		345077	B. WING				C 09/09/2015
NAME OF PF	ROVIDER OR SUPPLIER		I	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
SUNNYBR	OOK REHABILITATION	CENTER		25	SUNNYBROOK ROAD		
				R	ALEIGH, NC 27610		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 520	Continued From page	e 30	F	520			
	1.0				system compliance ongoing:		
					Twice monthly for a minimum of the months, the DON will report audit to the Quality Assurance and Performance Improvement Comm	results	
					The Quality Assurance and Perfor Improvement Committee will revie audits to make recommendations ensure compliance is sustained o and determine the need for furthe auditing beyond the three months	rmance ew the to ngoing; r	
	7/02-00) Previous Versions Obs	olete Event ID: V8			siih, ID: 923270 If		aboot Dago 21 of 2

Facility ID: 923270

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