PRINTED: 12/15/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED C			
		345233	B. WING _	B. WING			11/22/2016	
	ROVIDER OR SUPPLIER	RE	1	STREET ADDRESS, CITY, STATE, ZIP CODE  306 DEER PARK ROAD  NEBO, NC 28761				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	( (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 225 SS=D	(a) The facility must- (3) Not employ or oth who- (i) Have been found exploitation, misappr mistreatment by a co- (ii) Have had a findin nurse aide registry c exploitation, mistreatmisappropriation of the composition of the professional libody as a result of a exploitation, mistreatmisappropriation of result of the Stalicensing authorities actions by a court of which would indicate nurse aide or other face.	guilty of abuse, neglect, ropriation of property, or burt of law;  g entered into the State oncerning abuse, neglect, ament of residents or heir property; or any action in effect against his cense by a state licensure finding of abuse, neglect, ament of residents or esident property.  te nurse aide registry or any knowledge it has of law against an employee, a unfitness for service as a	F 2		DEFICIENCY)		12/16/16	
ABORATOP∀	abuse, neglect, exploincluding injuries of unisappropriation of reported immediately after the allegation is cause the allegation serious bodily injury,	oitation or mistreatment,	F	TITLE			X6) DATE	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

12/12/2016

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

**Electronically Signed** 

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		345233	B. WING _			C 11/22/2016	
	ROVIDER OR SUPPLIER REHABILITATION & CAI	RE	STREET ADDRESS, CITY, STATE, ZIP CODE 306 DEER PARK ROAD NEBO, NC 28761			11/22/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 225	abuse and do not res the administrator of the officials (including to adult protective service)	e the allegation do not involve sult in serious bodily injury, to ne facility and to other the State Survey Agency and ces where state law provides	F2	225			
	for jurisdiction in long-term care facilities) in accordance with State law through established procedures.  (2) Have evidence that all alleged violations are thoroughly investigated.  (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.						
	administrator or his o representative and to with State law, includ Agency, within 5 worl if the alleged violation corrective action mus	oother officials in accordance ing to the State Survey king days of the incident, and n is verified appropriate					
	facility failed to invest origin and file a 24 ho to the North Carolina	iew and staff interviews the tigate an injury of unknown our and 5 working day report Health Care Personnel CPI) for 1 of 1 resident of unknown origin		1. The 1 day and 5 day invest reports were submitted on 11/2 11/28/16 respectfully by the Act to the North Carolina Health C. Personnel Investigations (NCF resident #7.	22/16 & Iministrator are		
	The findings included Resident #7 was adn 09/03/14 with diagno behavioral disturbance	nitted to the facility on ses of dementia without		2. All residents have the poten affected. An audit of incident for 90 days was completed on 11/ the Director of Clinical Operation ensure known causes were property injury. Identified injuries with known cause were reported to	or the last 30/16 by ons to esent for ith no		

Facility ID: 923334

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
				_		(	2
		345233	B. WING _			11/22/2016	
NAME OF P	ROVIDER OR SUPPLIER	•	<u>'</u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
OUNDIOE	DELLA DU ITATION A 04		306 DEER PARK ROAD		06 DEER PARK ROAD		
SUNRISE	REHABILITATION & CA	ARE		N	EBO, NC 28761		
(X4) ID PREFIX TAG			ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD I			(X5) COMPLETION DATE
F 225	Continued From no	vo 2		205			
F 223	Continued From page		F 2	225			
	communication deficit. The annual Minimum Data				required by the administrator.		
		/22/16 indicated Resident #7			2. The administrator received advection	_	
		aired cognition but was			The administrator received education regarding the reporting the abuse.	1	
	understood and cou	ld usually understand.			regarding the reporting the abuse program, reporting requirements and		
	Review of the facility	/ incident reports for 09/2016			completing investigation for allegations	of	
		ealed an incident report of an			abuse, neglect, exploitation or	01	
	incident for Resident #7 on 09/13/16. The report indicated Resident #7 had a large hematoma to the left mid/inner thigh and a small bruise to the left side of the nose. The incident report was signed by Nurse #1, the Director of Nursing				mistreatment, to include injuries of		
					unknown origin by the Director of		
					Operational Support on 11/28/16.		
					The interim administrator received		
	(DON), and the Adm	ninistrator.			education regarding the reporting the		
					abuse program, reporting requirements	;	
		's notes from 08/22/16			and completing investigation for		
		vealed Nurse #1 had made			allegations of abuse, neglect, exploitati	on	
		hich read in part: 09/13/16 at			or mistreatment, to include injuries of	_	
		sistant (NA) reported			unknown origin by the Director of Clini	cal	
		ruise to the left thigh and to			Operations on 11/30/16.		
		ent was examined and noted			Facility stoff advection regarding report	ina	
		ized hematoma to the left , slightly bluish in color and			Facility staff education regarding report of abuse, neglect, exploitation,	ing	
		nately 2 centimeters (cm) by			mistreatment to include bruises was		
		e of the nose the area was			initiated on 11/25/16. Employees not		
		nysician Assistant (PA) was			working during the education time fram	e	
		orders were obtained and the			(i.e. FMLA, PRN); will receive this		
		ative was also notified.			education prior to their next scheduled		
	'				shift by the interim administrator or		
	Further review of the	e medical record revealed a			designee. Newly hired employees will		
	progress note dated	09/13/16 by the PA which			receive abuse training as part of the ne	w	
	-	t #7 was evaluated in regards			hire orientation.		
		matoma to the left medial					
		ndicated in the progress note			4. Incident reports will be reviewed to		
		s cooperative during the			ensure causes of injuries, to include, but	ut	
		concerned that the bruise was			not limited to bruises, skin tears or		
	there but was unawa	are of how it had happened.			fractures are known or that an		
	Ni. ma a #4 =	a ta ha intensioned in a second			investigation has been initiated and the	:	
		e to be interviewed in regards			incident reported to NCHCPI as	lelv	
	to being out of work	on medical leave.	1		appropriate; will be completed 5 X wee	riy	

Facility ID: 923334

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345233	B. WING		C 11/22/2016		
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CO		122/2010	
				306 DEER PARK ROAD			
SUNRISE	REHABILITATION & CAI	RE		NEBO, NC 28761			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 225	11/22/16 at 3:05 PM. was the 2nd shift sup was made aware of F Nurse #1. Nurse #2 show Resident #7 obta speculated that it was the mechanical lift slib between the resident.  An interview was condon 11/22/16 at 3:20 F not employed by the incident and she was 11/22/16. The DON freexpected a 24 hour a have been completed due to not knowing for had happened. The Eproblems with incident particular incident was 11/22/16. The DON freexpected a 24 hour of 5 working regards to the injury of An interview was conducted to the injury of Reside was made aware of the inj	ducted with Nurse #2 on Nurse #2 confirmed she ervisor on 09/13/16 and she Resident #7's hematoma by stated she was unaware of ained the hematoma but had a caused by the straps on ng which crisscrossed 's legs during transfer.  ducted with the interim DON PM. The DON stated she was facility at the time of the unaware of the incident until arther stated she would have nd a 5 working day report to at the time of the incident or 100 % certainty of what DON indicated there were nt reporting and this s not identified until arther indicated there was no day report completed in	F 2		Designee. De taken to the eeting X 3		
	and therefore there s	hould have been a 24 hour report completed for an					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345233	B. WING			C	
NAME OF DE	ROVIDER OR SUPPLIER	343233	B. WING_	STREET ADDRESS, CITY, STATE, ZIP CODE		/22/2016	
NAIVIE OF FF	COVIDER OR SUFFLIER			306 DEER PARK ROAD			
SUNRISE	REHABILITATION & CAR	RE		NEBO, NC 28761			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 226 SS=D	PM with the Administr confirmed her signature dated 09/13/16. The Accould not remember to the incident. She fut the incident report, signare some important of Administrator indicate ensure the safety of the facility and that a 24 for report should have be investigation conducted 483.12(b)(1)-(3), 483. DEVELOP/IMPLMEN POLICIES  483.12 (b) The facility must downitten policies and provided investigation of resider resident property,  (2) Establish policies investigate any such account of the freedom from abure requirements in § 483.95  (c) Abuse, neglect, and the freedom from abure quirements in § 483.95	ducted on 11/22/16 at 6:11 rator. The Administrator are on the incident report Administrator stated she he incident or the specifics arther stated she had read gned it, and stated "there hissing pieces." The add there was nothing done to the other residents in the nour and a 5 day working the completed and an ed.  95(c)(1)-(3) T ABUSE/NEGLECT, ETC  evelop and implement rocedures that:  ant abuse, neglect, and the and procedures to	F 2	226		12/16/16	

` ′		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345233	B. WING _			C 11/22/2016		
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 17.	22/2010	
					06 DEER PARK ROAD			
SUNRISE	REHABILITATION & CAI	RE			EBO, NC 28761			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 226	Continued From page	÷ 5	F 2	226				
	educates staff on-							
		onstitute abuse, neglect, appropriation of resident at § 483.12.						
		reporting incidents of abuse, or the misappropriation of						
	(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by:							
	Based on record rev facility failed to follow procedure to investig origin and file a 24 ho to the North Carolina Investigations (NCHO	iew and staff interviews the their abuse policy and ate an injury of unknown our and 5 working day report Health Care Personnel CPI) for a resident with a of 1 residents sampled for			<ol> <li>The 1 day and 5 day investigative reports were submitted on 11/22/16 &amp; 11/28/16 respectfully by the Administra to the North Carolina Health Care Personnel Investigations (NCHCPI) for resident #7.</li> <li>All residents have the potential to be</li> </ol>			
	The findings included				affected. An audit of incident for the las 90 days was completed on 11/30/16 by the Director of Clinical Operations to	1		
	05/01/14 indicated un Under section H titled that identify events, s	y's abuse policy dated of a section titled Process:  I Identification read in part of as suspicious bruising onces, patterns and trends			ensure known causes were present for any injury. Identified injuries with no known cause were reported to NCHPI required by the administrator.			
	•	estigate. The policy Administrator and Director of e notice to all appropriate			<ol> <li>The administrator received education regarding the reporting the abuse program, reporting requirements and completing investigation for allegations abuse, neglect, exploitation or mistreatment, to include injuries of</li> </ol>			
		nitted to the facility on ses of dementia without se, thrombocytopenia			unknown origin by the Director of Operational Support on 11/28/16.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CO		11/22/2010	
				306 DEER PARK ROAD			
SUNRISE	REHABILITATION & CAI	RE		NEBO, NC 28761			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 226	Continued From page	e 6	F 22	26			
1 220	(deficiency of platelet communication deficiency of MDS) dated 08/2 had moderately impa understood and could a review of the facility revealed there were reports submitted to the Care Personnel Invest through 11/21/16 revealed the nurse's through 11/21/16 revealed the following entry who is the following entry who is the nose. The resident to have an orange signiner mid-thigh area, noted to be approximant of the incolor. The Phynotified and no new or resident's representative in color. The Phynotified and no new or resident's representative in part Resident to a bruising with hen thigh area. The PA in that Resident #7 was exam and seemed continued to the progress note dated or the progre	is in the blood), and cognitive t. The annual Minimum Data 22/16 indicated Resident #7 ired cognition but was d usually understand.  y abuse investigations no 24 hour or 5 working day the North Carolina Health stigations for Resident #7.  s notes from 08/22/16 ealed Nurse #1 had made nich read in part: 09/13/16 at istant (NA) reported uise to the left thigh and to nt was examined and noted zed hematoma to the left slightly bluish in color and lately 2 centimeters (cm) by e of the nose the area was ysician Assistant (PA) was orders were obtained and the tive was also notified.  medical record revealed a 09/13/16 by the PA which #7 was evaluated in regards natoma to the left medial dicated in the progress note cooperative during the oncerned that the bruise was re of how it had happened.	F 22	The interim administrator receducation regarding the report abuse program, reporting recand completing investigation allegations of abuse, neglect or mistreatment, to include in unknown origin by the Direct Operations on 11/30/16.  Facility staff education regard of abuse, neglect, exploitation mistreatment to include bruis initiated on 11/25/16. Employ working during the education (i.e. FMLA, PRN); will receive education prior to their next shift by the interim administrates designee. Newly hired employereeive abuse training as pathire orientation.  4. Incident reports will be revenue causes of injuries, to not limited to bruises, skin te fractures are known or that a investigation has been initiat incident reported to NCHCPI appropriate; will be complete by the Administrator/ DON/D Results of these audits will be monthly QAPI Committee months to ensure ongoing strompliance.	orting the quirements of for the exploitation on the properties of the control of Clinical ding reporting on, sees was even not on time frame to the ethic scheduled attor or covers will refer to the new to the exploration of the new to the		
	was made aware of F	ervisor on 09/13/16 and she Resident #7's hematoma by stated she was unaware of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345233	B. WING			C <b>11/22/2016</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 306 DEER PARK ROAD NEBO, NC 28761	DE	11/22/2016
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 226	how Resident #7 obta speculated that it was the mechanical lift slip between the resident. An interview was con on 11/22/16 at 3:20 F not employed by the incident and she was 11/22/16. The DON for expected a 24 hour a have been completed due to not knowing for had happened. The Exproblems with incident particular incident was 11/22/16. The DON for 24 hour or 5 working regards to the injury of An interview was con 11/22/16 at 4:22 PM. was the interim DON of the injury of Reside was made aware of the injury of Reside was made aware of the injury no one in the injury of unknown original properties. An interview was con PM with the Administ	ained the hematoma but had a caused by the straps on any which crisscrossed is legs during transfer.  ducted with the interim DON PM. The DON stated she was facility at the time of the unaware of the incident until urther stated she would have and a 5 working day report to at the time of the incident of 100 % certainty of what PON indicated there were not reporting and this is not identified until urther indicated there was not any report completed in of unknown origin.  ducted with Nurse #3 on Nurse #3 confirmed she in 09/2016 during the time ent #7. Nurse #3 stated she he hematoma to Resident and on the nose on 09/13/16, we hematoma had defined in blue in color, and was eggother indicated at the time of the facility re-enacted the exactly what had happened should have been a 24 hour report completed for an incidence of 11/22/16 at 6:11 rator. The Administrator	F 2	226		
	confirmed her signatu	ure on the incident report Administrator stated she				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUAND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUAND PLAN OF CORRECTION (X3) MULTIPLE CONSTRUAND PLAN OF CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUAND PLAN OF CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUAND PLAN OF CORRECTION (X5) MULTIPLE CONSTRUAND PLAN OF CORRECTION (X6) PROVIDER/SUPPLIER/CLIA (X6) MULTIPLE CONSTRUAND PLAN OF CORRECTION (X6) PROVIDER/SUPPLIER/CLIA (X7) MULTIPLE CONSTRUAND PLAN OF CORRECTION (X7) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/SU	COMPLETED
<b>345233</b> B. WING	C 11/22/2016
	ESS, CITY, STATE, ZIP CODE
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE OSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE
F 226  Continued From page 8  could not remember the incident or the specifics of the incident. She further stated she had read the incident report, signed it, and stated "there are some important missing pieces." The Administrator indicated there was nothing done to ensure the safety of the other residents in the facility and that a 24 hour and a 5 day working report should have been completed and an investigation conducted.  F 309  SS=D  FOR HIGHEST WELL BEING  483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.  483.25  (k) Pain Management.  The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.  (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.  This REQUIREMENT is not met as evidenced	12/16/16

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		345233	B. WING _			11/	22/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
011115105				30	06 DEER PARK ROAD		
SUNRISE	REHABILITATION & CA	ARE		N	EBO, NC 28761		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION
TAG	•	R LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
F 309	Continued From pag	ge 9	F:	309			
	Based on record re	view and staff interviews the			1. Resident #7 hematoma was resolve	ed.	
		ess a hematoma for a resident			on 11/1/16.	-	
	-	der for 1 of 4 sampled					
		or maintaining well-being			2. All residents have the potential to be	1	
	(Resident #7).	or maintaining won boning			affected. An audit of incident for the las		
	(I tooldone ii I ).				90 days was completed on 11/30/16 by		
	The findings include	d·			the Director of Clinical Operations to		
	The illiangs molade	u.			identify any other bruises for residents		
	Resident #7 was ad	mitted to the facility on			with thrombocytopenia that may require	ے	
		oses of dementia without			further assessment. Residents with	,	
	•	nce, thrombocytopenia			thrombocytopenia were reviewed to		
		ets in the blood/platelet			ensure no bruising was present or in ne	موط	
		tive communication deficit.			of reporting on 11/30/16 by the Directo		
	disorder), and cogni			Clinical Operations and the weekly skir			
	An annual Minimum			checks were reviewed by the DON on			
		Resident #7 had moderately			12/13/16 to ensure the actual reflection	of	
		out was understood and could			these resident s.	Oi	
		The MDS revealed Resident			these residents.		
		ve assistance with transfers,			3. Licensed staff education was initiate	Ч	
	-	eting, and personal hygiene,			by the Director of Nursing (DON) on	u	
		endent on staff for bathing.			12/6/16 regarding documentation of		
		resident with impairments of			resident assessments, to include week	lv.	
		•				-	
	risk for skin breakdo	ower extremities and was at			skin assessments reflecting current stated of resident skin, to include identification		
	IISK IOI SKIII DIEAKUO	WII.			of any bruising, documentation in the	.1011	
	An undated care pla	in dated 10/23/16 identified			I		
		risk for skin breakdown. The			medical record regarding incidents to include suspicious bruising, and		
		aling of the areas. An			notification as appropriate to the		
	_	d weekly skin assessments			MD/RP/DON. Employees not working		
	and monitoring.	d weekly skill assessifierits			during the education time frame (i.e.		
	and monitoring.					n	
	A ravious of the pure	e's notes from 08/22/16			FMLA, PRN); will receive this education		
					prior to their next scheduled shift by the	;	
	•	vealed the following entry			DON/Designee.		
	•	09/13/16 at 1:30 PM:			4. Audito of the weekly skip assessmen	ato	
	Resident #7 had a bruise to the left thigh and to			4. Audits of the weekly skin assessmen			
		ent was examined and noted			for residents with thrombocytopenia wil	I	
		ized hematoma to the left			be completed weekly X 6 weeks, then		
		, slightly bluish in color and			every 2 weeks X 6 weeks, then monthl		
	noted to be approximately 2 centimeters (cm) by				by the DON/Designee/Unit Managers;	(O	

Facility ID: 923334

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345233	B. WING		11	C / <b>22/2016</b>	
	ROVIDER OR SUPPLIER  REHABILITATION & CAP	RE		STREET ADDRESS, CITY, STATE, ZIP COD 306 DEER PARK ROAD NEBO, NC 28761		72272010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG			(X5) COMPLETION DATE	
F 309	O9 Continued From page 10		F 30	9			
	1 cm and on the left swas blue in color. The was notified and no nand the resident's repnotified.  Further review of the following entries in reunknown origin, a hemid-thigh: 09/14/16 at 1:30 PM: size of fist on inner le 09/30/16 at 1:35 PM: thigh hematoma for 1 10/20/16 at 11:00 AV hematoma 11/01/16 at 2:25 PM: inner upper thigh, are A review of the medic progress note dated or read in part Resident to a bruising with hem thigh area. The PA in that Resident #7 was exam and seemed conthere but was unawal.  Further review of Resrevealed 2 more progression for abnormatingh with lesser bruis lower legs. The resident platelets as detailed was months ago with a grange 130-400). The	side of the nose the area a Physician Assistant (PA) ew orders were obtained presentative was also enurse's notes revealed the gards to the injury of matoma to the left inner.  Resident with hematoma ft thigh.  apply warm compress to left 5 minutes every shift.  It no further issue with the ediscontinue treatment to left are resolved.  The area of revealed a cop/13/16 by the PA which #7 was evaluated in regards natoma to the left medial dicated in the progress note cooperative during the concerned that the bruise was re of how it had happened.  Sident #7's medical record gress notes dated the evaluated by the facility's all bruising to the left inner sees noted over the arms and ent known to have low with the last laboratory draw platelet count of 98 (normal)		ensure accurate reflections of skin, to include the identification bruising and ongoing docume the medical record of such as Results of these audits will be monthly QAPI Committee me months to ensure ongoing su compliance.	ion of any entation in s appropriate. e taken to the eting X 3		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345233	B. WING	B. WING			C 11/22/2016	
	ROVIDER OR SUPPLIER REHABILITATION & CAF	RE		STREET ADDRESS, CITY, STATE, ZIP CODE  306 DEER PARK ROAD  NEBO, NC 28761			22/2010	
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F 309	platelet count on 09/1 A progress note dated part Resident #7 was hematoma to the left moist compress for 1 and to monitor for any hematoma.  A review of the weekly indicated the following 09/19/16: bruise to in size of a fist, swollen 09/26/16: bruises in standard to the left thigh 10/10/16: no descript to the left thigh 10/17/16: bruise to le compress as ordered 10/24/16: no bruising (healed)  An interview was contained to the left thigh 10/12/16 at 5:11 PM. was the 2nd shift sup was aware of Reside also confirmed she we completing the weekl Resident #7. She desobserving the resider for any breakdown or confirmed she had no skin assessments in thigh hematoma. She documented in regard	d 09/30/16 by the PA read in evaluated due to a leg. The PA ordered warm 0 minutes three times a day worsening of the  y skin assessments g assessments: ner left thigh with hematoma cattered areas ion or indication of a bruise ion or indication of a bruise if thigh still present, hot found on inner left thigh  ducted with Nurse #2 on Nurse #2 confirmed she ervisor on 09/13/16 and she ent #7's hematoma. Nurse #2 as responsible for y skin assessments for scribed skin checks was ent's entire body head to toe of discoloration. Nurse #2 of documented on the weekly regards to Resident #7's left estated she only looked and dis to new skin issues and about the hematoma since	F	809				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345233	B. WING			C 44/22/2046	
NAME OF PROVIDER	R OR SUPPLIER	343233	] B. Wille	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	11/	22/2016
SUNRISE REHABILITATION & CARE				30	6 DEER PARK ROAD		
SUNNISE KEHAL	DILITATION & CAP	\L		NI	EBO, NC 28761		
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An im on 11 not el incide 11/22 asses from confir docur thigh as to #7 on evalu stated asses F 520 483.7 SS=D COM QUAI (g) Q (1) A and a minim (i) Th (ii) Th (iii) Th (iii) Ar staff, admin individual (g)(2) comm	/22/16 at 5:35 P mployed by the intent and she was /16. The DON comments had not 09/26/16 until 10 med there was intented in regard hematoma and indicate why the 09/30/16 which ation by the facility sament of Reside (5(g)(1)(i)-(iii)(2)) MITTEE-MEMB RTERLY/PLANS unality assessment of the intented in regard in the director of nurricular must man in the intented in a leaders  The quality assessment in the intented in a leaders  The quality assentited must :	ducted with the interim DON  M. The DON stated she was facility at the time of the unaware of the incident until onfirmed the weekly skin addressed the hematoma 0/17/16. The DON also only 3 times a nurse had dis to Resident #7's left inner there was no documentation a PA had evaluated Resident a was 16 days from the last lity's physician. The DON a expected an ongoing ant #7's hematoma. (i)(ii)(h)(i) QAA ERS/MEET  int and assurance.  intain a quality assessment attee consisting at a  sing services; atter or his/her designee; ar members of the facility's who must be the a board member or other		520			12/16/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345233	B. WING _			C 11/22/2016		
NAME OF PROVIDER OR SUPPLIER  SUNRISE REHABILITATION & CARE				STREET ADDRESS, CITY, STATE, ZIP CODE  306 DEER PARK ROAD  NEBO, NC 28761				
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F 520	identifying issues wit assessment and ass necessary; and  (ii) Develop and implaction to correct identifying issues of information to correct identifying its process of such commutate with section.  (i) Sanctions. Good to committee with section.  (i) Sanctions. Good to committee to identifying deficiencies will not be sanctions.  This REQUIREMENT by:  Based on record revision facilities Quality Assection in the committee failed to procedures and more than the committee put in this was for one recordinally cited in Ocsurvey and subsequence 2016 on a current for the deficiency was in and services to main continued failure of the surveys of record shippers and services in the surveys of record shippers and services with a service in the surveys of record shippers and services with a service in the surveys of record shippers and services with a service in the surveys of record shippers and services with a service in the service in the service in the services with a service in the	the respect to which quality furance activities are sement appropriate plans of ontified quality deficiencies; formation. A State or the equire disclosure of the mittee except in so far as lated to the compliance of the requirements of this	F 5	1. The facility will ensure the committee maintains and eff monitor continued compliant deficiencies identified. Resid hematoma was resolved on  2. All residents have the pote affected. An audit of incident 90 days was completed on the Director of Clinical Opera identify any other bruises for with thrombocytopenia that in further assessment. Resider thrombocytopenia were revisensure no bruising was pres of reporting on 11/30/16 by the Clinical Operations and the schecks were reviewed by the	fective plan to ce of dent #7 11/1/16.  ential to be to for the last 11/30/16 by ations to residents may require nts with ewed to the Director of weekly skin			

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			B: Wii(0 _	CT	DEET ADDRESS CITY STATE ZID CODE	11/	22/2016	
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
SUNRISE	REHABILITATION & CA	ARE		30	6 DEER PARK ROAD			
				NE	EBO, NC 28761			
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F 520	Continued From page 14		F 5	520				
	This tag is cross refe	erred to:			12/13/16 to ensure the actual reflection these resident □s.	ı of		
	F-309 Provide care a	and services to maintain						
		Based on record review and			3. The facility Quality Assurance			
		acility failed to assess a			Performance Improvement committee			
	hematoma for a resi	dent with a platelet disorder			members were educated by the Director	or		
		esidents reviewed for care to			of Clinical Operations on 10/19/16			
	maintain well-being			regarding the revised QAPI process to				
				include the new forms and format. This	<b>;</b>			
	The facility was recited for F-309 for failing to				includes the facility will identify areas for	or		
	assess a hematoma for a resident with a platelet				continuous quality monitoring and the			
	disorder (blood clotting disorder). F-309 Provide				monitoring tools to be used. These			
	care and services to maintain highest well-being				monitoring activities should focus on			
	was originally cited during the October 6, 2016 complaint survey for failing to administer an anti-viral medication for 1 of 4 residents reviewed				those processes that affect resident			
					outcomes most significantly, to include			
					previous survey deficiencies. This ongoing monitoring is used to establish the			
	for care to maintain well-being (Resident #3).				facility s baseline and the predictability	v of		
	During an interview	on 11/22/16 at 6:31 PM the			various outcomes. Licensed staff	y Oi		
	During an interview on 11/22/16 at 6:31 PM the Administrator explained they had just had their November Quality Assessment and Assurance				education was initiated by the Director	of		
					Nursing (DON) on 12/6/16 regarding	-		
	Committee meeting last week. She stated during				documentation of resident assessment			
	the meeting they had reviewed the most recent survey deficiencies from the October 2016 survey				to include weekly skin assessments			
					reflecting current status of resident □s			
and the Quality Assurance and F					skin, to include identification of any			
	Improvement process. She explained they had				bruising, documentation in the medical			
	reviewed the inservices that had been done and				record regarding incidents to include			
	the audit tools and discussed how and why the				suspicious bruising, and notification as			
	audit tools were used that were specific to the				appropriate to the MD/RP/DON.			
		he stated they did not discuss			Employees not working during the	١.		
		d to the assessment of a			education time frame (i.e. FMLA, PRN)			
hematoma because it was not specifically cited in the previous survey.				will receive this education prior to their next scheduled shift by the				
	i ile previous survey.				DON/Designee.			
					4. The QAPI Committee will continue to	o		
					meet on a monthly basis to continue			
					monitoring identified areas of			
					improvement, to include, survey			

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NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 11/4	22/2016	
				306 DEER PARK ROAD			
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F 520	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 52	ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO			