PRINTED: 03/18/2019 FORM APPROVED OMB NO. 0938-0391

|                          | DF DEFICIENCIES CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                        | ` ′                 |        | STRUCTION                                                                                                         | СОМ  | E SURVEY<br>PLETED         |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------|-------------------------------------------------------------------------------------------------------------------|------|----------------------------|
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 345077                                                                                                                                                                                                                                                                                                                                                    | B. WING _           |        |                                                                                                                   |      | C<br>2/11/2019             |
|                          | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | N CENTER                                                                                                                                                                                                                                                                                                                                                  |                     | 25 SUN | TADDRESS, CITY, STATE, ZIP CODE<br>INYBROOK ROAD<br>IGH, NC 27610                                                 | 1 02 |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                       | ID<br>PREFI)<br>TAG | <      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE   | (X5)<br>COMPLETION<br>DATE |
| E 000                    | Initial Comments                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                           | E                   | 000    |                                                                                                                   |      |                            |
| F 622<br>SS=D            | conducted on 02/04                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | nt ID GWN511.<br>arge Requirements                                                                                                                                                                                                                                                                                                                        | F 6                 | 522    |                                                                                                                   |      | 3/11/19                    |
|                          | remain in the facility discharge the reside (A) The transfer or cresident's welfare ar cannot be met in the (B) The transfer or conductive because the resider sufficiently so the reservices provided by (C) The safety of incendangered due to status of the resider (D) The health of incotherwise be endangered to the endangered to the status of the resident has appropriate notice, the under Medicare or Monpayment applies submit the necessar payment or after the Medicare or Medicar esident refuses to president who become admission to a facility. | ry requirements- permit each resident to , and not transfer or ent from the facility unless- lischarge is necessary for the nd the resident's needs e facility; lischarge is appropriate nt's health has improved sident no longer needs the y the facility; dividuals in the facility is the clinical or behavioral out; dividuals in the facility would |                     |        |                                                                                                                   |      |                            |
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                           |                     |        |                                                                                                                   |      |                            |
| ARORATORY.               | DIDECTOR'S OR PROVIDE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | R/SUPPLIER REPRESENTATIVE'S SIGNATU                                                                                                                                                                                                                                                                                                                       | DE                  |        | TITI F                                                                                                            |      | (X6) DATE                  |

Electronically Signed 02/28/2019

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X2) MULTIP<br>A. BUILDING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | LE CONSTRUCTION     | (X3) DATE SURVEY<br>COMPLETED                                                                            |                 |
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|                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 345077                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | B. WING             |                                                                                                          | C<br>02/11/2019 |
|                                                                                                      | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | CENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  25 SUNNYBROOK ROAD  RALEIGH, NC 27610                             |                 |
| (X4) ID<br>PREFIX<br>TAG                                                                             | (EACH DEFICIENC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETION   |
| F 622                                                                                                | resident while the apl § 431.230 of this char exercises his or her r discharge notice from 431.220(a)(3) of this discharge or transfer or safety of the reside facility. The facility m that failure to transfer §483.15(c)(2) Docum When the facility transesident under any of in paragraphs (c)(1)(is section, the facility m or discharge is documedical record and a communicated to the institution or provider (i) Documentation in must include:  (A) The basis for the (i) of this section.  (B) In the case of parsection, the specific r be met, facility attemneeds, and the service facility to meet the net (ii) The documentation (2)(i) of this section m (A) The resident's phedischarge is necessar (A) or (B) of this section (B) A physician when | s to operate.  of transfer or discharge the peal is pending, pursuant to pter, when a resident ight to appeal a transfer or in the facility pursuant to § chapter, unless the failure to would endanger the health ent or other individuals in the nust document the danger or or discharge would pose.  The facility pursuant to § chapter, unless the failure to would endanger the health ent or other individuals in the nust document the danger or discharge would pose.  The facility pursuant to § chapter, unless the failure to would endanger the health ent or other individuals in the nust document the danger or discharge would pose.  The facility pursuant to § chapter in the facility pose.  The facility pursuant to § chapter in the facility pose.  The facility pursuant to § chapter in the facility pursuant the transfer or receiving health care in the resident per paragraph (c) (1) (i) (A) of this resident need(s) that cannot puts to meet the resident per available at the receiving sed(s).  The facility pursuant to § chapter in the facility pursuant to § | F 62                | 2                                                                                                        |                 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X2) MULTIPLE CONSTRUCTION A. BUILDING |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X3) DATE SURVEY<br>COMPLETED                                                                                   |                            |
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|                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 345077                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | B. WING _                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                 | C<br>)2/11/2019            |
| NAME OF PI                                                                                           | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <del></del>                            | STREET ADDRESS, CITY, STATE, ZIP COD                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                 | 271172010                  |
|                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                        | 25 SUNNYBROOK ROAD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                 |                            |
| SUNNYBR                                                                                              | OOK REHABILITATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | N CENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                        | RALEIGH, NC 27610                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                 |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                             | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                         | N SHOULD BE<br>E APPROPRIATE                                                                                    | (X5)<br>COMPLETION<br>DATE |
| F 622                                                                                                | must include a minir (A) Contact informating responsible for the contact information (B) Resident represe contact information (C) Advance Directing (D) All special instruction ongoing care, as ap (E) Comprehensive (F) All other necess copy of the resident consistent with §483 any other document a safe and effective This REQUIREMEN by:  Based on record refamily and staff inter Nurse Practitioner (I) (PA), the facility init discharge of a reside continual staff super to an Assisted Living sampled residents (I) discharges.  The findings include Resident #75 was a 9/26/2018 with diagram with behavioral distruction or designation of the resident with the physician orders for Physician orders for | ided to the receiving provider mum of the following: tion of the practitioner care of the resident. entative information including we information rections or precautions for propriate. care plan goals; cary information, including a state discharge summary, 3.21(c)(2) as applicable, and ation, as applicable, to ensure transition of care. It is not met as evidenced view, and interviews with reviews, and interviews with the NP) and Physician's Assistant fated an inappropriate ent who required 1 on 1 revision and therapy services of Facility (ALF) for 1 of 2 Resident #75) reviewed for the facility on moses to include dementia urbance, diabetes, adult ory of falls, difficulty walking | F 6                                    | F622 1-Interventions for affected re No interventions for Resident resident no longer resided in 2- Residents identified as hav potential to be affected: All residents who are discharger or discharged to another facil potential to be affected. 3-Systemic changes: On 2/8/2019 an in service was with the Social Worker by the Nursing to review the criteria appropriate discharges. Beginning 2/8/2019 residents potential discharges or plannatischarges will be reviewed be Director of Nursing/Assistant | t #75 as the the facility ving the ged to home lity have the as conducted a Director of for s who are ed by the |                            |
|                                                                                                      | Facility (SNF) service                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | tes were required to be given so because of the residents                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                        | Nursing or designee to ensur discharge criteria is met. The                                                                                                                                                                                                                                                                                                                                                                                                                                                        | e appropriate                                                                                                   |                            |

|                          | OF DEFICIENCIES<br>CORRECTION                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X2) MULT          |     | CONSTRUCTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X3) DATE                    | SURVEY                     |
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|                          |                                                                                                                                                                                                                                                                                                                                                   | 345077                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | B. WING            |     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                              | /<br>11/2019               |
| NAME OF P                | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                               | •                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ·                            |                            |
| CHANNE                   | OOK BEHABII ITATION                                                                                                                                                                                                                                                                                                                               | CENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                    | 2   | 5 SUNNYBROOK ROAD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                              |                            |
| SUNNYBR                  | ROOK REHABILITATION                                                                                                                                                                                                                                                                                                                               | CENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                    | R   | ALEIGH, NC 27610                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                              |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC                                                                                                                                                                                                                                                                                                                                   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                              | (X5)<br>COMPLETION<br>DATE |
| F 622                    | continuing basis for a inpatient hospital adr (SNF).  Physician orders for order for Physical Th Therapy (OT), Speed indicated, dated 9/26 clarification, dated 9/be seen 5 times per An order for OT clarification and the seweeks. An order for 9/27/2018 read: treat weeks.  A review of Resident 9/27/2018, included a mobility related to we | ng or rehab care on a conditions which required mission prior to transfer to  Resident #75 included an erapy (PT), Occupational ch Therapy (ST) to screen as 1/2018. An order for PT 26/2018 that read Patient to week for 12 weeks for PT. fication, dated 9/27/2018 een 5 times per week for 12 ST clarification, dated 5 times per week for 12 stimes per week for 12 weeks for 12 stimes per week | F                  | 622 | must meet one or more of the following  (A) The transfer or discharge is necess for the resident's welfare and the resident's needs cannot be met in the facility;  (B) The transfer or discharge is appropriate because the resident's hea has improved sufficiently so the resident no longer needs the services provided the facility;  (C) The safety of individuals in the facilis endangered due to the clinical or behavioral status of the resident;  (D) The health of individuals in the facilis would otherwise be endangered;  (E) The resident has failed, after reasonable and appropriate notice, to provide the facility.                                                                                                                                                                                                                    | alth<br>nt<br>by<br>lity     |                            |
|                          | ADLs as needed, and evaluate and treat room A nurse's note dated revealed the resident confusion and restles one to one care during the one to one care of the one to one care of the confusion and restles care during the shift. One care was docum.                                                                                            | mobility, transfer, meals, and d PT/OT to continue to utinely or as needed.  9/27/2018 at 10:46 PM the was alert and stable, with esness; the resident neededing the shift. No reason for was documented in the note.  9/29/2018 at 12:02 AM the was alert and stable, with esness; was on one to one No reason for the one to                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                    |     | Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third payment or after the claim and the resident refuses to provide for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charge under Medicaid; or  (F) The facility ceases to operate.  This review will be conducted daily Monday through Friday in the clinical meeting and will include review by the Director of Nursing/Assistant Director of Nursing or designee for clinical services therapy services and Social Services. | or<br>arty,<br>s<br>ay<br>es |                            |

| OLIVILIV                 | O I OIT WEDIONITE &           | WEDIO/ ND OLIVIOLO                                                                |                    |     |                                                                                                             | <u> </u>          | <del>7. 0000 000 1</del>   |
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|                          | OF DEFICIENCIES<br>CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                | , ,                |     | CONSTRUCTION                                                                                                | (X3) DATE<br>COMP | SURVEY                     |
|                          |                               |                                                                                   |                    |     |                                                                                                             | (                 | С                          |
|                          |                               | 345077                                                                            | B. WING            |     |                                                                                                             | 02/               | 11/2019                    |
| NAME OF P                | ROVIDER OR SUPPLIER           |                                                                                   |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE                                                                        |                   |                            |
| SUNNYBE                  | ROOK REHABILITATION           | CENTER                                                                            |                    |     | 5 SUNNYBROOK ROAD                                                                                           |                   |                            |
|                          |                               |                                                                                   |                    | R   | ALEIGH, NC 27610                                                                                            |                   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC               | TATEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION) | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE |
| F 622                    | Continued From page           | e 4                                                                               | F                  | 622 |                                                                                                             |                   |                            |
|                          | resident safety, no be        | ehavior problems noted.                                                           |                    |     | Discharge Review Form.                                                                                      |                   |                            |
|                          | ,                             | ·                                                                                 |                    |     | 4-Monitoring of the change to sustain                                                                       |                   |                            |
|                          | A nurse's note dated          | 10/1/2018 at 13:59 PM                                                             |                    |     | systemic compliance ongoing                                                                                 |                   |                            |
|                          |                               | care continued at this time                                                       |                    |     | The review will be ongoing and audited                                                                      | 1                 |                            |
|                          | _                             | dications and meals without                                                       |                    |     | weekly by the Director of Nursing or                                                                        |                   |                            |
|                          | problems.                     |                                                                                   |                    |     | designee for 8 weeks and then monthly                                                                       | •                 |                            |
|                          | A Nurse Practitioner          | (NP) Interval history and                                                         |                    |     | for 3 months. The review will continue the need for auditing will be reevaluate                             |                   |                            |
|                          |                               | 10/1/2018, revealed nursing                                                       |                    |     | the end of the time specified.                                                                              | u ai              |                            |
|                          |                               | inues to try and get out of                                                       |                    |     | Quality Assurance:                                                                                          |                   |                            |
|                          | 1                             | r, patient remains confused.                                                      |                    |     | The discharge reviews will be ongoing                                                                       |                   |                            |
|                          |                               | •                                                                                 |                    |     | daily Monday through Friday in the                                                                          |                   |                            |
|                          |                               | )e note dated 10/1/2018                                                           |                    |     | morning clinical/IDT meeting. The DON                                                                       |                   |                            |
|                          | 1                             | ke with the Director of the                                                       |                    |     | will report to the Quality Assurance and                                                                    | ţ                 |                            |
|                          | _                             | ty (ALF) who indicated                                                            |                    |     | Performance Improvement (QAPI)                                                                              |                   |                            |
|                          |                               | F would come the next day at for re-admission, and                                |                    |     | meeting monthly times 3 months to ensure on going compliance and to                                         |                   |                            |
|                          | I .                           | ctor of the ALF, the resident                                                     |                    |     | determine the need for future audits. T                                                                     | he                |                            |
|                          | _                             | -admission. There were no                                                         |                    |     | Administrator will monitor the results                                                                      |                   |                            |
|                          |                               | ded in the resident's medical                                                     |                    |     | presented to the QAPI Committee to                                                                          |                   |                            |
|                          | record.                       |                                                                                   |                    |     | ensure compliance.                                                                                          |                   |                            |
|                          |                               |                                                                                   |                    |     | The Administrator is the person                                                                             |                   |                            |
|                          |                               | Minimum Data Set (MDS)                                                            |                    |     | responsible for implementing the Plan                                                                       | of                |                            |
|                          |                               | 0/2/2018 revealed he had                                                          |                    |     | Correction.                                                                                                 |                   |                            |
|                          | -                             | airment, required extensive<br>aff for activities of daily living                 |                    |     |                                                                                                             |                   |                            |
|                          | (ADL), and had falls          |                                                                                   |                    |     |                                                                                                             |                   |                            |
|                          | (* 12 2), and nad take [      |                                                                                   |                    |     |                                                                                                             |                   |                            |
|                          | A nurse's note dated          | 10/2/2018 at 4:05 AM                                                              |                    |     |                                                                                                             |                   |                            |
|                          | revealed one to one           | care continued at this time,                                                      |                    |     |                                                                                                             |                   |                            |
|                          |                               | ly. No reason for the one to                                                      |                    |     |                                                                                                             |                   |                            |
|                          | one care was docum            | ented in the note.                                                                |                    |     |                                                                                                             |                   |                            |
|                          | A review of Resident          | #75's Medication                                                                  |                    |     |                                                                                                             |                   |                            |
|                          |                               | rds (MAR) for 9/2018 and                                                          |                    |     |                                                                                                             |                   |                            |
|                          |                               | od glucose monitoring was                                                         |                    |     |                                                                                                             |                   |                            |
|                          | conducted once a da           |                                                                                   |                    |     |                                                                                                             |                   |                            |
|                          | I .                           | per day on 9/27/2018,                                                             |                    |     |                                                                                                             |                   |                            |
|                          | 9/28/2018, 9/29/2018          | 3, 9/30/2018, and 10/1/2018.                                                      |                    |     |                                                                                                             |                   |                            |

|                          | DF DEFICIENCIES<br>CORRECTION                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                     | (X2) MULT<br>A. BUILDIN | IPLE CONSTRUCTION IG                                                                        |          | OATE SURVEY OMPLETED       |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|---------------------------------------------------------------------------------------------|----------|----------------------------|
|                          |                                                                                                                                                                                                                                                                                                                                                                          | 345077                                                                                                                                                                                                                                                                                                                                                                                                                 | B. WING _               |                                                                                             |          | C<br>02/11/2019            |
|                          | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                      | CENTER                                                                                                                                                                                                                                                                                                                                                                                                                 |                         | STREET ADDRESS, CITY, STATE, ZIP CODE 25 SUNNYBROOK ROAD RALEIGH, NC 27610                  | '        | 32.1.120.10                |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC                                                                                                                                                                                                                                                                                                                                                          | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 622                    | Continued From pag                                                                                                                                                                                                                                                                                                                                                       | e 5                                                                                                                                                                                                                                                                                                                                                                                                                    | F 6                     | 222                                                                                         |          |                            |
|                          | Summary dated 10/2 and was the only bas in the medical record                                                                                                                                                                                                                                                                                                            | disciplinary Discharge //2018 revealed the following sis for discharge documented : lischarge: returned to facility                                                                                                                                                                                                                                                                                                    |                         |                                                                                             |          |                            |
|                          | he was at prior to ho                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                             |          |                            |
|                          | The reason for of appropriate for this s                                                                                                                                                                                                                                                                                                                                 | lischarge diagnoses: not<br>etting                                                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                             |          |                            |
|                          | The discharge p<br>a Memory Care Unit                                                                                                                                                                                                                                                                                                                                    | otential: the resident needed                                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                             |          |                            |
|                          |                                                                                                                                                                                                                                                                                                                                                                          | ng Service Notes: returned to all admission, patient needs it.                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                             |          |                            |
|                          | PM with the family m<br>The FM stated she w<br>was at the facility, bu<br>couple of days, and w<br>he was doing, she w<br>been transferred bac<br>prior to his hospitaliz<br>asked why and was a<br>provide for his needs<br>The FM stated she h<br>go back to the same<br>hospitalization becau<br>was there. The FM s<br>notified, she would h<br>to discharge Resider | ember (FM) of Resident #75. isited the resident when he it she had been sick for a when she called to see how as told Resident #75 had is to the ALF he had been at ation. The FM stated she cold the facility could not as he needed 1 to 1 care. ad not wanted the resident to ALF he was at prior to his is each and 3 falls while he tated if she had been ave informed the facility not at #75 from the facility. |                         |                                                                                             |          |                            |
|                          | conducted with the S                                                                                                                                                                                                                                                                                                                                                     | 5 AM, an interview was<br>ocial Worker (SW). The SW<br>was admitted to the facility                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                             |          |                            |

|                          | OF DEFICIENCIES<br>CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1 ' '              |      | DNSTRUCTION                                                                                                           | (X3) DATE SURVEY<br>COMPLETED |                            |
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|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                    |      |                                                                                                                       | (                             | 0                          |
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 345077                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | B. WING            |      |                                                                                                                       | 02/                           | 11/2019                    |
| NAME OF P                | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | •                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | •                  | STRI | EET ADDRESS, CITY, STATE, ZIP CODE                                                                                    | -                             |                            |
| CHMMVD                   | ROOK REHABILITATIO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | NI CENTED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                    | 25 S | UNNYBROOK ROAD                                                                                                        |                               |                            |
| SUNNIBI                  | ROOK REHABILITATIO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ON CENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                    | RAL  | EIGH, NC 27610                                                                                                        |                               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFI<br>TAG | x    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 622                    | Resident #75 was clinical meeting dai Interdisciplinary Tes SW, Director of Nu Medical Records, I Director, and MDS for 1 to 1 care for both The SW stated the an urgency, that he because they could resident and could could not say who to transfer the resident and could could not say who to transfer the resident and could resident and could could not say who to transfer the resident and could could not say who to transfer the resident sake found out the reprior to his admissicalled that facility. responded to her the Resident #75 had go but they had been stated she did not obefore he left the fahave a contact nan medical record. The out the FMs name she put the informastated she did not soft therapy services going to another family and that was admitted that | one care. The SW stated discussed at the morning ily, which was attended by the am (IDT) which included the rsing (DON), Administrator, Dietary Manager, Activity nurse. Resident #75's needs being a fall risk were discussed. The second from the facility of not provide 1 to 1 care for the not meet his needs. The SW instructed her to find a facility dent to, only that it was a IDT was urgent. The SW stated esident had been at a ALF on to the hospital and she The SW stated the facility neey hadn't known where gone after his hospitalization, looking for him. The SW call the family of Resident #75 acility because she did not ne or number in the resident's ne SW stated she only found after the resident left, and then ation in the computer. The SW set up home health or any type for the resident since he was | F                  | 622  |                                                                                                                       |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ` ′                                                                                                                                                                                                                                                                                                                                                                                                                                                             | E CONSTRUCTION      | (X3) DATE SURVEY<br>COMPLETED                                                                            |                        |  |
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|                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 345077                                                                                                                                                                                                                                                                                                                                                                                                                                                          | B. WING             |                                                                                                          | C<br><b>02/11/2019</b> |  |
|                                                                                                     | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | N CENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  25 SUNNYBROOK ROAD  RALEIGH, NC 27610                             | 02/11/2010             |  |
| (X4) ID<br>PREFIX<br>TAG                                                                            | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLETION          |  |
| F 622                                                                                               | to admission. The A Admission Director stated Resident #75 for therapy services  On 2/6/2019 at 11:0 conducted with the Occupational Thera needed assistance occognitive abilities. The Occup discharge assessme because the resider discharge from the had reached any go On 2/6/2019 at 11:2 conducted with the stated he had only of days. The Physical was not discharged transferred to anoth On 2/6/2019 at 11:3 conducted with the stated he had only of the resident was not the resident was a fall right in the resident was a fall right in for 1 on 1 care a stated she did not resident was a fall right in the resident was a fall right in for 1 on 1 care a stated she did not resident was a fall right in the resident was a fall | AC conferenced the per telephone, and the AD is was admitted to the facility.  8 AM, an interview was Occupational Therapist. The pist stated Resident #75 with his ADLs due to his ore than his functional pational Therapist stated his ents were not conducted, at had an unscheduled facility and not because he als.  0 AM, an interview was Physical Therapist, who worked with Resident #75 on 3 Therapist stated the resident from therapy but had been | F 62:               |                                                                                                          |                        |  |

|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X2) MULTIPLE CONSTRUCTION A. BUILDING |                                                                                        |                                | (X3) DATE SURVEY<br>COMPLETED |  |
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|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 345077                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | B. WING _                              |                                                                                        |                                | C<br>)2/11/2019               |  |
|                          | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | CENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                        | STREET ADDRESS, CITY, STATE, ZIP CO<br>25 SUNNYBROOK ROAD<br>RALEIGH, NC 27610         |                                | 2711/2010                     |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>IE APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| F 622                    | him.  On 2/6/2019 at 9:53 / conducted with the N stated she understoo nursing home where resided wanted him be stated the resident net they provided for him.  On 2/6/2019 at 2:10 N conducted with the M Resident #75 was at days, and that was not formal care plan mee discussed in the IDT morning. The MDS retrying to meet the resone care and the nurshim because he was and get up by himself she knew the facility she had not expected.  On 2/6/2019 at 3:51 N conducted with the pustated he remembered facility was able to me understood that the rehis previous ALF. The not discharge but could resident had been on resident had been on the stated had not expected. | AM, an interview was urse Unit Manager, who d from the SW that the Resident #75 previously eack. The Unit Manager eeded one to one care which eeded one to one care which of the facility for a total of 6 ot long enough to have a ting, but his issues were clinical meeting every earse stated the facility was ident's needs with one to see were just awesome with a fall risk and he would try for the MDS nurse stated was meeting his needs, and I him to be transferred.  PM, an interview was revious Administrator who ad the resident, and the eet his needs, but esident wanted to go back to be Administrator stated he did ident with a 30-day out remember the specifics, the family wanted him back | F 6                                    | 22                                                                                     |                                |                               |  |

|                          | OF DEFICIENCIES<br>CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X2) MULT<br>A. BUILDII | FIPLE CONSTRUCTION  NG                                                        |                                 | (X3) DATE<br>COMP | SURVEY<br>LETED            |
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|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 345077                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | B. WING _               |                                                                               |                                 |                   | C<br>11/2019               |
|                          | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | CENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         | STREET ADDRESS, CITY, STATE, ZIP C<br>25 SUNNYBROOK ROAD<br>RALEIGH, NC 27610 | ODE                             | , 02              | 2010                       |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE    | TION SHOULD BI<br>THE APPROPRIA |                   | (X5)<br>COMPLETION<br>DATE |
| F 622                    | conducted with the p did not remember Resonant Programme | PM, an interview was revious DON who stated she esident #75.  AM, an interview was lurse Practitioner (NP). The the discharge order but did rout his discharge because it is NP stated most likely the ged as urgent because any ety situation that someone are, they would be sent out. cility was not a memory care service they provide. The #75 had dementia with and he was an unsafe falls risk one care. The NP stated he was aff that care could not be PM, an interview was assisted Living Facility are Resident #75 had resided ation. The ALD stated she was an unsafe falls risk one care. The NP stated he was allowed the SW that Resident #75 had resided ation. The ALD stated she was not accility transferred Resident on accility transferred Resident on further stated she was not taff that Resident #75 to resident supervision while anducted on 2/7/2019 at 1:02 an Assistant (PA) who worked dent #75 was discharged to. | F                       | 622                                                                           |                                 |                   |                            |

|                          | DF DEFICIENCIES<br>CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |     |                                                                                                                        | (X3) DATE SURVEY<br>COMPLETED |                            |
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|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 345077                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | B. WING                                 |     |                                                                                                                        | 1                             | C<br><b>/11/2019</b>       |
| NAME OF P                | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                         |     | STREET ADDRESS, CITY, STATE, ZIP CODE                                                                                  | 1 02/                         | 11/2019                    |
| SUNNYBR                  | ROOK REHABILITATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | CENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                         |     | 5 SUNNYBROOK ROAD<br>RALEIGH, NC 27610                                                                                 |                               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREF<br>TAG                       |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 623<br>SS=D            | re-admitted to the AL sugars were running the ALF to check the The PA explained that administration of insut to help in lowering the he had the ALF send.  On 2/11/2019 at 10:3. conducted with the Adworking at the facility employed at the facility employed at the facility employed at the facility expected discharges timely with notification Responsible Party. It stated Therapy perso input on a resident's cresident's goals and resident's goals and resident's goals and resident's goals and resident's facility transport of the facility most facility transport of the reasons for the manguage and manner facility must send a corepresentative of the Long-Term Care Ombound in Record the reason discharge in the residence with paralland. | F on 10/2/2018, his blood high, and the PA instructed blood sugars more often. It even with the lin on 10/4/2018, it did little eresident's blood sugar, so the resident to the hospital.  4 AM, an interview was diministrator who started on 10/3/2018 and was not try at the time of Resident 0/2/2018. He stated he from the facility to be made in of the Physician and the Administrator further nnel had a great deal of discharge based on the response to therapy.  Before Transfer/Discharge endischarges a mustand the resident's ine transfer or discharge and ove in writing and in a rethey understand. The popy of the notice to a Office of the State budsman. In the second in graph (c)(2) of this section; we the items described in |                                         | 622 |                                                                                                                        |                               | 3/11/19                    |

| STATEMENT OF DEF<br>AND PLAN OF CORF                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X2) MULTI<br>A. BUILDIN | IPLE CONSTRUCTION  IG                                                                                  |         | ATE SURVEY<br>DMPLETED     |
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| NAME OF PROVIDE                                                                                                                                        | ER OR SUPPLIER  REHABILITATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | CENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                          | STREET ADDRESS, CITY, STATE, ZIP CODE 25 SUNNYBROOK ROAD RALEIGH, NC 27610                             |         | 0271112010                 |
| (X4) ID<br>PREFIX<br>TAG                                                                                                                               | (EACH DEFICIENC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRE<br>( (EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE | (X5)<br>COMPLETION<br>DATE |
| §48 (i) E (c)(8 disc mac resic (ii) N befo (A) be e this (B) requ und (D) requ und (E) days §48 notic mus (ii) T (iii) T tran (iv) inclu and rece to o | a) of this section, harge required under by the facility and dent is transferred votice must be more transfer or districted and the section; The health of indicated and and section; The resident's heaven a more immediate transfer or districted by the resident paragraph (c)(A resident has not be a section and the section and the section and the section are paragraph (c)(A resident has not be a section and the se | of the notice. If in paragraphs (c)(4)(ii) and the notice of transfer or onder this section must be at least 30 days before the dor discharged. If it is a soon as practicable ocharge when-ividuals in the facility would or paragraph (c)(1)(i)(C) of it is in the facility would or paragraph (c)(1)(i)(D) of it is a soon as practicable ocharge when-ividuals in the facility would or paragraph (c)(1)(i)(D) of it is a soon as practicable ocharge when-ividuals in the facility would or paragraph (c)(1)(i)(D) of it is a soon as practicable of transfer or discharge, and the soon of the notice of the notice. The written aragraph (c)(3) of this section owing: If it is not the notice of the written aragraph (c)(3) of this section owing: If it is not the notice of the written aragraph (c)(3) of this section owing: If it is not the notice of the written aragraph (c)(3) of this section owing: If it is not the notice of the written aragraph (c)(3) of this section owing: If it is not the notice of the written aragraph (c)(3) of this section owing: If it is not the notice of the written aragraph (c)(3) of this section owing: If it is not the notice of the written aragraph (c)(3) of this section owing: If it is not the notice of the written aragraph (c)(3) of this section owing: If it is not the notice of the notice of the written aragraph (c)(3) of this section owing: If it is not the notice of the n | F 6                      | 23                                                                                                     |         |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | l ` ′               | PLE CONSTRUCTION  G                                                               |             | (X3) DATE SURVEY<br>COMPLETED |  |  |
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|                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 345077                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | B. WING_            |                                                                                   |             | C<br>)2/11/2019               |  |  |
|                                                                                                      | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | l                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                     | STREET ADDRESS, CITY, STATE, ZIP COD 25 SUNNYBROOK ROAD RALEIGH, NC 27610         | •           | 22111/2019                    |  |  |
| (X4) ID<br>PREFIX<br>TAG                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5)<br>COMPLETION<br>DATE    |  |  |
| F 623                                                                                                | telephone number of Long-Term Care Oml (vi) For nursing facilit and developmental d disabilities, the mailir telephone number of the protection and ac developmental disab C of the Developmental disable of the mail address and teagency responsible fradvocacy of individual established under the for Mentally III Individual established under the for Mentally III Individual established under the formation in the effecting the transfermust update the recipas practicable once the becomes available.  §483.15(c)(8) Notice In the case of facility the administrator of the written notification proto the State Survey A State Long-Term Carthe facility, and the rewell as the plan for the relocation of the residual the residual to the residu | ss (mailing and email) and the Office of the State budsman; y residents with intellectual isabilities or related ag and email address and the agency responsible for twocacy of individuals with allities established under Part atal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and the residents with a mental sabilities, the mailing and lephone number of the for the protection and als with a mental disorder en Protection and Advocacy that a set to the notice.  The notice changes prior to or discharge, the facility bients of the notice as soon the updated information | F6                  | 23                                                                                |             |                               |  |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                              | 1 ` ′               | (X2) MULTIPLE CONSTRUCTION  A. BUILDING                                                    |                              | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------------------------------|------------------------|-------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------|------------------------------|-------------------------------|--|
|                                                  |                        |                                                                                                 | 7 50.25             |                                                                                            |                              | С                             |  |
|                                                  |                        | 345077                                                                                          | B. WING _           |                                                                                            | 0:                           | 2/11/2019                     |  |
| NAME OF P                                        | ROVIDER OR SUPPLIER    |                                                                                                 |                     | STREET ADDRESS, CITY, STATE, ZIP COD                                                       |                              |                               |  |
| OLININ/DE                                        | OOK DELLA DIL ITATI    | ON OFNITED                                                                                      |                     | 25 SUNNYBROOK ROAD                                                                         |                              |                               |  |
| SUNNYBR                                          | ROOK REHABILITATI      | ON CENTER                                                                                       |                     | RALEIGH, NC 27610                                                                          |                              |                               |  |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICI           | Y STATEMENT OF DEFICIENCIES<br>ENCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CC<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
|                                                  |                        |                                                                                                 |                     |                                                                                            |                              |                               |  |
| F 623                                            | Continued From p       | page 13                                                                                         | F 6                 | 23                                                                                         |                              |                               |  |
|                                                  | Based on record        | review, family and staff                                                                        |                     | F623                                                                                       |                              |                               |  |
|                                                  | interviews, and Nu     | urse Practitioner interview the                                                                 |                     | 1-Interventions for affected re                                                            | esident:                     |                               |  |
|                                                  | facility failed to no  | tify the resident's family and                                                                  |                     | No interventions for Resident                                                              | #75 as the                   |                               |  |
|                                                  | provide a 30-day       | discharge notice for a                                                                          |                     | resident no longer resided in                                                              | the facility                 |                               |  |
|                                                  | facility-initiated dis | scharge of a cognitively                                                                        |                     | 2- Residents identified as have                                                            | ing the                      |                               |  |
|                                                  | impaired resident      | that was discharged to an                                                                       |                     | potential to be affected:                                                                  |                              |                               |  |
|                                                  | _                      | acility, for 1 of 2 residents                                                                   |                     | All residents who are discharge                                                            |                              |                               |  |
|                                                  | (Resident #75) rev     | viewed for discharge.                                                                           |                     | or discharged to another facil                                                             | ity have the                 |                               |  |
|                                                  |                        |                                                                                                 |                     | potential to be affected.                                                                  |                              |                               |  |
|                                                  | The findings inclu     | de:                                                                                             |                     | 3-Systemic changes:                                                                        |                              |                               |  |
|                                                  | Resident #75 was       | admitted to the facility on                                                                     |                     | On 2/8/2019 an in service wa                                                               | s conducted                  |                               |  |
|                                                  | 9/26/2018 with dia     | agnoses to include dementia                                                                     |                     | with the Social Worker by the                                                              | Director of                  |                               |  |
|                                                  |                        | sturbance, diabetes, adult                                                                      |                     | Nursing to review the criteria                                                             | for                          |                               |  |
|                                                  | failure to thrive, hi  | story of falls, difficulty walking                                                              |                     | appropriate discharges and n                                                               | otification of               |                               |  |
|                                                  | and muscle weak        | ness.                                                                                           |                     | impending discharges.                                                                      |                              |                               |  |
|                                                  | Physician orders f     | for Resident #75 included an                                                                    |                     | Beginning 2/11/2019 all resid                                                              |                              |                               |  |
|                                                  |                        | 2018, that read Skilled Nursing                                                                 |                     | potential discharges or plann                                                              |                              |                               |  |
|                                                  |                        | vices were required to be given                                                                 |                     | discharges will be reviewed b                                                              |                              |                               |  |
|                                                  |                        | sis because of the residents                                                                    |                     | Director of Nursing/Assistant                                                              |                              |                               |  |
|                                                  |                        | ursing or rehab care on a                                                                       |                     | Nursing or designee to ensur                                                               |                              |                               |  |
|                                                  | _                      | or conditions which required                                                                    |                     | responsible party and/or resid                                                             |                              |                               |  |
|                                                  |                        | admission prior to transfer to                                                                  |                     | notification of impending disc                                                             | narge is                     |                               |  |
|                                                  | (SNF).                 |                                                                                                 |                     | completed and documented.                                                                  | - d 4b -                     |                               |  |
|                                                  | The resident's 5 d     | lay Minimum Data Sat (MDS)                                                                      |                     | The review will be documented                                                              |                              |                               |  |
|                                                  |                        | lay Minimum Data Set (MDS)<br>d 10/2/2018 revealed he had                                       |                     | Discharge Review Form and documentation from the DON                                       |                              |                               |  |
|                                                  |                        | mpairment, required extensive                                                                   |                     | on family notification, the reas                                                           |                              |                               |  |
|                                                  | _                      | n staff for activities of daily living                                                          |                     | discharge and the date of the                                                              |                              |                               |  |
|                                                  |                        | lls prior to admission.                                                                         |                     |                                                                                            |                              |                               |  |
|                                                  | ,,                     |                                                                                                 |                     | This review will be conducted                                                              | l daily                      |                               |  |
|                                                  | A nurse's progress     | s note dated 10/2/2018 revealed                                                                 |                     | Monday through Friday in the                                                               | -                            |                               |  |
|                                                  |                        | discharged on 10/2/2018.                                                                        |                     | meeting and will include revie                                                             |                              |                               |  |
|                                                  |                        | -                                                                                               |                     | Director of Nursing/Assistant                                                              |                              |                               |  |
|                                                  | No documentation       | n was found in Resident # 75's                                                                  |                     | Nursing or designee for clinic                                                             |                              |                               |  |
|                                                  | medical record inc     | cluding progress notes,                                                                         |                     | therapy services and Social S                                                              | Services. The                |                               |  |
|                                                  |                        | or discharge summary that the                                                                   |                     | review will be documented or                                                               | n the                        |                               |  |
|                                                  | family was notified    | d of the discharge.                                                                             |                     | Discharge Review Form.                                                                     |                              |                               |  |

| CENTER                   | S FOR MEDICARE &                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | MEDICAID SERVICES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                    |     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | OMR NC                                    | ). 0 <u>938-0391</u>       |
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|                          | DF DEFICIENCIES<br>CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 1 ' '              |     | CONSTRUCTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                           | PLETED                     |
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 345077                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | B. WING _          |     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                           | C<br>11/2019               |
| NAME OF PR               | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                           |                            |
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                    | 25  | SUNNYBROOK ROAD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                           |                            |
| SUNNYBR                  | ROOK REHABILITATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | CENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                    | R   | ALEIGH, NC 27610                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                           |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFI<br>TAG | ×   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                           | (X5)<br>COMPLETION<br>DATE |
| F 623                    | PM with the family med The FM stated she viswas at the facility, but couple of days, and we see how he was doing #75 had been transfer Facility (ALF) he had hospitalization. The FW why and was told the his needs as he needs stated she did not was the same ALF becaus was there. The FM so notified, she would have discharge Resident What to discharge Resident What the Set stated Resident What the same and Interdisconsensus, with an unfrom the facility becaute to 1 care for the resident was discharged what the same was discharged when the same was discharged what the same after the resident was discharged what the same after the resident was discharged when the same was d | ducted on 2/5/2019 at 2:21 ember (FM) of Resident #75. sited the resident when he it she had been sick for a when she called the facility to g, she was told Resident irred to the Assisted Living been at prior to his FM stated she asked them facility could not provide for led 1 to 1 care. The FM int the resident to go back to se he had 3 falls while he tated if she had been ave informed the facility not it #75 from the facility.  AM, an interview was locial Worker (SW). The SW was admitted to the facility he care. The SW stated ciplinary Team (IDT) regency, that he be moved use they could not provide 1 ent and could not meet his led she found out the resident for to his admission to the led that facility. The SW I the family of Resident #75 rege from the facility because intact name or phone in the resident's medical led she only found out the sident left, so she put the mation in the computer after tharged. | F                  | 623 | 4-Monitoring of the change to sustain systemic compliance ongoing The review for discharge notification we be ongoing and audited weekly by the Director of Nursing/Assistant Director of Nursing or designee for 8 weeks and the monthly for 3 months. The review will continue and the need for auditing will reevaluated at the end of the time specified.  Quality Assurance: The discharge reviews which include responsible party and/or resident notification will be ongoing daily Mondathrough Friday in the morning clinical/I meeting by the DON/ADON or designed The DON will report to the Quality Assurance and Performance Improvement (QAPI) meeting monthly times 3 months to ensure on going compliance and to determine the need future audits. The Administrator will monitor the results presented to the Qaramittee to ensure compliance. The Administrator is the person responsible for implementing the Plan Correction. | of<br>nen<br>be<br>ay<br>DT<br>ee.<br>for |                            |
|                          | On 2/6/2019 at 10:31                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | AM, an interview was                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                    |     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                           |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X2) MULT<br>A. BUILDI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | TIPLE CONSTRUCTION | (X3                                                                                                             | (X3) DATE SURVEY<br>COMPLETED |                            |  |
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|                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 345077                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | B. WING            |                                                                                                                 |                               | C<br><b>02/11/2019</b>     |  |
|                                                                                                     | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | CENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                    | STREET ADDRESS, CITY, STATE, ZIP C<br>25 SUNNYBROOK ROAD<br>RALEIGH, NC 27610                                   | CODE                          | 02/11/2019                 |  |
| (X4) ID<br>PREFIX<br>TAG                                                                            | (EACH DEFICIENC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                    | ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |  |
| F 623                                                                                               | conducted with the A who stated she always name, number and rest that was admitted to arrival at the facility.  On 2/6/2019 at 1:53 I conducted with the S did not meet the crites she called the ALF to to this facility. The S and numbers of Resi accessible in the conresident's discharge, his family members to discharged to the ALI 30-day discharge not resident's situation was an urgency to get On 2/7/2019 at 8:40 A conducted with the N NP stated he signed not know anything abdischarge because it stated most likely the urgent because anyti situation that someon they would be sent of was not a memory caservice they provided #75 had dementia wif was an unsafe falls ri | dmissions Coordinator (AC), ys documented a contact elationship for every resident the facility, prior to their  PM, a second interview was W, who stated Resident #75 ria to stay at the facility and have him transferred back W stated the contact names dent #75's family were exputer at the time of the but she did not call any of contify them before he was F on 10/2/2018 or provide a sice. The SW stated this as different because there et the resident transferred.  AM, an interview was urse Practitioner (NP). The the discharge order but did yout Resident #75's was so long ago. The NP resident was discharged as me there was a safety he needed one to one care, but. The NP stated the facility are unit and it was not a lit. The NP stated Resident the behavioral issues, and he sk that required one to one he did not tell the facility not be provided. | F                  | 623                                                                                                             |                               |                            |  |
|                                                                                                     | conducted with the fa<br>Administrator, when I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | cility's previous                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                    |                                                                                                                 |                               |                            |  |

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|                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 345077                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | B. WING _           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 02/11/2019                    | 9     |
|                                                             | OK REHABILITATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | CENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  25 SUNNYBROOK ROAD  RALEIGH, NC 27610                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                               |       |
| (X4) ID<br>PREFIX<br>TAG                                    | (EACH DEFICIENC)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD E  CROSS-REFERENCED TO THE APPROPRI  DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                     |                               | ETION |
| F 641 A SS=D C ST T I I C G G G G G G G G G G G G G G G G G | stated the facility was needs but understood to back to his previous administrator stated he esident with a 30-day emember the specificamily wanted him back to received from staff on 2/11/2019 at 10:30 conducted with the factor who stated he expect acility to be made time Resident's Physician accuracy of Assessme CFR(s): 483.20(g) Accuracy The assessment must esident's status. This REQUIREMENT by:  Based on observation the Minimum Data Set of 21 residents (Resident Service) for MDS inaccuracy.  The findings included in Resident #175 was 1/12/2018 with diagrobstructive Pulmonar aminectomy (back suffischarged on 11/15/2018 is stated on 11/15/2018 is stated on 11/15/2018 with diagrobstructive Pulmonar aminectomy (back suffischarged on 11/15/2018 is stated on 11/15/20 | 2018. The Administrator able to meet the resident's able to meet the resident's able to meet the resident's able to meet the resident wanted to as ALF from staff. The me did not discharge the resident discharge but could not as, only that he thought the ack at the ALF from reports able to accurrent Administrator and discharges from the and Responsible Party. The resident was accurately reflect the accurately reflect the accurately code at (MDS) assessment for 2 dents #75 and #26) reviewed admitted to the facility on moses to included Chronic by Disease, and post argery). The resident was |                     | F641 Accuracy of assessments Interventions for affected resident(s): Resident #175 Minimum Data Set (MD was modified on 2/7/2019 to reflect accurate coding per the Resident Assessment Instrument (RAI) manual. Resident #26 Minimum Data Set (MDS was modified on 2/6/2019 to reflect accurate coding per the RAI Manual. Interventions for residents identified as having the potential to be affected: Discharge assessments completed in previous 90 days were reviewed for accuracy of coding A2100 of the discharge assessment. Assessments | (i)                           | 9     |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                                                                                                                                                                                                                                                                                                                              | IDENTIFICATION NUMBER:                                                               |                     | X2) MULTIPLE CONSTRUCTION  A. BUILDING |                                                                                                                                                                                                                             |          | (X3) DATE SURVEY<br>COMPLETED |  |
|-----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------|----------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|-------------------------------|--|
|                                                     |                                                                                                                                                                                                                                                                                                                              | 345077                                                                               | B. WING _           |                                        |                                                                                                                                                                                                                             |          | C<br>/11/2019                 |  |
| NAME OF PI                                          | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                          |                                                                                      | 1                   | S                                      | TREET ADDRESS, CITY, STATE, ZIP CODE                                                                                                                                                                                        |          |                               |  |
| 0                                                   |                                                                                                                                                                                                                                                                                                                              | 0-11-5                                                                               |                     | 25                                     | SUNNYBROOK ROAD                                                                                                                                                                                                             |          |                               |  |
| SUNNYBR                                             | ROOK REHABILITATION                                                                                                                                                                                                                                                                                                          | CENTER                                                                               |                     | R                                      | ALEIGH, NC 27610                                                                                                                                                                                                            |          |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC                                                                                                                                                                                                                                                                                                              | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)    | ID<br>PREFIX<br>TAG | ×                                      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)                                                                                                      |          | (X5)<br>COMPLETION<br>DATE    |  |
| F 641                                               | Continued From pag                                                                                                                                                                                                                                                                                                           | e 17                                                                                 | F 6                 | 641                                    |                                                                                                                                                                                                                             |          |                               |  |
|                                                     | under section A, his acute hospital.                                                                                                                                                                                                                                                                                         | lated 11/15/2018 revealed discharge status was to an note dated 11/15/2018           |                     |                                        | noted to be coded inaccurately will be modified per the RAI manual with a completion date of 3/1/2019. An audit was completed on all current residents that have indwelling catheters                                       | S        |                               |  |
|                                                     | revealed the residen and accompanied by                                                                                                                                                                                                                                                                                      | t was discharged to his home<br>his wife, per his request.                           |                     |                                        | (reviewing their 2 most recent MDS's o 2/8/2019), no further inaccuracies were noted.                                                                                                                                       |          |                               |  |
|                                                     |                                                                                                                                                                                                                                                                                                                              | ed to return home, and stated                                                        |                     |                                        | Systemic Change: On February 7, 2019 education was                                                                                                                                                                          |          |                               |  |
|                                                     | he no longer needed skilled nursing. The resident was discharged home with home health.                                                                                                                                                                                                                                      |                                                                                      |                     |                                        | completed by the Clinical Process Anal<br>on accuracy of assessments per the Ramanual with the MDS nurse. As of                                                                                                             |          |                               |  |
|                                                     | conducted with the N                                                                                                                                                                                                                                                                                                         | 3 AM, an interview was<br>IDS nurse who stated the                                   |                     |                                        | February 26, 2019 and moving forward MDS discharge assessments per week                                                                                                                                                     | (        |                               |  |
|                                                     |                                                                                                                                                                                                                                                                                                                              | as a data entry error and lischarged to his home.                                    |                     |                                        | will be audited by the Director of Nursir (DON) x 3 months for accuracy of local of discharge.                                                                                                                              |          |                               |  |
|                                                     | On 2/7/2019 at 11:09 AM, an interview was conducted with the Administrator who stated he expected staff to follow established guidelines and code the MDS appropriately.  2.Resident # 26 was admitted to the facility on 10/29/2014 with diagnoses to include neuromuscular dysfunction of bladder and Parkinson's Disease. |                                                                                      |                     |                                        | On February 8, 2019 education was completed by the Clinical Process Anal on accuracy of assessments per the Romanual with the MDS nurse. As of February 26, 2019 and moving forward the DON will complete a weekly audit of | AI<br>I, |                               |  |
|                                                     |                                                                                                                                                                                                                                                                                                                              |                                                                                      |                     |                                        | completed MDS assessments to include those residents that having indwelling catheters to ensure accurate coding of item set H0300.  Monitoring the change to sustain systematics.                                           |          |                               |  |
|                                                     | cognition to be intact<br>an indwelling cathete<br>always incontinent of                                                                                                                                                                                                                                                     | 2/18/2018 revealed her  The MDS section H listed er, and the resident was f bladder. |                     |                                        | compliance ongoing: The Director of Nursing will report the results of the audits to the QA committe for further review and recommendation monthly for three months and as deem necessary thereafter.                       | ee       |                               |  |
|                                                     |                                                                                                                                                                                                                                                                                                                              | ucted on 2/5/2019 revealed e a catheter and it was with a privacy cover.             |                     |                                        |                                                                                                                                                                                                                             |          |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X2) MULTIPLE CONSTRUCTION A. BUILDING                                       |     |                          | (X3) DATE SURVEY<br>COMPLETED |                            |
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|                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 7. 50.251                                                                    |     |                          | (                             | С                          |
|                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                       | 345077                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | B. WING _                                                                    |     |                          | 02/                           | 11/2019                    |
|                                                     | ROVIDER OR SUPPLIER ROOK REHABILITATION                                                                                                                                                                                                                                                                                                                                                                               | CENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE  25 SUNNYBROOK ROAD  RALEIGH, NC 27610 |     | )Ε                       |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC                                                                                                                                                                                                                                                                                                                                                                                                       | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFI<br>TAG                                                           |     | N SHOULD BI<br>APPROPRIA |                               | (X5)<br>COMPLETION<br>DATE |
| F 656<br>SS=D                                       | since admission to the The MDS nurse furthmot incontinent of black on the 12/18/2018 MI  On 2/7/2019 at 11:09 conducted with the Adexpected staff to following and code the MDS at Develop/Implement CCFR(s): 483.21(b)(1)  §483.21(b) Comprehe §483.21(b)(1) The face                                                                                                                                                | PM, an interview was IDS nurse who stated had an indwelling catheter e facility on 10/29/2014. er stated the resident was dder, and that was an error DS and she would correct it.  AM, an interview was dministrator who stated he we established guidelines opropriately. Comprehensive Care Plan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                              | 641 |                          |                               | 3/11/19                    |
|                                                     | care plan for each restresident rights set for §483.10(c)(3), that in objectives and timeframedical, nursing, and needs that are identifiassessment. The condescribe the following (i) The services that a or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483. provided due to the reunder §483.10, including treatment under §483. (iii) Any specialized s | sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial fied in the comprehensive in mere and the comprehensive in the comprehensive in the comprehensive of the comprehensive care plan must of the comprehensive care pl |                                                                              |     |                          |                               |                            |

|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                  | ` ′                 | PLE CONSTRUCTION  G                                                                                                                                                                                                                                                                                                       |                                                          | (X3) DATE SURVEY<br>COMPLETED |  |
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|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 345077                                                                                                                                                                                                                                                                                                                                                                                                              | B. WING             |                                                                                                                                                                                                                                                                                                                           |                                                          | C<br><b>2/11/2019</b>         |  |
| NAME OF PE               | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                     |                     | STREET ADDRESS, CITY, STATE, ZIP CODE                                                                                                                                                                                                                                                                                     |                                                          | 2/11/2019                     |  |
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                     |                     | 25 SUNNYBROOK ROAD                                                                                                                                                                                                                                                                                                        |                                                          |                               |  |
| SUNNYBR                  | OOK REHABILITATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | CENTER                                                                                                                                                                                                                                                                                                                                                                                                              |                     | RALEIGH, NC 27610                                                                                                                                                                                                                                                                                                         |                                                          |                               |  |
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                     |                     |                                                                                                                                                                                                                                                                                                                           |                                                          |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)                                                                                                                                                                                                                                    | SHOULD BE                                                | (X5)<br>COMPLETION<br>DATE    |  |
| F 656                    | Continued From page                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | e 19                                                                                                                                                                                                                                                                                                                                                                                                                | F 6                 | 56                                                                                                                                                                                                                                                                                                                        |                                                          |                               |  |
| F 656                    | recommendations. If findings of the PASAI rationale in the reside (iv)In consultation will resident's representa (A) The resident's produced desired outcomes.  (B) The resident's profuture discharge. Fact whether the resident's community was asseled local contact agencie entities, for this purpo (C) Discharge plans in plan, as appropriate, requirements set fort section.  This REQUIREMENT by:  Based on record revision facility failed to devel sampled residents reantidepressant medic findings included:  Resident # 72 was ac 7/19/18 with diagnos | a facility disagrees with the RR, it must indicate its ent's medical record. In the resident and the tive(s)-als for admission and reference and potential for silities must document so desire to return to the ssed and any referrals to so and/or other appropriate ose. In the comprehensive care in accordance with the in paragraph (c) of this residue is and staff interviews the op a care plan for 1 of 5 | F 6                 | F656 Development of Care Pl. Interventions for affected resid. Resident #72 care plan was up 2/6/19 to reflect the antidepres. Interventions for residents iden having the potential to be affect A review of residents who rece antidepressant medications was conducted on 2/8/2019 by the Nursing and the MDS nurse to | ent: odated on sant. ntified as sted: ive as Director of |                               |  |
|                          | revealed an order for mg. Give one tablet to insomnia.  Review of Resident # revealed a care plan                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | cian orders dated 8/31/18 Trazodone HIC tablet 50 by mouth at bedtime for  72's current care plan was not developed to                                                                                                                                                                                                                                                                                              |                     | development of antidepressant plans. Care plans were update deemed necessary.  Systemic Change:  On February 7, 2019 the MDS re-educated by the Clinical Pro Analyst on the development of As of February 26, 2019 and research                                                                                           | nurse was<br>ocess<br>care plans.<br>moving              |                               |  |
|                          | medication.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | s use of an antidepressant                                                                                                                                                                                                                                                                                                                                                                                          |                     | forward, 3 care plans of reside receiving an antidepressant wi                                                                                                                                                                                                                                                            |                                                          |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                    | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |                                                                                                                                                                                                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED |                            |
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| NAME OF P                                           | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <u> </u>                           | STRE                                    | EET ADDRESS, CITY, STATE, ZIP CODE                                                                                                                                                                                                                                                                       | 1 02/                         | 11/2019                    |
|                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                    |                                         | UNNYBROOK ROAD                                                                                                                                                                                                                                                                                           |                               |                            |
| SUNNYBR                                             | ROOK REHABILITATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | CENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                    |                                         | EIGH, NC 27610                                                                                                                                                                                                                                                                                           |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | PREFIX (EACH CORRECTIVE ACTION SHO |                                         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)                                                                                                                                                                                   |                               | (X5)<br>COMPLETION<br>DATE |
| F 656 F 660 SS=D                                    | A review of the Minim completed on 01/19/1 cogitatively intact. Sh diagnoses of insomni antidepressant medic the MDS review period Review of Resident # Medication Administrative revealed the resident each night from 2/1/1 In an interview on 2/6 Coordinator RN revealed she would be and take the care plasher evealed she misinsomnia for Resident resident was receiving medication.  During an interview of Director of Nursing resident receiving and a care plan for it. Discharge Planning FCFR(s): 483.21(c)(1) Discharge Planning FC | um Data Set (MDS) 9 identified the resident as e was noted to have a a and had received an ation on 7 of 7 days during id.  72's February 2019 ation Record on 2/06/19 received Trazodone HCL 9 to 2/05/19.  719 at 3:19 PM the MDS aled when a resident is first book at the physician orders in directly from their orders. Seed the Trazodone for t #72 and would update the ght away to include the g an antidepressant  10 2/6/19 at 3:50 PM the evealed she expected any antidepressant would have  11 2/6/19 at 3:50 PM the evealed she expected any antidepressant would have  12 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 | F6                                 |                                         | audited per week by the Director of Nursing (DON) x 3 months.  Monitoring the change to sustain systel compliance ongoing:  The Director of Nursing will report the audit findings to the QA committee for further review and recommendations monthly for three months and as deem necessary thereafter. |                               | 3/11/19                    |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 1 ' '                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | CONSTRUCTION       | (X3) DATE SURVEY<br>COMPLETED                                           |  |  |                            |
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|                                                                              | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | N CENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 1                  | STREET ADDRESS, CITY, STATE, ZIP C 25 SUNNYBROOK ROAD RALEIGH, NC 27610 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG                                                     | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFI<br>TAG | PREFIX (EACH CORRECTIVE ACTIO                                           |  |  | (X5)<br>COMPLETION<br>DATE |
| F 660                                                                        | rights set forth at 48 (i) Ensure that the d resident are identified development of a diresident. (ii) Include regular re identify changes that discharge plan. The updated, as needed (iii) Involve the inter by §483.21(b)(2)(ii), developing the disch (iv) Consider careginand the resident's or person(s) capacity a required care, as pa discharge needs. (v) Involve the resident representative in the discharge plan and resident representat (vi) Address the resi treatment preference (vii) Document that a about their interest i regarding returning (A) If the resident into the community, the referrals to local cor appropriate entities (B) Facilities must u comprehensive care appropriate entities. (C) If discharge to the | nsistent with the discharge 3.15(b) as applicable andischarge needs of each ad and result in the scharge plan for each e-evaluation of residents to trequire modification of the discharge plan must be to reflect these changes. disciplinary team, as defined in the ongoing process of harge plan. Ver/support person availability rearegiver's/support and capability to perform reare of the identification of ent and resident e development of the inform the resident and ive of the final plan. dent's goals of care and es. a resident has been asked in receiving information to the community. dicates an interest in returning the facility must document any witact agencies or other made for this purpose. | F                  | 660                                                                     |  |  |                            |

|                          | OF DEFICIENCIES<br>CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ` '                 | PLE CONSTRUCTION  G                                                                                                                                                                                                              | , ,                                                                      | (X3) DATE SURVEY<br>COMPLETED |  |
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|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 345077                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | B. WING _           |                                                                                                                                                                                                                                  | 0                                                                        | C<br>2/11/2019                |  |
|                          | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ON CENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                     | STREET ADDRESS, CITY, STATE, ZIP C<br>25 SUNNYBROOK ROAD<br>RALEIGH, NC 27610                                                                                                                                                    |                                                                          | 2/11/2010                     |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Y STATEMENT OF DEFICIENCIES<br>ENCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC                                                                                                                                                 | ION SHOULD BE<br>THE APPROPRIATE                                         | (X5)<br>COMPLETION<br>DATE    |  |
| F 660                    | SNF or who are di LTCH, assist resid representatives in provider by using limited to SNF, Hipatient assessment measures, and dathe data is availabilithe post-acute car assessment data, data on resource of the resident's goal preferences.  (ix) Document, colon the resident's record, the evaluation must be resident's represe information must be discharge plan to to avoid unnecess discharge or trans This REQUIREME by:  Based on record interviews, and interviews, and interviews, and interviews, and interviews and received 1:1 care services at the fact Assisted Living Faction assi | mation and why.  who are transferred to another ischarged to a HHA, IRF, or lents and their resident selecting a post-acute care data that includes, but is not HA, IRF, or LTCH standardized and data, data on quality ta on resource use to the extent ele. The facility must ensure that the standardized patient data on quality measures, and use is relevant and applicable to its of care and treatment  Implete on a timely basis based needs, and include in the clinical tion of the resident's discharge rige plan. The results of the ediscussed with the resident or intative. All relevant resident or incorporated into the facilitate its implementation and eary delays in the resident's | F 6                 | F660  1-Interventions for affected No interventions for Resideresident no longer resided 2- Residents identified as hotential to be affected: All residents who are dischor discharged to another fapotential to be affected and | ent #75 as the in the facility having the arged to home icility have the |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                           | ` ′           | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |                                                                                     |       | (X3) DATE SURVEY<br>COMPLETED |  |
|-----------------------------------------------------|-----------------------|----------------------------------------------------------------------------------------------|---------------|-----------------------------------------|-------------------------------------------------------------------------------------|-------|-------------------------------|--|
|                                                     |                       | 345077                                                                                       | B. WING _     |                                         |                                                                                     |       | C<br>/ <b>11/2019</b>         |  |
| NAME OF PI                                          | ROVIDER OR SUPPLIER   |                                                                                              | _             | ST                                      | TREET ADDRESS, CITY, STATE, ZIP CODE                                                | 1 02/ | 11/2010                       |  |
|                                                     |                       |                                                                                              |               |                                         | SUNNYBROOK ROAD                                                                     |       |                               |  |
| SUNNYBR                                             | ROOK REHABILITATI     | ON CENTER                                                                                    |               |                                         | ALEIGH, NC 27610                                                                    |       |                               |  |
| (X4) ID                                             | SUMMAR                | Y STATEMENT OF DEFICIENCIES                                                                  | ID            |                                         | PROVIDER'S PLAN OF CORRECTION                                                       |       | (X5)                          |  |
| PREFIX<br>TAG                                       | (EACH DEFICI          | ENCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)                             | PREFI)<br>TAG | X                                       | (EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |       | COMPLETION<br>DATE            |  |
| F 660                                               | Continued From p      | page 23                                                                                      | Fé            | 360                                     |                                                                                     |       |                               |  |
|                                                     |                       | 3                                                                                            | . ,           |                                         | Monday through Friday in the morning                                                |       |                               |  |
|                                                     | Resident #75 was      | admitted to the facility on                                                                  |               |                                         | clinical meeting.                                                                   |       |                               |  |
|                                                     |                       | agnoses to include dementia                                                                  |               |                                         | 3-Systemic changes:                                                                 |       |                               |  |
|                                                     |                       | sturbance, diabetes, adult                                                                   |               |                                         | 3.1                                                                                 |       |                               |  |
|                                                     |                       | story of falls, difficulty walking                                                           |               |                                         | On 2/8/2019 an in service was conduc                                                | ted   |                               |  |
|                                                     | and muscle weak       | ness.                                                                                        |               |                                         | with the Social Worker by the Director                                              | of    |                               |  |
|                                                     |                       |                                                                                              |               |                                         | Nursing to review the criteria for                                                  |       |                               |  |
|                                                     | -                     | for Resident #75 included an                                                                 |               |                                         | appropriate discharges, the discharge                                               |       |                               |  |
|                                                     |                       | 2018, that read Skilled Nursing                                                              |               |                                         | planning process to include the                                                     |       |                               |  |
|                                                     |                       | vices were required to be given                                                              |               |                                         | responsible party and the notification of                                           | t     |                               |  |
|                                                     |                       | isis because of the residents                                                                |               |                                         | the responsible party.                                                              |       |                               |  |
|                                                     |                       | ursing or rehab care on a<br>or conditions which required                                    |               |                                         | Beginning 2/8/2019 residents who are                                                |       |                               |  |
|                                                     |                       | admission prior to transfer to                                                               |               |                                         | potential discharges or planned                                                     |       |                               |  |
|                                                     | (SNF).                | admission prior to transfer to                                                               |               |                                         | discharges will be reviewed Monday                                                  |       |                               |  |
|                                                     | (5.1.)                |                                                                                              |               |                                         | through Friday in the daily clinical mee                                            | ting  |                               |  |
|                                                     | Physician orders      | for Resident #75 included an                                                                 |               |                                         | to ensure a discharge plan is develope                                              |       |                               |  |
|                                                     |                       | Therapy (PT), Occupational                                                                   |               |                                         | by the Interdisciplinary team. The review                                           | :ws   |                               |  |
|                                                     |                       | eech Therapy (ST) to screen as                                                               |               |                                         | will be documented on the new Discha                                                | rge   |                               |  |
|                                                     |                       | /26/2018. An order for PT                                                                    |               |                                         | review form. The discharge form will                                                |       |                               |  |
|                                                     |                       | d 9/26/2018 that read Patient to                                                             |               |                                         | include input from Clinical Services,                                               |       |                               |  |
|                                                     |                       | er week for 12 weeks for PT.                                                                 |               |                                         | Therapy Services and Social Services.                                               |       |                               |  |
|                                                     |                       | larification, dated 9/27/2018                                                                |               |                                         | This review will be senducted deily                                                 |       |                               |  |
|                                                     |                       | e seen 5 times per week for 12<br>for ST clarification, dated                                |               |                                         | This review will be conducted daily Monday through Friday in the clinical           |       |                               |  |
|                                                     |                       | reat 5 times per week for 12                                                                 |               |                                         | meeting and will include review by the                                              |       |                               |  |
|                                                     | weeks.                | cat o times per week for 12                                                                  |               |                                         | Director of Nursing/Assistant Director of                                           | of    |                               |  |
|                                                     | Wooks.                |                                                                                              |               |                                         | Nursing or designee for clinical service                                            |       |                               |  |
|                                                     | A review of Resid     | ent #75's care plan, initiated on                                                            |               |                                         | therapy services and Social Services.                                               |       |                               |  |
|                                                     |                       | include any focus or goals for                                                               |               |                                         | review will be documented on the                                                    |       |                               |  |
|                                                     | discharge.            |                                                                                              |               |                                         | Discharge Review Form.                                                              |       |                               |  |
|                                                     |                       |                                                                                              |               |                                         | 4-Monitoring of the change to sustain                                               |       |                               |  |
|                                                     |                       | ent #75's Medication                                                                         |               |                                         | systemic compliance ongoing                                                         |       |                               |  |
|                                                     |                       | cords (MAR) for 9/2018 and                                                                   |               |                                         | The review will be ongoing and audited                                              | i     |                               |  |
|                                                     |                       | blood glucose monitoring was                                                                 |               |                                         | weekly by the Director of Nursing or                                                |       |                               |  |
|                                                     |                       | day on 9/26/2018 and                                                                         |               |                                         | designee for 8 weeks and then monthly                                               |       |                               |  |
|                                                     |                       | 0/2/2018, and twice per day on 9/27/2018,<br>9/28/2018, 9/29/2018, 9/30/2018, and 10/1/2018. |               |                                         | for 3 months. The review will continue                                              |       |                               |  |
|                                                     | 312012010, 312912<br> | 010, 8/30/2010, and 10/1/2018.                                                               |               |                                         | the need for auditing will be reevaluate the end of the time specified.             | u al  |                               |  |
|                                                     | İ                     |                                                                                              | 1             | - 1                                     | and dried three specified.                                                          |       | 1                             |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                           | (X3) DATE SURVEY<br>COMPLETED |   |
|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------|---|
|                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                     | 345077                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | B. WING _                               |                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                           | C<br><b>02/11/2019</b>        |   |
| NAME OF P                                           | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                         | STREET ADDRESS, CITY, STATE, ZIP CC                                                                                                                                                                                                                                                                                                                                                                          | DDE                                                                                       | 02/11/2010                    | _ |
| SUNNYBROOK REHABILITATION CENTER                    |                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                         | 25 SUNNYBROOK ROAD                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                           |                               |   |
|                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                         | RALEIGH, NC 27610                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                           |                               |   |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIE                                                                                                                                                                                                                                                                                                                                                                                                                       | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY                                                                                                                                                                                                                                                                                                                       | ON SHOULD BE<br>HE APPROPRIAT                                                             | (X5)<br>COMPLETION<br>DATE    | ٧ |
| F 660                                               | Continued From page 24                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | F6                                      | 60                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                           |                               |   |
| F 660                                               | Resident # 75's 5-cassessment dated severe cognitive im extensive to total a daily living (ADL), a admission.  A nurse's progress Resident #75 was of Review of Resident revealed there was by staff for Resident Resident #75's Interessed Summary dated 10 and was the only be documented in the The reason for he was at prior to the Additional Nurse Additional Nurse | lay Minimum Data Set (MDS)  10/2/2018 revealed he had pairment, required sists from staff for activities of and had falls prior to  note dated 10/2/2018 revealed discharged on 10/2/2018.  It #75's medical record no discharge plan developed at #75.  Indisciplinary Discharge //2/2018 revealed the following asis for discharge medical record: Indischarge: returned to facility cospital admission  Indischarge diagnoses: not setting  potential: the resident needed it  sing Service Notes: returned to | F6                                      | Quality Assurance: The discharge reviews will be daily Monday through Friday morning clinical/IDT meeting will report to the Quality Ass Performance Improvement (meeting monthly times 3 more ensure on going compliance determine the need for futur Administrator will monitor the presented to the QAPI Compensure compliance. The Administrator is the persone responsible for implementing Correction. | y in the g. The DON urance and (QAPI) onths to e and to e audits. The e results mittee to |                               |   |
|                                                     | memory care unit  No documentation medical record incl                                                                                                                                                                                                                                                                                                                                                                              | was found in Resident # 75's uding progress notes, r discharge summary that the of the discharge.                                                                                                                                                                                                                                                                                                                                                                                                                 |                                         |                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                           |                               |   |
|                                                     | An interview was co                                                                                                                                                                                                                                                                                                                                                                                                                 | onducted on 2/5/2019 at 2:21                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                         |                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                           |                               |   |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                          | (X2) MULTIPL<br>A. BUILDING | E CONSTRUCTION                                                                                         | (X3) DATE SURVEY COMPLETED |  |
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|                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 345077                                                                                                                                                                      | B. WING                     |                                                                                                        | C<br><b>02/11/2019</b>     |  |
| NAME OF PROVIDER OR SUPPLIER  SUNNYBROOK REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                             |                             | STREET ADDRESS, CITY, STATE, ZIP CODE  25 SUNNYBROOK ROAD  RALEIGH, NC 27610                           | 02/11/2019                 |  |
| (X4) ID<br>PREFIX<br>TAG                                                                          | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)                                                                                         | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLETION              |  |
| F 660                                                                                             | The FM stated she was at the facility, be couple of days, and see how he was doi #75 had been transf Facility (ALF) he had hospitalization. The why and was told the his needs as he needs to the same AL while he was there, have any meetings of staff concerning the goals while the reside FM stated if she had #75's discharge, she facility.  On 2/6/2019 at 1:53 conducted with the Stated Resident #75 stay at the facility are him transferred back stated the contact not Resident #75 were in the res | nember (FM) of Resident #75. visited the resident when he ut she had been sick for a when she called the facility to ng, she was told Resident erred to the Assisted Living | F 660                       |                                                                                                        |                            |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION            |                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |                                                                                                                  |  | (X3) DATE SURVEY<br>COMPLETED |  |
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|                                                                |                                                                                                                                                                                                                                                                                                                                                                  | 345077                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | B. WING                                 |                                                                                                                  |  | C<br>02/11/2019               |  |
| NAME OF PROVIDER OR SUPPLIER  SUNNYBROOK REHABILITATION CENTER |                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                         | STREET ADDRESS, CITY, STATE, ZIP COD 25 SUNNYBROOK ROAD RALEIGH, NC 27610                                        |  | 2/11/2019                     |  |
| (X4) ID<br>PREFIX<br>TAG                                       | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRECTION  X (EACH CORRECTIVE ACTION SHOULD B  CROSS-REFERENCED TO THE APPROPRI  DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE    |  |
| F 660                                                          | Continued From pag                                                                                                                                                                                                                                                                                                                                               | ge 26                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | F 66                                    | 0                                                                                                                |  |                               |  |
|                                                                | was developed for R the SW stated she d therapy services for going to another faci On 2/7/2019 at 8:40 conducted with the N NP stated he signed not know anything a was so long ago. Th resident was dischart time there was a saf needed one to one of The NP stated the fa unit and it was not a NP stated Resident behavioral issues, at that required one to | eting, and no discharge plan desident #75. Additionally, id not make a referral for any the resident because he was slity.  AM, an interview was hurse Practitioner (NP). The the discharge order but did bout his discharge because it e NP stated most likely the reged as urgent because any ety situation that someone care, they would be sent out. acility was not a memory care service they provide. The #75 had dementia with and he was an unsafe falls risk one care. The NP stated he y staff that care could not be |                                         |                                                                                                                  |  |                               |  |
|                                                                | PM with the Physicia for the ALF that Res The PA stated when re-admitted to the Al sugars were running the ALF to check the The PA explained the administration of ins to help in lowering the had the ALF send On 2/6/2018 at 3:44 conducted with the ADirector (ALD) where prior to his hospitalize                                                            | nducted on 2/7/2019 at 1:02 an Assistant (PA) who worked ident #75 was discharged to. Resident #75 was F on 10/2/2018, his blood high, and the PA instructed blood sugars more often. at even with the ulin on 10/4/2018, it did little he resident's blood sugar, so d the resident to the hospital.  PM, an interview was assisted Living Facility e Resident #75 had resided ration and was admitted to on stated she received a call                                                                                         |                                         |                                                                                                                  |  |                               |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                    |                     | IPLE CONSTRUCTION  IG                                                              |                      | (X3) DATE SURVEY<br>COMPLETED |  |
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|                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 345077                                                                                                                                                                                                                                                                                                                                                                                                | B. WING             |                                                                                    |                      | C                             |  |
| NAME OF PROVIDER OR SUPPLIER  SUNNYBROOK REHABILITATION CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                       |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  25 SUNNYBROOK ROAD  RALEIGH, NC 27610       | <u> </u>             | 02/11/2019                    |  |
| (X4) ID<br>PREFIX<br>TAG                                       | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIVE ACTION SHOWS CROSS-REFERENCED TO THE API DEFICIENCY) | SHOULD BE COMPLETION |                               |  |
| F 660                                                          | from the SW that Residischarged back to the she evaluated the residential transferred Residual transferred Residual transferred Residual transferred Residual transferred Resident States and the Albara transferred for the resident supervision of An interview was considered to the Administrator states and t | sident #75 was ready to be seir facility. The ALD stated sident on 10/1/2018, and the sident #75 to the ALF on stated he did not come with services. The Director is not informed by facility is required 1 to 1 staff to while at the skilled facility.  ducted on 2/11/2019 at cility's current Administrator. Ited he expected a resident's gin shortly after admission in based on the resident's | F6                  |                                                                                    |                      |                               |  |