STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345233	A. BUILDING ______ B. WING ______	12/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE REHABILITATION & CARE	306 DEER PARK ROAD NEBO, NC 28761

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	Plan of Correction 12/11/11 Without admitting or denying the validity of existence of the alleged deficiencies, Sunrise Rehab and Care provides the following plan of correction. F 225-SS-D Failure to investigate allegations 1. Immediate and 5 day report has been submitted to the state agency for resident # 160. NA #1 has been counseled and re-educated on proper positioning of residents. LN #8 and LN #2 have been re-inserviced on abuse reporting. 2. Occurrence reports for the last six months have been re-reviewed to ensure there were no other potential abuse/lack of investigation issues and none were identified.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Winnie J. Allison — TITLE: administrator — (X6) DATE: 12/21/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are 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.

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F 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on review of facility records and staff and resident interviews the facility failed to report an incident of alleged abuse by a nurse aide within 24 hours and complete an investigative report within five days and submit it to the state agency for one (1) of three (3) residents (Resident # 160) . The findings are: Resident #160 was admitted to the facility with diagnoses of Cerebrovascular Accident (CVA) with left hemiparesis, general weakness, gait difficulty, chronic back pain, arthritis and fibromyalgia. A review of the latest Minimum Data Set (MDS) assessment of 10/14/2011 revealed the resident was cognitively intact and required extensive to total assistance of two staff with daily care, bed mobility and transfer. On 11/29/2011 at 10:44 a.m. during an initial interview Resident # 160 revealed a few weeks ago Nursing Assistant #1 (NA) turned her onto her "bad arm" (left) while putting her on the bedpan. Resident # 160 further stated she told NA # 1 the whole time her arm hurt and NA # 1 just looked at her and did not stop. A follow-up interview with Resident #160 on 11/30/2011 at 2:00 p.m. revealed when she reported the incident to the 7:00 a.m. to 3:00 p.m. nurse on 10/26/2011, LN # 8, the nurse told her she would take care of things. Resident # 160 reported she told her family that same evening and they talked to the 3:00 p.m. to 11:00 p.m. nurse identified as LN #2.	F 225	3. All staff were in-serviced by the administrator on the requirement of reporting any suspicions or actual event of abuse to the administrator immediately. 4. Nursing supervisors/ charge nurse will check reports each day for allegations. The review committee meets each day to review the occurrences and follow up if needed, if any allegations found. MDS nurse will audit occurrence log weekly X4, monthly X3 then quarterly to ensure that any allegations have been investigated by the administrator with committee documentation. Results will be given to QA committee monthly.	12/30/11

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F 225	Continued From page 2 On 11/30/2011 at 4:10 p.m. LN# 2 was interviewed and the "Resident Occurrence Report" reviewed. LN # 2 confirmed he filled out the "Resident Occurrence Report" on 10/26/2011 at 9:00 p.m. and placed it on the nurses station for that unit.. LN# 2 documented the following: "Resident said: "NA #1 was putting me on the bedpan and I told her she was hurting my arm". LN #2 confirmed when he assessed Resident # 160 the bruise was already in evidence. Interview with the Director of Nurses (DON) on 11/30/2011 at 4:25 p.m. revealed she expected her staff to report immediately any alleged abuse occurrences to her or the facility Assistant Director of Nurses (ADON). In addition the DON confirmed there was no date by her signature to indicate when she had reviewed it. On 11/30/2011 at 5:15 p.m. the Administrator was interviewed and confirmed the date by her signature as 11/10/2011 which was when she received and reviewed the report. When asked about the possibility of this occurrence being abuse the Administrator revealed staff must not have regarded it as abuse and she would have taken it as a transfer accident and not abuse. Continued interview revealed the Administrator indicated it should have been brought to her attention within 24 hours so she could follow facility procedure especially since an x-ray was done.	F 225		
F 253	483.15(h)(2) HOUSEKEEPING &	F 253		

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F 253 SS=B	Continued From page 3 MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure that resident care equipment, resident rooms and common areas were kept clean and orderly. (Residents #16, #59, #60, #61 and #65) The findings are: 1. Observations of resident rooms and common areas during the survey revealed the following issues: a. Observations on 11/29/11 at 11:00 a.m. revealed areas of peeling and chipping paint in Resident #65's room. Observations of this room's entry and bathroom doors revealed these doors had numerous scuffed areas and/or areas of exposed splintered wood. b. Observations on 11/29/11 at 11:10 a.m. revealed the entry door to Resident #60's room and this room's bathroom door had numerous scuffed areas and areas of exposed splintered wood. c. Observations on 11/30/11 at 2:11 p.m. of Resident #61's room revealed numerous areas of chipped paint on the room's walls.	F 253	F 253 SS-B 1. A. Room #65 has been painted and doors repaired. Room # 61 has been painted. Doors leading into 300 hall have been repaired. Doors entering 100 hall dinning room have been repaired. B. Resident # 59's wheelchair has been repaired/replaced. Resident # 16's side rail pads have been replaced. The 2 mechanical lifts have been cleaned. The geri-chair armrests have been repaired/replaced. 2. All resident rooms and equipment will be checked by Administrator and Maintenance Director for any needed painting/ repairs/replacements.	

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F 253	Continued From page 4 d. Observations on 12/01/11 at 11:25 a.m. and at 4:50 p.m. revealed the two (2) sets of double doors that led into the facility's 300 hallway contained a number of scraped areas and large areas of exposed splintered wood. e. Observations on 12/02/11 at 8:45 a.m. revealed the two (2) doors utilized to enter the facility's one hundred (100) hall dining room had scraped areas and large areas where the finish on the door was worn away. Interview with the facility's Maintenance Director on 12/01/11 at 4:50 pm revealed that staff was in the process of beginning to renovate resident rooms. The Maintenance Director stated that when staff stripped a floor in a resident's room they would also paint the room's walls and repair doors if needed. The Maintenance Director stated that he could not provide a date when all of the resident rooms would be completed, but stated that staff was just about to start the process. The Maintenance Director stated that the doors observed with rough and splintered wood would have to be sanded down, puttied and revarnish in order to completely repair each of them. 2. Observations of resident care equipment during the survey revealed the following issues: a. Observations on 11/29/11 at 1:08 p.m. revealed Resident #59's wheel chair had a large tear on its back support and multiple cracks on the vinyl fabric of both of the chair's arm rests. b. Observations on 11/29/11 at 11:34 a.m. revealed the side rail pads that were affixed to Resident #16's bed had numerous tears in their	F 253	F 253 SS-B 3. Staff has been re-in-serviced by DON on the process for notifying maintenance of any needed repairs. 4.QA nurse will audit rooms and equipment weekly X4, monthly X3 and quarterly after that.. Results will be reported to QA committee monthly.	12/30/11

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

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F 322 SS=D	Continued From page 6 RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and medical record review the facility failed to ensure that enteral products being administered to one (1) of one (1) sampled residents had expiration dates that had not expired. (Resident #24) The findings are: Review of Resident #24's medical record revealed that he was readmitted to the facility on 09/12/11 with a diagnosis of Dysphagia. Review of this resident's physician's orders revealed a 09/15/11 order, which specified that the resident's nightly tube feedings were to be discontinued, and that he was to be given one (1) can of Jevity 1.5 with 60 cc's of water if he consumed less than fifty (50) percent of his meals. The resident Minimum Data Set (MDS) assessments of 09/18/11 and 11/10/11 both indicated that a feeding tube was a nutritional approach. Review of Resident #24's care plan, which was updated on 11/10/11, specified the following	F 322	F 322 SS-D 1. The expired cans were removed from the cabinets and discarded. 2. All supply cabinets have been checked for any other expired supplements. A new log sheet has been started to document date placed on shelf and current expiration date. 3. All nursing and stock personnel were instructed and in-serviced by the DON on the importance of checking product expiration dates prior to administration of tube feedings. QA nurse and stocking personnel were instructed and in-serviced by the administrator on the use of new forms and rotation of stock. Stock is checked daily by the stock person.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 322	Continued From page 7 problem/need; "Receives a regular ground meat diet & eats 80% of most all meals. G-Tube feedings if less than 50 % of meals are consumed." Review of Resident #24's November 2011 Medication Administration Record (MAR) revealed the resident had received and consumed multiple cans of Jevity 1.5 during the month of November. Observations of the facility's two hundred (200) hall pantry room on 12/01/11 at 10:51 a.m. and on 12/02/11 at 9:30 a.m. revealed fifty-five (55) of fifty-five (55) eight ounce cans of Jevity 1.5, that were stored in this room, had expired expiration dates of 11/01/11. Interview with Licensed Nurse (LN) #7 on 12/02/11 at 9:38 a.m. revealed that Resident #24 was the only resident who received Jevity 1.5 on the facility's 200 hallway. LN #7 specified that Resident #24 had an order to receive a can of Jevity 1.5 by his gastrostomy tube when he consumed less than half of his meals and that staff would obtain this product from the facility's 200 hallway pantry room when it was needed for Resident #24. LN #7 reviewed the resident's December 2011 MAR and stated that he had not received any Jevity 1.5 on either 12/01/11 or 12/02/11. LN #7 further stated that she was unsure what staff was responsible for checking the expiration dates on the enteral products stored in the facility's 200 hall pantry area. On 12/02/11 at 10:10 a.m. the facility's administrator was interviewed. The Administrator stated that the facility's Quality Assurance staff	F 322	4. QA nurse is to check cabinet weekly X4, monthly x3, then quarterly. Results will be reported to QA committee monthly.	12/30/11

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F 322	Continued From page 8 and dietary staff were responsible for checking expiration dates of products stored in pantry cabinets on at least a weekly basis. The administrator stated that staff should have realized the fifty-five (55) cans of Jevity 1.5 had expiration dates of 11/01/11 and should have removed all of these cans on or before 11/01/11. The Administrator confirmed that Resident #24 had received Jevity 1.5 on multiple occasions during the month of November 2011.	F 322		