STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345077	A. BUILDING: _____ B. WING _____	9/9/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK REHABILITATION CENTER	25 SUNNYBROOK ROAD RALEIGH, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 514	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to give prescribed medications to 1 out 3 residents (Resident #1).

Findings Included:

A medical record review was completed and revealed Resident #1 was admitted on 10/13/13 with diagnoses of difficulty in walking, muscle weakness, osteoarthritis, gout, chronic kidney disease, cardiomegaly, urinary tract infection, depression, glaucoma, peripheral vascular disease, congestive heart failure, dementia, cerebrovascular disease and high cholesterol.
A record review of the Minimum Data Set (MDS) significant change assessment dated 6/3/2015 revealed Resident # 1 was moderately cognitively impaired, dependent for transfers, bed mobility and bathing with assist of two, extensive assist with assist of one with personal hygiene, eating, dressing and locomotion off and on the unit and dependent with one assist with toileting. Resident # 1 used a wheelchair and was always incontinent of bowel and bladder.
A record review of care plans updated on 5/20/15 revealed a care plan was in place for risk for falls. Interventions included getting resident out of bed to wheelchair upon waking in the morning if she chooses, cue for safety awareness, encourage out of room activities, keep call light within reach, and keep wedge on right side of bed while in bed. A care plan for impaired cognitive function related to dementia was in place with interventions to keep routine consistent and require approaches that maximize involvement in daily decision. A care plan for weakness related to decrease functional mobility and falls was in place. Interventions included offering assistance with toileting, provide two person assist with sit to stand transfers to and from wheelchair. A care plan for potential for pain related to gout/osteoarthritis was in place. Interventions included inviting and escorting as needed to activities of interest, medication for pain to knees as ordered and monitor effectiveness.
A record review of the Electronic Medication Administration Record (eMAR) on 8/24/15 at 4:30 pm revealed Resident # 1 had an order to receive Dorzolamide-Timolol 2% - 5%, one drop in the left eye two times per day for Glaucoma and Brimonidine Tartrate 0.2%, one drop in the left eye three times per day for Glaucoma. Resident # 1 was to receive the Dorzolamide-Timolol at 12:00 pm and 8:00 pm daily. The Brimonidine Tartrate was to be given at 9:00 am, 1:00 pm, and 5:00 pm. A review of the eMAR revealed the resident did not receive the 12:00 pm dose of the prescribed Dorzolamide-Timolol nor did the resident receive the 1:00

The above isolated deficiencies pose no actual harm to the residents

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F 514	Continued From Page 1

pm dose of the prescribed Brimonidine Tartrate. Resident # 1 also had an order to receive MedPass (a nutrition supplement) three times per day. A review of the eMAR revealed the resident did not receive the 1:00 pm prescribed MedPass.

A phone interview was conducted on 8/24/15 at 5:08 pm with the nurse that was taking care of Resident # 1 on 8/6/15. The nurse reported she gave the resident her eye medications and the MedPass The nurse could not answer why the eMAR was not signed off and replied, " I was fired from the facility, I don ' t really want to discuss it any further.

An interview with the Director of Nursing (DON) at 6:00 pm on 8/24/15 revealed her expectation of the nurses is to give the prescribed medications as ordered. The DON reported there should be no " blanks " on the eMar. All the medications should be given, and if they are not given, there is a key to follow as to why it was not given. Based on the fact the eMar block for both eye drops and the MedPass was left blank on August 6, 2015, the DON reported the prescribed medication was not given as ordered.