STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345077	A. BUILDING _____ B. WING _____	C 10/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK REHABILITATION CENTER	25 SUNNYBROOK ROAD RALEIGH, NC 27610

(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 000	INITIAL COMMENTS A complaint investigation survey was conducted on 9/28/21 to 10/1/21. Event ID DZD711. 1 of the 12 complaint allegations was substantiated resulting in a deficiency.	F 000		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff and nurse practitioner interview the facility failed to clarify a physician's order for lithium that resulted in an unintended dose of lithium for 1 of 1 resident's whose medications were reviewed (Resident #1).	F 757	F757POC 1-Resident #1 no longer resides in the facility. 2-Residents having the potential to be	10/11/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/11/2021

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 757	Continued From page 1 The findings included: Resident #1 was admitted to the facility on 3/12/21 and had a diagnosis of Bi-polar disorder. The hospital discharge orders included an order for Lithium 300 milligrams (mg) twice a day for bi-polar disorder. This order was continued by the facility and was scheduled on the Medication Administration record for 8:00 AM and 8:00 PM. The Admission Minimum Data Set (MDS) Assessment dated 3/16/21 noted the resident had severe cognitive impairment and required limited to extensive assistance with activities of daily living. The Care Area Assessment (CAA) dated 4/16/21 noted the resident had behaviors such as yelling out and verbal abuse at times. A Psychiatry (psych) Nurse Practitioner note dated 5/13/21 revealed that psych was asked to reassess the resident's medications for breakthrough restlessness and agitation. There was an order to check a lithium level on 5/17/21. Review of the clinical record revealed a lithium level was drawn on 5/17/21. A psych note dated 5/18/21 revealed the staff reported an increase in behaviors particularly in the afternoon and poor sleep at night. The note revealed the following: "Will add midday dose of Lithium 300mg/150mg/300mg for bi-polar disorder. Lithium level pending." Review of the MAR revealed the Lithium 150mg was scheduled to be given daily at 1:00 PM.	F 757	affected: Residents under the care of the psychiatry provider have the potential to be affected. The psychiatry provider reviewed the physician's orders of residents on caseload to ensure medication accuracy. This review included any medications which may be duplicated with different dosages. There were no concerns/issues. An audit of current residents who have orders from the psychiatry provider service was conducted by the DON/designee. The audit included review of duplicate medications with verification by the provider of accuracy. There were no concerns/issues. The psychiatry review and DON audits were completed by 10/11/2021. 3-Starting the week of 10/11/2021, the psychiatry provider's weekly visits will be conducted on Mondays. Prior to the scheduled visit, the psychiatry provider will email the DON/designee a list of residents to be seen. The residents' current medication orders will be printed by DON/Designee. The orders will be given to the psychiatry provider by the DON/Designee prior to the psychiatry visit. Changes will be noted on the orders and signed by the provider. The DON/designee will compare the noted changes on the printed orders to the electronic medical records for accuracy. 4-Weekly audits of the orders will be conducted by the DON/designee X 6 weeks and monthly X 3 months. The audits will be reviewed in the monthly QA	

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F 757	Continued From page 2 On 5/20/21 the Lithium level was reported as 0.54 (therapeutic range 0.50-1.20). The Psych Nurse Practitioner noted on 5/26/21 that the Lithium level was within therapeutic range. There was an order entered into the electronic record by the Psych Nurse Practitioner on 7/13/21 for Lithium 450mg twice a day and to check a Lithium level in one week. Review of the MAR revealed the Lithium 300mg was discontinued and the Lithium 450mg twice a day scheduled for 8:00 AM and 8:00 PM. The 1:00 PM dose of Lithium 150mg was not discontinued and continued to be given. On 10/1/21 an interview was conducted with the Psych Nurse Practitioner who stated when she entered the order for Lithium 450mg twice a day she did not intend for the resident to receive the 1:00 PM dose of Lithium 150mg. An interview was conducted with Unit Manager #1 on 10/1/21 at 9:21 AM. The Unit Manager stated when an order was entered in the electronic record the order would flag under a drop-down tab and she and Unit Manager #2 and the Director of Nursing (DON) would look for any new orders during the day and when they saw pending orders, they would confirm the order by clicking on the order and the order would go to the pharmacy and pop up on the MAR for the nurse to give. The Unit Manager stated if there was an order for Lithium 450mg twice a day and there was already an order for Lithium 150mg at 1:00 PM she would call the provider that ordered the medication to clarify the order.	F 757	meeting. The QA committee will evaluate the need for further monitoring.	

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F 757	Continued From page 3 On 10/1/21 at 9:42 AM an interview was conducted with Unit Manager #2 who confirmed the order for Lithium 450mg twice a day on 7/13/21. The Unit Manager #2 stated she could not recall confirming the order in July 2021 but when she did confirm an order, she was not able to see all the orders for that resident. The DON stated in an interview on 10/1/21 at 9:21 AM that Unit Manager #2 confirmed the order for Lithium 450mg twice a day on 7/13/21. The DON stated the dose of Lithium at 1:00 PM was a separate order so when the dose was changed from 300mg twice a day to 450mg twice a day, the 1:00 PM dose was not discontinued. The DON was asked if she would expect the nurse to clarify the order and the DON stated when the new order was clarified, the nurse could not see the other orders in the electronic record and the nurse would not see that an order for 150mg was ordered for the afternoon.	F 757		