PRINTED: 04/11/2013
FORM APPROVED
OMB NO. 0938-0391

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

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 ______	C 04/08/2013

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 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to supervise a resident who fell and sustained a head injury for 1 of 3 sampled residents (Resident #2). The findings include: Resident #2 was admitted to the facility on 11/09/11 with diagnoses that included dementia and history of falls. The Minimum Data Set (MDS) dated 01/02/13 specified the resident had moderately impaired cognitive skills, required extensive assistance with activities of daily living (ADL), was not steady moving from seated to standing position but propelled herself in her wheelchair. The MDS also specified the resident had falls with minor injuries. Review of Resident #2's fall care plan (not dated) specified the resident was at risk for falls and interventions included: - monitor whereabouts and what she is doing to prevent falls - canary alarm (personal alarming device)	F 323	Without admitting or denying the validity or existence of the alleged deficiency, Sunrise Rehab and Care provides the following plan of correction. F 323-SS=G 1) Resident #2 returned from hospital on 3/21/13. Resident #2 was re-assessed for fall risk on 3/21/13 and screened by therapy on 3/22/13. At that time, the PT screen indicated therapy was not appropriate due to resident's condition. Resident was assessed on 3/28/13 by attending physician who found no change in resident's physical condition. Resident was admitted to Hospice services per family request. Care plan meetings have been held with family members on 4-2-13, 4-10-13 and 4-17-13 and her care plan was up dated to reflect changes. Care plan meeting with family on 4/17 resulted in a referral to Therapy and PT	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Winnie Jo Allison
TITLE: Administrator
(X6) DATE: 5/2/13

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.

original signature 4-19-13 nh

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F 323	Continued From page 1 attached to wheelchair - resident is not to be left unattended in dayroom (03/21/13) Further review of the resident's medical record revealed a "care card" that contained information regarding the care and assistance the resident required. Resident #2's "care card" specified the resident was at risk for falls. A nurses' entry made by Nurse #1 dated 03/19/13 at 2:30 AM specified the resident was found in the South Dayroom laying on her right side and noted to have a 2.3 centimeter (cm) laceration to her forehead. The nurses' entry indicated the physician was notified and ordered the resident to be sent to the Emergency Department for evaluation. A document titled "Discharge Summary" dated 03/21/13 was reviewed and revealed Resident #2 was evaluated at a local hospital for a brain bleed and was transferred to a trauma center for further treatment. On 04/08/13 at 9:30 AM Resident #2 was observed in her room sitting in a wheelchair with her family. She stated to her family that she wanted to lie down. The resident was able to follow the instructions from the family member during the transfer. On 04/08/13 at 11:40 AM Nurse #1 was interviewed and reported that Resident #2 at times was very impulsive and would attempt to stand unassisted. She added that the resident was at risk of falls and required close supervision. She stated that staff were expected to stay with	F 323	started working with resident on 4-18-13. Medications were reviewed and Ativan was discontinued 4-10-13. Melatonin was ordered routinely instead of prn on admission on 3-21-13. Resident is on the Fall Prevention Program. Resident requires visual observation by staff members when out of bed during the 11-7 shift, and a staff member will document on the visual observation sheet. 2) Residents have been re-assessed for fall risk. A process has been developed where nurses will be able to look at the MAR or TAR to determine the level of supervision that an individual resident needs. Process includes placing a Yellow star with the level of supervision written on it on the MAR /TAR's for residents on the Fall Prevention Program. Nursing and Activity departments are enhancing activities programs and	

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F 323	Continued From page 2 the resident during times when she appeared agitated and keep her in areas that were highly visible. Nurse #1 reported that on 03/19/13 Resident #2 was refusing to stay in bed and the resident was kept in the dayroom to not disturb other residents. She explained that the nurse aides had taken turns monitoring the resident while she was in the dayroom. She added that Nurse #2 walked by the South dayroom and observed Resident #2 on the floor. She stated that Resident #2 was alone in the dayroom at the time of the fall. She stated the physician was contacted and ordered the resident to be sent to the Emergency Department for evaluation. On 04/08/13 at 11:50 AM the Director of Nursing (DON) was interviewed and reported that staff were expected to never leave residents at risk for falls unattended. She added she was aware that NA #1 had left Resident #2 unattended in the South dayroom when the resident attempted to stand, fell and struck her head sustaining a head injury. The DON reported that NA #1 should have taken the resident to the nurses' station for someone else to monitor before she left the resident in the dayroom unattended. She added that the NA was aware that Resident #2 was impulsive and made attempts to stand and required close supervision. She offered no explanation why NA #1 left the resident unattended in the dayroom. On 04/09/13 at 1:00 PM the physician was interviewed on the telephone and reported the resident sustained a small brain bleed that did not required surgical intervention. He added that it was possible the bleed would resolve on its own over time. He stated the resident returned to the	F 323	increasing frequency of times different activities are offered. Staffing assignments have been revised for 3rd shift to ensure a staff member is available to provide visual observation for any resident who may not be sleeping and are out of bed. Interactive activity supplies will be available on each unit for staff to utilize. 3) Nursing and Activity staff has been in-serviced on the expansion of activity program and staff responsibility to supervise residents to prevent falls. Staff involved with resident #2 have been in-serviced on the importance of resident supervision to prevent accidents. New nursing staffs are being in-serviced on the Fall Prevention program when they are hired and Fall Prevention program will be in-serviced annually for all staff. Staff has been in-serviced on the revised assignment sheets and	5-6-13

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F 323	Continued From page 3 facility under the care of Hospice because of the diagnosis and not because of a change in the resident's condition. He stated he assessed the resident on 03/28/13 and was unable to detect a change in her condition. On 04/09/13 at 7:00 PM NA #1 was interviewed on the telephone. She reported that Resident #2 required frequent supervision because she was at risk for falls and added that when the resident was agitated and made attempts to stand she needed one on one supervision. She stated that the night of 03/19/13 she reported for work at 11 PM and Resident #2 was refusing to go to bed which was not unusual for the resident. NA #1 explained that Resident #2 was kept in the dayroom and offered snacks and fluids. The NA added she and other staff working that night would go in and out of the dayroom to check on the resident and sit with her. The NA stated that the resident was not agitated and was not making attempts to stand unassisted and did not required one on one supervision during this time. She added that the resident had a personal alarm that would alert staff when the resident attempted to stand. She confirmed the alarm was on the resident the night she fell. She also explained that the resident would remove the alarm. She stated that she needed to answer a call light and left Resident #2 and NA #3 in the dayroom together. She added that while she was in a room assisting a resident she heard a nurse call for help and observed Resident #2 in the floor. She added that since the fall the resident continued to act the same and that she required the same level of assistance with her ADL. On 04/09/13 at 7:15 PM NA #2 a telephone	F 323	observation sheets. Staff will be in-serviced on the process to determine level of supervision a resident needs by DON/ADON/Designee. 4) QA Nurse/Team Leaders will review occurrence reports of residents who have falls to determine need for more supervision. DON/QA nurse/ ADON/or other designee will audit the Occurrence Reports to determine if enhanced activities and supervision of residents who are not sleeping, has affected frequency of falls, weekly x4, every 2 weeks x4, and monthly x3, then quarterly. Findings will be reported by the QA nurse at the monthly QA meeting.	5-6-13

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F 323	Continued From page 4 interview was conducted. She reported that Resident #2 was at risk for falls and needed close supervision when she was in her wheelchair. She stated the resident had a personal alarm that would alert staff if the resident attempted to stand up in her wheelchair. She added that the resident removed the alarm at times. NA #2 reported that when Resident #2 was agitated she needed to be monitored more closely. She added that on 03/19/13 she helped to watch Resident #2 in the dayroom but confirmed the resident was not agitated and was not making attempts to stand up in her wheelchair. She stated that she left the dayroom to answer a call light and that Resident #2 was in the dayroom with NA 1 and NA #3 prior to the fall. She reported that since the fall the resident appeared the same. On 04/09/13 at 7:30 PM NA#3 was interviewed on the telephone and reported that Resident #2 had been in the dayroom for the duration of the night shift on 03/19/13. She added that the resident was not agitated and appeared her usual self. NA #3 explained the resident did not want to go to bed which was not unusual for the resident so staff took turns sitting with her in the dayroom between making rounds and answering call lights. NA #3 was aware the resident required close supervision and stated the resident could not be left alone in her room because of the resident's risk for falls. She stated that prior to the fall she was in the dayroom but left to assist another resident. She stated that when she left the dayroom Resident #2 was with NA #1 and NA #2. She added that while she was in a resident's room she heard a call for help and observed the resident in floor of the dayroom. She explained that the resident had propelled herself near the	F 323		

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F 323	Continued From page 5 door of the dayroom and attempted to stand and fell. She reported that since the fall the resident's physical abilities had not changed and added the resident still talked about her children which she often did with the NA.	F 323		