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 11/08/2013

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=D	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 observation, staff interview, and record review, the facility failed to secure antifungal powder out of reach for 3 cognitively impaired residents on the 100 hall treatment cart (Residents #11, #12 and #13) The findings are: Review of Material Safety Data Sheet product label information for miconazole antifungal powder dated 12/03/10 read in part: "Avoid eye contact. Could be an inhalation hazard. Avoid ingestion. If ingested/swallowed contact physician or Poison Control Center." Resident #11 was admitted 06/30/11. Diagnoses included dementia. Minimum Data Set (MDS) dated 10/29/13 assessed the resident with moderately impaired cognition, requiring limited assist with ambulation and extensive assist with locomotion on/off unit. Resident #12 was admitted 07/21/10. Diagnoses included dementia. MDS dated 10/15/13 assessed the resident with severely impaired cognition, independent with ambulation and	F 323	Responses to the cited deficiencies do not constitute an admission or agreement by the Provider of the truth of the facts as alleged or conclusions set forth in the Statement of Defiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and state law. 1. The treatment nurse was immediately educated regarding proper storage of medication/treatments. — 11/7/2013 2. 100% of licensed nurses will be educated regarding the proper storage of medication/treatments. — 12/3/2013 3. Weekly audits will be conducted X 4, biweekly X 2, then monthly X 2 to ensure medication/treatments are stored properly. — 12/15/2013 4. Results of audits will be monitored in QA meeting monthly for 3 months. — 12/15/2013 Process owner will be DON/designee	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Wendy Allison — TITLE: Administrator — (X6) DATE: 12/04/13

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.

DHSR NHCS Black Mountain WRO Received DEC 05 2013 by: MMH

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F 323	Continued From page 1 locomotion on/off unit. Resident #13 was most recently readmitted 05/17/13. Diagnoses included dementia. MDS dated 08/14/13 assessed the resident with severely impaired cognition, independent with ambulation and locomotion on/off unit. On 11/07/13 at 3:25 PM until 3:54 PM a continuous observation was made of an unattended treatment cart on the 100 hall. The treatment cart was observed with a clear medicine cup on top of the cart containing approximately one half teaspoon white powdered substance accessible to residents on the hall. Resident #11 self propelled in her wheelchair back and forth in front of the unattended treatment cart. Resident #12 ambulated independently back and forth in front of the unattended treatment cart looking into rooms. Resident #13 self propelled in her wheelchair past the treatment cart and entered her room adjacent to where the unattended treatment cart was located. No residents were observed to touch any items on the treatment cart. On 11/07/13 at 3:54 PM Nurse #1 approached the treatment cart and placed the container into an open trash can attached to the bottom side of the treatment cart. Nurse #1 was interviewed at the time of this observation. Nurse #1 stated she removed the container off the treatment cart because the powder should not be left out where residents could get to it. The container was removed from the trash can with the contents still in the medicine cup. Nurse #1 stated she thought the substance was antifungal powder. On 11/07/13 at 4:00 PM the Treatment Nurse	F 323		

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F 323	Continued From page 2 was interviewed. The Treatment Nurse confirmed the white substance was antifungal powder. The Treatment Nurse stated she was interrupted while doing treatments and left the antifungal powder unattended on top of the treatment cart. The Treatment Nurse stated she usually kept skin treatments/supplies secured in her cart to ensure residents did not have access to potentially hazardous substances. On 11/08/13 at 3:00 PM the Director of Nursing (DON) was interviewed. The DON stated she expected nursing staff to store medications/skin care treatments securely to minimize resident access to hazardous substances.	F 323		