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 03/20/2014

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 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting	F 156	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F- 156 1.) How corrective action will be accomplished for the residents affected: The Survey Results Notebook is clearly labeled and located in the front lobby of the facility. Its location is clearly identified on the residents' information bulletin board. The State Complaint Line phone number is posted clearly on the bulletin board. The name and phone number for the Ombudsman is retyped and posted in large enough font for residents to clearly read it and it is located at a height for wheelchair viewing. 2.) How corrective action will be accomplished for those residents having the potential to be affected: All residents have the potential to be affected. No negative outcomes identified. DHSR NH Unit Black Mountain WRO Received APR 15 2014 by: SKH	4.17.14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: John Gibbs — TITLE: Administrator — (X6) DATE: 4.11.14

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.

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 03/20/2014

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 156	Continued From page 1 personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by	F 156	3.) What measures will be put in place or systemic changes made to ensure correction: The Social Worker is identified as responsible for compliance on the resident information bulletin board. The Administrator or designee will conduct weekly audits for four weeks and monthly audits for three months to ensure compliance with all information required to be posted for residents. The Resident Council President will be educated on the corrections made and location of complaint line and Ombudsman phone numbers as well the location of the Survey Notebook. The Administrator will address the Resident Council and ensure they are made aware of all changes. 4.) How the facility plans to monitor its performance to make that solutions are ensured: Results of compliance will be reviewed for the quarterly Quality Assurance Committee Meeting The Administrator is responsible for overall compliance.	

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 03/20/2014

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 156	Continued From page 2 such benefits. This REQUIREMENT is not met as evidenced by: Based on observations, and staff and resident interviews the facility failed to label the survey results, post the state complaint line phone number, and failed to print and place the Ombudsman's phone number large enough and low enough to be viewed by residents in a wheelchair. The findings included: Observations were made on 03/18/14 and throughout the survey of a bulletin board in the hall near the dining room which contained information for residents. On this bulletin board was the name and phone number of the Ombudsman in small regular type at eye level if standing at the board. Furthermore the number for the state complaint line was not posted. There was a note indicating the survey results notebook could be found on a table near the front door of the building. This notebook was observed with no markings indicating what it was. An interview was conducted on 03/20/14 at 9:15 AM with the Resident Council President. She stated she was unaware who the ombudsman was or where her number was posted. She further explained she did not know where the state complaint line phone number was posted or where the results of the state survey were kept. She stated she would like to read the survey results.	F 156		

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 03/20/2014

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 156	Continued From page 3 An interview was conducted on 03/20/14 at 11:30 AM with the Administrator. The Administrator stated it was her expectation the Ombudsman name would be posted where residents were able to read it. She further stated she expected the survey results to be labeled and the state complaints line number to be posted.	F 156	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to release a lap buddy during meals for 1 of 1 resident with restraints (Resident #16). The findings included: Resident #16 was admitted to the facility on 08/12/06 with diagnoses including Alzheimer's disease, hypertension and seizure disorder. The most recent Minimum Data Set (MDS) dated 12/18/13 noted the Resident #16 had severely impaired cognition with continuous inattention during the assessment period. Resident #16 required extensive two person assistance for transfers and was assessed as using a chair that prevented rising less than daily during the observation period. The Care Area Assessment (CAA) for physical	F 221	F- 221 1.) How corrective action will be accomplished for the residents affected: Staff re-educated by the Staff Development Coordinator how and when to release Resident #16 lap buddy restraint. Res. #16 restraint is being released during meals. Res #16 care plan and Pictorial reviewed and updated as necessary. 2.) How corrective action will be accomplished for those residents having the potential to be affected: Dependent residents with restraints are identified as potentially being affected. Audit conducted by the DON or designee to ensure all identified residents with restraints are being released during meals. No negative outcomes identified. 3.) What measures will be put in place or systemic changes made to ensure correction: The Staff Development Coordinator or designee re-educated the nursing staff regarding proper releasing of restraints during resident meals. The MDS Coordinator reviews Care Plans and	4.17.14

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 03/20/2014

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 221	Continued From page 4 restraints indicated Resident #16 was at risk of falls due to trying to get up unassisted, impaired balance, medication side effects and recent falls. The CAA summary further indicated he had experienced 3 falls without injury since the previous assessment and was out of bed daily as tolerated in a wheelchair with a lap buddy restraint. His care plan was last reviewed on 12/18/13 and included the problem of risk for falls with use of lap buddy restraint when in wheelchair noted as an appropriate intervention. The care plan did not address releasing the restraint during meals or 1:1 care. Review of the Resident Care Guide used by Nurse Aides (NAs) to direct the resident's care had "Lap Cushion" circled but did not indicate any instructions for releasing the restraint. A review of Resident #16's medical record revealed a restraint evaluation dated 09/18/13 which indicated he leaned forward with his head toward the floor while in wheelchair and needed a lap buddy to prevent falls from the wheelchair causing injury. On 03/17/14 from 11:45 AM until 12:40 PM Resident #16 was observed in the north wing day room being fed by Nurse Aide (NA) #5. A non-self release padded lap buddy was in place between the resident's abdomen and the armrests of the wheelchair. On 03/19/14 from 11:50 AM until 12:10 PM Resident #16 was observed in the north wing day room being fed by NA #5. A non-self release padded lap buddy was in place between the	F 221	Pictorials for those with restraints and updates them as necessary reflecting releasing for meals. DON or designee will conduct documented QA Audits to monitor restraint release during meals through direct random observation and record review audits 2x weekly for 4 weeks, then once weekly for four weeks and monthly x3 months for compliance. As necessary employees will be in-serviced to assure compliance with the facility restraint policy. The SDC will include provisions for restraint policy and procedure during orientation of new nursing personnel. 4.) How the facility plans to monitor its performance to make that solutions are ensured: Audit results will be reviewed and analyzed monthly by the DON or designee for three months, and then quarterly at the Quality Assurance Committee Meeting with subsequent plan of action developed and implemented as indicated by the QA Committee. The Director of Nursing is responsible for overall restraint compliance.	

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 03/20/2014

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 221	Continued From page 5 resident's abdomen and the armrests of the wheelchair. On 03/20/14 at 10:33 AM the MDS nurse was interviewed about the care plan not addressing the releasing of restraints and the MDS nurse stated the facility policy specified that restraints were to be released during meals and every 2 hours during toileting. When asked how the NAs knew they were expected to release the restraint every 2 hours, she stated the expectation was covered in periodic inservices. On 03/20/14 at 11:17 AM NA #5 was interviewed about what she was trained to do for residents with restraints during meals. NA #5 stated she was trained to release restraints during meals. When asked why she didn't remove Resident #16's restraint during lunch on 03/17/14 and 03/19/14, she stated she had only worked at the facility a few weeks and wasn't sure what the facility policy was about releasing restraints. On 03/20/14 at 11:55 AM the Staff Development Coordinator was interviewed. She stated she does orientation of all new employees and covers restraint usage during orientation. She stated she instructs the NAs on how to apply restraints and that they should be released every 2 hours when the resident is toileted and during meals. Review of NA # 5's orientation record revealed the use of restraints was covered during her orientation. On 03/20/14 at 3:41 PM the Administrator was interviewed about her expectation for the release of restraints. The Administrator stated she expected restraints to be released whenever the resident was directly supervised and during meals.	F 221		

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 03/20/2014

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 221	Continued From page 6 On 03/20/14 at 4:15 PM the Assistant Director of Nursing (ADON) was interviewed about her expectation for the release of restraints. The ADON stated she expected restraints to be released during meals and when residents were toileted every 2 hours. When asked about Resident #16's lap buddy, she stated it should be removed during meals.	F 221	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F- 241** **1.) How corrective action will be accomplished for the residents affected:** **Allegations from Residents #19 and #22 were reported in accordance with state guidelines. A complete investigation was completed and results reported per regulatory guidelines. Both residents remain in the facility and report no negative outcomes.** **2.) How corrective action will be accomplished for those residents having the potential to be affected:** **All residents are potentially affected. Audit conducted by the Administrator or designee ensuring all residents' dignity and respect (resident rights) are being maintained by interviewing all who are designated as interviewable. For those resident's identified as un-interviewable, staff observations during Guardian Angel rounds and random interviews with Responsible Parties will be completed to ensure those residents dignity and residents rights are maintained. No negative outcomes identified.** **3.) What measures will be put in place or systemic changes made to ensure**	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review the facility failed to ensure residents were treated with dignity for 2 of 4 residents reviewed for dignity. (Residents #19 and #22) The findings included: 1. Resident #19 was admitted to the facility on 11/09/14 with diagnoses which included Parkinson's disease. Resident #19's most recent Quarterly Minimum Data Set (MDS) assessed him as having moderate cognitive impairment with no behaviors. On 03/17/14 at 2:06 PM an interview was conducted with Resident #19. Resident #19 stated he could not remember who it was but she	F 241		4.17.14

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 03/20/2014

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 241	Continued From page 7 was going to make him do something. He stated he did not tell anyone because they would just laugh at him. On 03/18/14 at 5:00 PM during an interview with Resident #19 he stated someone did take his washcloths away but he could not remember who had done this. On 03/18/14 at 5:05 PM an interview was conducted with the Social Worker (SW). She stated the DON had spoken to Resident #19 in a short and hateful manner and jerked something out of his hand. The SW stated she had reported this to the Administrator. A telephone interview was conducted on 03/20/14 at 5:05 PM with the Administrative Assistant (AA) who worked with the Admission Coordinator. She stated she had witnessed the incident which occurred 01/20/14 with Resident #19. The AA stated a resident had gone to the doctor and left her wheelchair near the front door which was near her office. The AA stated Resident #19 had come up to the front of the building near her office as he frequently did using his rolling walker. She stated Resident #19 had sat in the empty wheel chair to rest. The AA then told Resident #19 that the wheelchair belonged to a resident who was soon going to need it. The AA stated Resident #19 was getting up when the DON came out of her office and told him to get out of the wheelchair. The DON then opened the compartment of Resident #19's rolling walker and took out several washcloths he had stored there. The AA stated Resident #19 used the washcloths because he drooled. The AA stated Resident #19 grabbed the washcloths and a tug of war ensued. She stated the DON started to twist the	F 241	**correction:** **The Staff Development Coordinator or designee re-educated all facility staff regarding proper understanding of the residents' rights to upholding their dignity and respect. Resident Rights education included customer service, dignity and respect, grievance process and abuse protocols. Guardian Angel focus and procedures reviewed with all Angels by the Administrator. Administrator or designee will conduct documented QA Audits of interviewable residents and responsible parties of un-interviewable resident to monitor resident feelings regarding dignity and respect once every two weeks for 4 weeks and monthly x3 months for compliance. The SDC will include provisions for resident rights during orientation of new facility personnel.** **4.) How the facility plans to monitor its performance to make that solutions are ensured:** **Audit results will be reviewed and analyzed monthly by the Social worker for three months, and then quarterly at the Quality Assurance Committee Meeting with subsequent plan of action developed and implemented as indicated by the QA Committee. The Administrator is responsible for overall resident rights compliance.**	

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 03/20/2014

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 241	Continued From page 8	F 241		

washcloths which was also twisting Resident #19's arm. Resident #19 then fell backward into the wheelchair. The AA stated the DON could have hurt Resident #19's arm as his arm and hand were being twisted. She stated this was reported to the previous Administrator by the SW.

2. Resident #22 was admitted to the facility on 06/28/3 with diagnoses which included depression and Parkinson's disease. Resident #22's most recent Quarterly MDS dated 12/26/14 assessed him as being cognitively intact.

An interview was conducted on 03/18/14 with Resident #22. Resident #22 reported the Director of Nursing (DON) yelled and hollered at him. He stated she got to talking real loud and he did not want other people to hear it. He told her he did not think she should be working there and that she needed to be gentle and quiet. He stated it was just himself and the DON in her office. He stated it was a matter of heavy scolding and her voice was very harsh and bitter.

On 03/18/14 at 5:05 PM an interview was conducted with the Social Worker (SW). She stated had heard the DON yelling at Resident #22. The SW stated she heard the DON speak down to Resident #22. The SW stated she reported the incident to the Administrator.

On 03/18/14 at 5:45 PM an interview was conducted with Resident #22 with the Administrator present. Resident #22 stated when the DON spoke to him the way she did it made him feel terrible. He stated he wondered if it was going to be that way all the time. Resident #22 then stated since then she just glared at me and does not speak. He stated he had been feeling

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 03/20/2014

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 241	Continued From page 9 pretty good about being in the facility but after this incident happened he just wanted to sit down and cry.	F 241	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on medical record reviews and resident and staff interviews the facility failed to assess and honor the choice for bathing frequency for 2 of 3 residents reviewed for choices. (Resident #34 and Resident #76). The findings included: 1. Resident #34 was re-admitted on 06/15/12 with diagnosis which included dementia, type II diabetes, hypertension, and chronic kidney disease. Resident #34's most recent quarterly Minimum Data Set (MDS) dated 02/18/14 assessed her as having moderately impaired cognition and needing limited assistance of one person with bathing. The most recent quarterly MDS indicated no rejection of care. Resident #34's most recent care plan indicated she required limited assistance with activities of daily living (ADL's). Resident #34's medical	F 242	**F- 242** **1.) How corrective action will be accomplished for the residents affected:** **Resident #34 and #76 shower choices were obtained by direct interviews and shower schedules updated to reflect their choices. Staff re-educated by the DON/designee on Res #34 and #76 shower schedules. Res #34 and #76 care plan and Pictorial are reviewed and updated by the MDS Coordinator as necessary to reflect resident choices.** **2.) How corrective action will be accomplished for those residents having the potential to be affected:** **All residents are identified as potentially being affected. Audits and assessments conducted by the DON or designee for all resident shower choices are obtained. Those residents who could not be interviewed, preference information obtained from the Responsible Party where applicable or through staff knowledge of resident, when Responsible Party did not verbalize any preference. No negative outcomes identified.** **3.) What measures will be put in place or systemic changes made to ensure**	4.17.14

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 03/20/2014

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 242	Continued From page 10 record revealed needing assistance of 1 person with bathing and was not resistive to care. On 03/19/14 at 9:12 AM an interview was conducted with Resident #34. She stated she gets two showers per week but would like to have a shower every day. During an interview with Nursing Assistant (NA) #1 on 03/19/14 at 2:29 revealed there was a shower schedule set up by the nurses which was determined by resident's room number. She stated residents get two showers per week. NA#1 stated if resident's wanted more than two showers a week they would have to request additional showers. NA #1 stated Resident #34 did not resist care. On 03/19/14 at 4:13 PM an interview was conducted with the Assistant Director of Nursing (ADON) she explained residents get two showers a week and if they wanted more they would have to request additional showers. On 03/20/14 at 11:52 AM an interview was conducted with the Activity Director (AD), she stated during the admission process residents were asked how they preferred to bathe/shower and if they preferred a morning, afternoon, or evening shower. The current shower schedule allows for each resident to have two showers a week. The AD stated if a resident wanted more than two showers a week the resident or the resident's family would have to communicate this to the nursing staff so their preferences could be accommodated. The AD stated she did not specifically ask residents upon admission how many showers a week they would like to have.	F 242	**correction:** **Admission Assessments by licensed nursing staff will include utilizing the "Bathing Preference Sheet" asking each new resident what their shower choices are. When applicable, MDS Coordinator or designee will contact the Responsible Parties for residents identified as un-interviewable. The Staff Development Coordinator or designee re-educated the nursing staff on honoring the resident's right for choosing their shower day and for ensuring the resident is asked for their choice. Choices will be updated by MDS coordinator during each quarterly care plan utilizing the "Bathing Preference Sheet" or when identified by the resident. MDS Coordinator to review Care Plans and Pictorials choice and updates them as necessary by offering resident choices and asking Responsible Party for those un-interviewable. "Bathing Preference Sheet"to be maintained in binder in MDS office for one year. A new "Bathing Preference Sheet" will be iniated annually. DON or designee will conduct documented QA Audits to monitor the shower schedule through direct random observation and record review audits 2x weekly for 4 weeks, then once weekly for four weeks and monthly x3 months for compliance. As necessary employees will be in-serviced to assure compliance with the facility shower policy. The SDC will include provisions for resident rights to choices during orientation of new nursing personnel.** **4.) How the facility plans to monitor its**	

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 03/20/2014

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 242	Continued From page 11 03/20/14 at 1:58 PM a follow-up interview was conducted with the ADON, she stated residents were not being assessed for preferences on the number of showers they would like to receive each week. The ADON stated it was her expectation that residents be assessed upon admission about their preferences specific to how many times a week they wanted to bathe/shower. 2. Resident #76 was re-admitted to the facility on 03/11/14 with diagnoses which included chronic kidney disease, diabetes mellitus, edema, legal blindness, hypertension, depression and psychosis. Resident #76's most recent quarterly Minimum Data Set (MDS) dated 12/24/13 assessed her as being cognitively intact, independent with bathing, and needing transfer assistance. The MDS indicated no rejection of care. Resident #76's most recent care plan indicated she was independent with activities of daily living (ADL's). On 03/19/14 at 9:21 AM an interview was conducted with Resident #76. She stated she gets two showers per week but would like to have showers three times a week on Monday, Wednesday, and Friday. She stated she had not been asked by facility staff the number of times a week she would like to bathe/shower. On 03/19/14 at 2:52 PM an interview was conducted with Nursing Assistant (NA) #2. NA #2 stated there was a shower schedule set up by the nurses which was determined by resident's room number. If a resident wants more than two showers a week they or their families had to request them.	F 242	**performance to make that solutions are ensured:** **Audit results will be reviewed and analyzed monthly by the DON or designee for three months, and then quarterly at the Quality Assurance Committee meeting with subsequent plan of actions developed and implemented as indicated by the QA Committee. The Director of Nursing is responsible for overall shower schedule compliance.**	

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 03/20/2014

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 242	Continued From page 12 On 03/19/14 at 4:13 PM an interview was conducted with the Assistant Director of Nursing (ADON) she explained residents get two showers a week and if they wanted more they would have to request additional showers. On 03/20/14 at 11:52 AM an interview was conducted with the Activity Director (AD), she stated during the admission process residents were asked how they preferred to bathe/shower and if they preferred a morning, afternoon, or evening shower. The current shower schedule allows for each resident to have 2 showers a week. The AD stated if a resident wanted more than 2 showers a week the resident or the resident's family would have to communicate this to the nursing staff so their preferences could be accommodated. The AD stated she did not specifically ask residents upon admission how many showers a week they would like to have. 03/20/14 at 1:58 PM a follow-up interview was conducted with the ADON, she stated residents were not being assessed for preferences on the number of showers they would like to receive each week. The ADON stated it was her expectation that residents be assessed upon admission about their preferences specific to how many times a week they wanted to bathe/shower.	F 242	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care	F 279	F- 279 1.) How corrective action will be accomplished for the residents affected: Resident #19 care plan is updated to reflect accurate dependency and current interventions which address assistance required for specific ADL's.	4.17.14

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 03/20/2014

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 279	Continued From page 13 plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a comprehensive care plan for activities of daily living for a resident who was dependent for care for 1 of 4 residents reviewed for activities of daily living. (Resident #19) The findings included: Resident #19 was admitted to the facility on 11/09/12 with diagnoses which included Parkinson's disease. Resident #19's most recent Quarterly Minimum Data Set (MDS) dated 01/14/14 assessed him as having moderate cognitive impairment. The MDS further assessed him as needing extensive assistance with toileting and personal hygiene. Review of Resident #19's most recent care plan dated 01/14/14 revealed he required limited to	F 279	2.) How corrective action will be accomplished for those residents having the potential to be affected: Dependent residents needing assistance with ADL's are identified. Care Plan and Pictorial audits completed by the MDS Coordinators for all dependent residents to assure compliance. Updates to Care Plans or Pictorials completed. No negative outcomes identified. 3.) What measures will be put in place or systemic changes made to ensure correction: The Administrator or designee re-educated the MDS Coordinators regarding proper individualized Care Plan documentation required for dependent residents for ADL's to include: individualized interventions and the amount of assistance required. All nurse staff re-educated on accurately	

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 03/20/2014

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 279	Continued From page 14 extensive assist with most activities of daily living (ADL). The goal of the care plan was that Resident #19 will continue to ambulate with his rolling walker through next review. There were no interventions which addressed specific ADL or what assistance was needed. Review of the Care Area Assessment (CAA) dated 10/16/14 revealed Resident #19 he did trigger for activities of daily living function. The CAA read: "Resident is alert and confused at times. Becomes easily agitated and resists and refuses care at times." On 03/20/14 at 2:42 PM an interview was conducted with Nurse #5 who was the MDS nurse and wrote Resident #19's care plan. She stated activities of daily living were considered hygiene and toileting. Nurse #5 stated the care plan stated Resident #19 needed extensive assistance to limited assistance with activities of daily living. She stated everyone would know what that meant. She stated the nursing assistants use the Resident Care Card which is how they know what to do for a resident. On 03/20/14 at 3:11 PM an interview was conducted with Nurse #4. Nurse #4 stated the care plan for Resident #19 did not help her to understand the needs of the resident's activities of daily living care. She stated Resident #19 needs to be prompted regarding the things he can do himself and sometimes he could not remember. An interview was conducted on 03/20/14 at 3:16 PM with Nurse #3, the unit coordinator. Nurse #3 stated residents' care plans were what the nurses to used to know what the resident's needs were.	F 279	implementing the resident Care Plan and Pictorials. The DON or designee will conduct documented QA Audits to monitor resident ADL documentation through direct random observation and record review audits of Care Plans and Pictorials for 5 residents 2x weekly for 4 weeks, then once weekly for four weeks and monthly x3 months for ongoing ADL care compliance. As necessary staff will be in-serviced to assure compliance with the facility policy. The SDC will include provisions for following the Care Plans and Pictorials during the orientation of new nursing personnel. 4.) How the facility plans to monitor its performance to make that solutions are ensured: Audit results will be reviewed and analyzed monthly by the DON or designee for three months, and then quarterly at the Quality Assurance Committee Meeting with subsequent plan of action developed and implemented as indicated by the QA Committee. The Director of Nursing is responsible for overall compliance.	

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 03/20/2014

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 279	Continued From page 15 She stated the care plan did not relate to Resident #19's personal care needs and should be more specific. On 03/20/14 at 3:42 PM an interview was conducted with the Administrator. The Administrator stated Resident #19's care plan did not address his ADL issues. The Administrator stated this was a work in progress and the facility was working on making care plans that actually tell the story of the resident's and their needs.	F 279	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F- 312** **1.) How corrective action will be accomplished for the residents affected:** **Resident #9 nails were trimmed and cleaned. Residents #9, #13, #19 received appropriate mouth care. Res #9 facial hair was trimmed. Nursing staff in-serviced on policy and procedures for ADL care provided dependent residents by the Staff Development Coordinator.** **2.) How corrective action will be accomplished for those residents having the potential to be affected:** **Dependent residents needing assistance with ADL's are identified. Nail care, mouth care, and facial hair grooming audits completed by the DON or DON designee for all dependent residents to assure compliance. Documented Guardian Angel round observations will include resident personal hygiene checks and be reported during daily management meetings. LNHA will maintain the Guardian Angel observations. No negative outcomes identified.** **3.) What measures will be put in place or systemic changes made to ensure correction:**	
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review the facility failed to provide mouth care for 3 of 4 residents (Residents #9, #13 and #19) and to provide nail care and trim facial hair for 1 of 4 residents reviewed for activities of daily living (Resident #9). The findings included: 1. Resident #9 was admitted to the facility on 06/27/12 with diagnoses which included dementia, diabetes and urinary incontinence. The most recent Quarterly Minimum Data Set (MDS) dated 12/09/13 assessed Resident #9 as being cognitively intact. The MDS further assessed	F 312		4.17.14

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 03/20/2014

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 312	Continued From page 16 Resident #9 as needing extensive assistance with personal hygiene. Review of Resident #9's care plan dated 03/05/14 revealed she needed total to extensive assistance for most activities of daily living. An observation was made on 03/19/14 at 10:15 AM of Resident #9 sitting in the hall in her wheelchair. Resident #9 was observed to have brown matter under her fingernails on both hands. She also had numerous white facial hairs on her chin and down her neck. The white hairs were approx 3/8 of an inch long and very noticeable. Resident #9 was further observed to have a white coating on her teeth which was very thick along the gum line and her gums were red and inflamed. An interview was conducted on 03/19/14 at 10:15 AM with Resident #9. She stated sometimes they clean her nails and trim her chin hairs on shower days. On 03/19/14 at 2:48 PM an interview was conducted with Nursing Assistant (NA) #3. NA #3 stated Resident #9 was unable to do for herself. She stated she had not tried to provide care for her that morning. NA #3 further stated she should have provided mouth care and cleaned her fingernails but she did not notice it. She stated she should also have trimmed her chin hairs. An interview was conducted with Nurse #4 who worked on the hall with Resident #9. She stated Resident #9's nails should be cleaned if they are dirty and her teeth should be brushed twice per day. She further stated chin hairs should be trimmed on Sundays as needed.	F 312	**The DON or designee re-educated the nursing staff regarding proper nail care, mouth care and facial hair grooming. The DON or designee will conduct documented QA Audits to monitor resident ADL care through direct random observation and record review audits for 5 residents 2x weekly for 4 weeks, then once weekly for four weeks and monthly x3 months for ongoing ADL care and resident personal hygiene compliance. As necessary employees will be in-serviced to assure compliance with the facility policy. The SDC will include provisions of nail care, mouth care and facial hair grooming during the orientation of new nursing personnel. Documented Guardian Angel round observations will include resident personal hygiene checks and be reported during daily management meetings.** **4.) How the facility plans to monitor its performance to make that solutions are ensured:** **Audit results will be reviewed and analyzed monthly by the DON or designee for three months, and then quarterly at the Quality Assurance Committee Meeting with subsequent plan of action developed and implemented as indicated by the QA Committee. The Director of Nursing is responsible for overall ADL compliance.**	

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 03/20/2014

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 312	Continued From page 17 An interview was conducted on 03/19/14 at 3:49 PM with Nurse #3 who was the unit coordinator. She stated the nursing assistants should provide mouth care after meals and at bedtime. Nurse #3 further stated chin hairs should be trimmed if needed. An interview was conducted with the Assistant Director of Nursing (ADON) on 03/19/14 at 4:38 PM. The ADON stated her expectation was that nails should be cleaned and chin hairs shaven on shower days and as needed. The ADON stated mouth care should be performed twice per day. 2. Resident #13 was admitted to the facility on 11/02/09 with diagnoses which included depression, diabetes and contractures in multiple joints. Resident #13's most recent Quarterly Minimum Data Set (MDS) dated 01/27/14 revealed she was cognitively intact, further review of the MDS revealed she was totally dependent for toileting and personal hygiene. Resident #13's care plan revealed she needed extensive to total assistance with all activities of daily living. An interview was conducted on 03/17/14 at 3:13 PM with Resident #13. Resident #13 stated staff had not offered to brush her teeth in several years. She went on to say that she had a top denture which she wipes off herself with a tissue. She stated since she had been admitted to the facility several of her bottom teeth had rotted below the gum line. She stated she had seen a dentist who told her they would have to be surgically extracted.	F 312		

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 03/20/2014

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 312	Continued From page 18 During a follow up interview on 03/19/14 at 10:41 AM an interview was conducted again with Resident #13. She stated staff had not offered to provide mouth care or denture care for her during the time they were providing her ADL care. An interview was conducted on 03/19/14 at 2:30 PM with Nursing Assistant (NA) #3 who stated mouth care should be performed daily as part of morning care. NA #3 further stated she had never offered to provide mouth care for Resident #13 because she was able to comb her own hair and do her own nails. NA #3 then went on to say Resident #13 did not have access to water to brush her own teeth. She stated she would need water and something to spit in. She then stated she should have been doing mouth care for all the residents. An interview was conducted on 03/19/14 at 2:48 PM with Nurse #4. Nurse #4 stated Resident #13's teeth should have been brushed and her denture taken out and cleaned daily. An interview was conducted on 03/19/14 at 3:49 PM with Nurse #3, the unit coordinator. She stated Resident #13's dentures should have been removed and placed in a denture cup and soaked in denture cleanser at night. She further stated mouth care should be preformed after meals and at bedtime. An interview was conducted on 03/19/14 at 4:29 PM with the Assistant Director of Nursing (ADON). She stated it was her expectation for Resident #13's teeth to be brushed twice per day and her dentures to be soaked and cleaned daily. 3. Resident #19 was admitted to the facility on	F 312		

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 03/20/2014

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 312	Continued From page 19 11/09/12 wit diagnoses which included Parkinson's disease and hypertension. Review of Resident #19's most recent Quarterly Minimum Data Set (MDS) assessed him as having moderate cognitive impairment. Further review of the MDS revealed he needed extensive assistance with personal hygiene. The MDS indicated there had been no resistance to care during the assessment period. Review of Resident #19's care plan revealed he required limited to extensive assistance with all activities of daily living. An observation was made on 03/17/14 2:18 PM of Resident #19. His teeth were coated with a yellow film and he had a large amount of food debris in his teeth along the upper gum line and in his lower teeth. An interview was conducted on 03/17/14 at 2:18 PM with Resident #19. He stated staff had cleaned his teeth once or twice. He further stated if there is a special occasion they will clean his teeth. An interview and observation was conducted on 03/18/14 at 2:55 PM. Resident #19 stated no one had offered to brush his teeth. He stated he would like it if someone would brush his teeth. His teeth continued to contain food debris and were covered with a yellow film. On 03/19/14 at 10:30 AM an interview and observation was conducted with Resident #19. Resident #19 stated no one had brushed his teeth. When asked if he had told anyone he stated it would not do any good. His teeth were observed to contain food debris and were	F 312		

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 03/20/2014

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 312	Continued From page 20 covered with a yellow film. On 03/19/14 at 2:30 PM an interview was conducted with Nursing Assistant (NA) #3. She state there had been times when Resident #19 had been resistive to care. NA #3 stated she had not tried to provide mouth care for Resident #19 and she should have tried. On 03/19/14 at 2:48 PM an interview was conducted with Nurse #4 who was the nurse for the hall where Resident #19 lived. Nurse #4 stated her expectation was for mouth care to be performed after each meal. She stated at the least mouth care should be performed every morning and every night. An interview was conducted on 03/19/14 at 3:49 PM with Nurse #3 who was the unit coordinator. She stated the nursing assistants should provide mouth care after meals and at bedtime. An interview was conducted with the Assistant Director of Nursing (ADON) on 03/19/14 at 4:38 PM. The ADON stated her expectation was mouth care should be performed twice per day.	F 312	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses.	F 356	F- 356 1.) How corrective action will be accomplished for the residents affected: Facility Staffing Sheet is revised to ensure all required components are included including: facility name, date, total actual hours worked by RN, LPN, and CNA. Staffing is posted daily and in the lobby which is readily accessible to residents, families and visitors.	4.17.14

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 03/20/2014

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 356	Continued From page 21 - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to post nurse staffing information in a place readily accessible to residents and visitors for four (4) consecutive days. The findings included: Observations on 03/17/14 at 12:45 PM, 03/18/14 at 8:30 AM, 03/19/14 at 2:37 PM, and 03/20/14 at 10:03 AM revealed no posting for nursing staffing information anywhere in the facility. During an interview on 03/20/14 at 1:45 PM with the Staff Development Coordinator (SDC), explained she posted daily nursing assignments	F 356	2.) How corrective action will be accomplished for those residents having the potential to be affected: No residents have the potential to be adversely affected. No negative outcomes identified. 3.) What measures will be put in place or systemic changes made to ensure correction: The Staff Development Coordinator is identified as responsible for posting this staffing sheet. SDC is educated by the Administrator on all requirements for posting the staffing information. The DON and a designated back-up are educated on all posting requirements. The Administrator or designee will conduct documented QA Audits to monitor posted staffing through direct random observation and record review audits of staffing sheets 2x weekly for 4 weeks, then once weekly for four weeks and monthly x3 months compliance. 4.) How the facility plans to monitor its performance to make that solutions are ensured:	

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 03/20/2014

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 356	Continued From page 22 on each unit in clear bins. The SDC stated she did not know nurse staffing information had to be posted daily in a visible location for residents and visitors. The SDC further explained she did not know the nurse staffing information included facility name, current date, resident census, and total number and actual hours worked by the following: registered nurses, licensed practical nurses, and certified nurse aides. During an interview on 03/20/14 at 1:47 PM the Assistant Director of Nursing (ADON), she explained she did not realize the nurse staffing information was not being posted and it was her expectation to have nurse staffing information posted daily within 30 minutes of the start of first shift and visible for the public to view.	F 356	Audit results will be reviewed and analyzed monthly by the DON or designee for three months, and then quarterly at the Quality Assurance Committee Meeting with subsequent plan of action developed and implemented as indicated by the QA Committee. The Director of Nursing is responsible for overall compliance. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on resident, family and staff interviews and record review the facility failed to follow through with the dentist's recommendation for extraction of lower teeth for 1 of 2 residents	F 412	**F- 412** **1.) How corrective action will be accomplished for the residents affected:** **Facility's dental referral follow-up continues to search for a dental provider able to extract the resident #13's teeth in a hospital setting per RP request. Resident on a waiting list for physician in Charlotte while facility explores other options. Res #13 care plan and Pictorial reviewed and updated as necessary for current oral/dental condition.** **2.) How corrective action will be accomplished for those residents having the potential to be affected:**	4.17.14

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 03/20/2014

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 412	Continued From page 23 reviewed for dental care (Resident #13). The findings included: Resident #13 was admitted to the facility on 11/02/09 with diagnoses which included depression, diabetes and contractures in multiple joints. Resident #13's most recent Quarterly Minimum Data Set (MDS) dated 01/27/14 revealed she was cognitively intact, further review of the MDS revealed she was totally dependent for toileting and personal hygiene. There was no assessment of her teeth noted on the Quarterly MDS. A dental referral dated 09/03/13 read, "extractions required - hospital or dental office." A Dentist's note dated 10/25/13 read in part, "Multiple decayed teeth in mandible, discussed the extractions under local anesthesia in 1 or 2 appointments." The Annual Minimum Data Set (MDS) assessment dated 10/30/13 assessed her as having no natural teeth or tooth fragments. A progress note dated 03/14/14 written by the Nurse Practitioner read in part, "...says she is a stressed a bit by her teeth and the need to see a dentist." An interview was conducted on 03/17/14 at 3:11 PM with Resident #13. She stated her bottom teeth had rotted below the gum line since she had been admitted to the facility. She stated she was seen by the dentist and he told her she would have to go to the hospital to have the teeth extracted.	F 412	**Residents with dental issues are identified as potentially being affected. 100% audit conducted by the DON or designee to ensure all identified residents with dental issues are assessed to determine necessity for a dental consult. No negative outcomes identified.** **3.) What measures will be put in place or systemic changes made to ensure correction:** **The Staff Development Coordinator or designee re-educated the nursing staff regarding proper oral assessments to determine status for referrals to a dentist. The MDS Coordinator reviews Care Plans for those with oral / dental issues and updates them as necessary. DON or designee will conduct documented QA Audits to monitor oral assessments or dental referrals through direct random observation and record review audits 2x weekly for 4 weeks, then once weekly for four weeks and monthly x3 months for compliance. As necessary licensed nurses will be in-serviced to assure compliance with the facility's oral assessment policy. The SDC will include provisions for assessment policy and procedure during orientation of new licensed nursing personnel.** **4.) How the facility plans to monitor its performance to make that solutions are ensured:**	

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 03/20/2014

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 412	Continued From page 24 On 03/19/14 at 11:02 AM an interview was conducted with Nurse #3, the unit coordinator. She stated the dental referral should have been noted by a nurse. She stated then they would let the doctor know and he would have given an order to follow the dentist's recommendation. On 03/19/14 at 1:13 AM an interview was conducted with the Transporter for the facility. The Transporter stated she transported the Resident #13 to the oral surgeon (October of 2013) and the resident's Responsible Party (RP) met them there. The Transporter stated there was a decision made regarding the resident needing the surgery to be done in the hospital and the oral surgeon could only do it in his office. An interview was conducted on 03/19/14 at 12:20 PM with Resident #13's RP. The RP stated she accompanied Resident #13 to the oral surgeon's who would only do the surgery in his office. She stated Resident #13 had ended up in the intensive care unit each time she had surgery. For this reason Resident #13 wanted to have the surgery done in a hospital. The RP stated the facility told her they would find another doctor to have the surgery done. The RP stated she came to the care plan meeting in late January or early February of 2014 and this was discussed. The RP stated it was important for Resident #13 as she enjoys eating and it was one of the few pleasures she could still enjoy. The RP stated sometimes she will bring the foods Resident #13 enjoyed but then she complains she could not chew them. An interview was conducted on 03/09/14 at 3:05 pm with Nurse #7 the unit manager who attended	F 412	**Audit results will be reviewed and analyzed monthly by the DON or designee for three months, and then quarterly at the Quality Assurance Committee Meeting with subsequent plan of action developed and implemented as indicated by the QA Committee. The Director of Nursing is responsible for overall nurse assessment and referral tracking compliance.**	

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 03/20/2014

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 412	Continued From page 25 the care plan meeting for Resident #13. She stated she could not remember what was discussed in the care plan meeting other than the resident's wound. She stated she could not find notes regarding the care plan meeting. She stated the Social Worker (SW) should have made notes about what was discussed in the care plan meeting. A telephone interview was conducted with the SW on 03/19/14 at 3:29 PM. She stated she did remember the discussion regarding Resident #13's the dental referral. The SW stated the RP wanted Resident #13 to have the surgery at the hospital. The SW stated she did not know whose responsibility it was to follow-up on an outside appointment. An interview was conducted on 03/19/14 at 3:42 PM with Nurse #3 who was the unit coordinator. Nurse #3 explained she was on vacation during the care plan meeting and Nurse #7 attended in her place. Nurse #3 stated the unit manager should have followed up and made the dental appointment for Resident #13. An interview was conducted on 03/19/14 at 4:36 PM with the Assistant Director of Nursing (ADON). The ADON stated there should have been a follow up done to get Resident #13 in to see a dentist who could admit her to the hospital to have her teeth extracted.	F 412	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441	F 441 1.) How corrective action will be accomplished for the residents affected:	4.17.14

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 03/20/2014

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 441	Continued From page 26 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to ensure blood glucose meters (glucometers) were	F 441	No negative outcomes identified for any Resident. Licensed nursing staff in-serviced on proper cleaning and disinfecting techniques for glucose monitors. The two identified glucose monitors are properly cleaned and sanitized according to manufacturer's instructions. 2.) How corrective action will be accomplished for those residents having the potential to be affected: Residents with diabetes requiring monitoring are potentially affected. Sweep of all residents with diabetes conducted by the DON or designee to ensure all glucose monitors are clean and disinfected. Diabetic residents are designated individual glucose monitors for their individual use only. Proper cleaning materials per manufacturer's cleaning instructions ordered, stocked and available to licensed nursing staff. Procedure for storage of monitors in a sanitized manner are established. 3.) What measures will be put in place or	

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 03/20/2014

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 441	Continued From page 27 disinfected/sanitized by the manufacturer's instructions during 2 of 2 observations of a glucometer being disinfected. The findings included: A facility policy entitled Cleaning and Disinfection of Blood Glucose Monitor dated 11/18/13 specified in part "follow manufacturer's label regarding time disinfectant must remain in contact with meter (visibly wet) for effectiveness." A review of the instructions provided by the manufacturer of the germicidal disposable wipe utilized by the facility was conducted. The directions specified to accomplish disinfection of a hard surface, treated surface must remain visibly wet for a full 2 minutes. Use additional wipes if needed to assure continuous 2 minute wet contact time. Let air dry. An observation was conducted on 03/18/14 at 3:53 PM of Nurse #1 obtaining a finger stick blood sugar (FSBS). Nurse #1 was observed entering Resident #55's room and following proper procedure for obtaining a FSBS. Upon completion, Nurse #1 returned to the medication cart, wiped the glucose meter (glucometer) with a germicidal wipe, tossed the wipe into the trash bin, and placed the glucometer in the medication cart. Continuous observation of the glucometer revealed the surface appeared dry in less than 30 seconds. Nurse #1 did not ensure the glucometer remained wet with germicidal solution for a full 2 minutes. An observation was conducted on 03/18/14 at 4:30 PM of Nurse #2 obtaining a finger stick blood sugar (FSBS). Nurse #2 was observed	F 441	systemic changes made to ensure correction: Licensed nursing staff in-serviced on center policy for infection control procedures of glucose monitors and manufacturer's disinfecting instructions by the DON or designee. The DON or designee will re-educate the licensed nursing staff regarding proper infection control techniques according to center policy and procedure and manufacturer cleaning instructions. The DON or designee will monitor for proper infection control techniques with emphasis on glucose monitor manufacturer cleaning instructions and proper storage of monitors. This QA tool will document through direct observation for 5 residents 2x weekly for 4 weeks, then monthly x3 months for ongoing compliance. As necessary employees will be given additional in-servicing to assure compliance with the facility policy. The SDC will include infection control provisions for glucose monitor cleaning in the orientation of new licensed nursing personnel. 4.) How the facility plans to monitor its performance to make that solutions are ensured; Audit results will be reviewed and analyzed monthly for three months and then quarterly at the Quality Assurance Committee Meeting with subsequent plan of action developed and implemented as indicated. The Director of Nursing is responsible for overall compliance of	

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 03/20/2014

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 441	Continued From page 28 entering Resident #52's room and following proper procedure for obtaining a FSBS. Upon completion, Nurse #2 returned to the medication cart, wiped the glucose meter (glucometer) with a germicidal wipe, tossed the wipe into the trash bin, and placed the glucometer on top of the medication cart. Continuous observation of the glucometer revealed the surface appeared dry in less than 30 seconds. Nurse #2 did not ensure the glucometer remained wet with germicidal solution for a full 2 minutes. An interview with Nurse #1 on 03/18/14 at 4:05 PM revealed it was facility procedure after utilizing a glucometer to wipe the glucometer down with a germicidal wipe. During visualization of the glucometer with Nurse 1, Nurse #1 confirmed the glucometer did not remain wet for the full 2 minutes and stated she had not been instructed that the glucometer needed to remain wet for 2 full minutes. Nurse #1 then read the instructions on the container of germicidal wipes and stated she was unaware of the need to ensure the glucometer remained wet with germicidal solution for 2 minutes to complete the disinfecting process. An interview with Nurse #2 on 03/18/14 at 4:53 PM revealed it was facility procedure after utilizing a glucometer to wipe the glucometer down with a germicidal wipe. During visualization of the glucometer with Nurse #2, Nurse #2 confirmed the glucometer did not remain wet for the full 2 minutes but stated she was doing what she was trained to do. Nurse #2 further revealed she was unaware of the need to ensure the glucometer remained wet with germicidal solution for 2 minutes to complete the disinfecting process.	F 441	glucose monitors.	

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 03/20/2014

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 441	Continued From page 29 During an interview on 03/18/14 at 5:21 PM the Director of Nursing (DON) was asked what her expectation was for cleaning of glucometers. The DON stated she had not been at the facility very long and referred to the facility's policy then stated she expected the nurses to follow the policy which stated staff were to sanitize and disinfect glucometers with a germicidal wipe according to manufacturer's directions between resident use for blood glucose monitoring. The DON was unaware of the need to ensure the glucometer remained wet with germicidal solution for 2 minutes to complete the disinfecting process. The DON confirmed the nurses were not disinfecting the glucometers per manufacturer guidelines.	F 441		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the	F 520	F- 520 1.) How corrective action will be accomplished for the residents affected: Facility has put in place a QA Tool called Bathing Preference Tool designed to determine resident choices for frequency of showers upon admission. Further, the Audit Tool for Showers is in place to monitor compliance with shower choices. 2.) How corrective action will be accomplished for those residents having the potential to be affected: All residents are identified as potentially being affected. Audit conducted by the DON or designee to ensure all resident shower choices are obtained and updated on the shower schedule. No negative outcomes identified.	4.17.14

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 03/20/2014

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 520	Continued From page 30 compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on medical record reviews and resident and staff interviews the facility's Quality Assurance process failed to maintain effective monitoring practices to address residents ' choice regarding bathing frequency (Resident #34 and #76). The findings included: Cross refer F 242. Based on medical record reviews and resident and staff interviews the facility failed to assess and honor the choice for bathing frequency for 2 of 3 residents reviewed for choices (Resident #34 and #76). An interview was conducted with the Administrator on 03/20/14 at 6:00 PM. During the interview the Administrator stated the facility's Quality Assessment and Assurance (QA) committee met on a monthly basis and included herself, the Medical Director, the Director of Nursing, and all department heads. There were no QA monitoring tools regarding residents' choice for bathing frequency available for review during the interview. The Administrator stated she expected residents to be assessed for preference for frequency of showers/bathing on admission.	F 520	3.) What measures will be put in place or systemic changes made to ensure correction; Facility schedules and conducts a monthly QA Committee meeting. All QA monitoring audit tools are reviewed for effectiveness of outcomes and analysis of information collected to include choice for bathing frequency. In addition the QA Committee reviews the status of each Plan of Correction created in response to survey citations. The Administrator ensures compliance is met according to the Plan of Correction at each QA Committee meeting, and that QA minutes are recorded to document compliance. 4.) How the facility plans to monitor its performance to make that solutions are ensured; PoC audit results will be reviewed and analyzed monthly for three months, and then quarterly at the Quality Assurance Committee meeting with subsequent plan of actions developed and implemented as indicated by the QA Committee. The Administrator is responsible for overall facility QA Committee compliance. The Senior Director of Clinical Services or designee will monitor QA meeting minutes a minimum of quarterly to ensure QA items have been resolved or followed.	