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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345233	A. BUILDING ______ B. WING ______	C 06/05/2015

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 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observations, record and policy reviews, and staff interviews, the facility did not follow its Abuse Prevention Policy to notify the State Abuse agency and to process the report according to state specific regulations within 24 hours for one of three residents reviewed for allegations of abuse, Resident #63. Findings included: A review of the facility's Abuse Prevention Policy, origin 05/01/2014, revealed on page one, Section B. under "Process" that the Administrator and Director of Nursing were responsible for investigation and reporting [of abuse allegations.] Section "K. 3" of the policy for reporting abuse allegations indicated that the State Abuse Agency should be notified by fax of telephone after the allegation of the alleged/suspected incident according to state-specific regulations within 24 hours. Resident #63 was initially admitted to the facility with cumulative diagnoses including dementia and anxiety disorder. A review of the quarterly Minimum Data Set	F 226	*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- 226 (SS=D)** **1.) How corrective action will be accomplished for the residents affected:** **DON re-educated by the Administrator when to submit reportable incidents to Health Care Personnel Registry. Investigation for Resident #63 had been completed at the time of the incident, resident #63 care plan interventions were in place, and the resident experienced no negative outcomes.** **2.) How corrective action will be accomplished for those residents having the potential to be affected:** **All residents have the potential to be affected. The Grievance Log reviewed for any potentially missed reportable incidents and none were identified. The Staff Development Coordinator conducted in-service education for all nursing home staff on the Abuse Prevention Policy, staff responsibilities, and how to recognize potentially reportable situations. In-service training completed on June 19, 2015.** **3.) What measures will be put in place or systemic changes made to ensure correction:**	6/28/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Reginald J Faddon — TITLE: Admin — (X6) DATE: 6-19-2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 226	Continued From page 1 (MDS) Assessment dated 05/15/2015 revealed Resident #63 required extensive assistance for her activities of daily living, including dressing, personal hygiene, bathing, and transfers, and that she was severely cognitively impaired. Resident #63's nursing care plan initiated on 06/30/2014 and last revised on 04/23/2015 included goals and interventions to address her difficulty finding the right words to express her needs. In addition, the care plan addressed her verbalization of non-factual statements. Some of the interventions listed on the nursing care plan were to monitor her cognitive status, to allow the resident to speak, to take time to listen, and to verify her voiced concerns. A nursing progress note dated 04/22/2015 at 8:25 PM stated the resident had returned to the facility (from the hospital after evaluation due to a fall) with the transportation service in good general condition. In addition, the same note indicated the resident had contusions on her back and head which were purple. Another nursing progress note dated 04/22/2015 at 8:40 PM revealed the following: "Resident in wheelchair, confusion, started to scream that she was going to die, they were trying to kill her. Went to calm resident and she stated, "Honey I am not crazy, they raped me with a knife to my throat and they had guns and I could hear the shots all around." Assessed resident's body for any marks, no injury found ....Tried to reassure resident that she is safe and no one would harm her." The nursing progress note was signed by Nurse #2.	F 226	**To ensure timely submissions of reportable incidents, on 17 June the Administrator educated all key and Department Head staff on:** • **Reportable Incident awareness and on what is worthy of investigation.** • **How to prepare and submit a 24-Hour Initial and 5-Working Day Reports to include where to access copies of the reports to complete.** • **Procedure to follow when completing these reports and** • **A complete review of the Abuse Prevention Policy.** **Copies of the 24-Hour and 5-Working Day Reports saved on the facility shared drive enabling any department head or other key staff to complete reports timely. Administrator, DON or designee will conduct documented QA Audits to monitor the Grievance Log for any potentially reportable incidents once weekly for four weeks and monthly x2 month for compliance. As necessary key staff will be in-serviced to assure compliance with reportable incident reporting.** **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 Administrator or designee for three months, and then quarterly at the Quality Assurance Committee Meeting with subsequent plan**	6-28-15

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F 226	Continued From page 2 During an observation of Resident #63 on 06/04/2014 at 10:30 AM, she was seated in her wheelchair alone in the hallway near the nurses' station. Resident #63 was talking as though she was in conversation with other residents, although no other resident was nearby. There was no bruising other injury noted on the resident's arms, legs, or head. In an interview with Nurse #1 on 06/03/2015 at 11:45 AM, she stated the resident was often confused and that the resident often "talked up a storm" and related stories about non-factual things, especially recently as her dementia had progressed. An interview was conducted with the Director of Nursing (DON) on 06/05/2015 at 11:23 AM. During the interview, the DON reviewed the nursing progress notes dated 04/22/2015 and stated that she had misunderstood the report from the staff members regarding the resident's statements of rape and murder. The DON explained that she thought the allegation of abuse by the resident was made while she was being assessed at the emergency room, and not while she was in the nursing facility. The Director of Nursing stated she believed the hospital had investigated the allegation. She added that she would have notified the appropriate state agency within 24 hours of the resident's allegation and would have completed a full investigation of the allegation if she had she realized the allegation was made by the resident at the facility. The DON also stated she would have completed the 5 Working Day Report, as well. In an interview with Nurse #2 on 06/05/2015 at	F 226	of action developed and implemented as indicated by the QA Committee. The Administrator is responsible for overall compliance.	6-28-15

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F 226 Continued From page 3

11:39 AM, she stated that she called the Director of Nursing to report the resident's behavior and allegation of abuse on the same date, and that she thought the DON understood the allegations were made while the resident was in the facility.

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 observation and staff interview the facility failed to honor food dislikes for 1 of 4 residents (resident # 33) reviewed for choices.
Findings included:

Resident #33 was admitted to the facility in April 2011 and was most recently readmitted in July 2013 with a diagnosis history that included osteoarthrosis, hypertension, dysphagia, failure to thrive, and chronic pain.

The most recent Minimum Data Set (MDS) for Resident # 33, dated 4/7/15, stated the resident had mild cognitive impairment, did not require assistance with eating, had weight loss, and was on a regular diet.

During an observation of the lunch meal, at 12:45 PM on 6/1/15, Resident # 33 was 60% finished

F 226

F 242

F- 242 (SS=D)
1.) How corrective action will be accomplished for the residents affected:

Resident #33 choices for meal preferences and dislikes were obtained and validated as accurate by the dietary manager through direct interview and resident #33's tray card checked as correct. Dietary staff re-educated by the Dietary Manager on Res #33 preferences and dislikes. Res #33 care plan and Care Guide are reviewed and updated by the MDS Coordinator as necessary to reflect resident choices.

6-28-15

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 Dietary Manager to ensure all resident meal choices, preferences, likes and dislikes are obtained and honored. No negative outcomes identified. Dietary staff re-educated on accurately reading tray cards to ensure dislike are honored and food trays accurately prepared.

3.) What measures will be put in place or systemic changes made to ensure correction:

Upon admission, Dietary Manger asks each new resident to specify their meal preferences including if they have any likes or dislikes. Dietary Manager re-

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F 242	Continued From page 4 with her lunch tray. She had eaten most of the meat, but there was gravy on her plate that had been pushed off the meat. During an interview with Resident #33 at 12:45 PM on 6/1/15, she stated that she always got gravy on her meats that were listed on the menu to be served with gravy although she had gravy down as a dislike on her tray slip. The tray slip was reviewed and gravy was listed as a dislike. On 6/2/15 at 6:15 PM, during an observation of the dinner meal, Resident # 33 received meat with gravy again. She pushed the top layer aside and was in the process of eating her meal. She stated that everything else looked ok, but she did not like the gravy on her meat again. At 12:25 PM on 6/4/15, during an observation of the lunch meal, the dietary manager (DM) was asked to visit Resident # 33's room to observe that she received gravy on peppered steak. This was the third observation of the resident receiving gravy on her meat during the survey. The dietary manager was made aware of the other two meals when the resident had received gravy and she stated that she was not aware that the resident had received gravy two other times during the week and acknowledged that the resident's dislike of gravy was documented on her tray slip. Resident# 33 informed the DM that she had informed dietary staff several times of her dislikes, including gravy, but she continued to received it on her tray. The DM apologized to Resident #33 and informed her that she would complete an in-service with her staff regarding reading tray slips and making sure likes and dislikes were honored at all times.	F 242	educated the dietary staff on honoring the resident's right for choosing their meal preferences, and for ensuring the resident dislikes are honored by accurately honored when preparing resident meals. Meal choices, likes and dislikes will be updated during each quarterly care plan or when identified by the resident. Staff Development Coordinator completed In-Service Education for all facility staff regarding resident choice and staff honoring resident Choices. Administrator or designee will conduct documented QA Audits to monitor the meal dislikes through direct random observation and record review audits 7x weekly for 2 weeks, then 3x weekly for four weeks and monthly x3 months for compliance. As necessary employees will be in-serviced to assure compliance with the resident's meal choices, likes and dislikes. The SDC will include provisions for resident rights to choices 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 Administrator 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 Administrator is responsible for overall compliance with resident choices.	6-28-15

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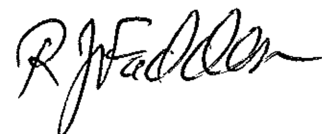
F 242	Continued From page 5 At 12:30 PM on 6/4/15, after leaving Resident #33's room, the DM stated that the process on the tray line was set up for the tray slips to be read once on the line and again before the plate was covered and placed on the cart. She stated that there were two people who should look to make sure they trays left the kitchen according to what was listed on the tray slips and she would expect that this should have been done with each tray and that likes and dislikes should be honored for each resident.	F 242		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to transcribe orders documented on lab results to the medication administration record (MAR) which resulted in 2 of 5 residents (Resident #182 and #168), reviewed for unnecessary medications, not receiving the ordered medications/products. Findings included: 1. Resident #182 was admitted to the facility on 05/20/15. His diagnoses included stasis ulcers and peripheral vascular disease. A 05/20/15 skin assessment documented the resident was admitted to the facility with multiple stasis ulcers to his bilateral lower extremities.	F 281	F- 281 (SS=D) 1.) How corrective action will be accomplished for the residents affected: Residents #168 and #182 lab results and consequent physician orders for medications/products reviewed and implemented as required/appropriate on 5 June 2015. DON re-educated Nurse staff on requirements and procedures for properly transcribing orders and updating MARs. Neither resident has experienced any adverse outcomes. 2.) How corrective action will be accomplished for those residents having the potential to be affected: Residents having any changes requiring new order transcriptions are potentially affected. Transcription procedures reviewed and nurses re-educated by the DON or designee. DON or designee screened all lab results and other orders in an effort to identify any other missed order transcriptions and none were found.	6-28-15



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F 281	Continued From page 6 A 05/25/15 physician order requested that a complete metabolic panel (CMP) be drawn on Resident #182. A 05/27/15 physician order initiated creams to the resident's toes on both feet for fungal infection and to his bilateral lower extremities for stasis ulcers. Review of the 05/28/15 lab results documented Resident #182's albumin level was low at 3.10 grams per deciliter (g/dL), with 3.5 to 5.7 g/dL being normal. The nurse receiving the results documented on the results sheet that the physician wanted to increase the resident's liquid protein to 30 cubic centimeters (cc) daily. The nurse practitioner (NP) had signed off on the lab results and consequent orders. Review of the resident's May and June 2015 MARs revealed Resident #182 had not received any liquid protein during his nursing home stay. At 9:08 AM on 06/05/15 unit manager #1 stated when a hall nurse received lab results a physician was notified of any abnormal values. She reported if the physician generated any new orders based on these lab results the hall nurse wrote the orders on the lab results paper, then wrote a telephone order, and placed the orders on the MARs. A review of Resident #182's telephone orders revealed there was no order to start the resident on liquid protein or to increase the dosage of the protein. At 10:30 AM on 06/05/15 the director of nursing	F 281	**3.) What measures will be put in place or systemic changes made to ensure correction:** **The DON or designee re-educated the nurse staff regarding proper transcription procedures. The DON or designee will conduct documented QA Audits to monitor resident lab results and other telephone orders through direct random record review audits on 6 residents daily for two weeks, six residents 2x weekly for 3 weeks, then once weekly for four weeks and monthly x3 months for ongoing transcription compliance. As necessary staff will be in-serviced to assure compliance with the facility policy and procedure. The SDC will include provisions for following transcription procedures 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.**	6-28-15

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F 281	Continued From page 7 (DON) stated if the physician or NP had signed off on medication orders noted on lab results there was no reason why they should not have been transcribed to the MAR and administered. She reported liquid protein would help heal Resident #182's stasis ulcers. She commented the hall nurse should have clarified the order to increase the resident's liquid protein since there was no record of the resident receiving liquid protein since his nursing home admission. According to the DON, the physician clearly intended for the resident to received protein supplementation to promote wound healing. 2. Resident #168 was admitted to the facility on 05/06/15. The resident's documented diagnoses included history of gastrointestinal bleed and hypertension. A 05/07/15 physician order requested that a complete metabolic panel (CMP) be drawn on Resident #168. 05/08/15 lab results documented the resident's calcium was low at 8.43 milligrams per deciliter (mg/dL), with normal being 8.5 - 10.8 mg/dL). The nurse receiving the results documented on the results sheet that the physician wanted the resident to be started on Caltrate (calcium supplement) one tablet three time daily (TID) with meals. The nurse practitioner (NP) had signed off on the lab results and consequent order. A 05/20/15 consultant pharmacist medication regimen review documented on 05/08/15 Resident #168 was to have been started on Caltrate TID with meals.	F 281		6-28-15

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F 281	Continued From page 8 Review of the resident's May and June 2015 MARs revealed Resident #168 had not received any Caltrate during his nursing home stay. At 9:08 AM on 06/05/15 unit manager #1 stated when a hall nurse received lab results a physician was notified of any abnormal values. She reported If the physician generated any new orders based on these lab results the hall nurse wrote the orders on the lab results paper, then wrote a telephone order, and placed the orders on the MARs. A review of Resident #168's telephone orders revealed there was no order to start the resident on Caltrate. At 10:30 AM on 06/05/15 the director of nursing (DON) stated if the physician or NP had signed off on medication orders noted on lab results there was no reason why they should not have been transcribed to the MAR and administered.	F 281		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371	F- 371 (SS=E) 1.) How corrective action will be accomplished for the residents affected: Those kitchenware that failed to air dry or be free of food particles were thoroughly rewashed and sanitized. All identified kitchen ware, cookware, and plastic serving pieces were identified, removed from service, and discarded. Kitchen staff were in-service educated on the proper procedure for identifying wet, dirty, or damaged items, the procedure for rewashing and sanitizing, as well discarding damaged, stained or abraded kitchenware.	6-28-15

R J Faddon

PRINTED: 06/15/2015
FORM APPROVED
OMB NO. 0938-0391

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F 371	Continued From page 9 Based on observation and staff interview the facility failed to air dry kitchenware before stacking it in storage, and failed to use kitchenware free of food particles during food preparation. The facility also failed to dispose of damaged kitchenware. Findings included: 1. During initial tour of the kitchen on 06/01/15, beginning at 11:37 AM, 1 of 5 tray pans stacked on top of one another in storage was found to have moisture trapped inside. During a follow-up tour of the kitchen on 06/03/15 at 9:14 AM 5 of 12 tray pans stacked on top of one another in storage were found to have moisture trapped inside. At this time the dietary manager (DM) stated these tray pans were stacked in storage the night before. At 9:48 AM on 06/03/15 a cook placed frozen roll dough in a muffin pan to thaw and rise. The pan was placed on top of the steam table. There were deposits of food debris inside the wells of the muffin pans. Inspection of three other muffin pans in storage revealed they also had deposits of food debris in their wells. At 3:02 PM on 06/04/15 the DM stated dietary staff had been in-serviced that kitchenware should be clean and dry before stacking it in storage. She reported stacking wet pieces of kitchenware on top of one another could lead to bacterial formation and possibly make residents sick from food poisoning. According to the DM, her staff was also trained to use only clean kitchenware when preparing food. She explained if kitchenware was found contaminated by food debris then it should be run through the dish	F 371	**2.) How corrective action will be accomplished for those residents having the potential to be affected:** **All residents have the potential to be affected. The Dietary Manager and Dietician concluded there was a need for additional air drying racks which are approved for purchase and are on order. Kitchen staff received in-service education on the proper procedure for identifying wet, dirty, or damaged items, the procedure for rewashing and sanitizing these items, as well discarding those that are damaged, stained or abraded kitchenware. A kitchen sanitation inspection was conducted by the Dietary Manager and identified damaged plates, cups, bowls, coffee cups, serving trays and cook ware. These items were discarded and new replacements ordered and received.** **3.) What measures will be put in place or systemic changes made to ensure correction:** **The Dietary Manager re-educated the kitchen staff regarding proper procedures for drying, cleaning and discarding damaged kitchen ware. As required the Dietary Manager will order replacement items for those found damaged. The Administrator or designee will conduct documented QA Audits to monitor kitchen sanitation through direct random observation audits daily for two weeks, 3x**	6-28-15

R J Fadler

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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 371	Continued From page 10 machine or three-compartment sink system before use in food preparation. She commented these processes would remove dried food debris and sanitize the kitchenware. At 3:10 PM on 06/04/15 the PM cook stated no kitchenware was supposed to be placed into storage unless it was dry and free of food particles. She also reported, unless dried food was removed from kitchenware, the use of dirty kitchenware during food preparation posed the risk of making residents sick due to germs and bacteria. 2. At 10:22 PM on 06/03/15 12 of 26 plastic soup/cereal bowls were found with abraded rings just inside the lips of the bowls (46 %). At this time the dietary manager (DM) stated she thought this abrasion was caused by staff heating foods such as soup in the microwave. At 3:02 PM on 06/04/15 the DM stated the dietary staff was in-serviced to throw away damaged or compromised kitchenware. She explained the staff was to let her know how many pieces were disposed of so she could replace them. The DM commented abrasions made it easier for bacteria to collect in kitchenware and make residents sick. At 3:10 PM on 06/04/15 the PM cook stated kitchenware that was cracked, chipped, or abraded was supposed to be disposed of and replaced with new kitchenware. She reported she thought reheating foods in the soup/cereal bowls caused the breakdown of the plastic inside the bowls.	F 371	weekly for 3 weeks, then once weekly for four weeks and monthly x3 months for ongoing kitchen sanitation compliance. As necessary staff will be in-serviced to assure compliance with the kitchen sanitation policy and procedure. The Dietary Manager will include provisions for following cleaning, drying and damaged item procedures during the orientation of new kitchen 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 Administrator 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 Administrator is responsible for overall compliance.	6-28-15