STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345077	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnybrook Rehabilitation Center	25 Sunnybrook Road Raleigh, NC 27610

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13030 Based on record review, family interview, and staff interview the facility failed to notify a responsible party after a resident fell , sustained a head injury, and was transferred to the hospital for one (Resident #1) of one resident reviewed for notification of change in condition. Findings included: Resident #1 was admitted to the facility on [DATE] with multiple diagnoses some of which included dementia and a chronic progressive neurological disorder. Documentation in a nursing progress note by Nurse #1 dated 6/5/2024 but crossed out as created in error revealed Resident #1 fell at an exit door hitting his forehead and was sent to the hospital. The documentation also revealed the power of attorney for Resident #1 was notified. Documentation on a hospital emergency department visit for Resident #1 dated 6/5/2024 revealed Resident #1 arrived in the emergency room at 4:12 AM from the nursing home with no identifying information. Nurse #1 was interviewed on 6/19/2024 at 1:19 PM. Nurse #1 explained she called 911 and when she went to look at the laptop on her medication cart to print out information to send Resident #1 to the hospital, she realized the electronic medical record was not available. Nurse #1 explained she did not have anything to send with Resident #1 when Emergency Medical Services (EMS) arrived. Nurse #1 stated she explained to EMS that she did not have access to any electronic medical records, but she did tell them the name of Resident #1. Nurse #1 also requested EMS take Resident #1 to the hospital he was admitted from as they would have his prior medical information on file. Nurse #1 stated after Resident #1 left with EMS to the hospital, a family member called the facility to check on the status of Resident #1. Nurse #1 revealed she told the family member about Resident #1 falling at the facility and being sent to the hospital with a head injury because prior to that she did not have access to emergency contact information from the electronic medical record. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnybrook Rehabilitation Center	25 Sunnybrook Road Raleigh, NC 27610

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A family member of Resident #1 was interviewed on 6/19/2024 at 2:56 PM. The family member stated on 6/5/2024 at approximately 5:00 AM in the morning the hospital called her and told her they thought Resident #1 was in their emergency room with a head injury. The family member said she was doubtful because she did not receive any phone call from the facility, but as the emergency room physician described Resident #1 there was no doubt in her mind it was Resident #1. The family member called the facility to inquire about Resident #1 after which she was notified the facility computer system was down and they did not have access to her phone number to notify her prior to sending Resident #1 to the hospital. An interview was conducted with the [NAME] President of Operations on 6/20/2024 at 2:24 PM. The [NAME] President of Operations explained the facility nursing staff had access on the desk top computers to all the medical information required to send a resident to the hospital on a backup electronic medication administration record. The [NAME] President of Operations stated he would have to check on where and how the nursing staff would access the contact information for a responsible party if the electronic medical record could not be accessed, as this information was not located on the backup electronic medication administration record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER Sunnybrook Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 25 Sunnybrook Road Raleigh, NC 27610	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13030 Based on record review, family interview, staff interviews, and hospital admission records the facility failed to send written documentation with identifying information, medication list, physician contact information, and responsible party contact information in an emergency transfer to the hospital for one (Resident #1) of one resident reviewed for hospital transfers. The findings included: Resident #1 was admitted to the facility on [DATE] with multiple diagnoses some of which included dementia and a chronic progressive neurological disorder. Documentation in nursing progress note by Nurse #1 dated 6/5/2024 but crossed out as created in error revealed Resident #1 fell at an exit door hitting his forehead and was sent to the hospital. Nurse #1 was interviewed on 6/19/2024 at 1:19 PM. Nurse #1 explained she called 911 and when she went to look at the laptop on her medication cart to print out information to send Resident #1 to the hospital, she realized the electronic medical record was not available. Nurse #1 explained she did not have anything to send with Resident #1 when Emergency Medical Services (EMS) arrived. Nurse #1 stated she explained to EMS that she did not have access to any electronic medical records, but she did tell them the name of Resident #1. Nurse #1 also requested EMS take Resident #1 to the hospital he was admitted from as they would have his prior medical information on file. Nurse #1 stated after Resident #1 left with EMS to the hospital, a family member called the facility to check on the status of Resident #1. Nurse #1 revealed she told the family member about Resident #1 falling at the facility and being sent to the hospital with a head injury because prior to that she did not have access to emergency contact information from the electronic medical record. Nurse #3 was interviewed on 6/19/2024 at 3:38 PM. Nurse #3 explained she was working as a nurse on another hallway in the facility on 6/5/2024 when Resident #1 fell . Nurse #3 stated she became aware of the electronic medical record system being down after Nurse #1 told her. Nurse #3 explained when EMS arrived, they were told EMS the name of Resident #1, and requested to take him back to the hospital he was admitted to the facility from. Nurse #3 stated Nurse #1 went to the medication cart and quickly looked through the medication cards to give confirmation to EMS that Resident #1 was not on any anticoagulants. Nurse #3 stated the hospital was called after EMS left the facility with Resident #1 to verbally confirm who the facility sent to the hospital. Documentation on an emergency department to hospital admission for Resident #1 dated 6/5/2024 revealed Resident #1 arrived in the emergency room with a head injury from the facility with no identifying information. Documentation in the hospital record under history of his present illness revealed Resident #1 was found by EMS to not open his eyes, to not respond to commands, and with garbled intelligible speech. The hospital record documented in the admission information, they had no confirmation of what medications Resident #1 was ordered to have and no referring provider information. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER Sunnybrook Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 25 Sunnybrook Road Raleigh, NC 27610	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A family member of Resident #1 was interviewed on 6/19/2024 at 2:56 PM. The family member stated on 6/5/2024 at approximately 5:00 AM in the morning the hospital called her and told her they thought Resident #1 was in their emergency room with a head injury. The family member said she was doubtful because she did not receive any phone call from the facility, but as the emergency room physician described Resident #1 there was no doubt in her mind it was Resident #1. The family member called the facility to inquire about Resident #1 after which she was notified the facility computer system was down and they did not have access to her phone number to notify her prior to sending Resident #1 to the hospital. An interview was conducted with the Director of Nursing (DON) on 6/19/2024 at 2:21 PM. The DON stated she received a phone call in the early morning hours notifying her of the fall sustained by Resident #1 and the electronic medical record system was down. The DON stated the Assistant DON came directly to the facility to resolve the issues with the electronic medical record system. The DON stated it was her expectation that the nursing staff notify her immediately so any issues with the electronic medical record system could be resolved. An interview was conducted with the [NAME] President of Operations on 6/20/2024 at 2:24 PM. The [NAME] President of Operations stated the facility already had a backup system in place when the electronic medical record system was down, but more training of the licensed nursing staff had been put into place on how to access the backup system after the 6/5/2024 hospital transfer for Resident #1. The [NAME] President of Operations revealed the following information as the back up plan for when the electronic medical record system was down for longer than 5 minutes. The licensed nursing staff will call nursing administration at the phone numbers posted at each nursing station. Information technology assistance will be contacted. The licensed nursing staff will access the backup electronic medication record on the desk top computers located at each nursing station. The [NAME] President of Operations provided an example of an electronic medication record to demonstrate diagnoses, medication orders, code status, and physician name will be available for each resident on the back up electronic medication administration record. The [NAME] President of Operations stated the phone numbers for the resident's physician was posted at each nursing station for easy availability. The facility provided a performance improvement plan initiated on 6/6/2024. The issue identified by the facility was the nursing staff did not access the Southern Healthcare Management (SHCM) electronic medication administration record (e MAR) back up system for Resident #1 prior to sending him to the hospital for evaluation after a fall. All residents have the potential to be affected by this deficient practice. The Director of Nursing and/or designee will complete audits of each SHCM e MAR back up system to ensure each computer was accessible to e MAR and had the availability to print. The e MAR in the backup system contains the medication orders, diagnoses, physician name, resident name, and code status. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345077	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnybrook Rehabilitation Center	25 Sunnybrook Road Raleigh, NC 27610

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The licensed nurses were provided re-education by the DON or designee on 6/6/2024 regarding how to contact nursing administration, call information technology support, and access the e MAR back up system. Specific directions on what to do if there was an interruption of internet service or the electronic medical record system was down for more than 5 minutes was posted at each nursing station on 6/6/2024. The licensed nursing staff were educated on the following already existing process for an interruption of the electronic medical record system. In the event of an internet service interruption and/or [Electronic Medical Record System name] downtime, MAR and TAR (treatment administration record) PDF (portable document format) files can be accessed from the eMAR Back up desktops located at the nursing stations and labeled with the machine name and number. These devices should be connected to a local printer supported by generator power for printing purposes. The files can also be saved to a thumb drive/USB (universal serial bus) and inserted directly into a printer supported by generator power if needed. New or agency licensed nurses will be provided the education during orientation. As of 6/6/2024, this education will be completed by the Director of Nursing or designee. Effective 6/8/2024, the DON and/or designee will review e MAR backup computers weekly. The DON will report the results of the audits to the Quality Assurance Improvement Committee for 2 months. The Committee will review the results to determine if further action is needed. Alleged date of compliance: 6/7/2024 The plan was validated for the alleged date of compliance of 6/7/2024 on 6/20/2024. Interviews were conducted with licensed nursing staff to confirm education was provided on what steps to take if the electronic medical record system goes down, how to access the e MAR back up system on the desktop computers, and the knowledge was retained. Observations were made of the instructions posted at each nursing station detailing the steps to take if the electronic medical record system was not available for access. Documentation of in-service records dated 6/6/2024 and audits to ensure the backup computers were working properly functioning dated 6/6/2024, 6/13/2024, and 6/17/2024 were reviewed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnybrook Rehabilitation Center	25 Sunnybrook Road Raleigh, NC 27610

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13030 Based on record review, resident interview, staff interview, and pharmacy manager interview the facility failed to obtain and administer narcotic pain medication as ordered for moderate to severe pain for one (Resident #3) of one resident reviewed for pain control. The findings included: Resident #3 was admitted to the facility on [DATE] with multiple diagnoses some of which included a healing hip fracture, anxiety disorder, and depression. Documentation on the hospital medication administration record (MAR) revealed Resident #3 was administered one tablet of Acetaminophen 650 milligrams (mg) and one tablet of Oxycodone 5 mg immediate release on 6/14/2024 at 5:18 PM. Acetaminophen and Oxycodone are pain medications. Resident #3 had a physician's order initiated on 6/14/2024 for one tablet of Norco (Hydrocodone-Acetaminophen) 7.5-325 mg to be administered by mouth every six hours as needed for moderate to severe pain for 175 days. Norco is a narcotic pain medication. There were no other physician orders upon admission for pain medication for Resident #3 in the electronic medical record. Documentation in an admission note dated 6/15/2024 at 12:29 AM stated, [Resident #3] arrived at [7:00 PM] this evening 06/14/2024 via stretcher from [hospital name]. [Vital Signs Stable] [complained of] right hip [relative to] fracture. Tylenol given effective. Alert and oriented times 3. An interview was conducted with Resident #3 on 6/19/2024 at 9:48 AM. Resident #3 explained when she was admitted to the facility it was a fiasco. Resident #3 elaborated providing the following information. Resident #3 stated her medications were not at the facility when she arrived like she assumed they would be. Resident #3 stated the very worst thing that happened was she was in extreme pain and became hysterical. Resident #3 explained that her pain medication did not arrive until late at night on 6/15/2024 and the facility was not able to give her anything that was strong enough to stop the pain until her medication arrived. An interview was conducted with Nurse Aide (NA #7) on 6/20/2024 at 10:51 PM. NA #7 confirmed she was the nurse aide for Resident #3 on 6/14/2024 for the 3:00 PM to 11:00 PM shift. NA #7 stated Resident #3 was crying and in pain on the night she was admitted . NA #7 confirmed she did notify the nurse and they both tried to calm her down. NA #7 stated she had to explain to Resident #3 she was not able to get out of bed to go to the bathroom and Resident #3 had to use a bed pan. NA #7 stated she had changed all the bedding for Resident #3 a couple of times requiring Resident #3 to roll from side to side causing the resident pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER Sunnybrook Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 25 Sunnybrook Road Raleigh, NC 27610	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with Nurse #6 on 6/20/2024 at 2:49 PM. Nurse #6 confirmed she had been the nurse for Resident #3 on the night of her admission on 6/14/2024 and again on 6/15/2024 for the 3:00 PM to 11:00 PM shift. Nurse #6 conveyed the following information. Resident #3 arrived and was assessed to be alert and oriented with a surgically repaired hip fracture. Nurse #6 explained to Resident #3 she was not allowed out of bed until therapy assessed her and she would have to use a bed pan. Nurse #6 revealed she also explained to Resident #3 she was going to have to use the mechanical sling lift to obtain her weight because the facility could not give any medication to Resident #3 without obtaining her weight. Nurse #6 said Resident #3 was extremely anxious about being put in the mechanical sling lift but with the assistance of two nurse aides she was able to obtain the weight of Resident #3 in the mechanical sling lift. Nurse #6 further explained Resident #3 had never used a bed pan before and a couple different times during the night the nurse aide had to change all the bedding for Resident #3 due to the bed pan spilling. Nurse #6 said Resident #3 had to do a lot of moving around in the bed with the changing of the bed linens and being put in the mechanical sling lift. Nurse #6 said Resident #3 was screaming in pain and hitting the walls. Nurse #6 stated she tried to calm her down and she gave Resident #3 Tylenol per standing orders, but it was not working. Nurse #6 revealed she faxed the pharmacy the medication orders for Resident #3 as soon as she arrived, but the orders were put in too late for the pharmacy to deliver the medications on the evening of 6/14/2023 and they would have to be delivered on the morning delivery. Nurse #6 explained she called the pharmacy and was not able to get a STAT (urgent) order due to there not being a driver. Nurse #6 revealed she was not able to get narcotic pain medication out of the automated medication dispensing cabinet because the Assistant Director of Nursing was working on getting her access. Additionally, Nurse #6 did not think any of the nurses on the 3:00 PM to 11:00 PM shift had access to the automated medication dispensing cabinet because there were no administrative staff working past 5:00 PM at the facility. Nurse #6 reiterated Resident #3 was in pain, and she did her best to comfort her on 6/14/2024 but thought perhaps Resident #3 was more anxious than in pain. Documentation on the MAR by Nurse #6 revealed Resident #3 had a pain level of 3 for the evening shift on 6/14/2024. The pain scale was 0 being no pain, 5 being moderate pain, and 10 being worst possible pain. There was no documentation on the Medication Administration Record of Resident #3 receiving any Tylenol on the evening of 6/14/2024. Nurse #7 was interviewed on 6/20/2024 at 3:26 PM. Nurse #7 revealed she was the nurse for Resident #3 for the 7:00 AM to 3:00 PM shift on 6/15/2024. Nurse #7 explained a family member of Resident #3 approached her at the nursing medication cart requesting to review the medications Resident #3 was receiving. Nurse #7 indicated she opened the drawer with Resident #3's family member present and discovered Resident #3 did not have any medication. Nurse #7 stated she called the pharmacy and was told the pharmacy was still working on the medications for Resident #3. Nurse #7 stated Resident #3 never expressed she was in any pain on her shift on 6/15/2024. Documentation on the MAR revealed Resident #3 had a pain level of 0 for the night shift on 6/14/2024 and a pain level of 0 for the day shift on 6/15/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER Sunnybrook Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 25 Sunnybrook Road Raleigh, NC 27610	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with Nurse #6 on 6/20/2024 at 2:49 PM. Nurse #6 revealed when she arrived the next day, 6/15/2024, for her shift on 3:00 PM to 11:00 PM, she found out in report that the medications for Resident #3 had not arrived. Nurse #6 stated Resident #3 was again in pain and requesting her pain medication. Nurse #6 indicated she gave Resident #3 Tylenol per a standing order, and this helped a little but not enough to relieve Resident #3's pain. Nurse #6 stated Resident #3 was no longer screaming in pain on 6/15/2024 but was visibly upset when I told her she was going to have to wait for her pain medication to come to the facility. Nurse #6 revealed Nurse #8 (Infection Preventionist) came to her during the shift on 6/15/2024 and asked her how her new admissions were doing. Nurse #6 explained to Nurse #8 that Resident #3 was in pain and her narcotic pain medication had not arrived at the facility yet. Nurse #6 revealed Nurse #8 looked in the automated medication dispensing cabinet and the narcotic pain medication needed by Resident #3 was not in there. Nurse #6 confirmed the ordered Norco arrived at the facility at around 11:00 PM on 6/15/2024, which was immediately administered to Resident #3 who was still awake. Nurse #3 explained Resident #3 was much calmer and understanding after receiving her pain medication on 6/15/2024. Nurse #8 was also interviewed on 6/20/2024 at 3:26 PM and 4:26 PM. Nurse #8 stated she went to the facility on [DATE] arriving at the facility at 9:30 PM. Nurse #8 stated at around 10:15 PM or 10:30 PM on 6/15/2024 she approached Nurse #6 who told her Resident #3 did not have her pain medication. Nurse #8 said Nurse #6 explained to her Resident #3 came in late on 6/14/2024, the pharmacy didn't have a driver, and Resident #3 was upset about her pain medication not coming in from the pharmacy. Nurse #8 stated she called the pharmacy and was told the medications for Resident #3 were in route to the facility. Nurse #8 stated she then went to check the automated medication dispensing cabinet and found the narcotic pain medication ordered for Resident #3, but it was not the same dosage ordered for Resident #3. Nurse #8 revealed she then went to Resident #3 and asked her if she wanted the dosage of narcotic pain medication from the automated medication dispensing cabinet or to wait for her dosage of narcotic pain medication to arrive from the pharmacy in route to the facility. Nurse #8 stated Resident #3 opted to wait for her pain medication to come to the facility. There was no documentation on the Medication Administration Record of Resident #3 receiving any Tylenol on the evening of 6/15/2024. Documentation on the MAR by Nurse #6 revealed Resident #3 was administered the physician ordered dose of Norco on 6/15/2024 at 11:03 PM for a pain level of 9. The Director of Nursing (DON) was interviewed on 6/20/2024 at 4:00 PM and 6:00 PM. The DON provided the following information. The DON was not at the building when Resident #3 arrived on 6/14/2024 and she was not notified by Nurse #6 of Resident #3 being in pain or the lack of access to the automated medication dispensing cabinet. The DON could have remotely obtained access to the automated medication dispensing cabinet for Nurse #6, or a unit manager could have come to the facility. The automated medication cabinet would have had the narcotic pain medication ordered for Resident #3, but not in the specific dose ordered for Resident #3. The DON stated Nurse #6 should have called her and should have utilized the automated medication dispensing cabinet for pain medication for Resident #3. The DON confirmed the facility had standing orders for the administration of Tylenol for residents in pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER Sunnybrook Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 25 Sunnybrook Road Raleigh, NC 27610	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with the pharmacy manager of the pharmacy the facility utilizes on 6/21/2024 at 8:51 AM. The pharmacy manager revealed the cut off time for medication orders to be received at the pharmacy for the evening delivery was 7:00 PM on 6/14/2024. The pharmacy manager stated the medication orders for Resident #3 were entered into the electronic system earlier in the day on 6/14/2024 but they could not be filled until after the resident arrived at the facility. The pharmacy manager stated the pharmacy was notified Resident #3 had arrived at the facility at 9:31 PM on 6/14/2024. The pharmacy manager confirmed the facility had all the medications ordered for Resident #3 in the automated medication dispensing cabinet on 6/14/2024 and 6/15/2024. The pharmacy manager further explained the dose of Norco in the automated medication dispensing cabinet did not match the ordered dose for Resident #3, but a one-time order could have been obtained from a physician. The pharmacy manager stated a STAT order for medications for Resident #3 would have required the facility to call the pharmacy with this request, a pharmacist would fill it, and an on-call driver would have delivered the medications. The pharmacy manager explained the pharmacy always had an on-call pharmacist and driver for a STAT delivery, but there was no record of the facility calling the pharmacy requesting a STAT delivery. The pharmacy manager revealed the facility only received one medication delivery on 6/15/2024 and the driver left the pharmacy at approximately 6:30 PM, delivering the medications for Resident #3 at 10:54 PM to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER Sunnybrook Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 25 Sunnybrook Road Raleigh, NC 27610	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 13030 Based on record review, resident interview, staff interview, consultant pharmacist interview, and pharmacy manager interview the facility failed to dispense medications from an approved pharmacy source for one (Resident #3) of one resident reviewed for pharmaceutical services. Findings included: Resident #3 was admitted to the facility on Friday, 6/14/2024 with multiple diagnoses some of which included a healing hip fracture, anxiety disorder, acute embolism and thrombosis of the right femoral vein (blood clots), and depression. The electronic record listed the physician orders initiated on 6/14/2024 for Resident #3 as the following: 60 milligrams (mg) Cymbalta delayed release particles to be given as two capsules by mouth at bedtime for depression; Vitamin D3 to be given as one capsule by mouth one time a day for supplement; 150 mg Trazadone HCL to be given as one tablet by mouth at bedtime for depression; 17 grams Polyethylene Glycol Powder to be given by mouth as needed for constipation once daily; 1 mg Lorazepam to be given as one tablet by mouth every six hours as needed for anxiety for 14 days; 300 mg Gabapentin to be administered as two capsules by mouth at bedtime for neuropathy; 10 mg Ezetimibe to be given as one tablet by mouth one time a day for Hyperlipidemia; 5 mg Apixaban to be given as two tablets by mouth two times a day for deep vein thrombosis for seven days; and 7.5-325 mg Norco to be given as one tablet by mouth every six hours as needed for moderate to severe pain for 175 days. An interview was conducted with Resident #3 on 6/19/2024 at 9:48 AM. Resident #3 explained when she was admitted to the facility it was a fiasco. Resident #3 stated her medications were not at the facility when she arrived like she assumed they would be. Documentation on the Medication Administration Record (MAR) revealed Resident #3 was administered per physician orders the medications Trazadone HCL, Apixaban, Cymbalta, and Gabapentin by Nurse #6 prior to bedtime on the evening of 6/14/2024. An interview was conducted with Nurse #6 on 6/20/2024 at 2:49 PM. Nurse #6 confirmed she had been the nurse for Resident #3 on the night of her admission on 6/14/2024 and again on 6/15/2024 for the 3:00 PM to 11:00 PM shift. Nurse #6 conveyed the following information. Resident #3 arrived and was assessed to be alert and oriented with a surgically repaired hip fracture. Nurse #6 revealed she faxed the pharmacy the medication orders for Resident #3 as soon as she arrived, but the orders were put in too late for the pharmacy to deliver the medications on the evening of 6/14/2023 and they would have to be delivered on the morning delivery. Nurse #6 explained she called the pharmacy and was not able to get a STAT (urgent) order due to there not being a driver. Nurse #6 revealed she was not able to get medication out of the automated medication dispensing cabinet because the Assistant Director of Nursing was working on getting her access. Additionally, Nurse #6 did not think any of the nurses on the 3:00 PM to 11:00 PM shift had access to the automated medication dispensing cabinet because there were no administrative staff working past 5:00 PM at the facility. Documentation on the MAR revealed Resident #3 was administered per physician orders Vitamin D3, Apixaban, and Ezetimibe by Nurse #7 on 7/15/2024 upon rising for the day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER Sunnybrook Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 25 Sunnybrook Road Raleigh, NC 27610	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurse #7 was interviewed on 6/20/2024 at 3:26 PM. Nurse #7 revealed she was the nurse for Resident #3 for the 7:00 AM to 3:00 PM shift on 6/15/2024. Nurse #7 explained a family member of Resident #3 approached her at the nursing medication cart requesting to review the medications Resident #3 was receiving. Nurse #7 indicated she opened the drawer with Resident #3's family member present and discovered Resident #3 did not have any medication. Nurse #7 stated she called the pharmacy and was told the pharmacy was still working on the medications for Resident #3. Nurse #7 explained she did not have access to the automated medication dispensing cabinet. Nurse #7 further explained she took medication from other resident's medication cards to give to Resident #3 except for the Vitamin D3, which was available from house stock. Nurse #7 confirmed the medications she took from other residents to give to Resident #3 were Apixaban and Ezetimibe. Documentation on the MAR revealed Resident #3 was administered per physician orders the medications Trazadone HCL, Apixaban, Cymbalta, and Gabapentin by Nurse #6 prior to bedtime on the evening of 6/15/2024. An interview was conducted with Nurse #6 on 6/20/2024 at 2:49 PM. Nurse #6 revealed when she arrived the next day, 6/15/2024, for her shift on 3:00 PM to 11:00 PM she found out in report that the medications for Resident #3 had not arrived. Documentation on the MAR revealed Resident #3 was administered per physician orders Lorazepam and Norco by Nurse #6 at 11:03 PM on 6/15/2024. Nurse #6 was reinterviewed on 6/20/2024 at 4:31 PM. Nurse #6 stated she had borrowed medications from other residents to give to Resident #3 on the evening of 6/14/2024 and 6/15/2024 because it was important that she take the medications ordered for her. Nurse #6 confirmed the medications she borrowed were the Trazadone HCL, Apixaban, Cymbalta, and Gabapentin. Nurse #6 added she knew she was not supposed to borrow medications from other residents and confirmed she did not borrow the Lorazepam or the Norco from other residents to give to Resident #3. An interview was conducted with the Director of Nursing (DON) on 6/20/2024 at 4:00 PM. The DON stated there was always someone on every shift who had access to the automated medication dispensing cabinet. The DON further stated if she had been called, she could have obtained access to the automated medication dispensing cabinet remotely for the nurses. The DON explained after thirty days the nurse's access to the automated medication dispensing cabinet will expire if the automated medication dispensing cabinet was not used by the nurse. The DON stated in addition the unit manager lives nearby and could have come to the facility to obtain medications from the automated medication dispensing cabinet for Resident #3. The DON explained the pharmacy has only one delivery on Saturday, but the pharmacy could have been called to deliver a STAT delivery if they had been called. The DON confirmed the nursing staff should call the DON or Administration for access to the automated medication dispensing cabinet, call in a STAT order to the pharmacy, or obtain hold orders from the physician. The DON stated the nurses should not borrow medications from other residents for a new admission. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER Sunnybrook Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 25 Sunnybrook Road Raleigh, NC 27610	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the facility consultant Pharmacist on 6/21/2024 at 8:21 AM. The Pharmacist confirmed there was a cut off time for delivery of medications in the evening after which medications will have to be obtained from the automated medication dispensing cabinet or a STAT order from the pharmacy. The Pharmacist stated she would have instructed the nurses to not borrow from other residents as this was not a pharmacy recommendation for dispensing medication. The Pharmacist conveyed she thought someone in the facility should have access to the automated medication dispensing cabinet at all times. An interview was conducted with the pharmacy manager of the pharmacy the facility utilizes on 6/21/2024 at 8:51 AM. The pharmacy manager revealed the cut off time for medication orders to be received at the pharmacy for the evening delivery was 7:00 PM on 6/14/2024. The pharmacy manager stated the medication orders for Resident #3 were entered into the electronic system earlier in the day on 6/14/2024 but they could not be filled until after the resident arrived at the facility. The pharmacy manager stated the pharmacy was notified Resident #3 had arrived at the facility at 9:31 PM on 6/14/2024. The pharmacy manager confirmed all the medications ordered for Resident #3 were available in the facility automated medication delivery cabinet except for the Norco and Lorazepam, which were available in alternate strengths. The pharmacy manager noted the facility did not remove any medications for Resident #3 from the automated medication dispensing cabinet on 6/14/2025 or 6/15/2024. The pharmacy manager stated a STAT order for medications for Resident #3 would have required the facility to call the pharmacy with this request, a pharmacist would fill it, and an on-call driver would have delivered the medications. The pharmacy manager explained the pharmacy always has an on-call pharmacist and driver for a STAT delivery, but there was no record of the facility calling the pharmacy requesting a STAT delivery. The pharmacy manager revealed the facility only received one medication delivery on 6/15/2024 and the driver left the pharmacy at approximately 6:30 PM, delivering the medications for Resident #3 at 10:54 PM to the facility.