PRINTED 12/08/2015
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: ______ B. WING ______	R-C 11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ASSISTED LIVING AT NORTH HILLS	615 SPRING FOREST ROAD RALEIGH, NC 27609

(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) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section and Wake County Human Services conducted a follow up survey and complaint investigation on 11/18/15-11/20/15. The complaint investigation was initiated by Wake County Human Services on 11/4/15.	{D 000}		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interview, and record review the facility failed to assure all residents were free of neglect related to Resident #7 sustaining a hip fracture while being assisted to the bathroom by 2 personal care aides. The findings are: Review of Resident #7's current FL-2 dated 11/24/14 revealed: -His diagnoses included cerebrovascular accident, dementia, and diabetes mellitus. -He was constantly disoriented. -He was ambulatory. Review of Resident #7's Resident Register revealed that the resident was admitted to the facility's special care unit (SCU) on 12/1/14. Review of Resident #7's progress notes revealed: -Since admission, Resident #7 had 11 falls,	D 338		

PoC Reviewed and accepted by TLC on 1/5/16

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including a recent fall on 10/16/15.
-On 10/16/15 during 3rd shift, he had a fall while going to a bathroom, he was sent to the emergency room (ER).
-On 10/17/15, he had surgery due to a fractured hip, then was transferred to a skilled nursing facility for rehab.

Review of Resident #7's current individual Service Plan (ISP), dated 5/23/15 revealed:
-He was at risk for falls.
-He had a history of falls.
-The staff was to monitor resident for balance and gait issues and notify wellness or resident coordinator if any concerns arise.
-The resident would often attempt to get up and walk, he was unsafe and unsteady.
-He required physical assistance of 1 person for mobility, transferring, grooming, bathing, toileting and dressing.
-The resident needed assist of one person for all transfers and offer to transfer the resident to the living room couch before and after meals for comfort; the resident liked to have his feet up on the ottoman.
-The facility staff added a note on 10/20/15, under "Assistance to Bathroom" section, the staff was to offer assist to toilet upon awaking, prior to bed time and 2-4 times during the night.

Review of the facility's "Residents on Toileting Program" list dated 9/18/15 and 10/20/15 revealed Resident #7 was not included.

Review of the facility's incident reports for Resident #7 revealed:
-On 10/16/15 at 5:30 am, the staff was trying to help the resident walk to the bathroom and he began falling, the staff helped lower the resident to a kneeling position, then after a few seconds,

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D 338	Continued From page 2 the resident fell slightly on his face to the floor and rolled on his side. During this process, the resident sustained a big skin tear on his right arm/elbow and abrasion on his right face (chin) due to the carpet. Review of Progress Notes for Resident #7 revealed: -On 8/13/15 at 6:00 pm, the resident was found on the floor in the living room in front of wheelchair without an injury. -On 8/26/15 at 5:30 am, the resident was found on the floor, beside the bed in a sitting position. -The resident had a skin tear on right elbow and right thumb; the resident was treated according to the facility's standing order. -On 8/26/15 at 5:04 pm, the resident needed to be monitored and re-directed often because of the high risk of falls due to advanced dementia and debility. -On 10/16/15 at 5:30 am, the staff was trying to help the resident to the bathroom and the resident began falling. -The staff helped lower the resident to a kneeling position, after a few seconds, the resident fell slightly on his face to the floor and rolled on his side. -The resident sustained a big skin tear on his right arm, elbow and abrasion on his right chin from the carpet. -On 10/16/15 at 8:00 am, the resident was seen by his practitioner assistant (PA). -The PA reported the resident had contusion/abrasion of right orbital region and pain of the left femur, knee region unable to bear weight, pain with range of motion (ROM) attempts. -On 10/16/15 at 12:59 pm, the resident was transported to emergency room (ER). -On 10/19/15 at 12:20 pm, the resident's family	D 338		

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reported to the facility that the resident's left hip was fractured and he had a surgery.

Review of Resident #7's primary care physician's (PCP) visit notes revealed:
-On 5/20/15 and 8/26/15, the physician wrote to monitor the resident closely as a high fall risk due to advanced dementia and debility.
-On 10/16/15, the physician wrote the resident had a fall and sustained contusion/abrasion of the right orbital region and pain of the left femur, knee region; unable to bear weight; pain with PROM attempts; sent to ER.

Interview with the 1st personal care aide (PCA) on 11/16/15 at 12:09 pm revealed:
-He was working on 10/16/15 when Resident #7 fell during 3rd shift.
-Resident #7 was not capable of using the call bell system to ask for help.
-Resident #7 didn't like getting up when the PCA had to clean him.
-On 10/16/15 around 5 am, the PCA was in Resident #7's room to check on him and provide incontinent care.
-The resident was wet and needed to be changed, but wouldn't turn over for the PCA so he went and got 2nd PCA for assistance.
-The 2nd PCA came and both PCAs tried to turn Resident #7 but the resident wouldn't turn so they could clean him up and change him in bed.
-They got him up from the bed to go to the bathroom.
-The resident stood up with both staff holding his underarms from both sides.
-The resident took less than 2 steps from the bed and he slumped down and started falling.
-Both PCAs had the resident's arms so they lowered him to the floor in a kneeling position.
-Both PCAs picked him up and put him to bed.

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D 338	Continued From page 4 -Resident #7 didn't verbalize any pain during the 3rd shift. Interview with the 1st PCA on and 11/19/15 at 9:03 am revealed: - On 10/16/15 around 5:00am Resident #7 had a bowel movement and needed to be changed, but wouldn't turn over for the PCA, so he went and got 2nd PCA for assistance. -The resident was awake and his eyes were open. -After the resident was lowered to the floor, the resident put out one of his hands on the floor; he was in a crawling position. -The 1st PCA briefly let go of the resident's arm to catch a breath and tried to find something to clean the resident with. -The 2nd PCA was not holding the resident when the resident was in a crawling position. -Then in a split second, the resident fell on his face from the crawling position. -The staff usually didn't need extra help from another staff with Resident #7 and "once in a while" he did need extra help. -Every night was different for Resident #7; there was no set pattern when the resident resisted care; it depended on his mood. -The resident did not like getting up during the 3rd shift. Interview with the PCA who assisted the 1st PCA on 11/13/15 at 5:40 am, revealed: -Resident #7 was confused pretty much all the time. -The resident used a wheelchair to ambulate. -This staff didn't work with the resident other than helping other staff who was assigned to Resident #7 and didn't remember the details of the 10/16/15 fall.	D 338		

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Interview with a 3rd PCA on 11/18/15 at 10:40 am, revealed:
-Resident #7 usually got up during 1st shift when the staff went into his room around 7:30 am to get him up and to provide morning care.
-The resident slept through the night and didn't get up during 3rd shift.
-The resident's pull-ups were usually dry (85% of the time) when it was checked 1st thing during 1st shift.
-The resident was mostly confused especially waking up in the morning; the PCA always had to explain to him what is being done to him to ease his mind.
-The resident may resist changing pull-ups when he didn't understand what was going on.
-The resident cried a lot when he was upset about something.
-The resident was a one person assist and needed care with everything.
-The resident was able to use a urinal in bed by himself when this staff gave it to him.
-The resident slept with just a top on and a pull-up because it was easier to change him in bed during 3rd shift.
-The resident did not go to the bathroom a lot during day time; he usually was not a heavy wetter but he could be.
-On 10/16/15, when the PCA came to work, she saw Resident #7's incident report.
-She was in the resident's room at 7:30 am and the resident was awake in bed.
-She put on his socks and was putting on one of the shoes when the resident shook in pain so she stopped dressing him.
-Resident #7 was assessed by the wellness nurse; seen by facility's onsite physician assistant (PA); then transported to a local hospital by EMS.

Interview with a medication aide (MA) on 11/13/15

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D 338	Continued From page 6 at 6:15 am, 11/18/15 at 10:25 am and 11/19/15 at 9:55 am, revealed: -Resident #7 used a wheelchair and a walker to ambulate. -He was a high risk for falls and his gait was always off. -He required one person assist with all of ADL tasks except for eating. -He liked to sit on the couch in the TV room and went to activities. -The 1st shift PCA got him up in the morning. -He was on the facility's "Toileting Program", the PCAs took all residents to toilet every 2 hours. -The lead care manager was the third shift PCA in the SCU when Resident #7 fell on 10/16/15. -The PCA was taking the resident to the bathroom because the resident was unsteady on his feet. -When the 1st PCA went into the resident's room to check on the pull-up, he was already awake during third shift. -Typically Resident #7 required 1-person assist unless the resident was agitated then he would require 2-person assist with transfer. -Resident #7 was a heavy wetter so if he was wet during 3rd shift, incontinent care was provided. -When the 1st shift PCA went into the resident's room after 7am to provide morning care, he was very agitated and wouldn't let PCA dress him; couldn't put his pants on because he was in pain. -The resident's left knee was swollen and his face had an abrasion from the carpet. -The 1st shift PCA came and got her (1st MA); when she went into the room, Resident #7 was in bed with his left leg turned outward. -Resident #7's left knee joint area looked swollen. -The facility PA looked at the resident and sent him out to the hospital. Interview with the SCU's floor supervisor on	D 338		

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D 338	Continued From page 7 11/13/15 at 5:55 am, revealed: -Resident #7 was able to follow simple commands, like if he was told to "stand up", then he would. -His gait was unsteady; he constantly got up and if you didn't watch him, he would get up even in the common area where staff was watching the residents. -Resident #7 required one person assist. -He could become agitated and combative a lot during care; the staff would sometimes walk him around the hallway. Interview with the SCU Resident Care Coordinator (RCC) on 11/13/15 at 6:50 am, revealed she wasn't familiar with Resident #7 because she was newly hired and the resident fell during her 1st week of work in October. Interview with Resident #7's family member on 11/20/15 at 11 am, revealed: -When the resident first moved in around December, he had a fall and injured his vertebrae and had a fracture. -The resident was wheelchair bound for 5-6 months and suffered back pain. -During this time period, Resident #7's family members took turns sleeping in his room because he wasn't sleeping well and he was getting up at night. -After his fracture healed, the resident slept through the night and didn't try to get up; the family stopped sleeping over. -Incontinent care was provided mostly in bed and the family did not have any concerns about the incontinent care. -The resident wasn't necessarily an easy person to provide incontinent care to due to his age, dementia and embarrassment. -In October 2015 (didn't remember the exact date	D 338		

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of the fall), the family member received 2 calls from the facility staff when the resident had a fall in the morning.
-The family member never got a full story as to what and how the fall happened; just that the fall happened when the resident was going to a bathroom with a staff.
-Resident #7 had a hip fracture from the fall and was hospitalized in the hospital for 2 weeks after the surgery and then he was transferred to a nursing home.

Interview with the Health Care Coordinator (HCC) on 11/19/15 at 2:30 pm and 11/20/15 at 10:30 am, revealed:
-Resident #7 was a tall (6 ' 1") and thin man (155 lbs.); he wasn't heavy.
-The facility did not have a written policy on providing incontinent care in bed, but their protocol was that for non- ambulatory resident, the staff changed them in bed during their routine rounds and repositioned them.
-If the resident had a bowl movement, then soap and water was used to clean the resident.
-For ambulatory resident, if the resident had a bowl movement, then the residents were taken to the bathroom to clean and change.
-If the resident didn't like being awakened, the staff would take their time.
-If the resident was combative, then the resident was left alone and the staff were to return a few minutes later to re-attempt.
-All their PCAs were nurse aides; they were trained on toileting (bowel and bladder training) during licensed health professional support (LHSP) class upon hire.
-The facility's LHPS training was conducted by the HCC and coordinators.
-Their training was return/demonstrated in the LHPS class.

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D 338	Continued From page 9 Resident #7 was not observed or interviewed during the visits because the resident was not at the facility. ________________ The plan of protection dated 5/29/15 included the following: Immediate action facility will take to abate the violation: -During shift change beginning 11/20/2015 for the next two weeks, the care managers will receive refresher training in transferring residents. -The training will be provided by therapy, the resident care coordinator (RCD), the assisted living coordinator (ALC), the reminiscent coordinator (RC) or a lead care manager (LCM). -The training will include actual demonstrations and will focus on wheelchair transfers during toileting, transfers during dining, and transfers in and out of bed. -Any lead care manager who serves in a trainer capacity will receive "train the trainer" instructions from therapy, the resident care director, assisted living coordinator or the resident coordinator prior to providing training to care managers during shift change. The facility plans to ensure residents are protected from further risk or additional harm by: -Weekly unannounced observations of care managers assisting with transfers will be conducted by the ALC, RC, RCD and executive Director for the next 3 days. -At that time, the Quality Assurance Performance Improvement Committee (QAPI) will determine if the observation period needs to be extended. -Any incidents that may occur will be reviewed and discussed at leadership stand up meetings and follow up action will be initiated if needed.	D 338		

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D 338	Continued From page 10 -Please note that this process is already in place and is led by the Executive Director. -During new team member orientation there will continue to be an emphasis on resident transfer training, including return demonstration. - In addition, the weekly falls and transfer training that is already in place (and began in September 2015) and is being provided by our therapy partner will continue through the end of 2015. -At that time the QAPI committee will determine the frequency for the first quarter of 2016. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 5, 2015.	D 338		
{D914}	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to assure all residents were free of neglect related to Resident #7 sustaining a hip fracture while being assisted to the bathroom by 2 personal care aides. [Refer to tag D338 Residents' Rights].	{D914}		

Sunrise Senior Living
Plan of Correction

Name of Community: Sunrise at North Hills
Address: 615 Spring Forest Road
License number: HAL-092-108
Inspection date(s): 11/20/15
Name and Title of Sunrise Representative Signing the Plan of Correction: **Andrea Nobis Executive Director**

Signature of Sunrise Representative: Andrea Nobis
Date of Submission: 12/31/15

Regulation	Target Date by Which Correction will be completed	Plan of Correction
10A NCAC 13 F.0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hinderance.	Beginning: 11/20/15 Target date: 1/4/2016	**A. With respect to the specific resident/situation cited:** Resident # 7 still resides in the community. The resident receives physical and occupational therapy and Nurse support from a home health agency and has a mental health professional who provides care support. During shift change beginning 11/20/2015 for the next two weeks, the Care Managers will receive refresher training in transferring residents. The training will be provided by therapy, the RCD, the ALC, the RC, or a Lead Care Manager. The training will include actual demonstrations and will focus on wheelchair transfers, transfers during toileting, transfers during dining, and transfers in and out of bed. Any Lead Care Manager who serves in a trainer capacity will receive "train the trainer" instructions from therapy, the RCD, ALC, or the RC prior to providing training to Care Managers during shift change. (POP dated 11/20/15)

Reviewed and accepted 1/5/16 TLC

Responses on the enclosed plan of correction do not constitute an admission or agreement of the truth of the facts alleged or the conclusion set forth in the regulatory report. The responses are prepared solely as a matter of compliance with law.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
	Beginning: 11/20/15 Target Date: 1/4/2016	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** Weekly unannounced observations of Care Managers assisting with transfers will be conducted by the ALC, RC, RCD, and ED for the next 30 days. At that time, the Quality Assurance Performance Improvement Committee (QAPI) will determine if the observation period needs to be extended. (POP dated 11/20/15)
	Beginning: 11/20/15 Target Date: 1/4/2016	**C. With respect to what systemic measures have been put into place to address the stated concern:** Any incidents that may occur will be reviewed and discussed at Leadership stand up meetings and follow up action will be initiated if needed. Please note that this process is already in place and is led by the Executive Director. During new team member orientation there will continue to be an emphasis on resident transfer training, including return demonstration. In addition, the weekly falls and transfer training that is already in place (and began in September 2015) and is being provided by our therapy partner will continue through the end of 2015. At that time, the QAPI committee will determine the frequency for the first quarter of 2016. (POP dated 11/20/15).
	11/20/15 and ongoing	**D. With respect to how the plan of correction will be monitored:** The ED or designee is responsible for ensure implementation and ongoing compliance with all components of this Plan of Correction and addressing and resolving any variance that may occur. The Executive Director or designee is responsible for ensuring the status of this Plan of Correction is reviewed and discussed

Responses on the enclosed plan of correction do not constitute an admission or agreement of the truth of the facts alleged or the conclusion set forth in the regulatory report. The responses are prepared solely as a matter of compliance with law.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		at Quality Assurance /Performance Improvement Meetings and action initiated if required.
G.S 131D-21(4) Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.	Beginning: 11/20/15 Target Date: 1/4/2016	**A. With respect to the specific resident/situation cited:** Resident # 7 still resides in the community. The resident receives physical and occupational therapy and Nurse support from a home health agency and has a mental health professional who provides care support. During shift change beginning 11/20/2015 for the next two weeks, the Care Managers will receive refresher training in transferring residents. The training will be provided by therapy, the RCD, the ALC, the RC, or a Lead Care Manager. The training will include actual demonstrations and will focus on wheelchair transfers, transfers during toileting, transfers during dining, and transfers in and out of bed. Any Lead Care Manager who serves in a trainer capacity will receive "train the trainer" instructions from therapy, the RCD, ALC, or the RC prior to providing training to Care Managers during shift change. (POP dated 11/20/15)
	Beginning: 11/20/15 Target Date: 1/4/2016	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** Weekly unannounced observations of Care Managers assisting with transfers will be conducted by the ALC, RC, RCD, and ED for the next 30 days. At that time, the Quality Assurance Performance Improvement Committee (QAPI) will

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Regulation	Target Date by Which Correction will be completed	Plan of Correction
		determine if the observation period needs to be extended. (POP dated 11/20/15)
	Beginning: 11/20/15 Target Date: 1/4/2016	**C. With respect to what systemic measures have been put into place to address the stated concern:** Any incidents that may occur will be reviewed and discussed at Leadership stand up meetings and follow up action will be initiated if needed. Please note that this process is already in place and is led by the Executive Director. During new team member orientation there will continue to be an emphasis on resident transfer training, including return demonstration. In addition, the weekly falls and transfer training that is already in place (and began in September 2015) and is being provided by our therapy partner will continue through the end of 2015. At that time, the QAPI committee will determine the frequency for the first quarter of 2016. (POP dated 11/20/15).
	Beginning: 11/20/15 Target Date: 1/4/2016	**D. With respect to how the plan of correction will be monitored:** The ED or designee is responsible for ensure implementation and ongoing compliance with all components of this Plan of Correction and addressing and resolving any variance that may occur. The Executive Director or designee is responsible for ensuring the status of this Plan of Correction is reviewed and discussed at Quality Assurance /Performance Improvement Meetings and action initiated if required.

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