DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: **HAL-092-222**	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/14/22

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise of Raleigh	**4801 Edwards Mill Road Raleigh, NC 27612**

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)	COMPLETE DATE
C 000	The Adult Care Licensure Section and the Wake County Department Social Services conducted a follow-up survey and a complaint investigation on 10/13/22 and 10/14/22. The complaint investigation was initiated by the Wake County Department of Social Services on 10/10/22.	C 000		
C 359	10A NCAC 13F .1004 MEDICATION ADMINISTRATION (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents for record review (#4) related to medications used to treat depression and anxiety. The findings are: Based on interviews and record reviews, Resident #4's current FL-2 was not available for review. a. Review of Resident #4's signed physician's orders dated 06/27/22 revealed there was an order for Lexapro 10mg once a day. (Lexapro is used to treat depression and anxiety.)	C 359		

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C 359	Continue from page 1 Review of a physician's progress note for Resident #4 dated 10/05/22 revealed there was an order for Lexapro to be titrated down with the following instructions: take ½ tablet once a day for 7 days, then take ½ tablet every other day for 7 days and then discontinue to the medication. Review of Resident #4's October 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Lexapro 10mg once a day. -Lexapro 10mg was documented as administered from 10/01/22 – 10/14/22. Refer to Interview with the Resident Care Director (RCD) on 10/14/22 at 2:09pm. Refer to telephone interview with Resident #4's primary care provider (PCP) on 10/14/22 at 3:05pm. Attempted telephone interview with Resident #4's mental health provider on 10/14/22 at 2:47pm was unsuccessful. b. Review of a physician's progress note for Resident #4 dated 10/05/22 revealed there was an order to start Zoloft 25mg once a day. (Zoloft is a medication used to treat depression and anxiety.)	C 359		

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C 359	Continued from page 2 Review of Resident #4's October 2022 eMAR revealed there was no entry for Zoloft 25mg once a day. Refer to interview with the Resident Care Director (RCD) on 10/14/22 at 2:09pm. Refer to telephone interview with Resident #4's primary care provider (PCP) on 10/14/22 at 3:05pm. Attempted telephone interview with Resident #4's mental health provider on 10/14/22 at 2:47pm was unsuccessful. _____ Interview with the Resident Care Director (RCD) on 10/14/22 at 2:09pm revealed: -She was not aware of Resident #4's provider's note on 10/05/22 with the recommended medication changes. -The providers had not been providing the facility with the dictated notes after their visits to the facility.	C 359		

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C 359	Continued from page 3 -There was not a system in place to retrieve provider notes after their visits. Telephone interview with Resident #4's primary care provider (PCP) on 10/14/22 at 3:05pm revealed: -Resident #4 was seen by mental health related to suicidal ideations with no plan. -The mental health provider adjusted the Lexapro and Zoloft orders after their visit with Resident #4. -He was not aware that the recommendations for the medication changes made by the mental health provider were not implemented. -The recommendations should have been implemented to decrease Resident #4's suicidal ideations.	C 359		
C 372	10A NCAC 13F .1004 MEDICATION ADMINISTRATION (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered in accordance with infection control measures to help prevent the	C 372		

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C 372	Continued from page 4 development and transmission of disease or infection and prevent cross-contamination between residents during the medication pass. The findings are: Requests for the facility's medication infection control policy on 10/14/22 at 2:38pm was not provided during survey. Observation of the second floor 7:00am medication pass on 10/14/22 revealed: -At 7:25am, the MA removed a resident's Spiriva handheld inhaler from the medication cart and inserted the Spiriva capsule using her fingernails to position the capsule in the handheld inhaler. -She was not wearing gloves. -The MA's fingernails were approximately two inches long and pointed. -At 7:30am, the MA prepared a topical medicated cream into a medication cup. -At 7:38am, the MA entered the resident's room, administered the oral medications, gave the Spiriva inhaler to the resident, and applied the medicated cream to the resident's left arm with a gloved hand. -The MA took the Spiriva inhaler from the resident with the gloved hand she used to apply the cream. -The MA removed her gloves and returned the Spiriva to the medication cart. -The MA opened the top drawer of the medication cart and prepared another topical cream for	C 372		

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C 372	Continued from page 5 administration to the resident. -The MA did not perform hand hygiene before returning the Spiriva to the cart or before removing the topical cream. -The MA applied gloves, returned to the resident's room and administered the topical cream. -The MA removed the gloves and returned to the medication cart. -The MA touched the mouse, opened the medication cart drawer and began preparing medications for the second resident. -The MA removed 10 individual oral medications from the foil packets into a medication cup for the second resident. -The MA touched the water pitcher handle, picked up the water pitcher, and poured water into a cup. -The MA entered the second resident's room, picked up the bed remote from the floor, and raised the head of the resident's bed. -At 8:15am, without gloves, the MA placed the medication cup to the resident's mouth and one at a time pushed the medication into the resident's mouth from the medication cup with her fingernails. -The MA alternated the medication cup to the resident's mouth with the water cup until there was no more water. -There was a small container of electrolyte beverage that was approximately 25% full that contained a straw on the resident's bedside table.	C 372		

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C 372	Continued from page 6 -The MA picked up the container of electrolyte beverage and placed the straw in the resident's mouth. -At 8:19am, the MA returned to the medication cart, touched the handle of the water pitcher on the cart, poured additional water into a cup, and returned to the resident's room. -The MA did not perform hand hygiene after administering medications to the second resident and before pouring water from the water pitcher. -The MA placed the medication cup to the resident's mouth and pushed the remining oral medications into his mouth from the medication cup with her fingernail alternating with the water as she placed the cup to the resident's mouth. -The MA returned to the medication cart, threw the cups into the trash, picked up her purse, entered the elevator, pressed the first-floor button, exited the elevator, and took the medication cart keys from her pocket to give to the Executive Director (ED). -The MA did not perform hand hygiene when she returned to the medication cart to pour additional water from the water pitcher for the second resident. -The MA did not perform hand hygiene after administering the final medications to the second resident. Interview with the MA on 10/14/22 at 8:30am revealed:	C 372		

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C 372	Continued from page 7 -She was an agency MA. -She was leaving the facility without completing the medication pass because there was too much involved with the medication pass. -She did not answer when asked how she was trained regarding infection control during medication pass. Interview with the Resident Care Director (RCD) on 10/14/22 at 2:38pm revealed: -Today was the agency MA's first day working in the facility. -She reviewed the agency MAs credentials to verify she was qualified to care for the residents through the agency staffing electronic site prior to her working at the facility. -The agency MA should not have touched medications with her fingernails. -The agency MA should have performed hand hygiene after administering medications and before preparing the next resident's medications. -The MA should not have taken the resident's handheld inhaler from her with a gloved hand used to apply a topical medication. Interview with the Executive Director (ED) on 10/14/22 at 3:45pm revealed: -The agency MA's credentials were verified by the facility's corporate staff prior to contract. -She expected agency staff to follow the same facility policy as facility staff regarding infection control during medication pass.	C 372		

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C 372	Continued from page 8 -She was unsure what the facility policy was regarding infection control during medication pass. -The agency staff should have washed her hands before approaching the medication cart to prepare medications for administration to prevent cross contamination. -The agency staff should have washed her hands before entering residents' rooms. -The agency MA should not have touched medications with her fingernails because of a breach in infection control.	C 372		
C 274	10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. FOLLOW-UP TO TYPE B VIOLATION Non-compliance continues with increased severity resulting in death, serious physical harm, abuse, neglect or exploitation. THIS IS A TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow- up to meet acute health care needs for 1 of 7 residents sampled (#1) by delayed response to	C 274		

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C 274	Continued from page 9 reported severe hip pain related to a right hip fracture. The findings are: Review of Resident #1's current FL-2 dated 07/25/22 revealed diagnoses included unwitnessed fall, acute cystitis with hematuria, dementia, age related physical debility, paroxysmal atrial fibrillation, and primary hypertension, hypokalemia. Review of Resident #1's Resident Register revealed she was admitted to the facility on 05/24/22. Review of written statement regarding Resident #1 from personal care aide (PCA) dated 09/14/22 revealed: -On 09/07/22, resident was acting her normal and allowed the PCA to assist her in toileting with no complaints of pain. -On 09/08/22, PCA was assigned resident for normal morning get up routine and the resident insisted she did not want to get up because she was hurting. -PCA told resident she would let her rest and check on her and hopefully get her up and dressed. -The resident's family member came in the middle of breakfast for his usual visit with resident and inquired why she was not in the dining room.	C 274		

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C 274	Continued from page 10 -The PCA told the family member that the resident refused to get up because she was in pain. -When PCA inquired if the family member would like her to get resident up, he responded yes. -The PCA, care manger, and the family member cleaned and dressed the resident who was screaming from the pain of being rolled from side to side to change the brief and pull pants up. -The resident was transferred to the wheelchair and pushed to the dining room where she began to slide down in the wheelchair. -Her family member stated he would rather have her back in bed. -The PCA reported the situation to lead medication aide who then gave the resident her pain medication. Review of written statement regarding Resident #1 from second shift care manager dated 09/14/22 revealed: -On 09/07/22, the resident was already up and stayed up until after dinner. -The resident was put in bed around 7:30pm. -The resident complained of pain when the care manager tried to change her. -The resident complained more when the care manager tried to roll resident to right side. -The MA was notified, and the care manager believed the as needed medication for pain was administered.	C 274		

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C 274	Continued from page 11 Review of Resident #1's physical therapy (PT) daily treatment note dated 09/08/22 at 4:36pm revealed: -The resident was lying face up in bed and reported left shoulder pain. -Per the care manager that was in the room with PT, the resident had not eaten lunch or been out of the bed. -The resident was transferred to the wheelchair with a two-person assistance. -The resident complained of lower leg pain and refused to flex her right knee. -The resident was stiffening her whole leg and was sliding off the chair groaning in pain. -Both legs were normal to touch. -The resident complained of pain with a gentle squeeze to right calf. -The resident had no pain in the left thigh. -The physical therapist informed MA in the hallway and per the MA the resident had already taken her pain medication. Review of written statement regarding Resident #1 from physical therapist #2 dated 9/14/22 revealed: -The resident was seen the morning of 09/08/22 and was lying face up in bed sleeping. -The physical therapist came back after lunch and resident was still in bed. -The physical therapist asked the care manager and was informed resident has not gotten out of bed and has not eaten lunch.	C 274		

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C 274	Continued from page 12 -The resident refused to get out of bed but was encouraged so she could eat lunch. -The resident continued to refuse and needed two-person assistance to sit up. -The resident was transferred from the bed to the wheelchair with two-person assistance. -The resident was stiffening her right leg and refused to bend her right knee. -The resident was sliding off her wheelchair and the physical therapist decided to transfer back to bed. -PT informed MA and was told resident had already taken Tylenol. Review of Resident #1's PT daily treatment note dated 09/09/22 at 4:55pm revealed: -The resident was lying face up in bed and reported left shoulder pain. -The resident cried out in pain with any attempts at right leg movement. -The resident complained of lower leg pain and refused to flex her right knee. -Attempts at gentle rolling to assist in change of adult brief required two-person assistance to support right leg in neutral position and the resident still cried out in pain. -The resident was assisted from bed to wheelchair per the MA, stating that he was awaiting orders for pain medication in addition to Tylenol. -The rehabilitation physician was notified.	C 274		

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C 274	Continued from page 13 Review of written statement regarding Resident #1 from the MA/care manager on 09/14/22 revealed: -On 09/08/22, the physical therapist approached her to discuss the resident's complaint of pain in leg. -The physical therapist stated the resident complained of pain in her leg but was currently on therapy caseload for left arm. -The Special Care Unit Coordinator (SCUC) informed the physical therapist the resident was admitted with left hip/leg fracture. -The physical therapist told the SCUC she was not aware of the diagnosis. -On 09/10/22, (Saturday) the resident's family member came to visit her. -The SCUC informed the family member the resident was still in pain. -The family member stated the resident began complaining of pain in her right hip on 09/07/22 (Wednesday) after her physical therapy visit. -The family member asked about a stronger medication than Tylenol and an x-ray. -The SCUC said she would send the wellness nurse to speak with family member. -The resident's family left the facility prior to wellness nurse visit. -On 09/11/22, (Sunday) the family member returned asking again about medication and x-ray, but again left prior to the wellness nurse's visit. -The SCUC let the wellness nurse know about the situation.	C 274		

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C 274	Continued from page 14 Review of Resident #1's electronic progress note created 09/10/22 at 2:39pm revealed: -The resident complained of pain in right hip. -The resident had order for Tylenol Extra Strength 500MG 2 tablets by mouth three times a day for pain. -The Physician Assistant was notified and requested to add the resident to Monday's schedule, 09/12/22 along with an x-ray of the right hip. -There was no prior documentation of hip/leg pain. Review of Resident #1's occupational therapy (OT) daily treatment note dated 09/12/22 at 6:50am revealed: -The resident was lying face up in bed at the start of the session. -The OT was made aware the resident had an increase of right leg pain since 09/08/22. -The OT discussed with the resident and resident reported "I'm not sure what's wrong…it just hurts." -The x-ray tech entered the room to complete x-rays of both hips. -The Physician Assistant confirmed a right hip fracture and would complete a comprehensive assessment. Review of Resident #1's Accident/Incident Report completed 09/13/22 at 12:13pm revealed: -The date and time of incident was 09/12/22	C 274		

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C 274	Continued from page 15 at 12:00pm. -The resident lived on the special care unit (SCU) on the third floor. -A mobile x-ray of the resident revealed a fracture in the right hip. -A visual assessment was completed. -The resident was sent to the emergency room (ER) for further evaluation on 09/12/22. -There was no location of the event documented on the incident/accident report. Review of Resident#1's electronic progress note created 09/12/22 at 12:46 pm revealed: -The resident was transferred to the hospital. -X-ray result showed right hip hairline fracture. Review of Resident # 1's Primary Care Prover (PCP) notes dated 09/12/22 revealed: -Patient is being seen today at staff request. The patient had a fall 2 weeks ago and at that point was sent to the ER. She did have a left humerus fracture reoccurring. No other injuries found. The patient has returned to the facility and was working physical therapy and then last week she had extreme pain in her right hip during PT. No falls reported or noted. No injury or trauma reported. However, we did obtain x-rays once we were notified by staff of her right hip pain, and these are positive for right hip fracture. Patient will be sent to ER as a plan.	C 274		

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C 274	Continued from page 16 -Patient had a fall a few weeks ago was sent to the ER for evaluation. She was found to have a humerus refracture, but no other injury sustained. She has been back to the facility at baseline but then started having some right hip pain last week after physical therapy. Staff notified us of this today and she does have severe right hip tenderness and pain, so x-rays were obtained. These were reviewed and positive for right femoral head fracture acute. No other falls or injury or trauma noted, the patient will be sent to the ER in light of this finding. Review of a hospital discharge summary for Resident #1 revealed: -She was hospitalized from 09/12/22 – 09/20/22. -She was taken to the hospital for complaints of increased right hip pain causing difficulty with ambulation. -On 09/12/22, an x-ray revealed an impacted right femoral neck fracture and on 09/13/22, she underwent a partial hip replacement. -She was discharged from the hospital on 09/20/22 to a skilled nursing facility in anticipation of skilled care. Review of email from the family member of Resident #1 dated 09/09/22 and 11:53am revealed: -The resident's family emailed both the Resident Care Director (RCD) and Resident Care Coordinator (RCC).	C 274		

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C 274	Continued from page 17 -The family member visited the resident on 09/08/22 and 09/09/22 to find her in horrible pain. -The family member was told pain was from PT on 09/07/22. -The pain was so severe the resident could not move and stopped eating and drinking. -The family member was concerned for her welfare and asked if there were any suggestions as to what could be done to help the resident. -On 09/12/22, the RCD responded to the family member via email and informed him that the resident would be seen by the PCP on this date. -The RCD also informed the family member a stronger pain medication had been requested. Interview with lead care manager (LCM) of the SCUC unit for Resident #1 on 10/14/22 at 9:33pm revealed: -The resident wanted to be independent and would attempt to take care of herself without asking for help, resulted in multiple falls. -The resident had 6 or 7 falls since her admission. -The last fall in September resulted in hip surgery. Interview with 2nd shift LCM/MA of the SCU for Resident #1 on 10/14/22 at 9:50am revealed: -The resident went to PT on a Wednesday and began complaining of pain in her leg on Thursday. -She was not sure of the exact dates. -On Saturday and Sunday of the same week, family member asked about a stronger pain medication	C 274		

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C 274	Continued from page 18 and a mobile x-ray. -The LCM/MA informed the wellness nurse of family concerns. -The family member left before the wellness nurse could see him. Interview with RCD on 10/14/22 at 11:00am revealed: -It was the responsibility of the MA to notify the RCD of changes in a resident's condition. -It was the RCD's responsibility to communicate resident changes in condition with the PCP and receive and process new orders. -Staff were expected to contact the RCD for issues concerning pain management when the wellness nurse was not available. -On 09/10/22, the RCD instructed the wellness nurse to notify PCP of right hip pain and request resident be added to Monday's schedule (09/12/22) along with an x-ray of the right hip. Interview with Executive Director on 10/14/22 at 11:15am revealed: -The Wellness nurse had the responsibility to contact provider with resident concerns. -If the Wellness Nurse was not available the RCD should have been contacted. _____ The facility failed to notify Resident #1's primary care provider (PCP) of new onset right hip pain for 3 days which caused her to have decreased mobility and decrease in appetite.	C 274		

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C 274	Continued from page 19 Resident #1 voiced complaints of increased pain to her right hip on 09/07/22 through 09/12/22 during personal care and transfers, the cause of the increased pain was unknown. Despite several requests from a family member, the physician was not notified of the pain in her hip, decreased appetite and decreased mobility until 09/10/22 whereby the PCP ordered an X-ray which revealed a fracture of the right hip. The resident was not sent out for medical evaluation until 09/12/22. The resident was sent to the hospital and underwent a partial hip replacement and was transferred to a higher level of care upon discharge. The facility's failure to notify the PCP of the resident's new onset hip pain resulted in serious physical harm and neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/14/22 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED NOVEMBER 13, 2022.	C 274		

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