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
	HAL092209	A. BUILDING: ______ B. WING ______	R-C **01/19/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF CARY	**1206 WEST CHATHAM STREET** **CARY, NC 27513**

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D 000	Initial Comments The Adult Care Licensure Section and the Wake County Department of Social Services conducted a follow-up survey and complaint investigation on January 18, 2023 to January 19, 2023. The complaint investigation was was initiated by the Wake County Department of Social Services on November 8, 2022.	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 A2 VIOLATION Based on observations, interviews, and record review, the facility failed to ensure 2 of 6 sampled residents (#3, #6) were treated with respect, dignity, and consideration related to the facility policy for resident refusal of personal care and reporting of behaviors (#3, #6), verbal threats (#6), and allowing them the right to refuse a shower (#3, #6) . The findings are: Review of the facility's policy for Resident Rights and Principles of Service dated 08/20/13 revealed: -The purpose of the policy included that resident rights were to be upheld. -Residents had the right to be valued and receive ethical treatment. -Residents were to have the freedom from abuse, neglect, exploitation, punishment, humiliation,	D 338		

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and intimidation.
-Residents were to be treated with dignity, respect, kindness, consideration, and as a person of worth.
-Residents would receive privacy and protection.
-Residents were to be free from the control and influence of others.
-Resident had the right to have staff members create opportunities for them to make choices.

Review of the facility's policy for Abuse, Neglect, and Exploitation - Prevention, Reporting, and Investigation (not dated) revealed:
-Every reasonable effort would be taken to prevent abuse, neglect, and exploitation of residents.
-Team members must not engage in or permit anyone else to engage in abuse, neglect, or exploitation of any resident.
-Team members were mandated reporters to known or suspected abuse, neglect, and/or exploitation and must immediately notify the ED or designee to ensure appropriate and timely action were taken for the safety of the resident and those potentially impacted.
-Abuse was defined to include unreasonable confinement, intimidation, or punishment with resulting harm, pain, or mental anguish.
-Verbal abuse was defined as disparaging, taunting, or derogating oral, written or gestured communication toward a resident.
-Psychological abuse was defined as non-physical mistreatment that may include humiliation, harassment, or threats.
-Involuntary seclusion or isolation was defined as the separation of the resident from others against their will.
-Neglect was defined as the failure to provide good and services necessary to protect the resident from health or safety hazards.

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-Staff were to have education upon hire and on-going on the prevention, reporting, and documentation of abuse, neglect, and exploitation to include how to report, definitions, strategies to identify and intervene, interventions to deal with aggressive or combative residents, and how to ensure resident safety.
-Upon notification of abuse, neglect or exploitation, the ED would have the resident evaluated by a nurse, remove alleged individuals involved, ensure the resident's physician, legal representative, and family member were notified, and follow the reporting process with an investigation, implanting corrective actions from the investigation, and a written report as required.

1. Review of Resident #6's current FL-2 dated 09/30/22 revealed:
-Diagnoses included Alzheimer's disease, Type 2 diabetes mellitus, hypertension, and anxiety.
-The resident resided on the Special Care Unit (SCU).
-The resident was ambulatory and incontinent of bladder and bowel.
-There was no documentation of orientation status or behaviors.

Review of Resident #6's previous FL-2 dated 11/15/21 revealed the resident was intermittently disoriented.

Review of Resident #6's Resident Register dated 11/15/21 revealed:
-The resident was admitted to the facility on 11/20/21 and discharged from the facility on 10/10/22.

Review of Resident #6's current care plan dated 09/13/22 revealed:
-The resident had impaired cognitive function due

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to Alzheimer's disease and could become combative when irritable requiring supervision, options, and the ability to make her own decisions.
-Staff were to report any signs or symptoms of mood change to include inability to focus or anxious behavior.
-The resident could become physically aggressive and staff were to contact her provider when this happened.
-Staff were to engage the resident with empathy being sensitive to her needs and offer choices while encouraging independence.
-Staff were to engage with the resident in a calm manner.
-The resident required assistance to the bathroom and incontinent episodes and staff were to assist her with dignity in getting cleaned up.
-The resident required assistance with bathing and showering and staff were to alert the Resident Care Director (RCD) if she refused to sit down during a shower reporting any changes observed.
-The resident preferred privacy during showers and staff should allow her to cover up as much as possible while bathing.

Interview with a medication aide (MA) 01/19/23 at 12:20pm revealed care plans provided shower and other personal care directives.

Review of an email correspondence dated 09/15/22 revealed:
-The email was from Resident #6's family member to the Executive Director (ED) and copied to the Assisted Living Resident Care Coordinator (RCC) and the Resident Care Director (RCD).
-The email requested to confirm a summary of a

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phone call that took place between the parties earlier that day with requests related to Resident #6's care that included:
-Looking into lessening the need of a private sitter (a sitter was initiated per the facility's request on 08/23/22 after behaviors of resident on resident aggression involving Resident #6).
-Having caregivers receive training to handle Resident #6 with an example that they would not yell at the resident and instead distract her.
-A request to have all interventions for Resident #6 provided to her in writing with outcomes.
-And to receive an update and plan on a weekly basis.

Review of an email correspondence dated 09/19/22 revealed:
-The email was from the ED to Resident #6's family member.
-The ED thanked the family member to their time to discuss Resident #6 and the concerns they had for the resident.
-The ED offered understanding to their frustrations and concerns and after discussion with the RCD and regional care team offered the following interventions:
-A request to keep a private sitter with Resident #6 24/7 due to aggression toward others to remain a resident at the facility.
-The ED attached a copy of Resident #6's care plan to define additional specific interventions for the resident.
-In closing, the ED noted that Resident #6 had not had any further unusual behaviors outside of her normal baseline documented.

Review of an email correspondence dated 09/19/22 revealed:
-The email was from Resident #6's family member to the ED, RCC, and RCD.

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-The family member requested clarification of Resident #6's incident that occurred on 09/18/22.
-The previous email indicated there had not been any further incidents of aggression however she received a call the previous day stating the resident had experienced an issue.
-To her knowledge, Resident #6 had an incontinent episode, refused to shower, was embarrassed, and the family member was told by a staff member that "We had to physically drag her (Resident #6) into the shower kicking and screaming or else she would have "xxxx" all over her".
-She questioned if that was normal facility protocol.
-She visited Resident #6 the same day in which the resident reported she "was beat up today".
-The family member acknowledged Resident #6 had behaviors but felt there was a better solution to getting the resident cleaned up and could have been offered time to calm down.

Review of Resident #6's progress note dated 09/19/22 revealed:
-The resident had an incontinence episode in her shoe and tried to put it back on.
-The staff attempted to provide the resident with a shower, and she resisted care.
-A shower was given per the personal care aide (PCA).
-The progress note was documented by the Assisted Living Resident Care Coordinator (RCC).

Review of Resident #6's progress note dated 09/19/22 revealed:
-Per the PCA, the resident had an incontinence episode in her shoe and was resistant to care.
-The resident required assistance and redirection.
-The resident was able to be bathed with "strong

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encouragement and reluctant to assistance" by staff.
-The shower was completed for the resident and a sitter remained in place for supervision.
-The progress note was documented by Resident Care Director (RCD).

Review of an email correspondence dated 09/20/22 revealed:
-The email was from the RCD to Resident #6's family member and the ED and RCC were copied.
-The RCD stated Resident #6 had an incontinent episode and needed a bath.
-The RCD stated she heard Resident #6 was reluctant to get into the shower but she ultimately did get washed off and bathed.

Interview with Resident #6's family member on 01/19/23 at 5:16pm revealed:
-She received a phone call from Staff C (a PCA), she could not recall who, on 09/18/23, who stated Resident #6 had a bowel movement and had "*xxxx*" on her feet in which she had refused assistance in getting cleaned up.
-Staff C made it sound as if the escalation of the incident was Resident #6's fault and she had to instruct the Staff C to calm down, give Resident #6 a medication that was prescribed as needed for anxiety, and after giving the medication some time to work, try again to assist the resident with care.
-Staff C told her that she had already cleaned Resident #6 up as best as she could at that point and had drug the resident into the shower to ensure the resident did not have any more feces on her.
-After the phone call from Staff C, the family member immediately went to the facility to assess Resident #6 and see her in person.

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-Upon seeing Resident #6, she did not have any marks or bruises that she could see on her, but the resident immediately told her she "got beat up today" and that the staff had been real rough with her.
-She reported the incident to a staff member (she could not recall who) who did not seem concerned and commented that Resident #6 "gave them a run for their money".
-She emailed the ED the next day, 09/19/22, and the ED called her back on 09/20/22 to let her know that Staff C involved in the incident no longer worked at the facility.
-The Resident Care Director (RCD) replied to her via email on 09/20/22 in which she acknowledged the episode and apologized for what happened.
-She subsequently requested a meeting with the facility that occurred on 09/26/22 in which she was told that the only intervention that was done in response to the incident was to fire Staff C after they did an internal investigation.
-The facility told her that due to Resident #6's history of aggression the family was required to continue to maintain a private sitter with out of pocket funds if the resident was to continue to reside at the facility.

Review of a facility Privileged and Confidential Statement of Event dated 09/26/22 revealed:
-The document was written by the RCD.
-During a care conference with Resident #6's family member and the ED included remotely, the family member expressed concern about an event that occurred on 09/18/22.
-The family member stated that a staff member called her to report Resident #6 had an incontinent episode and was resistant to bathing.
-The family member stated the staff member said, "I literally had to drag her in the shower kicking and screaming or she would have been

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covered in *xxxx*".
-The facility offered Resident #6's family member an apology and emotional support.

Review of the private sitter's written statement dated 09/25/22 revealed:
-Resident #6 had an incontinent episode on 09/18/22 but declined assistance in getting cleaned up so she requested facility staff to come in and assist.
-The facility staff tried multiple times to clean Resident #6 up but she was not cooperative.
-Staff C called for help and Staff A came and they cleaned the resident up.

Review of the private sitter's written statement dated 10/03/22 revealed Resident #6 was forced to take a bath.

Review of a written statement by Staff A (a PCA) dated 09/30/22 revealed:
-She was called to assist in giving Resident #6 a shower and the resident became aggressive.
-Resident #6 stated she did not want to take a shower and tried to run out of the shower.
-She and Staff C (a PCA) continued to try and wash the resident who was trying to throw herself down in the shower.
-They held the resident to keep her from falling and the resident bit her on the arm.
-They took Resident #6 out of the shower and the resident was "fussing", so they gave her a towel to dry herself off and left her with her private sitter to get dressed.

Interview with Staff A on 01/18/23 at 4:39pm revealed:
-She had been employed at the facility for approximately 9 months and was responsible to assist residents with their activities of daily living

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D 338	Continued From page 9 (ADLs). -She was working the day Resident #6 became aggressive (yelling, hitting, and biting) and upset about not wanting to shower on 09/18/22. -She did not witness the beginning of the incident and the interactions that led up to the resident becoming upset, but she was asked to assist Staff C in re-approaching the resident to attempt to provide the resident with a shower. -She entered the resident's room with Staff C and the resident's private sitter remained in the room the entire time. -Staff C encouraged Resident #6 to shower, and the resident was responding back verbally, but she was unable to understand what the resident was saying. -Resident #6 was willingly escorted into the bathroom where she willingly undressed, then she and Staff C escorted the resident into the shower. -Staff C washed Resident #6 while she stood in front of the resident to ensure the resident did not fall. -She did not recall the exact words Resident #6 said, but the resident almost immediately became upset when the shower began and wanted to get out but they needed to clean the resident. -Resident #6 began pulling her hair and bit her arm when she was trying to get out of the shower, but Staff C did not stop the shower and continued to wash the resident until she was clean. -When Resident #6 became upset about showering, they could have stopped sooner but it only took a short amount of time to clean the resident and she thought they were helping the resident. -During the incident, Staff C washed the resident while she tried to calm the resident and redirect her during the shower when the resident began trying to throw herself down.	D 338		

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-She and Staff C then assisted Resident #6 out of the shower and into her bedroom where her private sitter assisted the resident in getting dressed; she left the room, and Staff C came out of the room shortly thereafter.
-On the day of the incident it was only the second time she had worked with Staff C.
-She had never witnessed Resident #6 have any behaviors prior to the shower incident.
-She was trained upon hire to never force residents to do anything they did not want to do and to get a lead PCA or coordinator involved if a resident became upset and refused care.
-She was trained to allow residents space and time to calm down if they became upset and try again later with a different staff member.
-She was trained to report resident behaviors to the lead PCA and do an incident report when they occurred, but she did not do this because the resident was assigned to Staff C who said she was going to do it.
-She notified Staff B (the lead PCA) and the coordinator before she left that she and Staff C had showered Resident #6 and that the resident bit her.

Telephone interview with Staff C (a PCA) on 01/19/23 at 10:04am revealed:
-She was in the dining room when Resident #6's sitter requested assistance getting the resident cleaned up from a toileting accident.
-When she went to Resident #6's room, the resident was standing in the hallway and smelled like feces.
-She escorted Resident #6 into her room and the resident began to become irritated because she did not want to go to her room.
-She told Resident #6 that she smelled like feces and went into the bathroom with the resident where she encouraged the resident to allow her

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to clean her up and give her a shower.
-Resident #6 began calling her names and telling her she did not want to shower.
-Resident #6 became aggressive when she tried to remove the resident's clothes.
-She told Resident #6 she could either take a shower or be wiped down, and the resident declined both options.
-She then requested Staff B's assistance at that time because the resident needed a shower but did not want to be touched.
-When Staff B entered Resident #6's room the resident became more escalated, and she left the room to call and notify the resident's family member that the resident was refusing to shower.
-Staff B told her she was unable to provide Resident #6 with a shower and left her alone to calm down.
-She then went and asked Staff A to go back to Resident #6's room a little while later to help her shower the resident.
-She and Staff A entered the room together and Staff A removed Resident #6's clothes and showered her even though the resident said she did not want to shower.
-She did not go into the bathroom with Staff A and the resident but stood outside the door and observed the resident flailing her arms while Staff A held the resident in the shower and washed her.
-Staff A "man-handled" Resident #6 but never threatened or forced the resident and took a couple of punches from the resident.
-Staff A then assisted Resident #6 into her bedroom where her private sitter assisted her in getting dressed.
-She reported the shower incident to Staff B but did not do an incident report because she thought Staff A was going to do it since the resident bit her.

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-She did not report the incident to anyone else because she only thought she had to tell Staff B who was responsible to notify the Special Care Coordinator (SCC) who would then notify the Resident Care Director (RCD).

Review of Staff B's (lead PCA) written statement dated 09/26/22 revealed:
-Staff C asked her to assist with Resident #6.
-When she arrived to the room, she heard Staff C telling the resident "you're going to get in that shower or I'm going to throw you in the shower".
-Staff C then left the room as soon as she walked in because she was mad.
-Resident #6 was shaking and upset and she tried to calm her down, but she would not let her assist.
-She tried a few times to help Resident #6 but she did not want the assistance and became more upset the more she tried insisting she could clean herself up.
-She decided to give the resident a few minutes to settle down.
-Staff C and Staff A then forced Resident #6 into the shower and the Staff A was bit on the forearm by the resident.

Interview with Staff B on 01/19/23 at 8:48am revealed:
-She was in the dining room on 09/18/22 when Resident #6's sitter requested assistance and she asked Staff C to go to the resident's room to assist.
-Approximately 10-15 minutes later Staff C called her via the walkie talkie and requested her assistance to Resident #6's room where Staff C and sitter were attempting to get the resident to agree to a shower.
-When she walked into the room, she overheard Staff C telling Resident #6 something to the effect

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D 338	Continued From page 13 of, "You're going to get into the shower, or I am going to put you in the shower" and then Staff C threw her hands in the air and left the room seeming frustrated. -Resident #6 was visibly upset and had stool on her foot and in her shoe, and was stating she did not need assistance and could clean herself. -At that time she tried to calm Resident #6 because the resident was too upset to attempt to provide her any care. -She then told Staff C and the sitter to leave Resident #6 alone and give her time to calm down and she would try again a little later. -About 10-15 minutes after she left Resident #6's room she saw Staff C and Staff A in the hallway with wet shirts and the care manger stated something to the effect of "We got her (Resident #6) in the shower, she did not like it, but she got one" and the Staff A stated she had been bit by Resident #6. -She would have expected Staff C to not go into Resident #6's room again and wait for her to assign someone else to attempt to provide care to the resident after about 30 minutes. -She observed Resident #6 approximately 10 minutes later who was clean, dressed, and calm at that time. -She had never witnessed Staff C that upset or talk to a resident in an angry tone before the incident with Resident #6. -She did not instruct Staff C to re-approach Resident #6 to shower and if she had known Staff C was going to do so, she would have instructed another staff member to attempt to provide the resident with care per her training. -She was trained to allow residents time and space to calm down if they became upset and declined care, then to re-approach in approximately 30-minutes by another staff member.	D 338		

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-If that was not effective the process was to elevate the incident to a lead PCA, the SCC, or RCC.
-Resident #6 was usually easily redirected, did not usually decline care, and she was unsure why the resident had become so upset prior to her entering the room.
-She did not report the verbal threat she heard Staff C express to Resident #6, she did not know why.
-She should have reported the incident to the RCD because Resident #6 had been threatened verbally and was physically made to shower, but had notified the previous SCC verbally and assumed the previous SCC would have notified the RCD who oversaw the whole building.
-She did not document the incident in Resident #6's record, but she did document a handwritten note of what she witnessed for the previous executive director (ED).

Interview with Resident #6's primary care provider (PCP) on 01/19/23 at 10:31am revealed:
-Resident #6 resided on the Special Care Unit (SCU) due to neuro cognitive behaviors in which she had a private sitter and had medication management with a mental health provider (MHP).
-She was not notified of an incident in which Resident #6 was forced to shower after refusing to do so and would have expected the facility to notify her.
-The facility's Health and Wellness Nurse (HWN) had brought a concern to her attention about Resident #6 having a bruise on her arm of unknown origin which she assessed on 09/27/22 because she was told the resident had been combative with care.
-Resident #6 was not oriented enough to say where she obtained the bruise, but it appeared

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purple and in the healing stages - it was hard to say what time frame she had sustained the bruise.
-If she had known Resident #6 had been forced to shower, she would have ensured the resident's safety by ensuring the facility had taken appropriate steps to notify the resident's MHP and investigate the incident.

Telephone interview with Resident #6's MHP on 01/19/23 at 1:39pm revealed:
-She was not aware Resident #6 was forced to shower against her will and would have wanted to be made aware so she could assessment the resident and possibly provided orders for interventions or medication changes based on her behaviors.
-Not reporting incidents in which Resident #6 was under duress from verbal threats or being forced into care she did not want to participate in could lead to decompensation of the resident's mental health and stability, a safety risk to herself, other residents, or staff members and it was important to report for the resident's overall well-being..

Interview with the current SCC on 01/18/23 at 4:16pm revealed:
-She was very familiar with Resident #6 and the incident that occurred on 09/18/22, but she did not witness the incident.
-The progress report that she wrote in Resident #6's record was per a verbal report staff had told her and did not include that that the resident had been forced to shower.
-She was not aware that staff had forced Resident #6 to shower until the family reported a complaint a few days after the incident and an investigation was performed by the previous Executive Director (ED).
-Staff were trained upon hire to report any

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concerns of suspected or witnessed abuse immediately or as soon as possible.
-Staff were trained to allow residents to calm down when they refused care and became upset or agitated, then re-approach two more times using different staff members by requesting help from the lead PCA or RCD.
-If a resident continued to refuse care after 3 approaches staff were trained to request assistance from the resident's family member for further interventions.
-Residents had a right to refuse care and it was always inappropriate and unacceptable to force a resident to do something they did not want to do.
-She was not sure if any staff members admitted to forcing Resident #6 to accept care and there were no other incidents that she was aware of in which there had been any concerns.
-She was not familiar with the staff member that was involved in possibly forcing Resident #6 to shower.
-She was the Resident Care Coordinator during that time and assumed the Special Care Coordinator (SCC) or the Resident Care Director (RCD) reported the incident to the previous Executive Director (ED).

Second interview with the current SCC on 1/19/23 at 4:45pm revealed:
-Staff knew not to force showers (care); to re-approach the resident later; or seek another staff to attempt the shower.
-Staff's care expectations, residents' care plans and special instructions, and changes are documented in the facility's electronic documentation system
-After 3 care refusals, she would attempt to shower the resident, report the refusals to the Executive Director (ED), then investigate the incident.

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Interview with the previous ED on 01/19/23 at 1:22pm revealed:
-He was the ED at the facility from June 2022 to December 15, 2022 and was responsible for the overall operations and supervision of the entire building.
-Resident #6 was a resident on the SCU with a diagnoses of Alzheimer's disease who had occasional behaviors toward staff and other residents.
-He investigated an incident that occurred on 09/18/22 in which Resident #6 had stooled in her shoe and staff C had tried to shower her.
-Staff C had requested the assistance of Staff B which did not work and they left the resident's room.
-Staff C then returned to Resident #6's room with Staff A and showered the resident.
-He was told that Staff C told Resident #6 she was "going to throw the resident in the shower".
-He was unsure if Resident #6 was a willing participant in the shower but was told Staff C held the resident under her arms.
-The incident happened on a Saturday morning, and he was notified a few days later.
-He began an investigation within 30 minutes of being notified of the incident and interviewed Staff A, Staff B, and the RCD, but was unable to interview Staff C who was accused of being involved because she no longer worked at the facility and did not respond to his attempts to contact her.
-He was unable to interview Resident #6 due to her being disoriented.
-His investigation resulted in him substantiating that Staff C, who no longer worked at the facility, verbally abused Resident #6, but did not physically abuse the resident, based on his interviews.

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-He was not aware that Resident #6 had been forced to shower under duress and expected to have been notified of that information.
-He interviewed Staff A who told him "they (Staff A and Staff C) did force but did not force the resident to shower", meaning they essentially did force the resident to shower but did not feel they mistreated or abused the resident.
-Residents were expected to be safe and cared for without duress or abuse and treated with dignity and respect.
-He expected staff to report any issues immediately to the SCC or the RCD who in turn should have reported it to him.
-Staff were trained upon hire to report all incidents involving resident rights, abuse, or neglect immediately.
-Staff were trained to allow residents time to calm down if they became upset and never force residents into care.

Interview with the Corporate Executive Director (CED) on 01/19/23 at 3:32pm revealed:
-She came to the facility when the previous Executive Director (ED) stopped working at the facility on or around 12/22/22.
-The previous ED told her about the incident with Resident #6 in November 2022 and stated the resident was allegedly pushed or forced to take a shower.
-She was told that Resident #6 was soiled, declined to be cleaned up, and that two PCA's and a sitter showered her anyway.
-Resident #6 was verbally abused and forced to shower under duress.
-Staff were expected to never force residents to do anything they did not want to do and to stop when a resident said to stop.
-Staff were trained to get help when a resident has behaviors and to give the resident space and

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time to calm down.
-If a resident still declined care after being given space and time to calm down, a new staff member should attempt to meet the resident's needs.
-If on a third attempt to provide care to the resident and they still declined, staff were trained to get the resident's family involved.
-Staff should have never showered Resident #6 against her will and should have respected her wishes to stop immediately when told while ensuring the resident's safety.

Attempted telephone interviews with Resident #6's private sitter on 01/19/23 at 10:03am, 11:47am, and 1:12pm were unsuccessful.

Attempted telephone interview with the previous RCD on 01/19/23 at 1:11pm was unsuccessful.

Attempted telephone interview with the previous SCC on 01/19/23 at 3:23pm was unsuccessful.

Based on interviews and record reviews, it was determined that Resident #6 was not interviewable.

2. Review of Resident #3's FL-2 dated 11/08/22 revealed:
-Level of physician-recommended placement was the Special Care Unit (SCU).
-Diagnoses included dementia with Lewy bodies, anxiety, and osteoarthritis.
-The resident was intermittently disoriented and was ambulatory.

Review of Resident #3's Resident Register dated 11/08/22 revealed the resident had significant memory loss.

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Review of Resident #3's care plan dated 11/13/22 revealed:
-The resident had impaired communication skills.
-Resident #3 was a fall risk.
-Resident #3 required frequent checks for assistance.
-The resident required one-person assistance with bathing and dressing.

Review of Resident #3's facility progress notes revealed:
-Resident #3 was admitted to the SCU on 11/13/22.
-Resident #3 began exhibiting adjustment difficulties, confusion, and anxiety on 11/16/22.
-Mental health services and a sitter were arranged with the resident's power-of-attorney (POA).
-The POA hired a private sitter who began with Resident #3 on 11/13/22 for admission adjustment.

Review of Resident #3's progress notes by the health and wellness nurse (HWN) dated 11/29/22 at 8:47am revealed Resident #3 was 1-person assist with his Activities of Daily Living (ADLs).

Review of Resident #3's progress notes by the previous Special Care Coordinator (SCC) on 12/02/22 at 3:28pm revealed the SCC discussed with the resident's POA to change his sitter's shift from nights to days, since the resident experienced more agitation, anxiety, and aggressive behaviors during the day.

Review of Resident #3's late entry (for unspecified date/time) progress notes by the former SCC dated 12/03/22 at 8:45am revealed:
-Resident #3 became agitated and anxious when she and a personal care aide (PCA) attempted to

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toilet and change the resident's clothes.
-She and a PCA continued to provide personal care on Resident #3, while the sitter held the resident's hands, "so Resident #3 would not hit the care staff'".
-Resident #3 then became more anxious and agitated and tried to grab the PCA's wrist.
-It was documented that "Next Steps: personal care staff were to continue to redirect Resident #3's attention and use flashcards in an attempt to effectively communicate with the resident'".

Review of Resident #3's progress notes by a second HWN on 12/03/22 at 9:45am revealed Resident #3 exhibited increased signs of anxiety and agitation with PCAs during personal care and redirection attempts.

Review of Resident #3's progress notes by the former SCC dated 12/08/22 at 9:51am revealed Resident #3 was anxious, agitated, and aggressive (unspecified) towards PCAs providing toileting assistance to him.

Review of Resident #3's progress notes by the RCC dated 12/09/22 at 11:58am revealed Resident #3's anxiety and agitation continued.

Review of Resident #3's progress notes by the former SCC on 12/12/22 at 11:33am revealed:
-Resident #3 became more anxious and agitated when a PCA put socks on him.
-The PCA attempted to redirect Resident #3 and continued to put socks on him instead of stopping care and re-approaching another time causing increased anxiety and agitation increased.

Review of Resident #3's facility record revealed there was no documentation of an updated care plan with adjustment, anxiety, or shower

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interventions (flashcards, sitter, mental health) was not available.

Interview with the first PCA on 01/19/23 at 10:30am revealed:
-She worked in the facility's Assisted Living (AL) for 5 years and recently began working in the SCU.
-She did not know Resident #3's care plan for showers.
-Managers or lead PCAs did not instruct her how to shower or approach Resident #3.
-Coordinators, medication aides (MA) nor lead PCAs instructed her what to do when residents refused showers or other care.
-She was not trained on the facility's policy with resident care refusals.
-When Resident #3 refused a shower on the morning of 01/14/23, she called a MA to help her shower the resident.
-Resident #3 continued to refuse a shower when the MA arrived.
-She and the MA continued to force undressing and showering Resident #3, he physically resisted her and MA by holding up his arms to ward them off, raised a fist at them, and yelled at them in a different language.
-When Resident #3 resisted taking his clothes off, the MA held his forearms, while she took his clothes off.
-When he continued to refuse and resist a shower, she and the MA grabbed his forearms and pulled him into the shower.
-She and the MA then turned the shower on; then Resident #3 began to wash himself.
-Resident #3 refused another shower on the morning of 01/19/23.
-She called a second PCA to assist her to shower Resident #3 since he was resisting her and refusing to shower.

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-"We had to get Resident #3 in the shower" to complete the tasks assigned for the day.
-When Resident #3 resisted staff, she held his forearms with her forearms and hands, while the second PCA took his clothes off, then she held his hand and led him into the shower.
-When Resident #3 began to leave the shower, they turned the shower on; he then began to wash himself.

Interview with the second PCA on 01/19/23 at 10:40am revealed:
-Resident #3 could speak English but reverted to his primary language with the onset of dementia.
-The POA made pictorial flashcards for the staff to provide care for Resident #3, due to the resident's language barrier.
-The flashcards helped sometimes with the resident's care, but most staff did not use the flashcards.
-She assisted the first PCA to shower Resident #3 the morning of 01/19/23.
-She prepared the area for his shower and loosely held his forearms to bear his weight with her forearms, steadying him, while the first PCA took off the resident's clothes off.
-When Resident #3 refused showers with other staff, those staff would delay the shower and re-approached him at another time.
-It was the facility's policy when a resident refused a shower/care 3 times for staff to report this to the SCC.
-The SCC would then advise them how to do care, or the SCC would shower the resident herself.

Interview with a MA 01/19/23 at 12:20pm revealed:
-Care plans provided shower and other personal care directives.

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-She did not usually provide personal care, so she was not familiar with his care plan for showering.
-Resident #3 appeared to be a 2-person assist with showering, since he always tried to get out of the shower.
-To shower Resident #3, one staff member would hold his hands and distracted him, while a second staff member took his clothes off.
-Then one staff member would shower him while a second staff member would physically keep him from exiting the shower.
-Staff would hold Resident #3's hand to guide him to his room, shower, or other locations as needed.
-The resident did not verbally refuse showers; he would just physically leave the room.
-She did not assist with showering Resident #3 on 01/19/23.
-Resident #3 refused to allow the first PCA to take his clothes off and or get into the shower 01/14/23 and she was called in to assist her in showering to Resident #3 that day.
-Resident #3 was speaking another language to them and holding his clothes against his body.
-Resident #3 tried to hit her and the PCA on 01/14/23 when they began taking his clothes off.
-It was the facility's policy after a third resident care refusal to notify the SCC, who would notify the family, who usually came to assist with care.
-She did not report the shower on 01/14/23 to the SCC because she did not think to do so since they were able to shower the resident and she did not perceive the care to go against Resident #3's rights.

Interview with the current SCC 1/19/23 at 4:45pm revealed:
-She was not aware staff forced Resident #3 to shower on 01/14/23 and 01/19/23 and staff did

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not report these incidents to her.
-Staff knew not to force showers (care); to re-approach the resident later; or seek another staff to attempt the shower, and report care refusals or concerns of forced care to her as needed.
-Staff were to provide care per the residents' care plans and special instructions, and changes are documented in the facility's electronic charting system.
-After 3 care refusals, she would attempt to shower the resident, report the refusals or forced care to the Executive Director (ED), then investigate the incident.

Interview with the Corporate Executive Director (CED) on 1/19/23 at 4:30pm revealed:
-The former ED stopped working at the facility in mid-December 2022.
-She began at the facility 12/22/22.
-She was unaware and received no reports of Resident #3's forced showers on 01/14/23 and 01/19/23.
-All staff were trained on safe personal care and to re-approach residents who refused showers/care.
-Staff were trained to report all care refusals, injuries, forced care, and maltreatment to their supervisor, who should report the incidents to the facility nurse.
-Supervisors were expected to report forced resident care or maltreatment incidents to the nurse; the nurse was expected to report all incidents to the ED/CED.
-The CED expected the nurse to investigate resident maltreatment incidents and complete and submit county Human Services incident reports and Health Care Personnel Registry (HCPR) reports.
-She did not know why Resident #3's forced

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	HAL092209	A. BUILDING: ____ B. WING ____	R-C 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF CARY	1206 WEST CHATHAM STREET CARY, NC 27513

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showers were not reported to the ED or CED.

Attempted interview with Resident #3's PCP on 01/19/23 at 11:00am was unsuccessful.

Based on observations, interviews, and record reviews, it was determined that Resident #3 was not interviewable.

____

The facility failed to ensure the protection of resident rights for 2 of 6 sampled residents (#3, #6) who resided on the Special Care Unit (SCU) who were not treated with respect, dignity. Resident #6 was verbally intimidated and was subsequently forced to shower under duress. Resident #3 had a language barrier and was forced to shower on more than one occasion after declining both verbally and with body language. The failure of the facility resulted in risk for serious abuse and serious physical harm of the residents and constitutes a Type A2 Violation.

____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/14/22 that was amended on 01/18/23.

THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED February 18, 2023.

D 438 10A NCAC 13F .1205 Health Care Personnel Registry D 438

10A NCAC 13F .1205 Health Care Personnel Registry
The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102.

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This Rule is not met as evidenced by:
Based on observations, interviews, and record review, the facility failed to report allegations of abuse and neglect to the Health Care Personal Registry (HCPR) within 24 hours 1 of 1 sampled staff members after allegations of abuse in the Special Care Unit.

The findings are:

Review of Resident #6's current FL-2 dated 09/30/22 revealed:
-Diagnoses included Alzheimer's disease, Type 2 diabetes mellitus, hypertension, and anxiety.
-The resident resided on the Special Care Unit (SCU).
-The resident was ambulatory and incontinent of bladder and bowel.
-There was no documentation of orientation status or behaviors.

Review of Resident #6's previous FL-2 dated 11/15/21 revealed the resident was intermittently disoriented.

Interview with Resident #6's family member on 01/19/23 at 5:16pm revealed:
-She received a phone call from Staff C (a personal care aide (PCA)), on 09/18/23, who stated Resident #6 had a bowel movement and had "*xxxx*" on her feet in which she had refused assistance in getting cleaned up.
-Staff C made it sound as if the incident was Resident #6's fault and she had to instruct Staff C to calm down, give Resident #6 a medication that was prescribed as needed for anxiety, and after giving the medication some time to work, try again to assist the resident with care.
-Staff C told her that she had already cleaned

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Resident #6 up as best as she could at that point and had dragged the resident into the shower to ensure the resident did not have any more feces on her.
-After the phone call from Staff C, she immediately went to the facility to assess Resident #6 and see her in person.
-Upon seeing Resident #6, she did not have any marks or bruises that she could see on her, but the resident immediately told her she "got beat up today" and that the staff had been rough with her.
-She reported the incident to a staff member (she could not recall who) who did not seem concerned and commented that Resident #6 "gave them a run for their money".
-She emailed the Executive Director (ED) the next day, 09/19/22, and the ED called her back on 09/20/22 to let her know Staff C involved in the incident no longer worked at the facility.

Review of an email correspondence dated 09/19/22 revealed:
-The email was from Resident #6's family member to the ED, Resident Care Coordinator (RCC), and RCD.
-The family member requested clarification of what occurred on 09/18/22 since she received a call the previous day stating the resident had experienced an issue.
-To her knowledge, Resident #6 had an incontinent episode, refused to shower, and she was told by a staff member that "We had to physically drag her (Resident #6) into the shower kicking and screaming or else she would have *xxxx* all over her".
-She questioned if that was normal facility protocol and then went to see Resident #6 the same day in which the resident reported she "was beat up today".
-The family member acknowledged Resident #6

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had behaviors but felt there was a better solution to getting the resident cleaned up and could have been offered time to calm down.

Review of Resident #6's progress note dated 09/19/22 revealed:
-Per the staff, the resident had an incontinence episode in her shoe and was resistant to care.
-The resident required assistance and redirection.
-The resident was able to be bathed with "strong encouragement and reluctant to assistance".
-The progress note was documented by the RCD.

Review of a facility Privileged and Confidential Statement of Event dated 09/26/22 revealed:
-The document was written by the RCD.
-During a care conference with Resident #6's family member and the ED included remotely, the family member expressed concern about an event that occurred on 09/18/22.
-The family member stated that a staff member called her to report Resident #6 had an incontinent episode and was resistant to bathing.
-The family member stated the staff member said, "I literally had to drag her in the shower kicking and screaming or she would have been covered in *xxxx*".
-The facility offered Resident #6's family member an apology and emotional support.

Review of the Health Care Personnel Registry (HCPR) 24-hour report dated 09/27/22 revealed:
-The report was dated and submitted to the HCPR 8 days after the family member reported the incident to the ED, RCC, and RCD via email and received a response back from the RCD on the same day.
-The report was completed by the RCD regarding an incident with Resident #6 who resided on the SCU who experienced resident abuse.

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-An incident on 09/18/22 was reported in which the power of attorney (POA) of a resident reported that a staff member left her a voice message stating that the staff member "literally had to drag the resident into the shower kicking and screaming or else she would have had "*xxxx*" all over her".
-Staff C was reported as an alleged abuser to Resident #6 and there were no other staff members reported to the HCPR.

Review of the private sitter's written statement dated 10/03/22 revealed Resident #6 was forced to take a bath.

Interview with the previous ED on 01/19/23 at 1:22pm revealed:
-He was the ED at the facility from June 2022 to December 15, 2022, and was responsible for the overall operations and supervision of the entire building.
-He investigated an incident that occurred on 09/18/22 in which Resident #6 had stooled in her shoe and Staff C had tried to shower her and completed the appropriate reports that were sent to the Health Care Personnel Registry (HCPR).
-Staff C had requested the assistance of Staff B which did not work, and they left the resident's room.
-Staff C then returned to Resident #6's room with Staff A and showered the resident.
-He was told that Staff C told Resident #6 she was "going to throw the resident in the shower".
-The incident happened on a Saturday morning, and he was notified a few days later.
-He began an investigation within 30 minutes of being notified of the incident and interviewed Staff A, Staff B, and the RCD.

Interview with the Corporate Executive Director

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(CED) on 01/19/23 at 3:32pm revealed:
-She came to the facility when the previous ED stopped working at the facility on or around 12/22/22.
-The previous ED told her about the incident on 09/18/22 with Resident #6 and stated the resident was allegedly pushed or forced to take a shower.
-She instructed the previous ED to perform a full investigation of the incident and assumed he did so; she was not involved with the situation after that conversation.
-The previous ED filed a 24 hour report and 5-day report that was sent to the HCPR detailing his investigation and she was unsure why it had not been completed within 24-hours.