STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092222	A. BUILDING: _____ B. WING _____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF RALEIGH	4801 EDWARDS MILL ROAD RALEIGH, NC 27612

(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 conducted an annual survey on July 19 - 21, 2022.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 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. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure coordination of care with a primary care provider and mental health provider for 1 of 5 sampled residents (#4) who had acute behavior changes including aggression towards other residents, destruction of property and progressive insomnia which required hospitalization and an emergency room visit. The findings are: Review of Resident #4's current FL-2 dated 04/28/22 revealed diagnoses included Alzheimer's dementia, coronary artery disease and major depression. Review of Resident #4's physician's order summary (POS) dated 05/26/22 revealed an order for Trazadone 100mg one half tablet every 8 hours as needed (PRN) for behaviors. (Trazadone is used to treat anxiety, mood and depression.) Review of Resident #4's Resident Register	D 273		

Reviewed and acknowledged (SOD and attachments) 12 September 2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 273	Continued From page 1 revealed she was admitted to the facility on 04/30/22. Review of Resident #4's current care plan dated 05/18/22 revealed: -The facility's contracted PCP was listed as the resident's physician. -The PCP had not signed the care plan. Observations of Resident #4 on 07/21/22 from 8:35am until 9:38am revealed: -The resident walked from one end of the third floor to the other end repeatedly. -She sat for brief periods yawning and closing her eyes until distracted by a noise and then returned to walking the halls. -She spoke nonsensical words, sang and had bursts of loud laughter while walking. Interview with a medication aide (MA) on 07/21/22 at 9:18am revealed: -About two to three weeks ago Resident #4 started having increased agitation. -She started yelling, banging on furniture, doors and walls, yanking on things such as door handles and breaking dishes and glasses from the kitchen area. -The episodes of increased agitation happened "out of the blue". -Resident #4 did not sleep, she was awake and pacing the halls constantly. -She would sit for a few minutes and then get up and go back to pacing. -A Life Enrichment Manager (LEM) would separate her from other residents and stay with her until she was calm when personal care aides (PCAs) and MAs were not able to redirect her. -MAs reported behaviors to the Wellness Nurse (WN) or the Special Care Unit Coordinator (SCUC) for follow up with the PCP.	D 273		

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D 273	Continued From page 2 Review of Resident #4's electronic progress notes dated 04/30/22 through 06/20/22 revealed the resident's baseline behavior included anxious pacing and attempts to enter other resident's rooms. Review of Resident #4's electronic progress note dated 06/27/22 revealed a PRN dose of Trazadone was administered for unspecified behaviors without effect. Review of Resident #4's electronic progress note dated 06/28/22 revealed emergency medical services (EMS) was called due to the resident having "unusually aggressive" behaviors and throwing things at other residents. Review of Resident #4's hospital discharge instructions dated 07/01/22 revealed: -The resident was admitted on 06/28/22 and discharged on 07/01/22 for altered mental status and coronary artery disease. -There were changes to orders for Seroquel (used to treat psychosis). -There were no instructions for follow up care or appointments. Review of Resident #4's electronic progress note dated 07/02/22 revealed: -The resident was combative towards others in the common area. -There was no documentation the PCP was notified. Review of Resident #4's electronic progress note dated 07/07/22 revealed: -The resident was disruptive, yelling and screaming while going through the halls and going into other resident's rooms.	D 273		

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D 273	Continued From page 3 -There was no documentation the PCP was notified. Review of Resident #4's electronic progress note dated 07/08/22 revealed: -The resident was destructive to the property or community (no detail documented). -EMS was called because the resident was a threat to herself and others. Review of Resident #4's emergency room (ER) discharge instructions dated 07/08/22 revealed: -The resident was seen for aggressive behavior. -There were no changes in medications for behaviors. -There were no instructions for follow up care or appointments. Review of Resident #4's electronic progress notes dated 07/11/22 revealed: -The resident was being "physically/verbally aggressive" (no detail documented). -A PRN dose of Trazadone was administered without effect. -There was no documentation the PCP was notified. Review of Resident #4's electronic progress note dated 07/12/22 revealed: -An electronic mail (email) including enrollment forms for the facility's contracted PCP and a mental health provider (MHP) was sent to the resident's Power of Attorney (POA) by the WN. -The POA reported that she and the resident's family were upset that the resident continued to be transported to the hospital for behaviors. -The WN advised the POA that establishing the resident with the facility's contracted PCP and a MHP might prevent further hospital visits by controlling behaviors through medication	D 273		

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D 273	Continued From page 4 management. Review of Resident #4's electronic progress notes dated 07/14/22 revealed: -The resident was destructive to the property or community (no detail documented). -A PRN dose of Trazadone was administered without effect. -There was no documentation the PCP was notified. Review of Resident #4's electronic progress note dated 07/15/22 revealed: -At 3:08pm, the resident was being aggressive towards staff and the facility's contracted PCP was notified. -At 3:11pm, the Assisted Living Coordinator (ALC) notified the resident's POA of the aggressive behavior including yelling, attempts to hit other residents, attempts to lift the kitchen table off the floor and being difficult to redirect for 30 minutes. -The ALC planned for the resident to see the facility's contracted PCP at the next visit to the facility (week of 07/18/22). Review of Resident #4's electronic progress note dated 07/16/22 revealed: -The resident slapped staff's arm and was aggressive with attempts to redirect to the dining room for breakfast. -There was no documentation the PCP was notified. Review of Resident #4's electronic progress note dated 07/18/22 revealed: -The resident was being "physically/verbally aggressive" (no detail documented). -There was no documentation the PCP was notified.	D 273		

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D 273	Continued From page 5 Telephone interview with Resident #4's POA on 07/21/22 at 3:08pm revealed: -She was concerned the resident's health was not being managed because the resident did not have a PCP. -She did not know the resident did not have a PCP until one week ago. -She completed a care plan which named the facility's contracted PCP as the resident's PCP when the resident was admitted to the facility. -Resident #4 had new behaviors and did not seem to be adjusting to the facility. -The resident was manic, laughing loudly and having aggressive behaviors. -Another family member had visited the resident within the last two weeks and saw the resident with increased pacing and talking and the laughing was new. -The WN told her the resident was having aggressive behaviors but did not say what she was doing. -She was not told what happened on 06/28/22 and 07/08/22; only that the resident was being sent to the emergency room. -The WN told her the resident was sent to the ER on 07/08/22 because she did not have a PCP. -The WN told her they were going to have Resident #4 see the PCP a few weeks ago, but were unable. -The WN then called and said the PCP could not see the resident because the paperwork had not been completed to enroll the resident for services. Interview with the facility's contracted PCP on 07/21/22 at 1:35pm revealed: -Resident #4 had not been seen and was not contracted for services with the physician's group practice. -The facility had a folder for the PCP with	D 273		

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D 273	Continued From page 6 documents to be signed. -Normally, he checked the names on the documents before signing to ensure they were his clients. -He was new to the facility and was not familiar with all residents on the service and may have not noticed Resident #4's POS before signing. Interview with the WN on 07/21/22 at 4:50pm revealed: -She was responsible for admissions of residents and scheduling follow up visits with the facility's contracted PCP after hospitalization. -According to the facility's electronic chart system, Resident #4 was on service with the facility's contracted PCP. -She did not know the resident did not have a PCP until 2 days ago (07/19/22). -She documented Resident #4's electronic progress note dated 06/28/22 when the resident was sent to the hospital. -The PCP should have been contacted; she could not remember if she contacted the facility's contracted PCP on 06/28/22. -She did not have any documentation of contact with the facility's contracted PCP regarding Resident #4 except a message through an electronic application communicating directly with the physician's office (TeleMed) on 07/08/22 requesting a medication for agitation. -The PCP responded that Resident #4 had not been seen, was not on their service and therefore a medication order could not be given. -The Administrator instructed her to send the resident to the ER. -She could not remember if she tried to make a follow up visit for Resident #4 after the 07/08/22 ER visit. -Normally, she made the initial appointment for new residents to see the facility's contracted	D 273		

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D 273	Continued From page 7 PCP. -She could not remember if she made an initial appointment for Resident #4. -She did not know where Resident #4's signed enrollment paperwork for the facility's contracted PCP on admission to the facility was. Interview with the Resident Care Director (RCD) on 07/21/22 at 10:42am revealed: -Resident #4 was admitted from another facility with an FL-2 signed by the facility's contracted PCP who was also contracted with the previous facility. -Resident #4's POSs on 05/26/22 and 06/27/22 were signed by the facility's contracted PCP. -Facility admission paperwork documented the resident's PCP was the facility's contracted PCP. -They did not know Resident #4 did not have a PCP until they started calling for medications for her increased agitation (07/08/22). -The facility's contracted PCP informed the WN on 07/08/22 that she had not seen Resident #4 and the resident was not listed on their service. -She and the WN were working on getting Resident #4 established with a PCP. -The resident's POA had informed the facility they were moving the resident out of the facility on 07/15/22, so they put their efforts to establish a PCP on hold. -Normally, a newly admitted resident was seen by the facility's contracted PCP on the first Thursday after their admission to the facility. -The WN was responsible for adding the newly admitted resident to the PCP's visit list. -Normally, when a resident returned from the hospital the WN was responsible for adding the resident to the facility's contracted PCP's next visit list via an electronic application communicating directly with the physician's office (TeleMed).	D 273		

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D 273	Continued From page 8 -She was responsible for reviewing completed admission paperwork and ensuring residents were seen by the PCP. -There were forms she used to track new admissions for 30 days and follow up when residents were sent out to the hospital. -The WN was new to her position when Resident #4 was admitted (04/30/22). -She had been on leave shortly after the resident was admitted and the review process was incomplete for her paperwork and initial PCP visit. -She did not have a specific date or documentation of efforts to establish a PCP for Resident #4 prior to 07/08/22. Interview with the RCD on 07/21/22 at 4:05pm revealed: -Resident #4's POA had returned signed enrollment forms for the facility's contracted PCP dated 07/19/22. -She did not know why the resident was not seen today (07/21/22) when the PCP was at the facility. -She and the WN had started trying to get the resident a follow up visit when she was discharged from the hospital on 07/01/22. -The WN was responsible for scheduling follow up appointments after a resident was discharged from the hospital. Interview with the Administrator on 07/21/22 at 5:30pm revealed: -The Director of Sales (DOS) collected all move in paperwork at the time of new resident admission which included enrollment forms for the facility's contracted PCP . -The WN and RCD got copies of move in paperwork for review. -She, the WN and RCD reviewed paperwork in the move in debriefing. -She did not know if the review process had been	D 273		

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D 273	Continued From page 9 completed for Resident #4 to ensure the enrollment paperwork for the facility's contracted PCP was completed and the resident was seen for an initial visit. -The WN and RCD were expected to follow up on residents' health care needs including behavior changes, ER visits and hospital admissions and document contact with the PCP in the resident's electronic progress notes. Upon request on 07/21/22, Resident #4's signed contract with the facility's contracted PCP was not available for review. Based on observations, interviews and record reviews, it was determined Resident #4 was not interviewable. The facility failed to establish care with a primary care provider (PCP) for Resident #4. The facility's failure resulted in the resident having acute behavior changes including aggression towards other residents, destruction of property and progressive insomnia with hospitalization and an emergency room visit without the oversight, follow up and management of a PCP. The facility's failure was detrimental to the health, safety and welfare of Resident #4 and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/21/22 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 4, 2022.	D 273		

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D 358	Continued From page 10	D 358		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult 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 medication in accordance with a physician's orders for 1 of 5 residents (Resident #2) related to an antibiotic medication. The findings are: Review of Resident #2's current FL-2 dated 03/10/22 revealed: -Diagnoses included Parkinson's disease and benign hypotrophic prostate (BPH) disease with a history of an indwelling catheter, - He needed extensive assistance with toileting and was incontinent of bladder. Review of Resident #2's physician's orders dated 6/23/22 revealed: -Diagnosis listed was acute cystitis. -Resident #2 had a new order for Nitrofurantoin/Macrobid 100 mg taking one capsule twice a day for 7 days. Review of Resident #2's June 2022 electronic Medication Administration Record (eMAR) revealed:	D 358		

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D 358	Continued From page 11 -There was an entry for Nitrofurantoin/Macrobid 100mg to take one capsule twice a day for one day. -There was documentation that the Nitrofurantoin/Macrobid was administered on 06/23/22 at bedtime and on 06/24/22 in the morning. -There was no documentation on the eMAR that Nitrofurantoin/Macrobid was given twice a day for 7 days. Review of Resident #2's June 2022 Progress Notes revealed: -There was an entry on 06/24/22 documenting Resident #2 had a urinary tract infection (UTI) and the resident's provider had ordered Nitrofurantoin/Macrobid 100mg twice a day for 7 days. -There were entries on 06/25/22 and 06/26/22 that Resident #2 took his antibiotic. Interview with a Medication Aide (MA) on 07/21/22 at 11:04am revealed: -Resident #2 normally took his medications without concerns. -He had administered Resident #2's antibiotic on 06/24/22. -Sometimes Resident #2 had antibiotics he would take for one day. -Records for antibiotic administration were kept on the eMAR. Interview with Resident #2's primary care provider (PCP) on 07/21/22 at 1:00pm revealed: -Resident #2 had gone to the emergency room (ER) on 06/23/22 and been diagnosed with acute cystitis. -Resident #2 had started on Nitrofurantoin/Macrobid at the ER before the urine culture results returned.	D 358		

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D 358	Continued From page 12 -When he returned to the facility, the PCP was not sure if the medication would be continued depending on the results of the culture. -The PCP received the results of the culture, and wanted the medication continued for the full 7 days. -It was important for Resident #2 to receive his antibiotics as prescribed because he had recurrent UTIs. Telephone interview with the facility contracted pharmacist on 07/21/22 at 12:32pm revealed: -Resident #2 had an order for Nitrofurantoin/Macrobid 100mg twice a day for 7 days. -Fourteen pills were dispensed by the pharmacy on 06/23/22. -Nitrofurantoin/Macrobid was an antibiotic ordered for acute cystitis and UTI. -If Resident #2 did not complete a full order of antibiotics, he would be at risk of a more serious infection or sepsis. Interview with the Resident Care Director (RCD) on 07/21/22 at 3:00pm revealed: -The antibiotic was put into the eMAR system incorrectly at the facility. -Resident #2 had recurrent UTIs. - Resident #2 needed the full dose of his antibiotic in order for it to be effective in resolving his cystitis. -The RCD was expected to ensure medications were administered as ordered. Interview with the Administrator on 07/21/22 at 5:00pm revealed: -The RCD was responsible for ensuring medication administration was completed as ordered. -It was expected that staff would administer	D 358		

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D 358	Continued From page 13 antibiotics as ordered.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to health care. The findings are: Based on observations, interviews and record reviews, the facility failed to ensure coordination of care with a primary care provider and mental health provider for 1 of 5 sampled residents (#4) who had acute behavior changes including aggression towards other residents, destruction of property and progressive insomnia which required hospitalization and an emergency room visit [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	D912		

Sunrise Senior Living
Plan of Correction

Name of Community: Sunrise of Raleigh
Address of Community: 4801 Edwards Mill Rd. Raleigh NC 27612
License number: HAL-092-222
Inspection date(s): July 19-21, 2022
Name/Title of Legal Entity Representative Signing the Plan of Correction:
Audria Wilson, Executive Director

Signature of Sunrise Representative: Audria Wilson
Date of Submission: 8-19-22

Regulation	Target Date by Which Correction will be completed	Plan of Correction
D 273 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.		***A. With respect to the specific resident/situation cited:***
	7/25/2022	*Resident #4 no longer resides in community but did established care with primary care physician on July 25, 2022. Resident moved out before psych consult could be established.*
		B. With respect to how the facility will identify residents/situations for the identified concerns:
	7/29/2022	The Resident Care Director (RCD)/Wellness Team conducted an audit of residents to confirm a primary physician was active with recent visits.
		C. With respect to what systemic measures have been put into place to address the stated concern:
	8/17/2022	Refresher training regarding residents need for an established primary care physician prior to move in was conducted by Executive Director with Leadership Team.
	08/18/2022 – 11/18/2022	The RCD and Wellness team will conduct audits bi-weekly for 1 month and then monthly for 2 months to confirm that resident physicians are active and involved in residents plan of care.
		D. With respect to how the plan of correction will be monitored:
	8/13/2022- 11/13/2022	The Executive Director, Resident Care Director, or designee will report findings of the audits (described in section C) to the Quality Assurance Performance Improvement Committee monthly for 3 months.
		During and after the 3 months, the QAPI Team will re-evaluate and

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		initiate necessary action or extend the review period, as needed based on issues identified or trends observed. The Executive Director is responsible for confirming implementation and ongoing compliance with the components of the plan of correction and addressing and resolving variances that may occur.
D 358 10A NCAC 13F .1004 Medication Administration (a) An adult 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.	7/22/2022 7/29/2022 7/22/2022 7/22/2022 8/03/2022-11/03/2022	***A. With respect to the specific resident/situation cited:*** Resident #2 did not experience a negative outcome due to transcription error. Resident did not miss a dose of Nitrofurantoin. ***B. With respect to how the facility will identify residents/situations for the identified concerns:*** The Resident Care Director (RCD)/Wellness Team conducted an audit of resident's orders to confirm accuracy of medication orders and that the medication was available for administration. Issues identified or observed were addressed and resolved Refresher training for the Wellness Nurse and the Med Techs regarding confirming the accuracy of med orders in EMAR and the processes for communicating issues with medication orders or their availability was conducted by the Resident Care Director. ***C. With respect to what systemic measures have been put into place to address the stated concern:*** Medication orders or change in orders will be reviewed by a licensed nurse to confirm accurate entry into the EMAR system. Medication changes are being discussed during Med Tech shift to shift crossover, and the Resident Care Director or Wellness Nurse and Physician contacted if clarification is required. The RCD and Wellness team will conduct EMAR audits weekly for 1 month and then monthly for 2 months to confirm that resident orders are entered into the EMARs as prescribed by physicians and that medications are available for administration. If necessary, orders will be clarified with the Physician and updated as needed into the EMAR system.

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	8/13/2022-11/13/2022	***D. With respect to how the plan of correction will be monitored:*** The Executive Director, Resident Care Director, or designee will report findings of the audits (described in section C) to the Quality Assurance Performance Improvement Committee monthly for 3 months. During and after the 3 months, the QAPI Team will re-evaluate and initiate necessary action or extend the review period, as needed based on issues identified or trends observed. The Executive Director is responsible for confirming implementation and ongoing compliance with the components of the plan of correction and addressing and resolving variances that may occur.
D912 G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	*7/25/2022* *8/03/2022* *8/17/2022* *08/18/2022 - 11/18/2022* *8/13/2022-11/13/2022*	***A. With respect to the specific resident/situation cited:*** *Resident #4 no longer resides in community but did established care with primary care physician on July 25, 2022. Resident moved out before psych consult could be established.* ***B. With respect to how the facility will identify residents/situations for the identified concerns:*** The Resident Care Director (RCD)/Wellness Team conducted an audit of residents to confirm a primary physician was active with recent visits. ***C. With respect to what systemic measures have been put into place to address the stated concern:*** Refresher training regarding residents need for an established primary care physician prior to move in was conducted by Executive Director with Leadership Team. The RCD and Wellness team will conduct audits bi-weekly for 1 month and then monthly for 2 months to confirm that resident physicians are active and involved in residents plan of care. ***D. With respect to how the plan of correction will be monitored:*** The Executive Director, Resident Care Director, or designee will report findings of the audits (described in section C) to the Quality Assurance Performance Improvement Committee monthly for 3 months.

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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.

Sunrise Senior Living
Plan of Correction

Name of Community: Sunrise of Raleigh
Address of Community: 4801 Edwards Mill Rd. Raleigh NC 27612
License number: HAL-092-222
Inspection date(s): July 19-21, 2022
Name/Title of Legal Entity Representative Signing the Plan of Correction:
Audria Wilson, Executive Director

Signature of Sunrise Representative: Audria Wilson
Date of Submission: 9/6/22

Regulation	Target Date by Which Correction will be completed	Plan of Correction
D 273 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.	*9/4/2022*	***A. With respect to the specific resident/situation cited:*** *Resident #4 no longer resides in community but did established care with primary care physician on July 25, 2022. Resident moved out before psych consult could be established.* ***B. With respect to how the facility will identify residents/situations for the identified concerns:*** The Resident Care Director (RCD)/Wellness Team conducted an audit of residents to confirm a primary physician was active with recent visits. ***C. With respect to what systemic measures have been put into place to address the stated concern:*** Refresher training regarding residents need for an established primary care physician prior to move in was conducted by Executive Director with Leadership Team. The RCD and Wellness team will conduct audits bi-weekly for 1 month and then monthly for 2 months to confirm that resident physicians are active and involved in residents plan of care. ***D. With respect to how the plan of correction will be monitored:*** The Executive Director, Resident Care Director, or designee will report findings of the audits (described in section C) to the Quality Assurance Performance Improvement Committee monthly for 3 months. During and after the 3 months, the QAPI Team will re-evaluate and

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D 358 10A NCAC 13F .1004 Medication Administration (a) An adult 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.	*9/4//2022*	***A. With respect to the specific resident/situation cited:*** Resident #2 did not experience a negative outcome due to transcription error. Resident did not miss a dose of Nitrofurantoin. ***B. With respect to how the facility will identify residents/situations for the identified concerns:*** The Resident Care Director (RCD)/Wellness Team conducted an audit of resident's orders to confirm accuracy of medication orders and that the medication was available for administration. Issues identified or observed were addressed and resolved Refresher training for the Wellness Nurse and the Med Techs regarding confirming the accuracy of med orders in EMAR and the processes for communicating issues with medication orders or their availability was conducted by the Resident Care Director. ***C. With respect to what systemic measures have been put into place to address the stated concern:*** Medication orders or change in orders will be reviewed by a licensed nurse to confirm accurate entry into the EMAR system. Medication changes are being discussed during Med Tech shift to shift crossover, and the Resident Care Director or Wellness Nurse and Physician contacted if clarification is required. The RCD and Wellness team will conduct EMAR audits weekly for 1 month and then monthly for 2 months to confirm that resident orders are entered into the EMARs as prescribed by physicians and that medications are available for administration. If necessary, orders will be clarified with the Physician and updated as needed into the EMAR system.

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D912 G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	9/4/2022	***A. With respect to the specific resident/situation cited:*** *Resident #4 no longer resides in community but did established care with primary care physician on July 25, 2022. Resident moved out before psych consult could be established.* ***B. With respect to how the facility will identify residents/situations for the identified concerns:*** The Resident Care Director (RCD)/Wellness Team conducted an audit of residents to confirm a primary physician was active with recent visits. ***C. With respect to what systemic measures have been put into place to address the stated concern:*** Refresher training regarding residents need for an established primary care physician prior to move in was conducted by Executive Director with Leadership Team. The RCD and Wellness team will conduct audits bi-weekly for 1 month and then monthly for 2 months to confirm that resident physicians are active and involved in residents plan of care. ***D. With respect to how the plan of correction will be monitored:*** The Executive Director, Resident Care Director, or designee will report findings of the audits (described in section C) to the Quality Assurance Performance Improvement Committee monthly for 3 months.

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Washington, Bynithia T

From: Raleigh.ED (Wilson, Audria) <Raleigh.ED@sunriseseniorliving.com>
Sent: Friday, August 19, 2022 8:37 PM
To: Washington, Bynithia T
Cc: Raleigh.RCD (Smith, Catrina)
Subject: [External] Sunrise of Raleigh Plan of Correction for Survey Ending 072122
Attachments: Plan of Correction for Sunrise of Raleigh 2022-08-08 SODL YOU111 (4).pdf

Good evening,

Please see attached the plan of correction for survey ending 072122.

Best Regards.

Audria Wilson | Executive Director

Sunrise of Raleigh
4801 Edwards Mill Road Raleigh, North Carolina 27612
Direct: 919-787-0777 **Mobile:** 919-607-3630

www.sunriseseniorliving.com/communities/sunrise-of-raleigh