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 _____	R 01/26/2023

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 a follow-up survey on 01/25/23 - 01/26/23.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 5 sampled staff (Staff B and C) completed their 5, 10, or 15 hour training for medication staff. The findings are: Review of Staff B's personnel record revealed: -Staff B was hired on 09/14/17 as a medication aide (MA). -There was documentation the 10- hour training was completed. -There was no documentation the 5-hour training was completed.	D 125		

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 125	Continued From page 1 Review of Staff C's personnel record revealed: -Staff C was hired on 07/26/12 as a medication aide (MA). -There was no documentation the 5-, 10-, or 15-hour training was completed. Interview with the Business Office Manager (BOM) on 01/26/23 at 5:02pm revealed: -She reviewed personnel records daily. -She never reviewed the medication aide training because she does not have to enter the information in her system. -She expected the RCD to give her the medication aide training certificates. Interview with the Administrator on 01/26/23 at 4:55pm revealed: -The Resident Care Director (RCD) was responsible to ensure the 5-, 10-, or 15-hour training for the MAs was done. -There was not an RCD in the facility. -She and the BOM were responsible for auditing the personnel records. -She had not audited personnel records since she started in February 2022. -She was not aware Staff B and Staff C were missing their 5-, 10- or 15-hour training.	D 125		
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	D 358		

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 358	Continued From page 2 (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 6 residents (#3, #6, #7) observed during the medication pass including errors with a medication used to treat nerve pain (#7); a skin protectant ointment for skin irritation and rashes (#6); supplements for bone disorders, immune system health, heart disease, high blood pressure, high cholesterol and triglycerides (#3); and for 1 of 5 sampled residents (#4) who received multiples doses of expired insulin. The findings are: 1. The medication error rate was 15% as evidenced by 4 errors out of 26 opportunities during the morning and lunchtime medication passes on 01/25/23. a. Review of Resident #7's current FL-2 dated 06/21/22 revealed: -Diagnoses included dementia, hypertension, status post pacemaker, obstructive sleep apnea, benign prostatic hypertrophy, and gastroesophageal reflux disease. -There was an order for Gabapentin 300mg at bedtime (Gabapentin may be used to treat nerve pain.) Review of Resident #7's physician's order dated 08/29/22 revealed an order for Gabapentin 300mg 1 capsule 2 times a day for nerve pain.	D 358		

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 358	Continued From page 3 Review of Resident #7's physician's order dated 10/13/22 revealed an order to increase Gabapentin to 300mg 1 capsule 3 times a day for neuropathy (nerve pain). Review of Resident #7's physician's order dated 11/10/22 revealed an order to discontinue Gabapentin 300mg and start Gabapentin 400mg 1 capsule 3 times a day for neuropathy. Review of Resident #7's physician's order dated 12/01/22 revealed an order to discontinue Gabapentin 400mg and start Gabapentin 300mg 1 capsule 3 times a day. Observation of the 11:00am/12:00pm medication pass on 01/25/23 revealed: -The medication aide (MA) prepared and administered one Gabapentin 400mg capsule to Resident #7 at 11:26am. -The resident was administered Gabapentin 400mg instead of Gabapentin 300mg as ordered. Review of Resident #7's December 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Gabapentin 400mg take 1 capsule 3 times a day related to hereditary and idiopathic neuropathy (nerve pain) with scheduled administration times of 9:00am, 3:00pm, and 9:00pm. -Gabapentin 400mg was documented as administered 3 times a day from 12/01/22 through 9:00am on 12/02/22. -There was a second entry for Gabapentin 300mg take 1 capsule 3 times a day for pain. -Gabapentin 300mg was scheduled 3 times a day at resident-centered medication pass times of "OA2" (on arising = 6:00am to 10:00am); "MM2"	D 358		

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 358	Continued From page 4	D 358		

(mid-morning = 10:00am to 12:00pm); and "HS2" (bedtime = 6:00pm to 10:00pm.
-Gabapentin 400mg was documented as administered from 12/02/22 (MM2) through 12/09/22 (MM2).
-There was a third entry for Gabapentin 400mg take 1 capsule 3 times a day related to hereditary and idiopathic neuropathy with scheduled administration times of OA2, MM2, and HS2.
-Gabapentin 400mg was documented as administered from 12/09/22 (HS2) through 12/31/22.

Review of Resident #7's physician's orders revealed there was no order to restart Gabapentin 400mg after it was discontinued and changed to 300mg on 12/01/22.

Review of Resident #7's January 2023 eMAR revealed:
-There was an entry for Gabapentin 400mg take 1 capsule 3 times a day related to hereditary and idiopathic neuropathy (nerve pain).
-Gabapentin was scheduled at resident-centered medication pass times of OA2, MM2, and HS2.
-Gabapentin 400mg was documented as administered from 01/01/23 - 01/25/23.
-There was no entry for Gabapentin 300mg.

Observation of Resident #7's medications on hand on 01/25/23 at 2:08pm revealed:
-There was a supply of Gabapentin 400mg capsules dispensed on 01/16/23 with instructions to take 1 capsule 3 times a day.
-There was no supply of Gabapentin 300mg capsules on hand.

Interview with the MA on 01/25/23 at 2:10pm revealed:
-He thought Resident #7's Gabapentin was

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 358	Continued From page 5	D 358		

decreased to 300mg at one time because the resident was complaining of feeling dizzy.
-He could not recall when the dosage for Gabapentin changed.
-He administered Gabapentin 400mg because that was the instructions on the eMAR and the label on the medication.
-He thought the resident was better now and not complaining of feeling dizzy.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/26/23 at 2:30pm revealed:
-The pharmacy entered orders into the eMAR system when received and the facility had to approve the orders prior to the orders becoming active on the eMARs.
-The facility also had access to the eMAR system and could enter orders into the eMAR system.
-The eMAR system was unilateral and if the facility entered a discontinue order into the eMAR system, it would not "flow" back to the pharmacy electronic system.
-The most current order they received for Resident #7's Gabapentin was dated 11/17/22 for 400mg 1 capsule 3 times a day.
-The pharmacy had not received any order for Gabapentin after 11/17/22 including the order dated 12/01/22 to discontinue Gabapentin 400mg and start 300mg 3 times a day.
-The pharmacy last dispensed Gabapentin 400mg with 90 capsules on 01/16/23.

Interviews with Resident #7 on 01/26/23 at 1:24pm and 2:04pm revealed:
-He knew he was taking Gabapentin but he did not know the dosage.
-He felt dizzy in the past, but he was dizzy before he started taking the Gabapentin.
-He was having problems with diarrhea.

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 _____	R 01/26/2023

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D 358	Continued From page 6	D 358		

-He had diarrhea off and on for about a month or more.
-He did not know the cause of the diarrhea.

Interview with the Wellness Nurse on 01/26/23 at 4:12pm revealed:
-She or the MAs were responsible for faxing medication orders to the pharmacy.
-She sometimes received fax confirmation when orders were faxed but sometimes she did not receive confirmation.
-She also had access to enter orders into the eMAR system.
-She did not recall if Resident #7's order dated 12/01/22 for Gabapentin 400mg to be discontinued and 300mg started was faxed to the pharmacy.
-She was unsure why Resident #7's order to decrease Gabapentin to 300mg 3 times day dated 12/01/22 was never implemented.
-No one had reported the resident having any issues with diarrhea to her.

Telephone interview with Resident #7's primary care provider (PCP) on 01/26/23 at 1:37pm revealed:
-Resident #7's Gabapentin was ordered to be decreased on 12/01/22 due to concerns that it was contributing to the resident having diarrhea.
-She was not aware the Gabapentin had not been decreased as ordered on 12/01/22.
-Not decreasing the dose of Gabapentin could cause the resident to have diarrhea.
-The resident had no recent complaints of diarrhea to her knowledge.

b. Review of Resident #3's current FL-2 dated 04/13/22 revealed:
-Diagnoses included cognitive impairment, hypertension, atrial fibrillation, coronary artery

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 358	Continued From page 7	D 358		

disease, and chronic kidney disease - stage 3b.
-There was an order for Vitamin D3 take 1000 units once a day. (Vitamin D3 is a supplement used to treat and prevent bone disorders and used in kidney disease to keep calcium levels normal.)

Observation of the morning medication pass on 01/25/23 revealed:
-The medication aide (MA) prepared and administered one Vitamin D3 2000 units capsule to Resident #3 at 9:08am.
-Resident #3 received Vitamin D3 2000 units instead of Vitamin D3 1000 units, double the ordered dose.

Review of Resident #3's January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Vitamin D3 1000 units take 1 tablet one time a day for supplement scheduled at resident-centered medication pass time of "OA2" (on arising = 6:00am to 10:00am).
-Vitamin D3 1000 units was documented as administered from 01/01/23 - 01/25/23.

Observation of Resident #3's medications on hand on 01/25/23 at 8:57am revealed:
-There was an over-the-counter (OTC) supply of Vitamin D3 2000 units softgels in the original manufacturer's container.
-There was no Vitamin D3 1000 units on hand for the resident.

Interview with Resident #3 on 01/26/23 at 4:20pm revealed:
-She took supplements including Vitamin D.
-She was not sure what dosage she was supposed to receive.
-She denied any side effects.

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 _____	R 01/26/2023

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D 358	Continued From page 8 Interview with the MA on 01/25/23 at 2:17pm revealed: -The resident's family brought her over-the-counter (OTC) medications to the facility. -There were 2 bottles of Vitamin D3 2000 units softgels that he had been administering to the resident. -He had not noticed the entry on the eMAR was for Vitamin D3 1000 units. -There was no Vitamin D3 1000 units softgels on hand for the resident. Interview with the Senior Resident Care Director (SRCD) on 01/25/23 at 2:40pm revealed: -The Wellness Nurses or the MAs were allowed to receive medications from family members. -There was a form that was supposed to be filled out to document what medication was received and a copy should be given to the family and a copy kept by the facility. -The Wellness Nurse or MA who received the medication from the family was responsible for filling out the form and for making sure the medication brought match the current physician's order. -She could not locate any forms documenting medications brought by the family for Resident #3. -The MAs were supposed to compare the entries on the eMAR with the label on the medication to make sure the correct medication was administered. -Resident #3 should have received Vitamin D3 1000 units as ordered. Telephone interview with Resident #3's family member on 01/26/23 at 3:08pm revealed: -She usually took OTC medications to the facility	D 358		

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 _____	R 01/26/2023

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D 358	Continued From page 9	D 358		

for Resident #3.
-No one documented on a form or gave her a copy of a form when she brought medications to the facility.
-No one at the facility notified her that she brought the wrong strength of Vitamin D3 for the resident.

Telephone interview with Resident #3's primary care provider (PCP) on 01/26/23 at 1:37pm revealed:
-She was not aware Resident #3 was receiving Vitamin D3 2000 units instead of 1000 units as ordered.
-The Vitamin D3 was low dose so she was not concerned the resident would get too much Vitamin D3.
-She would check the resident's Vitamin D level.

Review of Resident #3's lab results revealed the most current Vitamin D level was 53.49 (reference range 30 - 100) on 05/31/22.

c. Review of Resident #3's physician's order sheet dated 12/27/22 revealed an order for Vitamin C (no strength noted) take 1 tablet once daily. (Vitamin C is a supplement used for immune system health.)

Review of Resident #3's physician's order dated 01/03/23 revealed a clarification order for Vitamin C 500mg 1 tablet once daily.

Observation of the morning medication pass on 01/25/23 revealed:
-The medication aide (MA) prepared and administered two Vitamin C 500mg tablets to Resident #3 at 9:08am.
-The resident was administered 1000mg of Vitamin C, double the dose ordered to be administered.

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 _____	R 01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 358	Continued From page 10 Review of Resident #3's January 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Vitamin C 500mg take 1 tablet one time a day for supplement scheduled at resident-centered medication pass time of "OA2" (on arising = 6:00am to 10:00am). -Vitamin C 500mg for this entry was documented as administered from 01/04/23 - 01/25/23. -There was a second entry for Vitamin C (no strength noted) take 1 tablet one time a day for supplement scheduled at resident-centered medication pass time of "OA2". -Vitamin C for the second entry was documented as administered from 01/01/23 - 01/25/23. Observation of Resident #3's medications on hand on 01/25/23 at 8:57am revealed: -There was an over-the-counter (OTC) supply of Vitamin C timed-release 500mg tablets in the original manufacturer's container. -There was a supply of Vitamin C 500mg tablets dispensed by the pharmacy in a bubble card on 01/03/23. -The instructions on the bubble card were to take 1 tablet every day and there were 13 of 30 tablets remaining. Interview with Resident #3 on 01/26/23 at 4:20pm revealed: -She took supplements including Vitamin C. -She was not sure what dosage she was supposed to receive. -She denied any side effects. Interview with the MA on 01/25/23 at 2:17pm revealed: -The resident's family brought her over-the-counter (OTC) medications to the	D 358		

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 _____	R 01/26/2023

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 358	Continued From page 11	D 358		

facility.
-There were two entries for Vitamin C on the eMAR and two different supplies of Vitamin C on hand for Resident #3.
-He administered Vitamin C from each supply each time he administered the Vitamin C to the resident because both entries "popped up" on the eMAR.

Interview with the Senior Resident Care Director (SRCD) on 01/25/23 at 2:40pm revealed:
-There was a duplicate order for Vitamin C in the eMAR system.
-The MAs should have notified her or the Wellness Nurse of the duplicate order.
-Resident #3 should have received one Vitamin C 500mg tablet as ordered.

Telephone interview with Resident #3's primary care provider (PCP) on 01/26/23 at 1:37pm revealed:
-She was not aware Resident #3 was receiving two Vitamin C 500mg tablets instead of one tablet as ordered.
-She was not concerned about the resident getting too much Vitamin C; it may boost the resident's immune system.
-It was concerning that the MAs were not administering the medications as ordered because depending on the medication, receiving too much could cause side effects.

d. Review of Resident #3's physician's order sheet dated 12/27/22 revealed an order for Flaxseed Oil take 1 capsule two times a day for supplement. (Flaxseed Oil is a supplement that may be used for heart disease, high blood pressure, and high cholesterol. Flaxseed Oil contains multiple fatty acids including omega-3 fats.)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 358	Continued From page 12	D 358		

Review of Resident #3's physician's order dated 01/03/23 revealed an order to discontinue Flaxseed Oil.

Review of Resident #3's telephone order dated 01/18/23 revealed an order for Omega-3 dietary supplement (no strength noted) take 1 softgel two times daily. (Omega-3 is fatty acids that help lower triglycerides to reduce the risk of heart disease and stroke.)

Observation of the morning medication pass on 01/25/23 revealed:
-The medication aide (MA) prepared and administered one Flaxseed Oil 1300mg softgel to Resident #3 at 9:08am instead of the current order for Omega-3.
-Omega-3 was not administered as ordered on 01/18/23.

Review of Resident #3's January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Flaxseed Oil take 1 capsule two times a day for supplement with scheduled resident-centered medication pass times of "OA2" (on arising = 6:00am to 10:00am) and "HS2" (bedtime = 6:00pm to 10:00pm.
-Flaxseed Oil was documented as administered from 01/01/23 - 01/03/23 and noted to be discontinued on 01/03/23.
-There was an entry for Omega-3 Capsule take 1 capsule two times a day with scheduled resident-centered medication pass times of "OA2" and "HS2".
-Omega-3 Capsule was documented as administered from 01/19/23 - 01/25/23.

Observation of Resident #3's medications on

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 _____	R 01/26/2023

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 358	Continued From page 13	D 358		

hand on 01/25/23 at 8:55am revealed:
-There was an over-the-counter (OTC) supply of Flaxseed Oil 1300mg with Omega-3 softgels in the original manufacturer's container.
-There was no Omega-3 on hand for the resident.

Interview with Resident #3 on 01/26/23 at 4:20pm revealed she took supplements but she was not sure of all of the supplements she received.

Interview with the MA on 01/25/23 at 2:17pm revealed:
-The resident's family brought her over-the-counter (OTC) medications to the facility.
-He thought he was administering Omega-3 when he administered the Flaxseed Oil because the label had "with Omega-3" below the words "Flaxseed Oil".
-There was no supply of Omega-3 on hand for the resident.

Interview with the Senior Resident Care Director (SRCD) on 01/25/23 at 2:40pm revealed:
-Resident #3's Flaxseed Oil should have been removed from the medication cart when it was discontinued.
-The MAs were supposed to compare the entries on the eMAR with the label on the medication to make sure the correct medication was administered.
-Resident #3 should have received Omega-3 instead of Flaxseed Oil.

Telephone interview with Resident #3's primary care provider (PCP) on 01/26/23 at 1:37pm revealed:
-She was not aware Resident #3 was receiving Flaxseed Oil instead of Omega-3 as ordered.
-Both supplements could be used to lower

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 _____	R 01/26/2023

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 358	Continued From page 14	D 358		

cholesterol.
-She did not have any immediate concerns about the resident receiving Flaxseed Oil after it was discontinued or not receiving the Omega-3.

Review of Resident #3's lab results revealed:
-The most current cholesterol level was 127 (reference range less than 200) on 11/02/22.
-The most current triglycerides level was 182 (reference range 0 - 150) on 11/02/22.

e. Review of Resident #6's current FL-2 dated 09/12/22 revealed:
-Diagnoses included hypoxia, respiratory distress, bradycardia, and urinary tract infection.
-There was an order for Zinc Oxide 10% Ointment with no directions for use. (Zinc Oxide Ointment is a skin protectant used to treat and prevent skin irritation and skin rashes.)

Review of Resident #6's telephone order dated 09/05/22 revealed:
-There was an order for Zinc Oxide Ointment apply topically to buttocks 3 times a day.
-The order did not include the strength of Zinc Oxide Ointment to be administered.

Review of Resident #6's hospital discharge form dated 09/13/22 revealed an order for Zinc Oxide 10% Ointment apply topically 3 times a day.

Review of Resident #6's physician's order sheet dated 01/16/23 revealed an order for Zinc Oxide Ointment 10% apply to buttock topically 3 times a day for redness.

Observation of the 12:00pm medication pass on 01/25/23 revealed:
-The medication aide (MA) applied Zinc Oxide Ointment 20% to Resident #6's buttocks at

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 _____	R 01/26/2023

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 358	Continued From page 15	D 358		

11:19am instead of Zinc Oxide Ointment 10% as ordered.
-The resident's buttocks had some redness with purple discoloration and the skin was intact.

Review of Resident #6's January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Zinc Oxide Ointment 10% apply to buttocks topically 3 times a day for redness scheduled at 7:00am, 12:00pm, and 7:00pm.
-Zinc Oxide Ointment 10% was documented as administered from 01/01/23 - 01/25/23.
-There was no entry for Zinc Oxide Ointment 20%.

Interview with the MA on 01/25/23 at 2:02pm revealed:
-Resident #6 had a bedsore on her buttocks that "comes and goes".
-The bedsore was currently healed with no broken skin, but the resident still had some redness on her buttocks.
-He did not notice the entry on the eMAR was for Zinc Oxide Ointment 10% and the supply on hand that he administered was Zinc Oxide Ointment 20%.

Observation of Resident #6's medications on hand on 01/25/23 at 2:03pm revealed:
-There was a supply of Zinc Oxide Ointment 20% in a tube dispensed on 01/23/23.
-The instructions on the prescription label were to apply topically to buttocks 3 times a day.
-There was no supply of Zinc Oxide Ointment 10% on hand for the resident.

Based on observations, interviews, and record review, Resident #6 was not interviewable.

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 _____	R 01/26/2023

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 358	Continued From page 16 Interview with the Senior Resident Care Director (SRCD) on 01/25/23 at 2:40pm revealed: -If the eMARs and the medication labels did not match, the MAs should stop and check with her or the Wellness Nurse. -The order dated 09/05/22 that was incomplete with no strength for Zinc Oxide Ointment should have been clarified. -She thought the pharmacy sent Zinc Oxide Ointment 20% because that was the only strength the pharmacy had available. Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/26/23 at 2:30pm revealed: -The pharmacy had Zinc Oxide Ointment 10% and 20% available to dispense. -The most current order the pharmacy had on file for Zinc Oxide Ointment was dated 09/05/22 and there was no strength noted on the order. -It appeared the order should have been clarified. -The pharmacy entered the order as Zinc Oxide Ointment 20% but the order should have been clarified. -The facility was responsible for approving the order after it was entered by the pharmacy. -If there was a discrepancy, the facility should notify the pharmacy and not approve the order. Telephone interview with Resident #6's primary care provider (PCP) on 01/26/23 at 1:37pm revealed: -Resident #6 had a history of skin breakdown on her buttocks and the Zinc Oxide Ointment was being used to treat and prevent the skin breakdown. -She was not concerned about the wrong strength of the Zinc Oxide Ointment being used because there had been no outcome to the	D 358		

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 _____	R 01/26/2023

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 358	Continued From page 17	D 358		

resident.
-The order for Zinc Oxide Ointment should have been clarified if it was not clear which strength should be used.

2. Review of the facility's insulin storage recommendations provided on 01/26/23 revealed:
-Novolog flex pen which was unopened and refrigerated was good until the expiration date marked on the package.
-Novolog flex pen which was opened and stored at room temperature was good for 28 days from the date opened.

Review of the facility's Diabetes and Insulin Management policy dated 2017 revealed:
-It was important to store insulin according to the manufacturer's directions.
-Insulin was to be stored in the appropriate place.
-Insulin is composed of a protein dissolved in water and will spoil after a period (did not specify the time frame).
-Insulin past the expiration date should be discarded.

Review of the facility's Community Medication Oversight Program V2.0 dated 07/01/19 revealed:
-This was a program that takes a standardized approach to the management and administration of/assistance with resident medications.
-Two of the program's components were requirements for licensed nurses and training for team members who do not hold a nursing license to administer medications and proper medication handling, storage and inventory.
-One objective was listed as describe the requirements for safe medication handling, storage and inventory.
-Weekly medication carts/medication administration record (MAR) checks listed goals

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 _____	R 01/26/2023

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 358	Continued From page 18	D 358		

as follows:
-Medication carts were to be checked weekly for expired medications, poor storage practices, general cleanliness and organization of the care.
-Issues were identified were to be corrected immediately and reported to a licensed nurse.
-Monthly medication carts/medication administration record (MAR) checks listed goals as follows:
-In-depth audit of medication carts/MARs assessed for expired medications, poor storage practices, general cleanliness and organization of the care.
-The effectiveness of the weekly medication cart/MAR checks was evaluated.
-Training and/or education opportunities for Medication Care Managers (MCM).
-There were some medications that once they were opened, were stable for a shorter period than the printed expiration date.
-These medications were designated within a specified number of days after they were opened.
-These medications would be indicated by a pharmacy sticker that must be dated when opened and the sticker would indicate the date the unused medication should be discarded.

Review of Resident #4's current FL-2 dated 09/05/22 revealed:
-Diagnoses included insulin dependent diabetes mellitus type 2, chronic atrial fibrillation, essential primary hypertension, hypothyroidism, hyperlipidemia, atherosclerotic heart disease, and coronary heart disease.
-The resident was semi-ambulatory.

Observation of Resident #4's medications on hand on 01/26/23 at 1:32pm revealed:
-An Aspart flex pen (Novolog) insulin was dispensed on 11/29/22 for Resident #4.

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 _____	R 01/26/2023

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 358	Continued From page 19	D 358		

-There was a yellow sticker on the flex pen that had a handwritten note that the open date was 12/16/22.
-There was no expiration date written on the yellow tag.
-The expiration date would be 28 days from 12/16/22 which calculated to be 01/13/23.

Review of Resident #4's January 2023 electronic medication administration record (eMAR) revealed:
-There was an order to check the finger stick blood sugar (FSBS) three times a day 8:00am, 12:00pm, and 5:00pm with meals, and to call the doctor if the FSBS was below 60 or above 400.
-There was an order for Novolog Flex Pen Insulin to check finger stick blood sugars before meals.
-There was an order to inject Novolog Flex Pen Insulin subcutaneously with meals according to sliding scale with the following parameters: If the FSBS was 170-209 = 3 units, 210 - 249 = 4 units, 250 - 289 = 5 units, 290 - 329 = 6 units, 330 - 369 = 7 units, 370 - 409 = 8 units, 410 - 449 = 9 units, 450 - 490 = 10 units and to notify RCD if FSBS was less than 60 or greater than 400.
-There was documentation of Novolog Flex Pen Insulin being administered subcutaneously 17 times from 01/13/23 to 01/25/23.
-There was documentation of Novolog Flex Pen Insulin 3 units being administered subcutaneously on 01/13/23, 01/14/23, 01/15/23, 01/17/23, 01/18/23, and 01/25/23 at 12:00pm.
-There was documentation of Novolog Flex Pen Insulin 4 units being administered subcutaneously on 01/16/23, 01/19/23, 01/23/23, and 01/24/23 at 12:00pm.
-There was documentation of Novolog Flex Pen Insulin 5 units being administered subcutaneously on 01/21/23 at 12:00pm.
-There was documentation of Novolog Flex Pen

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 _____	R 01/26/2023

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 358	Continued From page 20	D 358		

Insulin 3 units being administered subcutaneously on 01/20/23, 01/21/23 and 01/22/23 at 5:00pm.
-There was documentation of Novolog Flex Pen Insulin 4 units being administered subcutaneously on 01/15/23 and 01/17/23 at 5:00pm.
-There was documentation of Novolog Flex Pen Insulin 5 units being administered subcutaneously on 01/14/23 at 5:00pm.

Attempted interview with the medication aide (MA) on 01/26/23 at 1:55pm was unsuccessful as he was in a staff meeting.

Interview with the Regional Nurse on 01/26/23 at 2:20pm revealed medication aides (MAs) were trained check all medication for expiration dates, to dispose of insulin after 28 days from opening and not to use any expired medications.

Telephone interview with Resident #4's primary care provider (PCP) on 01/26/23 at 1:55pm revealed:
-Resident #4 was an insulin dependent diabetic with meals to help control his blood sugar levels.
-She was concerned that the expired insulin would not be effective, and Resident #4 should not be given expired insulin.
-If Resident #4 received expired insulin, it could result in the insulin being less effective in lowering his blood sugar.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/26/23 at 2:30pm revealed:
-The Novolog insulin expiration date would be 28 days for the date it was opened.
-Medications should be discarded when expired.
-The insulin's stability could be affected after the expiration date.
-The expired insulin should not be given as it may

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 _____	R 01/26/2023

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 358	Continued From page 21 not work as expected as prescribed. _____ The facility failed to administer medications as ordered to 3 residents observed during the medication passes on 01/25/23, resulting in 6 medication errors and a 24% error rate. Resident #7's medication for nerve pain was not decreased as ordered on 12/01/22, resulting in the resident continuing to experience diarrhea as a side effect. Resident #4 received 17 doses of expired rapid-acting insulin putting the resident at risk of high blood sugars due to expired insulin being unstable which could cause the insulin to be less effective. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/26/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 12, 2023.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of	D 367		

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 _____	R 01/26/2023

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 367	Continued From page 22	D 367		

medications or treatments as needed (PRN) and documenting the resulting effect on the resident;
(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 5 sampled residents (#3) including inaccurate documentation for a medication for yeast infections and supplements for bone disorders, immune system health, heart disease, high blood pressure, high cholesterol and triglycerides.

The findings are:

Review of Resident #3's current FL-2 dated 04/13/22 revealed diagnoses included cognitive impairment, hypertension, atrial fibrillation, coronary artery disease, and chronic kidney disease.

a. Review of Resident #3's physician's order dated 12/27/22 revealed an order for Fluconazole 150mg take 1 tablet by mouth for 1 dose. (Fluconazole is used to treat yeast infections.)

Review of Resident #3's December 2022 electronic medication administration record (eMAR) revealed:

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 _____	R 01/26/2023

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 367	Continued From page 23	D 367		

-There was an entry for Fluconazole 150mg give 1 tablet one time a day for yeast scheduled at resident-centered medication pass time of "OA2" (on arising = 6:00am to 10:00am).
-The start date for Fluconazole was documented as 12/28/22 but no stop date was noted.
-Fluconazole 150mg was documented as administered daily from 12/28/22 - 12/31/22.

Review of Resident #3's January 2023 eMAR revealed:
-There was an entry for Fluconazole 150mg give 1 tablet one time a day for yeast scheduled at resident-centered medication pass time of OA2.
-The start date for Fluconazole was documented as 12/28/22 but no stop date was noted.
-Fluconazole 150mg was documented as administered daily from 01/01/23 - 01/25/23.

Observation of the morning medication pass on 01/25/23 revealed Fluconazole was not administered to Resident #3 when she received her other scheduled morning medications but it was documented as administered on the eMAR.

Observation of Resident #3's medications on hand on 01/25/23 at 8:57am revealed there was no Fluconazole on hand for the resident.

Interview with a medication aide (MA) on 01/25/23 2:17pm revealed:
-He did not administer Fluconazole to Resident #3 that morning on 01/25/23.
-The Fluconazole was a one-time dose that he thought was administered to the resident last week.
-The pharmacy only sent one Fluconazole 150mg tablet.
-The MAs did not have access to make changes to the eMAR system but the facility's nurses could

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 _____	R 01/26/2023

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 367	Continued From page 24	D 367		

change it.
-He did not know why the Fluconazole order continued to appear on the eMAR system.
-He had not reported it to anyone but gave no explanation as to why he had not reported the discrepancy.
-The eMAR was not accurate because the resident only received one dose of Fluconazole.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/26/23 at 2:30pm revealed they dispensed one Fluconazole 150mg tablet on 12/27/22.

Interview with the Senior Resident Care Director (SRCD) on 01/25/23 at 2:40pm revealed:
-Either Wellness Nurses or the RCD could enter orders into the eMAR system.
-She thought either a Wellness Nurse or the previous RCD had entered Resident #3's Fluconazole order incorrectly in the eMAR system.
-Fluconazole should have been set up as a one-time dose in the eMAR system.
-The MAs should have notified her or the Wellness Nurses that the Fluconazole order was still active on the eMAR.
-The MAs should not document a medication was administered when it was not administered.

Refer to interviews with the Wellness Nurse on 01/25/23 at 9:28am and 01/26/23 at 4:12pm.

b. Review of Resident #3's current FL-2 dated 04/13/22 revealed an order for Vitamin D3 take 1000 units once a day. (Vitamin D3 is a supplement used to treat and prevent bone disorders and used in kidney disease to keep calcium levels normal.)

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 _____	R 01/26/2023

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 367	Continued From page 25 Observation of the morning medication pass on 01/25/23 revealed the medication aide (MA) prepared and administered one Vitamin D3 2000 units softgel to Resident #3 at 9:08am. Review of Resident #3's January 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Vitamin D3 1000 units take 1 tablet one time a day for supplement scheduled at resident-centered medication pass time of "OA2" (on arising = 6:00am to 10:00am). -Vitamin D3 1000 units was documented as administered from 01/01/23 - 01/25/23. Observation of Resident #3's medications on hand on 01/25/23 at 8:57am revealed: -There was an over-the-counter (OTC) supply of Vitamin D3 2000 units softgels in the original manufacturer's container. -There was no Vitamin D3 1000 units on hand for the resident. Interview with the MA on 01/25/23 at 2:17pm revealed: -The resident's family brought her over-the-counter (OTC) medications to the facility. -There were 2 bottles of Vitamin D3 2000 units softgels that he had been administering to the resident. -He had not noticed the entry on the eMAR was for Vitamin D3 1000 units. -There was no Vitamin D3 1000 units softgels on hand for the resident. -He had documented the resident was receiving Vitamin D3 1000 units on the eMAR but the resident had actually been receiving 2000 units. -The documentation on the eMAR was not accurate for Resident #3's Vitamin D3.	D 367		

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 _____	R 01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 367	Continued From page 26	D 367		

Interview with the Senior Resident Care Director (SRCD) on 01/25/23 at 2:40pm revealed:
-The MAs were supposed to compare the entries on the eMAR with the label on the medication prior to administering medications.
-The MAs should not have documented Vitamin D3 1000 units was administered when they were administering Vitamin D3 2000 units.
-The eMARs should be accurate.

Refer to interviews with the Wellness Nurse on 01/25/23 at 9:28am and 01/26/23 at 4:12pm.

c. Review of Resident #3's physician's order sheet dated 12/27/22 revealed an order for Vitamin C (no strength noted) take 1 tablet once daily. (Vitamin C is a supplement used for immune system health.)

Review of Resident #3's physician's order dated 01/03/23 revealed a clarification order for Vitamin C 500mg 1 tablet once daily.

Observation of the morning medication pass on 01/25/23 revealed the medication aide (MA) prepared and administered two Vitamin C 500mg tablets to Resident #3 at 9:08am.

Review of Resident #3's January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Vitamin C 500mg take 1 tablet one time a day for supplement scheduled at resident-centered medication pass time of "OA2" (on arising = 6:00am to 10:00am).
-Vitamin C 500mg for this entry was documented as administered from 01/04/23 - 01/25/23.
-There was a second entry for Vitamin C (no strength noted) take 1 tablet one time a day for

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	HAL092222	A. BUILDING: _____ B. WING _____	R 01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 367	Continued From page 27	D 367		

supplement scheduled at resident-centered medication pass time of "OA2".
-Vitamin C for the second entry was documented as administered from 01/01/23 - 01/25/23.

Observation of Resident #3's medications on hand on 01/25/23 at 8:57am revealed:
-There was an over-the-counter (OTC) supply of Vitamin C timed-release 500mg tablets in the original manufacturer's container.
-There was a supply of Vitamin C 500mg tablets dispensed by the pharmacy in a bubble card on 01/03/23 with instructions to take 1 tablet every day.

Interview with the MA on 01/25/23 at 2:17pm revealed:
-The resident's family brought her over-the-counter (OTC) medications to the facility.
-There were duplicate entries for Vitamin C on the eMAR and two different supplies of Vitamin C on hand for Resident #3.
-He administered Vitamin C from each supply each time he administered the Vitamin C to the resident because both entries "popped up" on the eMAR.

Interview with the Senior Resident Care Director (SRCD) on 01/25/23 at 2:40pm revealed:
-There was a duplicate order for Vitamin C in the eMAR system.
-The MAs should have notified her or the Wellness Nurse of the duplicate order.

Refer to interviews with the Wellness Nurse on 01/25/23 at 9:28am and 01/26/23 at 4:12pm.

d. Review of Resident #3's physician's order sheet dated 12/27/22 revealed an order for

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D 367	Continued From page 28	D 367		

Flaxseed Oil take 1 capsule two times a day for supplement. (Flaxseed Oil is a supplement that may be used for heart disease, high blood pressure, and high cholesterol. Flaxseed Oil contains multiple fatty acids including omega-3 fats.)

Review of Resident #3's physician's order dated 01/03/23 revealed an order to discontinue Flaxseed Oil.

Review of Resident #3's telephone order dated 01/18/23 revealed an order for Omega-3 dietary supplement (no strength noted) take 1 softgel two times daily. (Omega-3 is fatty acids that help lower triglycerides to reduce the risk of heart disease and stroke.)

Observation of the morning medication pass on 01/25/23 revealed:
-The medication aide (MA) prepared and administered one Flaxseed Oil 1300mg softgel to Resident #3 at 9:08am instead of the current order for Omega-3.
-Omega-3 was not administered as ordered on 01/18/23.

Review of Resident #3's January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Flaxseed Oil take 1 capsule two times a day for supplement with scheduled resident-centered medication pass times of "OA2" (on arising = 6:00am to 10:00am) and "HS2" (bedtime = 6:00pm to 10:00pm.
-Flaxseed Oil was documented as administered from 01/01/23 - 01/03/23 and noted to be discontinued on 01/03/23.
-There was an entry for Omega-3 Capsule take 1 capsule two times a day with scheduled

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D 367	Continued From page 29	D 367		

resident-centered medication pass times of "OA2" and "HS2".
-Omega-3 Capsule was documented as administered from 01/19/23 - 01/25/23.

Observation of Resident #3's medications on hand on 01/25/23 at 8:55am revealed:
-There was an over-the-counter (OTC) supply of Flaxseed Oil 1300mg with Omega-3 softgels in the original manufacturer's container.
-The active ingredients listed on the back of the manufacturer's container included: Organic Flaxseed Oil with Lignans 1300mg which typically contains Omega-3 650mg, Omega-6 143-312mg, and Omega-9 143-312mg.
-There was no Omega-3 on hand for the resident.

Interview with the MA on 01/25/23 at 2:17pm revealed:
-He thought he was administering Omega-3 when he administered the Flaxseed Oil because the label had "with Omega-3" below the words "Flaxseed Oil".
-There was no supply of Omega-3 on hand for the resident.
-He documented Omega-3 as being administered on the eMAR when he actually administered Flaxseed Oil because he thought it was the Omega-3.

Interview with the Senior Resident Care Director (SRCD) on 01/25/23 at 2:40pm revealed:
-The MAs were supposed to compare the entries on the eMAR with the label on the medication prior to administering medications.
-If the eMARs and the medication labels did not match, the MAs were supposed to let her or the Wellness Nurses know.
-The eMAR should be accurate and reflect what medication was actually administered.

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D 367	Continued From page 30 Refer to interviews with the Wellness Nurse on 01/25/23 at 9:28am and 01/26/23 at 4:12pm. Interviews with the Wellness Nurse on 01/25/23 at 9:28am and 01/26/23 at 4:12pm revealed: -She entered medication orders into the eMAR system. -She also checked the eMAR system but did not specify how often. -The MAs should notify her if the eMAR and the medication labels did not match. -The eMARs should be accurate. -She was not aware of the discrepancies with Resident #3's medications on the eMARs.	D 367		