STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092152	A. BUILDING: _____ B. WING _____	01/08/2015

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

(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 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure 2 of 7 sampled residents (#4, #7) were tested for tuberculosis (TB) in compliance with control measures using the 2 step TB skin test. The findings are: 1. Review of Resident #4's current FL2 dated 3/13/14 included diagnoses of depression and psychosis. Review of the Resident Register revealed Resident #4 was admitted to the facility on 3/7/13. Review of Resident #4's physician orders revealed: - Resident #4's orders dated 10/8/14 revealed resident had "No Known Allergies". - The resident had a chest X-ray dated 3/6/13 to "Rule out TB for Skill Nursing Facility" which revealed "No evidence of active TB". - There was no documentation of a Step 2 TB test.	D 234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092152	A. BUILDING: _____ B. WING _____	01/08/2015

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

(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 234	Continued From page 1 Interview with Resident #4 on 1/8/15 at 9:38 a.m. revealed the resident did not remember having any TB skin test since admission into the facility. Interview with the Executive Director (ED) on 1/8/15 at 10:30 a.m. revealed: - The Sales Director was responsible for making sure residents have a step 1 TB test completed prior to moving into the facility. - The Health Care Coordinator was responsible for making sure both steps of TB testing were completed on all residents. Interview with the Health Care Coordinator (HCC) on 1/8/15 at 11:04 a.m. revealed: - The HCC thinks Resident #4 was allergic to an ingredient in the TB derivative and therefore the resident received a chest x-ray instead of a TB skin test. - The HCC was waiting for documentation from Resident #4's doctor to "confirm" the resident had an allergy to the TB solution. - The Sales Director was responsible for ensuring residents had a Step 1 TB skin test prior to moving into the facility. - All management are responsible on checking for residents TB skin tests. Interview with the Sales Director (SD) on 1/8/15 at 11:28 a.m. revealed: - Resident #4 was a "quick move-in" from the hospital which was why the resident received the chest x-ray (to rule out TB). - The SD thought once a resident received a chest x-ray, the resident would not need a 2 Step TB skin test. Telephone interview with clinical support staff at Resident #4's doctor office on 1/8/15 at 9:17 a.m.	D 234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092152	A. BUILDING: _____ B. WING _____	01/08/2015

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

(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 234	Continued From page 2	D 234		

revealed Resident #4 has "No Known Drug Allergies" listed in the chart but she would have to ask the doctor to make sure.

Telephone interview with Resident #4's doctor on 1/8/14 at 10:21 a.m. revealed:
- The doctor had no documentation of Resident #4 having any type of allergies.
- The doctor had no documentation of Resident #4 having a TB skin test.

2. Review of Resident #7's current FL-2 dated 9/16/14 revealed the resident's diagnoses included seizures and hyponatremia.

Resident #7 was admitted to the facility on 5/20/13 per Resident Register.

Review of Resident #7's immunization record revealed:
-The resident had a tuberculosis (TB) test placed on 5/17/13 and the test was read on 5/19/13 as negative.
-There was no documentation of another TB test.
-Resident #7 had a TB screening (5/21/13) given by the facility when there was a shortage of Tubersol; resident had no signs/symptoms of TB. Tubersol isused for TB testing).

Interview with the HCC on 1/8/15 at 9:41 a.m. revealed:
-When Resident #7 was admitted to the facility May 2013, there was a shortage of Tubersol.
-Resident #7 had a Step 1 TB test completed before the resident was admitted to the facility.
-The HCC completed a TB screening on Resident #7 May 2013.
-Resident #7 had not completed a second step TB test, because the HCC thought there was still a Tubersol shortage. The HCC was not aware

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092152	A. BUILDING: _____ B. WING _____	01/08/2015

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

(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 234	Continued From page 3	D 234		

the Tubersol shortage had expired.
-Residents are required to have a first step TB test completed before admitted to the facility. The second step TB test can be placed before a resident is admitted to the facility, but the test had to be read before or on day the resident had moved into the facility.
-The Sales Director was responsible for making sure a resident had a Step 1 completed before admission to the facility and the HCC was responsible for making sure residents had documentation of a two step TB test completed.

Telephone interview with Resident #7's primary care physician's nurse on 1/8/15 at 10:29 a.m. revealed:
-Resident #7 had a TB test placed on 5/17/13.
-There was no documentation when the test was read and there was no documentation of any other TB tests.

Interview with Resident #7 on 1/8/15 at 11:06 a.m. revealed the resident had a TB test, but the resident could not remember when the TB test was completed or if the resident had another TB test.

Interview with the Sales Director on 1/8/15 at 2:00 p.m. revealed:
-Before a resident is admitted to the facility, she made sure the resident had documentation of a Step 1 TB test.
-The Executive Director and the HCC determined when a resident can be admitted to the facility.
-Resident #7 was admitted to the facility from an independent living facility May 2013.
-Resident #7 only had documentation of a Step 1 TB test before the resident was admitted to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092152	A. BUILDING: _____ B. WING _____	01/08/2015

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

(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 234	Continued From page 4 Interview with the Executive Director on 1/8/15 at 11:55 a.m. revealed: -The Sales Director and the HCC are responsible for making sure before a resident is admitted to the facility, the resident had a Step 1 TB test completed. -The HCC was responsible for making sure residents had documentation of a two step TB testing. -Residents are required to have a first step TB test completed before admission to the facility. The second step TB test can be placed before a resident is admitted to the facility, but the test had to be read before or on day the resident moved into the facility. -The Executive Director was not aware Resident #7 did not have documentation of a 2 Step TB test. -Resident #7 was admitted to facility during the shortage of Tubersol. -The Executive Director was aware the Tubersol shortage had lifted, but she was not aware the residents who did not have documentation of the two step TB tests completed during the shortage of Tubersol needed to have documentation of the two step TB testing.	D 234		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by:	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092152	A. BUILDING: _____ B. WING _____	01/08/2015

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

(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 270	Continued From page 5 TYPE B VIOLATION Based on interview, observation and record review, the facility failed to assure supervision for 1 of 4 sampled residents (Resident #2) who was at risk for falls. The findings are: Resident #2 was observed wheeling his wheelchair throughout the Reminiscent Unit during the initial tour on 1/6/2015 between 9:30 and 10:00am. Review of Resident #2's current FL-2 dated 12/15/2014 revealed: - The resident's diagnoses included Dementia due to Cerebral Vascular Accident, Peripheral Neuropathy, and Left Hand Cellulitis and Skin Tear. - The resident was semi-ambulatory with a walker. - The resident was intermittently disoriented. Review of Resident #2's current individualized service plan dated 12/16/2014 and updated 1/5/2015, revealed: - The resident was admitted to the facility on 12/16/2014. - The resident is a "high falls risk." - The resident "needs supervision throughout the day." - The resident is "unsteady and gait shuffles." - The resident "does not adjust to changes and/or stressful events." - The resident napped during the day and was frequently up at night. - The resident required assistance based on cognition and memory. - The resident required the assist of one	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092152	A. BUILDING: _____ B. WING _____	01/08/2015

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

(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 270	Continued From page 6	D 270		

person to promote safety.
- The resident required assistive devices (walker, wheelchair).

Physician visit summary notes for Resident #2 dated 12/22/2014 revealed:
- Resident still tries to get up on his own; high risk for falls.
- Resident has skin tear on left hand and both shins.
- Shin skin tears are mild.

Review of "BERG BALANCE SCALE" Physical Therapy assessment for Resident #2 dated 12/22/2014 revealed:
- Resident needs assistance to keep from falling.
- Resident is unable to stand 30 seconds unassisted.
- Resident needs one person to assist with transfers.

Interview with Physical Therapy supervisor on 1/7/2015 at 11:50am revealed Resident #2 needed assistance with ambulation and that this information had been communicated to staff on the Reminiscent Unit.

Review of incident reports for Resident #2 revealed the resident had 6 falls since admission that revealed the following:
- 12/17/2014 at 1:15pm, resident fell in bedroom; complained of "bottom hurting."
- 12/17/2014 at 9:00pm resident, fell in dining room; "upset about leaving."
- 12/20/2014 at 2:20pm, resident fell in community bathroom: " buttocks and right elbow hurting; "EMS called; no hospitalization."
- 12/22/2014 at 12:40am, resident was found on the floor during rounds. Skin tears on both

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092152	A. BUILDING: _____ B. WING _____	01/08/2015

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

(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 270	Continued From page 7 knees had re-opened. - 12/28/2014 at 6:30pm fell (location questionable). A skin tear was noted on the right leg. - 1/6/2015 at 11:30pm, resident fell outside resident ' s bedroom. A new skin tear was noted on the right knee. Interview with Personal Care Aide for Resident #2 on 1/7/2015 at 2:30pm revealed: - The resident required assistance with dressing and grooming. - The resident will get out of his wheelchair to walk independently and fall. - The resident mostly falls in his room during the second shift. - The resident needs assistance with ambulation; this is why he falls. - The resident may not fall as frequently if someone walked with him or if he had a pendant to ring for assistance. Interview with Care Manager (second/third shift) on 1/8/2015 at 1:41pm revealed: - Resident #2 had many falls on third shift and fell 2-3 days ago. - The resident was found on the floor of his room. - Since admission, the resident has fallen 4 or 5 times. - Resident #2 had been checked every 2 hours and care managers had not been told to increase the resident ' s supervision to every hour. Interview with Reminiscent Care Unit Supervisor on 1/8/2015 at 11:15am, revealed: - Resident #2's falling were discussed during daily stand-up meetings. - Plan of action has been to engage the resident in activities following a fall.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092152	A. BUILDING: _____ B. WING _____	01/08/2015

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

(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 270	Continued From page 8 - Supervision for the resident has been 2-hour checks when the resident is in his room. - The resident is "laid eyes on "3 to 4 times a day." - Incident reports of the resident's falls are given to the Wellness Coordinator. - Supervision for Resident #2 should have been increased to prevent his falling incidents. Interview with the Wellness Coordinator on 1/8/2015 at 12:01pm, revealed: - More frequent checks for Resident #2 may have prevented his falls. - Supervision for Resident #2 should have been increased. Interview with the Executive Director on 1/8/2015 at 12:15noon, revealed: - After knowing about Resident #2's falls the Reminiscent Coordinator and/or Wellness Coordinator should have initiated "One-hour" checks to increase supervision for the resident. - Labs should have been done to rule out UTI for Resident #2. Interview with Resident #2's family on 1/8/2015 at 1:00pm revealed: - The main concern for Resident #2 is the provision of safety and comfort. - Family has been made aware of most of Resident #2's falls. - Family was not aware of the fall on 1/6/2015. The Executive Director provided the following plan of protection on 1/8/2015: - More frequent checks (5-6 times per shift) have been implemented for residents at risk for falls. - A private-duty aide for Resident #2 will be hired for 1:1 care.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092152	A. BUILDING: _____ B. WING _____	01/08/2015

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

(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 270	Continued From page 9 - Discharge for Resident #2 and assistance on finding placement will be discussed with the resident's family. - Continue to discuss residents with high risk for falling at the daily stand-up meetings. - Staff in-services will be provided on falls interventions and strategies. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 22, 2015	D 270		
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 observation, interview and record review, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to falls. The findings are: Based on interview, observation and record review, the facility failed to assure supervision for 1 of 4 sampled residents (Resident #2) who was at risk for falls. [Refer to Tag D270, 10A NCAC 13F .0901 (b). (Type B Violation)]	D912		