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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 03/11/25 - 03/12/25.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the facility was free from hazards as evidenced by unsecured oxygen cylinders stored in a resident's room (#1). The findings are: Review of Resident #1's current FL2 dated 04/30/24 revealed diagnoses included cerebral infarction, type 2 diabetes mellitus, obstructive sleep apnea, hypertension, and osteoarthritis. Observation of Resident #1's apartment on 03/11/25 from 8:58am to 9:06am revealed: -There was a sign beside the door reading "no smoking, oxygen in use". -There were 2 rooms and a bathroom in the apartment. -In the room on the right side of the apartment, there were 2 oxygen cylinders on the floor beside the door.	D 079		

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D 079	Continued From page 1 -The 2 oxygen cylinders were not secured in a storage rack. -The 2 oxygen cylinders had a green band around the valve post opening. Interview with Resident #1 on 03/12/25 at 10:35am revealed: -She used oxygen continuously. -She always used her oxygen concentrator. -She did not usually use her portable oxygen cylinders. -She was unsure if she had racks to store her oxygen cylinders. -The staff assisted her with her oxygen when she needed assistance. Interview with a lead personal care aide (PCA) on 03/11/25 at 12:01pm revealed: -Residents who were on oxygen stored their oxygen cylinders in their rooms. -The oxygen cylinders should be stored in a rack or crate. -Oxygen cylinders should never be stored on the floor and should always be in a rack. -It was not safe for oxygen cylinders to be left unsecured. -She was unsure why Resident #1's oxygen cylinders were on the floor and not stored in a rack. -Sometimes the oxygen providers delivered oxygen to residents' rooms and did not place the oxygen cylinders in a rack. Interview with a medication aide (MA) on 03/12/25 at 10:30am revealed: -Residents who were on oxygen stored their oxygen cylinders in their rooms. -The oxygen cylinders should be stored in a rack. -Oxygen cylinders should never be stored on the floor.	D 079		

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-Resident #1 did not use her portable oxygen cylinders because she did not leave her room.
-Resident #1 always used her oxygen concentrator because she was always in bed.
-She was unsure why Resident #1's oxygen cylinders were not stored in a rack on 03/11/25.

Interview with a representative from Resident #1's hospice agency on 03/12/25 at 11:18am revealed:
-The hospice agency provided Resident #1's medical equipment, including oxygen.
-The agency kept a record of all oxygen and medical equipment deliveries for Resident #1.
-Their records indicated that Resident #1 last had oxygen delivered to the facility in June 2024.
-The delivery consisted of an oxygen concentrator and oxygen cylinders.
-She was unsure if a storage rack was provided at the time of delivery.
-Their records did not show any other oxygen deliveries for Resident #1.

Interview with the Resident Care Coordinator (RCC) on 03/12/25 at 2:40pm revealed:
-Residents who were on oxygen usually stored their oxygen cylinders in their closet.
-Oxygen cylinders should be stored in a rack.
-She saw Resident #1 had oxygen cylinders on the floor in her room on 03/11/25, so she placed the cylinders in a rack.
-She had some extra storage racks for oxygen cylinders in the facility.
-She was unsure why the oxygen cylinders were on the floor on 03/11/25.
-She thought the oxygen cylinders were just delivered this week or taken out of a closet and left on the floor.
-The green band around the valve post indicated the oxygen tank was full.
-Full, unsecured oxygen cylinders could explode if

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D 079	Continued From page 3 they fell over, so the oxygen cylinders should be stored securely in a rack. Interview with the Administrator on 03/12/25 at 3:22pm revealed: -Residents who used oxygen stored their oxygen cylinders in their rooms. -Oxygen cylinders should never be stored on the floor, and always in a storage rack. -If there was not a rack in the resident's room for oxygen cylinders, the staff should have contacted the resident's oxygen vendor and requested a rack for storage. -She thought the RCC also had some extra storage racks for oxygen cylinders, so the oxygen cylinders should have been secured. -Full, unsecured tanks were dangerous and a safety concern to the residents because the tank could explode if overturned.	D 079		
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 ensure medications were administered as ordered for 2 of 6 residents (#6, #7) observed during the medication pass	D 358		

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including a medication used to treat or prevent skin infections (#6) and a medication used to treat acid reflux (#7).

The findings are:

The medication error rate was 10% as evidenced by 3 errors out of 30 opportunities during the 8:00am medication passes on 03/11/25 and 03/12/25.

1. Review of Resident #6's current FL2 dated 10/15/25 revealed diagnoses included unspecified dementia, elevated blood pressure reading without diagnosis of hypertension, age-related cognitive decline, and history of malignant neoplasm of the breast.

a. Review of Resident #6's podiatry visit order dated 03/10/25 revealed there was an order to apply triple antibiotic ointment and band-aid to the third toe of right foot daily for 7 days (Triple antibiotic ointment is a topical medication used to treat or prevent minor skin infections).

Observation of the 8:00am medication pass on 03/11/25 from 8:40am to 9:18am revealed:
-The medication aide (MA) began preparing Resident #6's medications at 8:46am.
-The MA was unable to locate Resident #6's triple antibiotic ointment in the medication cart.
-The MA entered Resident #6's room at 8:48am.
-The MA administered Resident #6's oral medications at 8:49am.

Review of Resident #6's March 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for triple antibiotic ointment, apply to third toe of right foot every day for 7

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days, cover with band-aid with a start date of 03/11/25, scheduled at 7:00am-9:00am.
-Triple antibiotic ointment was documented as medication pending delivery at 7:00am-9:00am on 03/11/25.

Interview with the MA on 03/11/25 at 8:51am revealed:
-She was unable to locate Resident #6's triple antibiotic ointment in the medication cart.
-Resident #6's triple antibiotic ointment order was a new order, so the medication had not arrived from the facility's contracted pharmacy.
-She was unsure if Resident #1's triple antibiotic ointment was ordered from the pharmacy.

Second interview with the MA on 03/11/25 at 12:45pm revealed:
-The MAs did not process new medication orders.
-When new medication orders were received, the MAs gave those orders to the Resident Care Coordinator (RCC) and the RCC sent the orders to the pharmacy to be added to the resident's eMAR.
-The RCC processed all new medication orders.
-The RCC ordered all new medications from the facility's contracted pharmacy.
-If a medication was not available during a medication pass, the MAs documented medication pending on the eMAR and notified the RCC.
-Resident #6's triple antibiotic ointment was not in the medication cart this morning, so she documented medication pending.
-She had not notified the RCC that Resident #6's triple antibiotic ointment was not in the medication cart.
-She had not contacted the pharmacy to see when Resident #6's triple antibiotic ointment would be delivered.

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-She had been busy but needed to report to the RCC that Resident #6's triple antibiotic ointment had not been delivered.

Interview with the RCC on 03/12/25 at 2:40pm revealed:
-She was a registered nurse (RN).
-There were two Licensed Practical Nurses (LPNs) who worked at the facility.
-Either she or the LPNs were the only staff members who sent residents' medication orders to the pharmacy and ensured the medication orders were added to the eMAR.
-The MAs did not process the medication orders or order new medications from the pharmacy.
-Either she or the LPNs confirmed the residents' medication orders on the eMARs after the pharmacy entered the order.
-The medication could not be administered by the MAs until the order was confirmed by one of the nurses.
-She was not informed Resident #6 did not have triple antibiotic ointment in the medication cart on 03/11/25.
-Resident #6's family did not want the facility to order over the counter medications from the pharmacy.
-The MA who worked on 03/11/25 should not have documented administered medication pending because there was a supply of triple antibiotic ointment in the facility.
-MAs should not document medication pending without being instructed to do so by one of the nurses in the facility.
-The MA should have asked one of the nurses if there was a question about Resident #6's triple antibiotic ointment order.

Based on observations, interviews, and record reviews, it was determined that Resident #6 was

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not interviewable.

Attempted telephone interview with Resident #6's primary care provider (PCP) on 03/12/25 at 1:55pm was unsuccessful.

Attempted telephone interview with Resident #6's podiatrist on 03/12/25 at 3:07pm was unsuccessful.

Refer to interview with the Administrator on 03/12/25 at 3:22pm.

Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 03/12/25 at 11:31am.

b. Review of Resident #6's podiatry visit order dated 03/10/25 revealed there was an order to apply triple antibiotic ointment and band-aid to the third toe of right foot daily for 7 days (Triple antibiotic ointment is a topical medication used to treat or prevent minor skin infections).

Observation of the 8:00am medication pass on 03/12/25 from 7:43am to 7:52am revealed:
-The medication aide (MA) began preparing Resident #6's medications at 7:46am.
-The MA was unable to locate Resident #6's triple antibiotic ointment in the medication cart.
-The MA administered Resident #6's oral medications at 7:50am.

Review of Resident #6's March 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for triple antibiotic ointment, apply to third toe of right foot every day for 7 days, cover with band-aid with a start date of 03/11/25 scheduled for 7:00am-9:00am.

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-Triple antibiotic ointment was documented as medication pending delivery on 03/11/25 at 7:00am-9:00am.
-There were 2 documentation entries dated 03/12/25.
-Triple antibiotic ointment was documented as medication pending delivery on 03/12/25 at 7:00am-9:00am by the MA.
-Triple antibiotic ointment was documented as administered on 03/12/25 at 7:00am-9:00am by the Resident Care Coordinator (RCC).

Interview with the MA on 03/12/25 at 7:53am revealed:
-The facility's contracted podiatrist was at the facility on 03/10/25 to see residents.
-The podiatrist must have ordered the triple antibiotic ointment for Resident #6 on 03/10/25.
-The pharmacy must not have delivered Resident #6's triple antibiotic ointment because she could not locate the medication in the medication cart.
-She documented the medication as medication pending because the medication was not at the facility.
-If medications were not on the medication cart during the medication pass, she notified the Resident Care Coordinator (RCC) or the pharmacy.
-The RCC was responsible for ordering any new medications from the pharmacy.
-She was unsure if the pharmacy was contacted about Resident #6's triple antibiotic ointment because she did not work on 03/11/25.

Interview with the RCC on 03/12/25 at 2:40pm revealed:
-She was a registered nurse (RN).
-There were two Licensed Practical Nurses (LPNs) who worked at the facility.
-Either she or the LPNs were the only staff

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members who sent residents' medication orders to the pharmacy and ensured the medication orders were added to the eMAR.
-The MAs did not process the medication orders or order new medications from the pharmacy.
-Either she or the LPNs confirmed the residents' medication orders on the eMARs after the pharmacy entered the order.
-The medication could not be administered by the MAs until the order was confirmed by one of the nurses.
-The MA who worked this morning, 03/12/25, informed her about Resident #6's triple antibiotic ointment order and that Resident #6 did not have triple antibiotic ointment in the medication cart.
-She kept a supply of triple antibiotic ointment in the facility.
-She applied the triple antibiotic ointment to Resident #6's toe this morning, 03/12/25, when the MA informed her about the order.
-Resident #6's triple antibiotic order could have been started on 03/11/25 because there was triple antibiotic ointment in the facility.

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

Attempted telephone interview with Resident #6's primary care provider (PCP) on 03/12/25 at 1:55pm was unsuccessful.

Attempted telephone interview with Resident #6's podiatrist on 03/12/25 at 3:07pm was unsuccessful.

Refer to interview with the Administrator on 03/12/25 at 3:22pm.

Refer to telephone interview with a pharmacist at

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D 358	Continued From page 10 the facility's contracted pharmacy on 03/12/25 at 11:31am. _____ Interview with the Administrator on 03/12/25 at 3:22pm revealed: -The RN or LPNs sent all new medication orders to the pharmacy and the pharmacy entered the orders in the eMAR system. -The MAs did not order the medications or send the medication orders to the pharmacy. -The MA should inform the RN or LPNs if a medication was not on the medication cart and was not administered. Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/12/25 at 11:31am revealed: -The pharmacy received Resident #6's order for triple antibiotic ointment on 03/10/25. -The pharmacy filled Resident #6's prescription medications, but there was a note on Resident #6's profile not to fill over the counter medications. -The pharmacy did not fill Resident #6's triple antibiotic ointment because the medication was available over the counter. -Triple antibiotic ointment was used to decrease bacteria on the skin and decrease the risk of minor skin infection. -Missing doses of triple antibiotic ointment increased Resident #6's risk of skin infection at the affected area. 2. Review of Resident #7's current FL2 dated 10/15/24 revealed: -Diagnoses included vascular dementia, diverticulosis of intestine, atherosclerotic heart disease, prediabetes, edema, and vitamin D deficiency. -There was an order for Omeprazole 20mg take 1	D 358		

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capsule every morning 30 minutes before a meal (Omeprazole is a medication used to reduce acid in the stomach).

Observation of the 8:00am medication pass on 03/11/25 from 8:40am to 9:18am revealed:
-The medication aide (MA) began preparing Resident #7's medications at 9:06am.
-There were 6 tablets and capsules in the plastic medication cup, including Omeprazole 20mg.
-The MA entered Resident #7's room at 9:11am.
-Resident #7 was sitting at a table in his room eating breakfast.
-Resident #7 had a plate with a waffle, diced melon, sausage, and bacon.
-Resident #7 had consumed approximately 25% of his breakfast meal.
-Resident #7 began taking his oral medications at 9:12am.
-Resident #7 completed taking his medications at 9:18am.

Review of Resident #7's March 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Omeprazole 20mg take 1 capsule every morning 30 minutes before a meal scheduled at 7:00am-9:00am.
-Omeprazole 20mg was documented as administered at 7:00am-9:00am daily from 03/01/25 to 03/11/25.

Interview with the MA on 03/11/25 at 12:45pm revealed:
-She followed the instructions on the eMAR when administering medications.
-She had not noticed Resident #7's Omeprazole order should be administered 30 minutes before a meal.
-She administered the medication because the

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Omeprazole was on the eMAR to be administered at the same time as the rest of his morning medications.
-She usually started administering medications on the second floor of the facility when she worked on the assisted living (AL) medication carts.
-Resident #7 lived on the first floor, and she administered medications to the residents on the first floor during the last part of her medication pass.
-Breakfast was served at 8:00am, so Resident #7 was usually eating breakfast in his room by the time she started administering medications on the first floor.
-If there were any questions about medications, she asked the Resident Care Coordinator (RCC).
-If a resident's medication was ordered before meals, the medication should be administered before the resident started eating their meal.

Interview with the Dietary Manager (DM) on 03/11/25 at 10:30am revealed:
-The facility served a light continental breakfast of grits, oatmeal, and beverages daily at 7:00am for residents who wanted an early breakfast.
-The facility served the other residents a full breakfast at 8:00am, served lunch at 12:00pm, and served dinner at 5:00pm.

Interview with the RCC on 03/12/25 at 2:40pm revealed:
-The facility served a continental breakfast at 7:30am and a seated breakfast meal between 8:00am and 8:30am.
-Resident #7 usually ate breakfast in his room.
-Sometimes Resident #7 ate his breakfast when it was delivered and sometimes he did not eat right away.
-Resident #7 did not eat breakfast at the same time every day, so it would be difficult to schedule

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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
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a medication to be administered before his meal.
-MAs should read the instructions on the eMAR when administering medications.
-If a resident's medication was scheduled before meals, the medication should be administered before the resident ate their meal.
-If MAs had questions about the time medications were scheduled, they should ask her for clarification.
-Either she or the pharmacy could adjust the times for medications to be administered on the eMAR.

Interview with the Administrator on 03/12/25 at 3:22pm revealed:
-MAs should follow the instructions on the eMAR when administering medications.
-If a medication was ordered to be administered before a meal, the medication should be administered before the resident began eating their meal.
-If the MAs were unsure if a medication should be administered, the MA should seek clarification from the RCC or one of the Licensed Practical Nurses (LPNs).
-The MA should have administered Resident #7's Omeprazole before he started eating breakfast.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/12/25 at 11:31am revealed:
-Omeprazole helped to neutralize acid in the stomach.
-Omeprazole was more effective when administered on an empty stomach.
-Resident #7 could have acid reflux or heartburn if the medication was not administered as ordered.
-The facility staff should administer medications according to the instructions indicated on the

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	HAL092222	A. BUILDING: _____ B. WING _____	03/12/2025

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D 358	Continued From page 14 eMAR. -Resident #7's Omeprazole was scheduled at 7:00am-9:00am, which was the facility's default time for all medications administered once daily. -Resident #7's Omeprazole should be scheduled 30 minutes before his morning meal. -The facility staff had the ability to change the time a medication was administered on the eMAR or the pharmacy could change the time on the eMAR at the request of the facility. Based on observations, interviews, and record reviews, it was determined that Resident #7 was not interviewable. Attempted telephone interview with Resident #7's primary care provider (PCP) on 03/12/25 at 1:55pm was unsuccessful.	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 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,	D 367		

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D 367	Continued From page 15 (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 medication administration records were accurate for 1 of 5 sampled residents (#1) related to a medication used to treat pain. The findings are: Review of Resident #1's current FL2 dated 04/30/24 revealed diagnoses included cerebral infarction, type 2 diabetes mellitus, obstructive sleep apnea, hypertension, and osteoarthritis. Review of Resident #1's after visit summary dated 02/01/25 revealed there was an order for Lidocaine 4% patch, place 2 patches on the skin daily (Lidocaine 4% patch is a topical medication used to treat pain). Observation of the 8:00am medication pass on 03/11/25 from 8:40am to 9:18am revealed: -The medication aide (MA) began preparing Resident #1's medications at 8:52am. -The MA prepared Resident #1's oral medications, then removed 2 Lidocaine 4% patches from the medication cart. -The MA removed the Lidocaine patches from the individually wrapped packaging and wrote the date (03/11/25) and her initials on the non-sticky side of the patch.	D 367		

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-The MA entered Resident #1's room to administer her medication at 8:59am.
-The MA explained to Resident #1 that she was going to apply patches to her chest.
-The MA lifted Resident #1's shirt and there were 2 Lidocaine patches applied to Resident #1's chest, one on the right side chest, and one on the left side of the chest, both dated 03/10/25.
-The MA removed both patches from Resident #1's chest at 9:02am.
-The MA applied 1 Lidocaine patch on the right side of Resident #1's chest, and 1 on the left side of Resident #1's chest at 9:03am.

Observation of Resident #1 on 03/12/25 at 7:39am revealed there were 2 Lidocaine patches on Resident #1's chest, one on the right side chest, and one on the left side of the chest, both dated 03/11/25.

Review of Resident #1's March 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Aspercreme Lidocaine patch 4% patch, apply 2 patches transdermally to affected area every day scheduled to apply at 8:00am and remove at 8:00pm (Transdermally is a medical term meaning through the skin).
-Aspercreme Lidocaine patch was documented as applied daily at 8:00am from 03/01/25 to 03/11/25.
-Aspercreme Lidocaine patch was documented as hold/progress note required at 8:00am on 03/12/25.
-Aspercreme Lidocaine patch was documented as removed nightly at 8:00pm from 03/01/25 to 03/11/25.

Interview with Resident #1 on 03/12/25 at 10:35am revealed:

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D 367	Continued From page 17 -The facility staff applied patches to her chest daily. -She was unsure how long she was supposed to wear the patches or when the patches should be removed. Interview with a MA on 03/12/25 at 7:40am revealed: -She was usually assigned to administer medications on the floor where Resident #1 lived. -Most of the time, Resident #1's Lidocaine patches were removed when she administered Resident #1's morning medications. -There had been times when she entered Resident #1's room and found Resident #1 still had the previous day's patches on her chest. -If she saw the patches were not removed the night before, she usually told the MA who was working that shift that the patches were left on Resident #1. -She did not notify Resident #1's primary care provider (PCP) or the Resident Care Coordinator (RCC) the times she saw the Lidocaine patches were left on Resident #1. -MAs were supposed to document when the patches were applied and when the patches were removed on Resident #1's eMAR. -She was unsure if she should reapply the patches since they were left on Resident #1 overnight, so she wanted to check with the RCC or Resident #1's primary care provider (PCP) before she applied the patches to Resident #1. Interview with the RCC on 03/12/25 at 2:40pm revealed: -MAs should follow instructions on the eMAR when administering medications. -Resident #1's Lidocaine patches were to be applied at 8:00am and removed at 8:00pm. -Resident #1's eMAR had clear instructions on	D 367		

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when to apply and remove Resident #1's Lidocaine patches.
-MAs should not document that the patches were removed if they did not remove the patches from Resident #1.

Interview with the Administrator on 03/12/25 at 3:22pm revealed:
-MAs should follow instructions on the eMAR when administering medications.
-Any documentation on the eMAR should be accurate.
-MAs should carefully read instructions on the eMAR and make sure they documented correctly.
-MAs should not have documented that Resident #1's Lidocaine patches were removed unless they made sure they removed the patches from Resident #1.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/12/25 at 11:31am revealed:
-Resident #1's eMAR included instructions to remove Resident #1's Lidocaine patch at 8:00pm.
-Lidocaine patches were usually ordered to be left on the skin for 12 hours, then removed.
-The facility staff should follow the instructions on Resident #1's eMAR.
-Resident #4's Lidocaine patch should be removed at the time indicated and the documentation on the eMAR should be accurate.

Attempted telephone interview with Resident #1's primary care provider (PCP) on 03/12/25 at 11:26am was unsuccessful.