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SUNRISE ASSISTED LIVING AT NORTH HILLS	615 SPRING FOREST ROAD RALEIGH, NC 27609

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D 000	Initial Comments The Adult Care Licensure Section conducted an Annual Survey and incorporated a county monitoring with the Wake County Human Services on 5/5/27/15, 5/28/15,and 5/29/15.	D 000		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure the electrical and mechanical equipment were in safe and operating condition related to the walkie-talkie systems and pagers throughout the facility that were used to notify staff of door alarms activiation and care service needs. The findings are: Observations on 5/27/15 at 10:15 am revealed Medication Aides and personal care aides throughout facility used pagers and walkie talkies as part of their daily required equipment. Eleven confidential staff interviews revealed there were problems with the facility pagers and walkie-talkies and there was a lack of on-going training related to equipment as follows: -At the beginning of each shift, staff were responsible to clear all the pages on the beepers and grab a walkie-talkie.	D 105		

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-If the pager was "full," it would not accept any new data and it appeared a resident or staff was still calling for help.
-The battery picture on the pager indicated a low charge.
-Extra batteries for the pagers were stored in the medication room and the managers' offices.
-Staff were supposed to put walkie-talkies back on their charge bases before the end of their shift.
-"I am still vey unfamiliar with the walkie-talkie system and what to do during an elopement."
-"We have not had formal training on the pagers or the walkie-talkies."
-The walkie-talkie makes a long tone and then it was dead.
-"I had no training on the beepers and walkie-talkies. When we get our assignment we grab a walkie-talkie that has been charging all night. The walkie-talkies will go dead. Some use batteries; some go on chargers. I go through about 3 or 4 a shift. It has definitely affected my care. Other co-workers have needed me and thought I wasn't responding to them when it was just faulty equipment. I just grab another one and hope that it lasts."
-Staff was shown how to use the pagers and walkie-talkies at hire, but had not received any additional training or in-services related to this equipment.
-It was possible to be in a resident's room and not be able to hear an alarm which is why staff counted on the pagers and walkie-talkie devices.
-Since 4/18/15, a lead manager or some sort of manager was supposed to listen for both doors in the special care units.
-"Whenever I have a dead walkie-talkie, I just grab another one off its base."
-At the beginning of each shift, staff had been told by their supervisors to make sure their equipment

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is functioning.
-"We report this to management and are told to just grab another walkie-talkie."
-It was not uncommon to have to switch out 3 walkie-talkies before half the shift was over.
-"Most staff don't even know how to place the walkie-talkies back on its rechargeable base correctly."
- "The walkie-talkies on Assisted living never work; there are so many being used they don't have enough charge to last the whole shift so we end up relying on the pagers/beepers. Sometimes there are not enough walkie-talkies to go around."
-The Life Enrichment Managers were not required to carry pagers or walkie-talkies but they are supposed to be available to monitor for door alarms and listen for care staff that need help.
-There had been occasions where the staff member could not leave one resident to take care of another situation and this staff member had tried to call for back-up on the walkie-talkie system but the device was "dead."
-The walkie-talkies were still not functioning properly.
-There had been no new training on equipment since the resident's elopement on 4/18/15.

Observation on 5/28/15 at 10:45am revealed a Life Enrichment Manager was leading a walking group on the third floor of facility. The group was from the Special Care Unit.

Confidential staff interviews revealed Life Enrichment Managers responsibilities included the following:
- Monitoring the Special Care Units when care staff were busy in resident rooms, during mealtimes and during shift changes.
-"Someone is always supposed to be on the floor.

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D 105	Continued From page 3 There is supposed to be someone supervising or managing at all times." -This was put into place after 4/18/15. -A Lead Care Manager, Medication Aide or Life Enrichment Manager will step in if staff needs extra help. -The door alarm does not signal to staff pagers until the chain on the door has been broken and the door opened all the way. " -It was true the manager/floater was not able to be on that side of the special care unit when Resident #3 eloped. That is why staff started walking the exit seekers 3 times a day. - The Life Enrichment Managers were not required to carry pagers or walkie-talkies but they were supposed to be available to monitor for door alarms and listen for care staff that need help. Interview with the Special Care Unit Coordinator on 5/28/15 at 3:30pm revealed: -She managed both of the facility's Special Care Units. -It was not possible for the doors to alarm any louder so management was considering a different alarm system. -The employee that was working on 4/18/15 was aware his pager and walkie-talkie were not functioning properly but he chose to start his shift anyway. He was no longer employed at the facility. Interview with the Special Care Unit Coordinator on 5/29/15 at 1pm revealed: -The Life Enrichment Managers had multiple responsibilities and could be anywhere in the community. -The Special Care Units were their home bases. -They would not be able to be on the special care units exclusively. They were not required to carry pagers and walkie-talkies.	D 105		

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-She was aware that sometimes there were issues with faulty equipment. When managers received a complaint of faulty equipment they let the Maintenance Director know of the problems and the Maintenance Director will either repair the device or order a new one.
-The Special Care Unit Coordinator got a report after 4/18/15 that a caregiver's equipment was faulty and he chose to start his shift knowing he had faulty equipment.
-The Maintenance Director had trained the Special Care Unit Coordinator how to use walkie-talkies.
-A new employee would shadow a another employee and would be taught at hire how to use the equipment.
-If a direct care staff was busy giving care then the responsibility fell to the Special Care Unit Coordinator and other managers to ensure the safety of the residents.
-"Care staff responded to each other by pager and walkie-talkie; if staff really needed someone, they could always use the pull cord in the residents' rooms."
Observation of the countertop located in the Care Manager's office on 5/29/15 at 11:30 a.m. revealed:
-Eleven walkie-talkies with base units located on countertop were plugged in to wall sockets.
-An additional five empty walkie-talkie base units only were plugged into wall sockets.
-Eight of the eleven walkie-talkies had non functioning charge indicator lights.
-Ten of the eleven walkie-talkies had missing battery covers.
-Seven of the eleven walkie-talkies would not turn on.
-Ten of the eleven walkie-talkies were loose or tilted in the charging bases which prevented contact with the base as indicated by the red

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charging light.
-All walkie-talkies had function buttons where the wording for each button function had been worn off.

Observation of the Dietary Manager on 5/29/15 at 12:00 p.m. revealed he was in the care manager's office wiggling each of the 11 available walkie-talkies in the charging base units.

Interview with the Dietary Manager on 5/29/15 at 12:00 p.m. revealed:
-He had to wiggle each walkie-talkie to find a good one because they failed to make contact with the charging base.
-It took approximately 10 minutes to find a working walkie-talkie with a full charge.

Observation and interview with Maintenance Director on 5/29/15 at 12:05 p.m. revealed:
-All employees report to her all broken or non-functioning equipment.
-She was unaware of the broken charge indicator lights on the walkie-talkies.
-She was unaware of missing battery covers on the walkie-talkies.
-She did not know there was any problems with the functioning of any of the walkie-talkies.
-She did not have a system in place to check the functioning of the walkie-talkies.
-She ordered 15 new walkie-talkies 4 weeks ago.
-She could not explain or demonstrate how to operate or charge a walkie-talkie.
-She only maintained the walkie-talkies in working order.
-The walkie-talkie training responsibility fell on any staff worker who already knows how to use one.
-No staff had reported non-functioning walkie-talkies.

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D 105	Continued From page 6 Interview with Lead Care Manager on 5/29/15 at 12:15 revealed: -Each shift is supposed to ensure the pagers and walkie-talkies are charged and operational. -The walkie-talkies frequently have a low battery signal. -The Maintenance Director was informed if any walkie-talkie or pager was non-functioning. -There was no formal training on walkie-talkies provided. Interview with the Assisted Executive Director on 5/29/15 at 3:30 p.m. revealed: -The Lead Care Managers used the pagers, walkie-talkies and a scout phone. -The Care Manager's used the pagers and walkie-talkies. -The pager and the walkie-talkie had a battery, which had to be charged. -The pager alerts the staff when a door opens. -Sometimes the walkie-talkie's battery may go dead. The walkie-talkie had to be charged by placing the walkie-talkie on the charger. -If staff needed a battery for the pagers, they had access to the batteries either in the maintenance office or "on the floor." -The care team should charge the walkie-talkies between shifts. -If the pagers or walkie-talkies were not working properly, the Care Manager should inform the Lead Care Manager and the Lead Care Manager should inform a manager. -The equipment, which included the walkie-talkies and the pagers, should be checked daily by the Care Team to make sure it is working properly. -Sometimes the walkie-talkies do not charge properly. -The Maintenance Director had bought new walkie-talkies March 2015, because the Care	D 105		

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D 105	Continued From page 7 Team had complained the walkie-talkies were not charging properly. -The Care Team (Lead Care Manager, Care Manager) signed out the pagers and walkie-talkies when on duty. -Staff equipment should include a walkie-talkie and pager at all times. -The Assistant Executive Director checked the charges for the Care Teams equipment weekly during rounds. She made sure the equipment was charging properly. -All of the pagers and the walkie-talkies had a battery light signal to indicate the status of the charge of the battery. Interview with the Executive Director on 5/29/15 at 4:00 p.m. revealed: -The Lead Care Managers used the pagers, walkie-talkies and a scout phone. -The Care Manager's used the pagers and walkie-talkies to communicate with the Care Team and to help alarm staff if an exit door had opened. -The pagers and walkie-talkies should be charged properly. -The Care Team (Lead Care Managers, Care Managers) are not taking care of the equipment (pagers and walkie-talkies) properly. -If the equipment was not working or charging, staff should inform a supervisor. -The Maintenance Director bought 10-15 new walkie-talkies March 2015, because staff had complained the walkie-talkies were not charging. -In January 2015, many of the pagers were missing. So, staff had to start signing out to make sure the pagers were returned. -The Lead Care Manager should make sure the equipment was charged properly. -There was enough walkie-talkies and pagers for staff to have charged.	D 105		

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D 105	Continued From page 8 -If the Care Team needed batteries, the batteries are located in the Care Manager's office and the Maintenance office. _____ The plan of protection dated 5/29/15 included the following: -The facility will purchase replacement walkie-talkies today for the walkie-talkies that are not holding a charge. -The lead care managers are responsible for distributing pagers and walkie-talkies on every shift and collecting equipment at the end of each shift. -Lead care managers and care managers need to report any faulty equipment immediately to their supervisor or an available manager. -The maintenance director will inspect all pagers and walkie-talkies to ensure they are in working condition on a twice a week basis. -The Assisted Living Coordinator and the Special Care unit Coordinator will check equipment daily on their scheduled work days and report to the Executive Director and Maintenance Director if there are any issues. -The Executive Director(ED) and Associate Executive Director (AED) will spot check equipment while the lead care managers and care managers are on duty. -Each shift will be trained by the lead care manager on how to charge the walkie-talkies and operate them. -The Maintenance Director will train the lead care managers to be proficient in using walkie-talkies and to train the team. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 7/13/15.	D 105		

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D 270	Continued From page 9	D 270		
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: TYPE A2 VIOLATION Based on record review, interviews and observations, the facility failed to provide adequate supervision for 1 of 9 sampled residents (#3) residing in the special care unit who had a history of elopement and eloped from the facility without staff knowledge. The Findings are: Review of Resident #3's FL-2, dated 1/26/15, revealed: -Resident #3's level of care was Memory Care Unit (SCU). -Diagnoses included pulmonary embolism (PE), deep vein thrombosis (DVT), gout, dementia, prostate cancer, skin cancer and polycystic kidney disease. -The resident was intermittently disoriented. -The resident was ambulatory. -Medication orders for Alprazolam 0.25 mg by mouth daily as needed for anxiety. (Alprazolam is used to treat anxiety disorders). Review of Resident #3's Resident Register revealed the resident was admitted to the facility's special care unit (SCU) on 1/27/15.	D 270		

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D 270	Continued From page 10 Review of Resident #3's pre-admission assessment "Service Evaluation & Health Assessment (SEHA)", dated 1/16/15, revealed: -This was an assessment for SCU placement. -The resident had 5 falls since Sunday (1/11/15) and has processing delay, 30 seconds. -The resident tends to elope and needs redirection/assurance. -The resident has early dementia. -The resident has a prior history of wandering in the past ninety days. -The resident needs assistance finding his way around in the community. Review of Resident #3's "Individual Service Plan (ISP)", dated 1/28/15, revealed: -Under "Special Instruction" section, the resident has 15-30 second processing delay; allow extra time to respond to questions. -High risk for falls; supervise the resident and report any balance or gait issues to Wellness and Resident Coordinator (RC). -The facility's Health Care Coordinator (HCC) added a note to the same ISP, on 4/18/15 that " The resident exit seeks by pushing doors. Engage the resident in conversation about the car and get the car book located in the activity room. Life Enrichment Manager (LEM) to take the resident out to look at cars and discuss the car. LEM to do 1:1 at 7 am until breakfast time. " -Under "Socialization & Leisure Activities" section, the RC added a note on 5/1/15, " Resident is able to be redirected when out on walks. Continue to encourage involvement in activities throughout the day." -"Wander-guard bracelet was placed on the resident on 5/1/15." -On 5/11/15, "The resident is no longer allowed to leave the facility. No more outing or drives.	D 270		

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Needs to settle in this environment with his poor memory."
-Under "Safety" section, the resident eloped from independent living (IL) recently; monitor and report any issues to the resident coordinator (RC).
-The resident is a risk for elopement.
-Hand written note added on 4/21/15, "LEM to encourage resident in walks 2-3 times a day."
-Hand written note added on 5/1/15, "Dr. to review meds to see if any can help for anxiety and exit seeking. MD to sign for wander-guard. LEM to stay with the resident when taking to day program. Resident is easily redirected when engaged in walking."

Review of Accident/Incident Reports, dated 4/18/15, at 7:30 am, revealed:
-The staff noticed [Resident #3] outside the front entrance to building when the staff was walking towards "East Reminiscence (SCU)" unit.
-The staff asked the resident how he got out; the resident said through the door to look for the resident's car.
-The staff assisted the resident back to the Special Care Unit east reminiscence.
-The resident's family, doctor and all supervisors were notified.

Review of the facility's 4/18/15 "Alarm Reports" revealed:
-At 7:24:44 am, the exit door #126 was alarmed for few seconds.
-At 7:24:49 am, the exit door #126 reset automatically.
-At 7:25:43 am, the exit door #126 alarm was set; the alarm sounded for 8 minutes.
-At 7:33:41 am, the exit door #126 was reset manually.

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D 270	Continued From page 12 Observation of the immediate surroundings, from the SCU's exit door #126 to the facility's front entrance, on 5/20/15 at 5 pm, revealed: -Exit door #126 led out to the parking lot. -It is a 7 feet from the exit door to the top of the steps. -There are 5 steps leading down to the sidewalk. -Right below the steps, there are cars parked along the sidewalk. -The sidewalk/parking area was located next to a small secondary street which connected to a busy, 4 lane road. -The distance from the bottom of the steps from the SCU, exit door #126, to the major road was approximately 180 ft. -The sidewalk by the parking lot wraps around to the front of building to the front entrance. -The distance from the sidewalk at the base of the steps to the front of the building is 125ft - 150 ft. Review of the facility's "daily assignment sheet" from 4/18/15 revealed: -Resident #3 was 1 of 9 residents assigned to a designated care manager. -Under "Special Instructions", "[Resident #3's name] was documented as High elopement risk and very disoriented." Review of the facility progress notes, for Resident #3, written by the facility's registered nurse (RN), revealed: -1/28/15 at 12:38 pm, the resident was asking staff to let him out of the secure unit. -The resident had a private caregiver in the morning for the transition period. -3/13/15 at 8:33 am, the resident has adjusted; he wants and needs to stay busy with activities. -4/18/15 at 12:49 pm, this morning at 7:30 am, staff member noted resident walking outside by	D 270		

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the front entrance of the building
-The resident stated he went outside looking for his car.
-The resident was escorted back inside without resistance.
-4/18/15 at 12:57 pm, at 8:30, alarm went off and resident opened the door again.
-The staff was nearby and got by the door in time; the resident did not go outside.
-The resident stated "looking for my car."

Interview, on 5/20/15 at 4:15 pm, with the facility's Wellness Nurse (WN), who had written on Resident #3's electronic program notes, revealed:
-Upon admission, the WN followed up with Resident #3 for 4 days (including admission date), 1/28/15 - 1/31/15.
-During the F/U visits, the resident said to the WN, "I don't want to stay here" and wanted to know how long the resident was going to stay.
-From 1/31/15 - 3/31/15, the resident was more settled and stopped asking to get him out of the facility therefore determined that the resident adjusted to the new environment.
-As part of the WN's routine, daily logs and incident reports were reviewed every morning in the SCU.
-The WN have to follow up on what happened to the residents overnight.
-The resident was not a fall risk; very ambulatory and walks well without assistance.
-The WN was aware of the elopement incident on 4/18/15
-On 4/18/15 around 8:30am, the WN was in the medication room in the East SCU and heard the exit door alarm; looked to see what was going on.
-Resident #3 pushed the door (#126) and set off the alarm; the door opened and he peeked outside but didn't go outside.
-The resident said "he was looking for his car."

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D 270	Continued From page 14 Interview with SCU's Medication Aide (MA), on 5/12/15 at 11:00am and 5/20/15 at 2:50 pm, revealed: -The MA was working on 4/18/15, 1st shift passing medications in the West & East SCUs. -Daily routine was to pass medication in the West SCU first and then East SCU. -On 4/18/15 about 7:30 am, the MA finished passing medications at the West SCU and was on her way to the East SCU. -The MA happened to look out the window and Resident #3 was outside by the main entrance of the building. -Resident #3 was from East SCU. -The MA went outside and brought the resident inside. -Resident #3 told the MA that "he was looking for his car." -The MA said that "there were no staff call outs on walkie-talkie about any door alarm going off." -The MA used walkie-talkie to notify the East SCU Care Managers (CMs) about Resident #3 being outside the building and for the CMs to check all the exit doors. -However, the walkie-talkie had too much static and her voice was breaking so the MA wasn't sure if anybody heard her or not. -When the MA walked up to the East SCU's main door, alarm sound was heard. -Once inside the East SCU, #126 exit door alarm was still sounding because after Resident #3 walked out the exit door, it didn't close all the way and no one had closed the door. -The MA peeked outside the door to make sure there weren't any other residents out there. -Then secured the exit door #126, by re-latching the magnet seal and reset the door. -CM #3 came out of the resident's room and reported that "she heard something on the	D 270		

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walkie-talkie but wasn't clear and that she finally heard the MA's voice over walkie-talkie."
-CM #3 told the MA that she didn't hear the door alarm because she was assisting a resident in the bathroom with CM #2.
-The MA did the headcounts of the residents.
-When the CMs are in the residents' rooms during care and the doors closed (such as water running in the bathroom), they can't hear the door alarm sound.
-When the door alarm goes off and the magnet seal breaks, the alarm signal goes to the CMs pagers they carry and the CMs are supposed to respond to the pager alerts.
-Sometimes even when the pager beeps, they cannot check their pagers because they are in the middle of assisting residents such as toileting, changing pull-ups or showers, especially if they had the gloves on.
-On 4/18/15, there were three CMs who worked the East SCU; 2 CMs were assisting with a resident who required 2-person assist and 1 CM was in a resident's bathroom providing care.
-When Resident #3 eloped from exit door #126, the three CMs did not hear the exit door alarm sound and they also did not respond to the pager alarms because they were in the middle of assisting residents in their rooms.

Observation of Resident #3, on 5/27/15 at 11:10 am and 3:55 pm, revealed:
-Resident #3 and 2 other residents went for a walk with LEM #1 in the morning.
-Resident #3 participated in a large group activity after the walk.
-Resident #3 came up to the 2nd shift SCU MA and asked her "where is my car?"

Interview with the SCU's Lead Care Manager #1 (LCM #1), on 5/12/15 at 11:25 am, revealed:

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D 270	Continued From page 16 -Resident #3 had exit seeking behaviors; very energetic and at first glance, the resident appeared to look alert enough to be mistaken for a visitor. -Resident #3 resided in the East SCU. -On 4/18/15, the LCM #1 was working as lead for both East & West SCUs; the LCM #1 was working in West SCU in the morning, assisting 2 residents in one room. -The LCM #1 also had resident care assignments plus other duties. -On the morning of 4/18/15, the LCM #1 did not check the pager for the alarms because he was in another resident's room assisting another resident. -The LCM #1 was not aware Resident #3 exitied the alarmed door. -According to the facility protocol, all CMs were supposed to respond to the pager alerts and use the walkie-talkie to communicate with each other to check on the status of the alarm alerts. Telephone interview with Care Manager #1 (CM #1), on 5/18/15 at 2:29 pm and 5/19/15 at 6:18 pm, revealed: -CM #1 worked in the East SCU on 4/18/15 during 1st shift and was the designated care manager for Resident #3. -Before starting the shift on 4/18/15, the walkie-talkie passed to CM #1 by a previous shift CM, didn't have power so CM #1had to switch it out with a powered one. -The pager battery was bad so didn't have a pager because CM #1 didn't have access to the batteries. -The Lead Care Manager was the one with the access to the batteries; the lead was working on the West unit on 4/18/15 so CM #1 was supposed to call LCM #1 but got busy and didn't get to call LCM #1.	D 270		

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D 270	Continued From page 17 -CM #1 checked on Resident #3 right after 6 am; the resident was awake, dressed and lying on the bed. -CM #1 moved on to other residents' rooms to assist them with morning tasks and learned about the elopement after the incident. -CM #1 was assisting another resident with a shower so he didn't hear the exit door alarm go off and the pager wasn't working. -CM #1 heard through the walkie-talkie from the MA about the alarm but couldn't leave the resident in the shower alone so couldn't respond to that either. -CM #2 & CM #3 were also in another resident's room providing care before breakfast. -The CMs usually don't leave the residents in the common room by themselves. -There was always somebody there to watch them; there was no designated CM because they worked as a team; whoever was available at that time will stay and watch over the residents. -Sometimes it could be the coordinator, supervisor or medication aide or care managers in charge of activities. -CM #1 couldn't answer who was on the floor on 4/18/15 to supervise the residents. -Resident #3 was an exit seeker and always wanted to go outside since his admission. -The resident thought he was a guest at the facility and he'd return home after spending a few days there. -Sometimes the resident was aware that he lived at a facility and thanked the staff for taking good care of him. -The resident thought his car was parked outside, so on 4/18/15 the resident went outside to locate his car. -The only times when resident didn't ask to go out or didn't have exit seeking behaviors were when the resident was busy with activities, eating,	D 270		

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taking a walk with staff or he was with a companion.
-When the resident talked about wanting to leave the facility, the staff would get him involved with activities or take him to the unit's enclosed garden area to distract him.
-After the 4/18/15 elopement incident, Resident #3 started going to the West unit for activities and the staff at West unit was responsible for supervision.

Telephone interview with CM #2, on 5/18/15 at 6:09 pm and 5/19/15 at 6:55 pm, revealed;
-Resident #3 was always looking for his car; the resident thought his car was located outside the exit door from where he eloped on 4/18/15.
-The resident was not always confused; he is a very smart man.
-The resident did not exit seek daily but sporadic; he'd be ok and then a couple of days later, he would try to go out again.
-By using the walkie-talkie, the staff who is the closest is supposed to respond to the alarm and let other staff know.
-On the morning of 4/18/15, CM #2 & CM #3 were assisting a resident who required 2-person assist (resident used a Hoyer lift); resident's room door was closed.
-CM #2 didn't remember whether the pager went off or not because the pagers are not always reliable.
-CM #2 checked own walkie-talkie & pager before the shift.
-CM #2 realized the SCU MA was hollering through the walkie-talkie but the voice was breaking.
-CM #2 could hear the SCU MA talking about Resident #3 so CM #2 said it over the walkie-talkie that she was with a resident with CM#3 in a room but the MA couldn't hear CM #2.

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D 270	Continued From page 19 -CM #3 went out the resident's room to find out what was going on. · There are at least 5 residents who have set the exit door alarm off but wasn't aware of any resident eloping. · There wasn't any one staff designated to supervise the residents when other CMs were busy assisting the residents in their room; the staff are supposed to use the walkie-talkie to communicate with each other but CM #2 didn't remember if there was communication on the morning of 4/18/15. · CMs were not instructed as to what they need to do for supervision when they were in the residents' rooms. · The residents were to be ready for breakfast by 8-8:30 am. · The average time CM #2 spent in the residents' rooms for assisting the resident, depending on the type of task and the residents' needs, was from 10 to 30 minutes. · If the resident needed a shower and required a lot of assistance, it could be longer than 30 minutes. Interview with CM #5, on 5/27/15 at 3:40 pm, revealed: · When CM's daily assignment sheet documented Resident #3 was a "High Elopement Risk" meant the staff were to be on highest alert and CMs knew where the residents were at all times. · CMs made sure the surrounding areas were quite (music was turned down) so door alarm sound can be heard. · There had to be at least 1 staff in the common area at all times to supervise residents and to respond to alarms. · The staff used "switch off & take turn" method during residents care hours where 1 CM	D 270		

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stayed in the common area and other CMs provided care then switched the roles; bringing out 1-2 resident(s) at a time.

Interview with the Life Enrichment Manager #1 (LEM #1), on 5/20/15 at 2:06 pm, revealed:
· LEM #1 was not working on 4/18/15 so did not know the details of what happened with Resident #3's elopement.
· Resident #3 was a wanderer; he walked all the time; he was very mobile.
· The resident was an exit seeker especially in the morning and was sun-downing; always looking for his car or wanting to pack and go home or saying "got work to do".
· The resident would push doors few times a week and he set off exit door alarms once a week.
· When LEM #1 saw the resident push the exit doors, she did more 1:1 activities with him to distract him; Resident #3 needed constant 1:1.
· The exit door alarm sound is fairly loud but it has been reported that the alarm sound can't be heard if CMs have water running in the bathroom or the residents are yelling loud.
· LEM didn't provide personal care services to the residents but have provided supervision to the residents when CMs were busy assisting the residents.
· There was supposed to be 1 staff observing the residents while other CMs provide care to the residents like a tag team type.

Interview with the SCU Coordinator (SCUC), on 5/20/15 at 12:35 pm and 5/27/15 at 4:45 pm, revealed:
· The staff were aware of the facility protocol to have one staff remaining in the common area to watch the residents while rest of the CMs provided care to residents.

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D 270	Continued From page 21 · On 4/18/15, during 1st shift, the staff did not follow the protocol because they were focused on getting the residents ready in the morning. · SCU supervisor (SCUS) or LCM was responsible for updating the CMs "Special Instructions" section of "daily assignment sheet" which documented Resident #3 was a "High Elopement Risk." · SCUS or LCM get the information from resident's assessments and update whenever there were changes. · Each resident's special instructions were also documented on the staff 's "daily log " and "working ISP." · Resident #3's family hired a private caregiver for the resident when the resident was admitted for transition period and the family continued using the caregiver to keep the resident engaged and for companion purpose. Interview with the Administrator, on 5/20/15 at 12:20 pm, revealed: · Prior to start of a shift, a lead care manager (LCM) is responsible for getting the new daily assignment sheets to the care managers; updates the care manager (CM) on the residents; passing over the devices (pager & walkie-talkie) in working condition. · In the SCU, the devices (including batteries) are kept in the medication room and CMs do not have access to the room. · Upon start of a shift, CMs do their rounds with previous CMs. · CM starts doing their care with residents. · The facility protocol is for 1 CM (this staff also can be the MA, LCM or LEM) to provide monitoring of the residents in the common area while rest of CMs provide care. · Once the rest of CMs complete the care, they would bring the residents out to the common area	D 270		

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and would assume supervision of residents in the common area.
· This ensured that there was coverage to watch the residents.
· On 4/18/15, the facility protocol was not followed by the SCU staff.

Review of Accident/Incident Reports, dated 5/1/15 at 1:30 pm, revealed:
· The lead care manager (LCM), from the assisted living (ALU), saw a gentleman in the hallway, who asked for help.
· The LCM questioned the man but he was not able to answer the questions, only gave his name.
· The LCM became aware that the name sounded familiar.
· The resident was taken to the Wellness center where the doctor was and an order was given for wander-guard.
· Resident's family and the facility management were notified.

Review of the facility progress notes, for Resident #3, written by the facility's registered nurse (RN), revealed:
· 5/1/15 at 6:42 pm, the resident was on the 2nd floor of ALU, asking staff for help.
· The staff knew the resident was not from AL.
· Escorted the resident back to the SCU.

Interview, on 5/20/15 at 4:15 pm, with the facility's the Wellness Nurse (WN), who had written on Resident #3's electronic program notes, revealed:
· The WN was aware of Resident #3's 5/1/15 incident but not present when the resident was found on the ALU's 2nd floor.
· Nobody knew the resident got out of the West SCU and how he got on the 2nd floor; the resident was not able to tell the staff.

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D 270	Continued From page 23 · The resident was on the ALU's 2nd floor at 1:30 pm and he asked ALU's LCM to help him get out. · ALU's LCM didn't know the resident was from the SCU. · ALU LCM took the resident to the wellness center and one of the LPN recognized the resident from the SCU. · The LPN called LCM #2 at the West SCU; the LCM did not know that the resident was missing. · A wander-guard bracelet was put on Resident #3 after the incident. Interview with the SCU's lead care manager #2 (LCM #2), on 5/20/15 at 1:40 pm, revealed: · LCM #2 was working on the 1st shift on 5/1/15 and lead for both East & West SCUs. · LCM #2 wasn't working on 4/18/15 but aware of Resident #3's elopement incident. · 5/1/15 was the first time the LCM #2 saw Resident #3 in the West SCU. · No one had told the LCM #2 what to do with him. · LEM #2 brought the resident to the West unit. · Resident #3 was not put on assignment sheets for any specific CMs. · On 5/1/15 after lunch (little after 1 pm), LCM #2 saw Resident #3 sitting in the dining room with another resident. · As LCM #2 was taking another resident to the room, there were visitors by the door who has just comer. · LCM #2 did not see Resident #3 in the dining room after she came back from helping another resident. · Around 1:30 pm, LCM #2 got a call from the facility's licensed practical nurse (LPN) on the 2nd floor, asked if we were missing a resident; LCM #2 didn't believe the LPN so checked the unit.	D 270		

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· LCM #2 did not know Resident #3 was missing; didn't remember who told her who last saw the resident.
· LCM #2 went upstairs to get the resident; Resident #3 was talking about his car.

Interview with care manager #4 (CM #4), on 5/20/15 at 1:25 pm, revealed
· CM #4 was working on 5/1/15 during 1st shift at 6am.
· On 5/1/15, LEM #1 brought Resident #3 to the West SCU.
· Lunch was done around 1 pm; CM #4 saw LEM #1 looking for a resident to take upstairs for activities or something, as CM #4 was going into a resident's room.
· CM #4 stayed in the resident's room for about 20 minutes and when he came out of the room, LEM #1 was gone.
· There was no alarm going off while he was with the resident.
· CM #4 overheard LCM #2 talking about how Resident #3 was found on the 2nd floor.
· Resident #3 was not assigned to any CMs when the resident was in the West unit but CMs would assist Resident #3 with care while there.

Interview with the life enrichment manager #1 (LEM), on 5/20/15 at 2:25 pm, revealed:
· The LEM #1 was working on 5/1/15 and the LEM #2 was not working.
· Around 2:30 pm on 5/1/15, LEM #1 heard about the incident where Resident #3 was found on the 2nd floor in ALU; didn't know how he got there.
· After Resident#3's 4/18/15 elopement incident, the 2 LEMs' schedules changed from 8:30 am to 7am, to be with the resident from 7 am until breakfast time.
· LEM #2 started taking Resident #3 to the

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	HAL092108	A. BUILDING: _____ B. WING _____	05/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ASSISTED LIVING AT NORTH HILLS	615 SPRING FOREST ROAD RALEIGH, NC 27609

(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 25	D 270		

West SCU for a day program; it didn t always work well for the resident because he would look for his room in the West side and would ask "What am I doing here."
· Resident #3 was fast and very observant.
· Resident #3 was in the West SCU as soon as he was dressed and ready (usually before breakfast); ate 3 meals at the West unit.
· Once Resident #3 was in the West unit, CMs engaged him in activities, including general activities, small group & 1:1.
· There was no specific CM assigned to the resident once in the West unit.
· On the morning of 5/1/15, the LEM #1 took Resident #3 to the West SCU.
· On the afternoon of 5/1/15, LEM #1 was planning to take 2 SCU residents to a holiday activity on the 2nd floor of ALU but she only took a resident from the East SCU.
· LEM #1 saw Resident #3 in the afternoon when LEM #1 stopped by the West SCU to pick up a resident for an activity on assisted living unit (ALU).
· At any time, when the SCU residents were upstairs in ALU, they are always with the staff (either CM or LEM).
· LEM #1 heard about Resident #3 being found on the 2nd floor; did not know how he got to the ALU.

Interview with the SCU Coordinator (SCUC), on 5/12/15 at 2 pm, revealed:
· The SCU thought that West SCU ' s day program might be more appropriate for Resident #3 so the resident started going to the West side after 4/18/15 elopement incident.
· Resident #3 went to the West after he got up; ate breakfast in West and returned to his room in East after dinner.
· LCMs manage the staff assignment sheets;

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D 270	Continued From page 26	D 270		

LCM #2 assigns Resident #3 to a CM; didn't know which CM was assigned. The LEM did the 1:1 activities with Resident #3 throughout the day while the LEM was working the shift.
· LEM #1 took Resident #3 to the West SCU.

Interview with the Executive Director (ED), on 5/12/15 at 1 pm, revealed:
· The ED was notified of Resident #3's 2 elopement incidents, 4/18/15 & 5/1/15.
· After 4/18/15 incident, Resident #3 started a day program in West SCU where he would spend majority of the day there.
· The main reason for him to go to the West unit was because the exit doors in the unit were more secure; all exit doors are connected to a keypad access to open.
· Resident #3 started the day program in the West SCU under the condition that Resident #3 would go to the West unit only if LEM was there.
· LEM #1 knew that she wasn't supposed to leave Resident #3 in the West SCU on 5/1/15 when LEM #2 was not working that day.

Review of the Plan of Protection dated 5/12/15 revealed:
· Following the 4/18/15 incident, the facility had an immediate training ongoing for all team members regarding the pager and alarm system.
· Walked Resident #3 three times a day and one on one for LEM.
· The facility changed the schedule for LEM from 9 am - 5 pm to 7 am-3 pm and 10 am to 6 pm to ensure coverage early in the morning and throughout the day.
· Increased outings for Resident #3.
· For 5/1/15 incident, the facility posted signs by the door to ensure everyone remembers to

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D 270	Continued From page 27 check the door upon entering and leaving. · Retraining staff on alarm & pager system. · Had doctor assess Resident #3 to ensure the resident was on appropriate meds and rule out any physical/ medical concerns. · Added a wander guard for Resident #3 on 5/1/15. · Changed memory care key pad code to ensure that families visiting were not letting residents out accidentally. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED 6/28/15.	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 ensure residents recieved care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to non-functioning equipment(walkie-talkies and pagers) throughout the facility. The findings are: Based on observations, interviews, and record	D912		

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D912	Continued From page 28 reviews, the facility failed to assure the electrical and mechanical equipment were in safe and operating condition related to the walkie-talkie systems and pagers throughout the facility that were used to notify staff of door alarms activiation and care service needs. [Refer to Tag 105 10A NCAC 13F.0311(a)(Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to assure every resident to be free of neglect related to inadequate supervision of a resident residing in the special care unit. The findings are: Based on record review, interviews and observations, the facility failed to provide adequate supervision for 1 of 9 sampled residents (#3) residing in the special care unit who had a history of elopement and eloped from the facility without staff knowledge. [Refer to Tag 270 10A NCAC 13F .0901 (b) (Type A2 Violation)].	D914		