Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092024	A. BUILDING: 01 B. WING _____	01/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF RALEIGH	3101 DURALEIGH 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
C 000	Initial Comments This is a Report of a Biennial Construction Survey conducted by Greg Cates and Frank Strickland on January 12, 2016. Based on information gathered from our files, the Facility was first licensed or submitted for licensure on or about January 16, 1996 for One-Hundred Fifteen (115) Beds, including Twenty-Five (25) Special Care Beds. Based on the above information, the facility is required to meet the 1996 Minimum and Desired Standards and Regulations for Homes for the Aged and Disabled; the applicable portions of the 2005 Rules for Adult Care Homes of Seven or More Beds; and the 1996 North Carolina State Building Code Section 409.1- Group I.	C 000		
C 116	Plans Submittals and Approvals SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0304 PLANS AND SPECIFICATIONS (a) When construction or remodeling of an adult care home is planned, two copies of Construction Documents and specifications shall be submitted by the applicant or appointed representative to the Division for review and approval. As a preliminary step to avoid last minute difficulty with final plan approval, Schematic Design Drawings and Design Development Drawings may be submitted for approval prior to the required submission of Construction Documents. (b) Approval of Construction Documents and specifications shall be obtained from the Division prior to licensure. Approval of Construction Documents shall expire after one year unless a building permit for the construction has been obtained. (c) If an approval expires, renewed approval	C 116		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE Executive Director (X6) DATE 2/29/16

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C 116	Continued From page 1 shall be issued by the Division, provided revised Construction Documents meeting all current regulations, codes and standards are submitted by the applicant or appointed representative and reviewed by the Division. (d) Any changes made during construction shall require the approval of the Division to assure that licensing requirements are maintained. (e) Completed construction or remodeling shall conform to the requirements of this Section including the operation of all building systems and shall be approved in writing by the Division prior to licensure or occupancy. Within 90 days following licensure, the owner or licensee shall submit documentation to the Division that "as built" drawings have been received from the builder. (f) The applicant or designated agent shall notify the Division when actual construction or remodeling starts and at points when construction is 50 percent, 75 percent and 90 percent complete and upon final completion. This Rule is not met as evidenced by: 1- Based on observations, the facility has failed to obtain the required approvals for changes to the magnetic locking systems. This may affect all persons in the Special Care Unit by prohibiting them from exiting in the event of an emergency. Findings include: a- On February 5, 2015, a letter was received by DHSR-Construction for "changes in the egress door operation" at the exterior doors. This document indicates that the doors were special locking and have emergency release switches at each exterior door. No	C 116		

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C 116	Continued From page 2 response was received by DHSR-Construction to the review letter sent April 21, 2015. At the January 11, 2016 survey, it was observed that there are no emergency release switches at the exterior doors and that changes appear to have been made to the previously existing system without approval from DHSR-Construction.	C 116		
C 164	Housekeeping and Furnishings-Clean, Repaired SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0306 HOUSEKEEPING AND FURNISHINGS (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; (2) have no chronic unpleasant odors; (3) have furniture clean and in good repair; (e) This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: 1- Based on observations, the facility has failed to maintain the building and furnishings in good repair and clean. Findings include: a- The carpet in the Living of Room 357 is stained and discolored. b- One of the drawer pulls on the vanity in the bathroom of Room 164 is loose. c- The ceiling tiles in the Living Room of the Special Care Unit are stained and discolored. d- There is a ceiling tile missing in the Activity Room.	C 164		

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C 166	Housekeeping-Maintained Free of Hazards SECTION .0300 - PHYSICAL PLANT 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; (e) This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: 1- Based on observations, the facility has failed to maintain the building free of hazards by not storing oxygen containers securely to prevent them from falling over or rolling around. This could affect all persons in the facility as the oxygen containers could fall over, damaging the cylinder or nozzle. Findings include: a- There are oxygen bottles in Room 342 that are not properly supported. b- There are oxygen bottles in Room 214 that are not properly supported. c- There are oxygen bottles in Room 241 that are not properly supported. 2- Based on observations, the facility has failed to maintain the building free of hazards by not securing grab bars tightly to the wall. This could affect persons who may need the assistance of a grab bar when seating or rising from the commode. Findings include: a- The grab bar beside the commode in the unisex Bath on the 3rd Floor is loose.	C 166		

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C 166	Continued From page 4 3- Based on observations, the facility has failed to maintain the building free of hazards by not securing the commode seat tightly to the commode. This could affect anyone who may use the toilet by allowing them to slide off the commode. Findings include: a- The seat is loose on the commode in the Unisex Bathroom on the 3rd Floor b- The seat is loose on the commode in the Unisex Bathroom on the 2nd Floor. 4- Based on observations, the facility has failed to maintain the emergency exiting from the refrigerator. This could allow a person to become locked in the refrigerator with no way of exiting in the event of an emergency. Findings include: a- The emergency exiting hardware on the inside of the refrigerator is broken and cannot be turned to release the lock.	C 166		
C 189	Building Equipment Maintained Safe, Operating SECTION .0300 - PHYSICAL PLANT 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. (k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities.	C 189		

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C 189	Continued From page 5 This Rule is not met as evidenced by: 1- Based on observations, the facility has failed to ensure that the building is safe by not maintaining the fire resistance of building components. This deficiency directly affect all residents, personnel, and visitors by allowing the possible spread of smoke beyond the compartment of origin. Findings include: a- There is a kick-down device on the corridor door of the Staff Breakroom. b- There is a kick-down device on the corridor door of the Maintenance Office. c- In the Community Laundry Rooms, there is a hole approximately 1-inch in diameter above the door for data cabling that is not sealed. d- In the 1st Floor Storage Room, there is a communications conduit that is not sealed on the ends. e- In the 1st Floor Storage Room, there are several electrical conduits where the wall above them is not sealed. f- In the Main Mechanical Room, there is a hole around a conduit above the corridor door that is not sealed. g- In the Main Mechanical Room, there is a conduit above the telephone equipment that is not sealed on the end. h- In the 3rd Floor in the Laundry, there is an open gap above the door at the closer. i- The corridor door to the Maintenance Office does not latch when closed. 2- Based on observations, the facility has failed to maintain the safety systems in operating condition. This could affect all occupants of the	C 189		

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C 189	Continued From page 6 building in the event of a power failure. Findings include: There is a pattern of emergency lights that do not illuminate on battery. Locations to include but not limited to: a- EL #96 b- EL #28 c- EL #14 d- Stair 1, Level 1 3- Based on observations, the facility has failed to maintain the building electrical system safe and operating. This deficiency may affect those persons using the receptacles by allowing the possibility of electrical shock. Findings inlcude: a- In the Beauty Parlor, there are quad GFCI receptacles beside the two sinks that are within 2 feet of the sinks but are not GFCI protected. b- There is a light fixture in the 2nd Floor Storage Room that is not secure to the wall. c- There is an open junction box on the ceiling in the Main Mechanical Room.	C 189		

Sunrise Senior Living
Plan of Correction

Name of Community: Brighton Gardens of Raleigh
Address: 3101 Duraleigh Road Raleigh NC 27612
License number: HAL-092-024
Inspection date(s): 1/11/16
Name and Title of Sunrise Representative Signing the Plan of Correction:
Jaime Pacheco, Executive Director
Signature of Sunrise Representative:
Date of Submission: 2-20-16

Regulation	Target Date by Which Correction will be completed	Plan of Correction
Section .0300 10A NCAC 13F .0304 Plans and Specifications C116		**A. With respect to the specific resident/situation cited:** Residents, team members, and visitors did not experience any negative outcomes. Executive Director reviewed with Maintenance Coordinator the requirements needed when seeking to make changes to the magnetic locking systems in an Adult Care Home. Maintenance Coordinator is working with outside contractor to install 6 switch key release buttons on the exit doors in the Reminiscence neighborhood. This work will be completed by 2/25/16.
	2/8/16 2/25/16	
		B. With respect to how the facility will identify residents/situations with the potential for the identified concerns: The Executive Director and Maintenance Coordinator completed walking rounds of the Reminiscence neighborhood to identify all exit doors that require a switch key release button. No doors were identified or observed as requiring a key release button. Maintenance Coordinator conducted training with team members on the three shifts on 2/26 - 2/29, regarding the switch key release button function. Maintenance Coordinator will continue to conduct refresher with staff members through
	2/8/16 2/26/2016 through 2/29/16 & ongoing	

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		2/29/16 to ensure knowledge of the switch key release button function.
		C. With respect to what systemic measures have been put into place to address the stated concern:
	12/25/16 and ongoing	The Maintenance Coordinator has added the switch key release buttons to the monthly preventative maintenance checklist to ensure they are working properly once installed.
	2/26/2016 through 2/29/16 & ongoing	Maintenance Coordinator conducted training with team members on the three shifts on the following dates 2/26 - 2/29, regarding the switch key release button function. Maintenance Coordinator will continue to conduct refresher with staff members through 3/31 to ensure knowledge of the switch key release button function.
	2/8/16 & ongoing	Maintenance Coordinator/Designee will complete in-service for new hires as part of the onboard training to ensure all team members have knowledge of the function and location of the switch key release buttons.
		D. With respect to how the plan of correction will be monitored:
	Ongoing	The Executive Director or Designee is responsible for ensuring implementation and ongoing compliance with all components of this Plan of Correction and addressing and resolving any variance that may occur.
	2/24/16 and Ongoing	The Executive Director or Designee is responsible for ensuring the status of this Plan of Correction is reviewed and discussed at the monthly Quality Assurance/Performance Improvement meetings and action initiated if required.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
Section .0300-Physical Plant 10A NCAC 13F .0306 Housekeeping and Furnishings-Clean, Repaired C164	 1/12/16 1/12/16 1/20/16	**A. With respect to the specific resident/situation cited:** Maintenance Coordinator extracted the carpet in room 357. Maintenance Coordinator tightened the drawer pull on the vanity in the bathroom of room 164. Maintenance Coordinator installed new ceiling tile in the Activity Room and in the Reminiscence (special care) Neighborhood living room.
	2/5/16	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The Executive Director and Maintenance Coordinator completed walking rounds to identify needed repairs or cleaning. No repairs or cleanliness issues were identified.
	2/15/16	**C. With respect to what systemic measures have been put into place to address the stated concern:** The Executive Director and Maintenance Coordinator/Designee will conduct monthly walking rounds of community as a component of the preventative maintenance program to check for cleanliness, and repair status. Any issues identified during rounds will be documented and resolved.
	Ongoing 2/24/16 and	**D. With respect to how the plan of correction will be monitored:** The Executive Director or Designee is responsible for ensuring implementation and ongoing compliance with all components of this Plan of Correction and addressing and resolving any variance that may occur. The Executive Director or Designee is responsible for

Regulation	Target Date by Which Correction will be completed	Plan of Correction
	Ongoing	ensuring the status of this Plan of Correction is reviewed and discussed at the monthly Quality Assurance/Performance Improvement Meetings and action initiated if required.
Section .0300 10A NCAC 13F .0306 Housekeeping and Furnishings C166		**A. With respect to the specific resident/situation cited:**
	2/5/16	Assisted Living Coordinator put racks for the oxygen bottles in rooms 342, 214, 241.
	1/12/16	Maintenance Coordinator tightened the grab bar beside the commode in the unisex bath on the 3rd floor.
	1/12/16	Maintenance Coordinator tightened the commode seat in the Unisex bathroom on the 3rd floor and 2nd floor.
	2/19/16	Maintenance Coordinator installed a new emergency exiting hardware on the inside of the main refrigerator.
		B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:
	2/5/16	The Executive Director and Maintenance Coordinator completed walking rounds to identify needed repairs, to check oxygen storage, and to check equipment functionality. No issues were identified.
		C. With respect to what systemic measures have been put into place to address the stated concern:
	2/15/16	The Executive Director and Maintenance Coordinator/Designee will conduct monthly walking rounds of community as a component of the preventative maintenance program to check for cleanliness, and safe storage or oxygen, and equipment functionality.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		Any issues identified during rounds will be documented and resolved.
	Ongoing 2/24/16 and Ongoing	**D. With respect to how the plan of correction will be monitored:** The Executive Director or Designee is responsible for ensuring implementation and ongoing compliance with all components of this Plan of Correction and addressing and resolving any variance that may occur. The Executive Director of Designee is responsible for ensuring the status of this Plan of Correction is reviewed and discussed at the monthly Quality Assurance/Performance Improvement Meetings and action initiated if required.
Section .0300 10A NCAC 13F .0306 Housekeeping and Furnishings C189	1/12/16 1/12/16 1/12/16 1/12/16 1/12/16 2/3/16	**A. With respect to the specific resident/situation cited:** The Maintenance Coordinator removed the kick-down device on the corridor door of the Staff Break room and the Maintenance Office. The Maintenance Coordinator applied fire caulking in the Community Laundry Rooms. The Maintenance Coordinator applied fire caulking in the 1st floor storage room communication conduit and electrical conduit. The Maintenance Coordinator applied fire caulking in the conduit above the corridor door and above the telephone equipment in the Main Mechanical Room. The Maintenance Coordinator installed drywall to seal the gap above the door in the 3rd Floor Laundry. The Maintenance Coordinator adjusted the corridor door to the Maintenance Office so it latches when closed. The Maintenance Coordinator replaced the batteries in the emergency lights on fixtures EL #96, EL #28, EL #14, and

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		Stair 1, Level 1.
	2/3/16	The Maintenance Coordinator installed a GFCI protected receptacle in the Beauty Parlor.
	2/3/16	The Maintenance Coordinator secured the light fixture to the wall in the 2nd Floor Storage Room.
	2/3/16	The Maintenance Coordinator installed a cover on the junction box in the Main Mechanical Room.
	2/5/16	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The Executive Director and Maintenance Coordinator completed walking rounds to identify needed repairs to the building and physical plant systems. No repairs were identified.
	2/15/16	**C. With respect to what systemic measures have been put into place to address the stated concern:** The Executive Director and Maintenance Coordinator/Designee will conduct monthly walking rounds of community as a component of the preventative maintenance program to check for repair status and physical plant systems. Any issues identified during rounds will be documented and resolved.
	Ongoing 2/24/16 and Ongoing	**D. With respect to how the plan of correction will be monitored:** The Executive Director or Designee is responsible for ensuring implementation and ongoing compliance with all components of this Plan of Correction and addressing and resolving any variance that may occur. The Executive Director or Designee is responsible for ensuring the status of this Plan of Correction is reviewed and discussed at the monthly Quality Assurance/Performance

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		Improvement Meetings and action initiated if required.