STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 000}	Initial Comments The Adult Care Licensure Section and Wake County Human Services conducted a follow-up survey and complaint investigation on 9/1/15-9/4/15. The complaint investigation was initiated by Wake County Human Services on 8/11/15.	{D 000}		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interview and record review, the facility failed to assure in homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer each exit door accessible by residents had the alarm alert system device activated when the door was opened for two of two sampled residents with disorientation and wandering. (#11, #12). The findings are:	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 067	Continued From page 1 1. Review of Resident #11's current FL-2 dated 6/8/15 revealed: -Resident #11 had a diagnosis of dementia. -Documented under "Disoriented" was intermittently. -Documented under "Ambulatory" was semi-ambulatory with a rolling walker. -Documented under admission date was 4/02/10 Review of Resident #11's current Care Plan dated 7/8/15 revealed: -Resident is forgetful. Please check on resident hourly at night. Resident does not sleep well at night and will get up and start wandering the community. Please redirect back to the room when you see her up wandering around the community at night. -Resident required monitoring and redirection because she wandered inside the facility. Review of the Facility's Incident Report for Resident #11 dated 6/28/15 at 11:30 p.m. revealed: -Resident #11 was still inside the facility. -Resident #11 was found in the entryway which connected the front lobby door and the outside door. -Resident #11 was trying to get back into the lobby. Review of the facility's door alarm log dated 6/28/15 from 11:30:28 p.m. to 11:30:40 p.m. (18 sec.) revealed: - Resident #11 pushed the front lobby door which triggered the alarm and opened the door. -Staff found Resident #11 in the entryway between the lobby door and the outside door. Observation of Resident #11's wrist on 9/1/15 at	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 067	Continued From page 2 10:45 a.m. revealed no placement of a Wander Guard. Interview with Resident #11 on 9/1/15 at 10:45 a.m. revealed she did not have to be supervised outside of the facility. Telephone interview with Resident #11's family member on 9/4/15 at 10:45 a.m. revealed: -She was aware that Resident #11 had been enclosed in the entry way door on 6/28/15. -Staff reported Resident #11 was requiring more redirection and becoming more confused. Interview the 1st medication aide on 9/1/15 at 11:00 a.m. revealed: -Resident #11 wandered in the facility, but not outside. -Staff monitored Resident #11 every hour. Interview with 1st personal care aide on 9/1/15 at 11:15 a.m. revealed: -Resident wandered in the hallway, but not outside. -Staff monitored Resident #11 every hour. Interview with the Health Care Coordinator (HCC) on 9/3/15 at 3:00 p.m. revealed: -She was aware of the incident report for Resident #11 dated 6/28/15 at 11:30 p.m. - Resident #11 pushed the front lobby door which triggered the alarm and opened the door. -Staff found Resident #11 in the entryway between the lobby door and the outside door. -Resident #11 was trying to get back into the building. -Staff reported Resident #11 wandered in the community at night. -The front entrance door was alarmed between the hours of 8:00 p.m. and 8:00 a.m.	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 067	Continued From page 3 -The concierge was at the front entrance desk between the hours of 8:00 a.m. and 10:00 p.m. -The staff were instructed to check on Resident #11 every hour at night. Interview with the Executive Director (ED) on 9/03/15 at 3:30 p.m. revealed: -She was aware of the incident report for Resident #11 dated 6/28/15 at 11:30 p.m. -Resident #11 was found in the front entry way doors trying to get inside the building. -The staff were instructed to check on Resident #11 every hour at night. -No specified hours were given. -The front entrance door was alarmed between the hours of 8:00 p.m. and 8:00 a.m. -The concierge was at the front entrance desk between the hours of 8:00 a.m. and 10:00 p.m. Interview on 9/03/15 at 4:20 p.m. with the Executive Director (ED) revealed: - The door alarms on the patio and sunroom doors leading out to the unsecured garden area were only alarmed at 8 p.m. - 8 a.m. - At these times when doors were opened, an alert went to staff pagers and there was no alarm heard. - No door alarm alerts were sent between 8 a.m. and 8 p.m. Review of Resident #11's physician's "Visit Summary" dated 9/2/15 revealed: -Dementia: continue the supportive care in the assisted living facility. -Patient with ongoing, confusion, disorientation and increased risk for wandering behaviors. -Would recommended a Wander Guard at this time and may need to consider a secured living environment in the future.	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 067	Continued From page 4 Observation of Resident #11's right wrist on 9/3/15 at 10:30 a.m. revealed she had a Wander Guard placed on her wrist. Interview with Resident #11 on 9/3/15 at 10:30 a.m. revealed she did not know why a bracelet had been placed on her right wrist. Interview with 2nd medication aide on 9/3/15 at 11:00 a.m. revealed: -Resident #11 was wearing a Wander Guard. -The Designated Care Manager was responsible for checking for the placement of the Wander Guard on Resident #11's wrist at least once a shift. -Resident #11 wandered inside the building, but not outside. -Resident #11 should be monitored every hour. Interview with 2nd personal care aide on 9/3/15 at 11:20 a.m. revealed: -Resident #11 was wearing a Wander Guard. -She checked the placement of the Wander Guard on Resident #11's wrist at least once on per shift. -She monitored Resident #11 every hour. Interview with 3rd medication aide on 9/3/15 at 3:15 p.m. revealed: -Resident #11 was wearing a Wander Guard. -The Designated Care Manager (DCM) checked the placement of the Wander Guard on Resident #11's wrist at least once per shift. -Resident #11 was monitored from 30 minutes to an hour. -Resident #11 was confused and had to be redirected. -Resident wandered in the building, but she did not go outside unsupervised.	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 067	Continued From page 5 Interview 3rd personal care aide on 9/3/15 at 3:45 p.m. revealed: -Resident #11 was wearing a Wander Guard. -She checked the placement of the Wander Guard on Resident #11's wrist at least every shift. - Resident #11 was confused and disoriented. -She monitored Resident #11 at least every hour per shift. Telephone interview with Resident #11's family member on 9/4/15 at 10:45 a.m. revealed: -Staff reported Resident #11 was requiring more redirection and becoming more confused. - She had been made aware of Resident #11 wandering in the facility. -On 9/02/15, a Wander Guard had been recommended by the team. -Eventually, Resident #11 may need a more secured unit in the facility. Interview with the Physician Assistant's (PA) on 9/4/15 at 11:30 a.m. revealed: -He had been made aware of Resident #11 wandering in the facility. -Staff reported Resident #11 was requiring more redirection. -He decided to write an order for the Wander Guard on 9/2/15 after he observed Resident #11 wandering in the hallway. -Eventually, Resident #11 may need a more secured unit in the facility. Interview with the Health Care Coordinator (HCC) on 9/4/15 at 2:00 p.m. revealed: -Resident #11 wandered inside the building. -On 9/2/15, the team just decided it was time for the placement of the wander guard on Resident #11. -There was no change in Resident #11's level of confusion.	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 067	Continued From page 6	D 067		

-The assigned staff was responsible for checking placement of the Wander Guard on Resident #11's wrist every shift.
-The assigned staff should monitor Resident #11 every hour.

Interview with the Executive Director (ED) on 9/4/15 at 3:30 p.m. revealed:
-Resident #11 wandered inside the building.
-On 9/2/15, the team came to the decision that Resident #11 required a Wander Guard to monitor her exit seeking behavior.
-Resident #11 had no major incidents of exit seeking behaviors.
-The assigned staff was responsible for checking placement of the Wander Guard on Resident #11's wrist.
-The assigned staff should monitor Resident #11 every hour.

2. Review of the current FL-2 dated 7/20/15 for Resident #12 revealed:
- The resident was admitted on 8/29/12.
- Diagnoses of Alzheimer's Dementia, History of paroxysmal atrial fibrillation of the heart, hypertension, osteoarthritis, and gastro-esophageal reflux disorder.
- The FL-2 listed the resident as constantly disoriented.
- The resident was listed as semi-ambulatory with a walker.
- There was no information related to wandering.

Review of the Resident Register dated 8/30/12 revealed Resident #12 had a memory assessment of being forgetful - needing reminders.

Review of Resident #12's Individualized Service Plan (ISP) / Assessment and Care Plan dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 067	Continued From page 7 3/20/15 included: - Resident #12 was listed as having Alzheimer's Dementia and difficulty walking. - The Socialization Section of the form listed the resident as having a sleep pattern of frequently being up at night because she was confused. - The Direct Care Manager (DCM) was to orient the resident to time so the resident could rest at those times. - The Memory Cognition and Approach Section documented: The resident was listed as needing assistance by staff for outings. Assistance was required due to "... a history of dementia which is a loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgement, and behavior." The resident was listed as oriented to person only and was only oriented to time with extensive cueing. The DCM was to orient the resident as to place and when necessary, escort Resident #12 to and from meals, activities, socials and outings. DCM was to anticipate the resident's needs because at times the resident was confused and may or may not require assistance. - The Safety Section documented the resident was not at risk for elopement. Review of the facility's "Behavioral, Intermittently Confused, or Diagnosis of Dementia Residents" list dated 5/5/15 maintained at the first floor front desk entrance exit area with the concierge revealed Resident #12 was on the list. Review of physician notes dated 7/09/15 revealed the resident had been having increased distress and paranoia regarding fear of someone trying to kill her for the last several months.	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 067	Continued From page 8 Review of facility Progress Notes for Resident #12 revealed an increased period of confusion due to a urinary infection: - 4/01/15 Resident seen today for more pronounced confusion. - 4/02/15 Resident became upset when asked questions and showed signs of confusion. - 4/03/15 Resident still had some confusion. - 4/04/15 Resident walking around with her normal amount of confusion. - 4/09/15 Resident was at baseline of confusion. There were no facility notes or other documentation related to increase supervision and assistance of Resident #12 for disorientation when out of the facility according to her current assessed needs on her ISP. Interview on 9/03/15 at 9:30 a.m. with a medication aide (MA) revealed: - Resident #12 was confused and disoriented. - The resident could participate with resident activities. - The resident had a routine of going back and forth to her room (on the third floor), and on the second floor the activity room and the dining room. Observation on 9/03/15 at 9:52 a.m. of Resident #12 revealed: - The resident was out in the second floor garden area next to a row of bushes that backed up to a fence across the entire back length of the garden. - The garden area was not a secured area. - There was not a gate or fence on either end of the large garden area. - One side of the unsecured garden led to a back of the facility parking area. - The other end of the unsecured garden area led to a very busy city street.	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 067	Continued From page 9 - The resident was seated in front of the bushes near the back of the garden on a large bench alone. - No staff members were observed in the living room, hallway, on the patio nor in the garden area observing Resident #12. - One staff person was observed across the hall from the living room in an eating area. - The staff member was calling a BINGO game and was surround by many residents and could not see the resident from her sitting position. - The resident was observed to easily walk with a walker from the back of the garden and through the door of the large living room. - No door alarm sounded and no staff responded to the resdient coming into the building. Interview on 9/03/15 at 10:10 a.m. with Resident #12 revealed: - The resident was slightly hard of hearing. - The resident was spoken to with a sufficiently loud voice for her to hear and answer the questions. - The resident said she liked to sit outside in the garden. - The resident did not know what day it was nor where she was and kept asking where all the people were. - The resident was not able to be interviewed further. Observation of Resident #12 on 9/03/15 at 10:26 a.m. revealed: - Resident #12 was walking rapidly down the second floor hall to the elevator. - The resident got on the elevator and went directly to her third floor room and shut the door. - No staff were assisting/supervising the resident at this time.	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 067	Continued From page 10 Observation on 9/03/15 at 4:50 p.m. of Resident #12 revealed: - The resident had come down to the second floor with no staff assisting her. - The resident was walking rapidly up the 200 hall with her walker and went to the end of the hall and around a corner to the computer area. - The resident was in the computer area for 3 - 4 minutes when a staff person redirected her to the dining room. Interview on 9/03/15 at 2:20 p.m., with the supervisor-in-charge (SIC) on the third floor revealed: - Resident #12 can do a lot for herself with Activities of Daily Living (ADL). - The resident needed reminders for the meals; the resident can go to the dining room (2nd floor) and order meals by herself. - Resident #12 has "sundowning" behaviors, especially late in the evening like 8-9 p.m. - Resident #12 thought someone was going to hurt her; says her family member ws dead if she did not visit for awhile, but the family member comes at least once or twice a week. - Resident #12 had no wander-guard; did not have exit seeking behaviors. - The resident did not require extra supervision or checks. - All residents get every 2 hour checks. - The SIC was not aware of any incident in 2015 that Resident #12 went outside the facility building. Interview with the MA on the third floor, on 9/3/15 at 2:30 p.m. revealed: - Resident #12 was independent with ADLs like toileting, dressing, eating or grooming about 4-5 months ago, but a month ago her knee started to bother her so she required some assistance now.	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 067	Continued From page 11	D 067		

- Resident #12 has had confusion depending on the day.
- The resident would ask "What's wrong with me? This is not old [first name] I used to be, I think I'm getting old."
- The resident always knew how to get to the dining room & to the bedroom.
- On some days, the resident needed reminders during meal times.
- The staff checked on the residents who were declining mentally, in their rooms, at shift changes, during medication passes and hydration time.
- The staff use a "daily log" to document changes with the resident conditions; all staff can document on the log.
- The MA was not aware if the resident wore wander-guard.

Interview on 9/3/15 at 3:20 p.m. with a Wellness Nurse revealed:
- Resident #12 had been known to walk the circular paved pathway in the second floor garden about two times per week.
- The resident was known to be able to walk in and out to the garden on her own and back and up to her room on third floor without supervision.
- The resident had been known to stay on the walking path and not wander off of it while in the garden.
- The nurse did not realize the resident was observed sitting in and walking in the back of the garden near the fence that led to the two unsecured exits of the garden.
- The resident had not gotten out of the garden area on either side of the unsecured garden.
- She did not know of any supervision currently needed for this resident when out in the unsecured garden area.
- She was not aware of any disorientation in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 067	Continued From page 12 Resident #12. - She was not aware the resident's supervision did not match her assessed needs of constantly disoriented. Interview on 9/03/15 at 3:30 p.m. with a second floor evening shift MA revealed: - Resident #12 was a little confused. - The resident walked independently around on the third floor where she lived and came down to the second floor for meal times. - She sometimes visited the first floor area and sometimes followed staff around on the halls. - She was redirected at these times but was not supervised for disorientation. - She was not aware the resident was listed as constantly disoriented and would need a system of supervision and that the door alarm systems at the doorways leading to the unsecured garden and main exit since the alert area alarm system would not be activated until dark - 8 p.m. Interview on 9/03/14 at 3:40 p.m. with the Life Enrichment Director revealed: - Resident #12 came down to the second floor alone and did not require supervision for disorientation. - The doors from the activity living room and the enclosed patio room off of the dining room did not have door alarms on. - Resident # 12 had not been seen today and had never been noted to be on the grass in the garden, she just walked on the concrete path. Interview on 9/3/15 at 4:20 p.m. with the Executive Director (ED) revealed: - Resident #12 had hearing loss. - Staff speak of the resident and her routines; she had no exit seeking behavior. - The resident did not seem confused. She had a	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 067	Continued From page 13	D 067		

purpose on going out.
- Resident was known to walk a lot out back in the garden area a few times per day, morning and afternoon.
- The resident "...could sign out and walk without being supervised.".
- She was not aware of supervision of Resident #12 due to disorientation when outside of the facility in areas leading to the unsecured garden and when door alarms were not active in the daytime.
- The door alarms on the second floor patio and sunroom doors leading to the unsecured garden and the front exit doors were only alarmed at 8 p.m. - 8 a.m. and then when doors were opened, an alert went to staff pagers and there was no alarm heard.
- The front door exit had a concierge to survail the door from 8 a.m. to 8 p.m.
- No door alarm alerts were sent between 8 a.m. and 8 p.m.

Interview on 9/03/15 at 5:10 p.m. with the Lead Care Manager (LCM) revealed:
- Staff were to use the resident's ISP and notes in the daily log to determine how to care and supervise residents.
- The LCM thought since Resident #12 had a walker she should not go out of the facility without assistance.
- The resident goes down to the second floor for activities and to go out to garden area.
- The resident can go to all of the floors and knew how to return to her room.
- The resident was not an elopement risk, there were no signs such as trying to go to the door to go home.
- She had nite time delusions and paranoia now.
- The resident's mind would be "off sometimes" and she would be talking like her husband was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 067	Continued From page 14	D 067		

there.
- Staff would not have to watch her while outside the facility on the front porch on the first floor or the garden on the second floor.
- Door alarms to the garden and the front door were turned on at dark time around 8 p.m.

Attempt telephone interview on 9/04/15 at 9:13 a.m. with a family member of Resident #12's revealed they were unavailable for interview.

Interview on 9/04/15 at 10:40 a.m. with the Health Care Coordinator (HCC) revealed:
- The HCC was not worried about elopement for Resident #12.
- The resident had a routine of going from her room to the dining room to the activity room.
- Resident #12 only went on the first floor accompanied by her family or staff.
- The HCC did not see Resident #12 as a person who was disoriented.
- The resident appeared disoriented when spoken to because the resident was hard of hearing.
- The resident had not been exit seeking.
- The resident did not need a lot of supervision.
- Nothing had been put in place for supervision for Resident #12.
- Door alarms for the unsecured garden and front door exit were not activated until 8 p.m.

Based on observation, interview and record review, Resident #12 was not being supervised based on the resident's assessed needs when exiting to the unsecured garden area during the time door alarms were not activated from 8 a.m. - 8 p.m.

A Plan of Protection was requested from the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 067	Continued From page 15 provider on dated 9/21/15. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 20, 2015.	D 067		
{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: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observation, interviews and record review, the facility failed to ensure the locking mechanism for 1 of 2 exit doors (REM Door by 126), in the special care unit to the outside, was maintained in a safe and operating condition resulting in 1 resident exiting the building without staff knowledge. (Resident #4). The Findings are: Review of Accident/Incident Report, dated 8/11/15 at 6:15 p.m., revealed: - The staff went out to take a break and saw Resident #4 in the parking lot. - The staff brought the resident back to the SCU; closely monitoring. - Notified HCC & maintenance director.	{D 105}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 105}	Continued From page 16 Interview with the facility's health care coordinator (HCC), on 8/11/15 at 9:05 am, revealed: - Resident #4 got out of an exit door (REM Door by 126) in the SCU. - The resident opened the door and it didn't alarm. - No staff heard the alarm. - The exit door alarm was deactivated. - The exit door alarm could be deactivated by turning off a "kill switch" next to the exit door. - The door's "kill switch" also had an alarm that went sounded when the "kill switch" box cover was opened. The alarm did not go sound until the plastic cover was put back in the box correctly. - No one had heard a door alarm or the "kill switch" alarm go off at the time Resident #4 exited. - The facility was not aware of the exit door alarm being deactivated & was not aware of when the "kill switch" was turned off. The facility did not know how the "kill switch" cover alarm could not have been heard unless the "kill switch" cover was replaced immediately. - The facility didn't know how long the exit door was deactivated. - When an exit door opened, the magnet strip on the top of the door was detached, and triggered an "alarm" (pager message) that went to all staff pagers alerting them which specific exit door had opened. Interview with the Maintenance Coordinator (MC), on 8/17/15 at 4 p.m., revealed: - The MC was not aware of one of the SCU's exit doors being deactivated. - The SCU staff reported to the MC that the exit door (REM Door by 126) alarmed during 1st shift on 8/11/15. - The alarm door system had an override/kill switch.	{D 105}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 105}	Continued From page 17 - The covered plastic box on the wall protected the on-off kill switch. - If the cover to the box was opened, an alarm would sound. - When the kill switch was turned to "off", that would disarm the door and enabled the door to open. - If the door opened, the secondary "silent" alarm would alert the staff pagers. - The pager identified the door as being opened. - When the exit door opened on 8/11/15, 2 SCU staff were providing care to the residents but it did not alarm the staffs' pagers. - By the time 2 staff came out to the hallway, another staff had brought Resident #4 back into the SCU. - The MC was unable to determine when the exit door was deactivated. - There are 2 ways to deactivate the exit door alarm; 1st was by using the key pad and 2nd was by turning the "kill switch" to off which would have made a loud alarm sound. - The MC suspect that it probably was a resident who deactivated the exit door ' s "kill switch" because staff could have easily use the key pad to exit the door. - The MC & her assistant performed monthly alarm system at the end of the month and 8/2015 alarm checks haven't been done. - The facility didn't have reporting system that could identify the alarm system's activation status. - After 8/11/15 elopement incident, she provided an In-Service training to the SCU staff on 8/12/15. - Following topics were covered in the training: how to check doors in the SCU for proper operations, how to override switch works & how to reset, and answering pagers & clearing pagers	{D 105}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 105}	Continued From page 18 out. Interview with the facility's security system vendor, on 8/19/15 at 9:35 a.m. revealed - The facility's "kill switch" was not connected to any monitoring system. - They didn't have any record of the exit doors' activation status. Observation of the special care unit (SCU) on 9/2/15 at 10:40 a.m., revealed; - There were 6 exit doors in the SCU (East). - 2 doors were exit to the outside of the building. - 1 door was an exit from the unit into assisted living. - 3 doors were exit from the unit into the enclosed courtyard. Observation of the SCU's exit door (REM Door by 126), on 8/17/15 at 9:15 a.m., revealed: - Resident #4's room is the last room and door on the hall; - It was approximately 38 feet from the Resident's room door to the exit door. - Outside the exit door was a concrete stoop and 5 steps down to the facility parking lot. - The exit door alarm, when sounding, was loud enough to be heard throughout the SCU unit. - The "kill switch" alarm, when sounding, was hard to hear in the SCU dining room (approximately 100 feet), and was not loud enough to be heard throughout the facility. Review of the facility's "Safety System Reports" from May 2015 through July 2015, revealed the monthly alarm checks were done at the end of each month and the August check had not been done.	{D 105}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 105}	Continued From page 19 Interview with Resident #4, on 8/17/15 at 10:40 a.m., revealed: - The resident was confused; unable to tell his age. - The resident didn't recall the incident; didn't recall being outside. Review of Resident #4's FL-2, dated 8/14/15, revealed: - The resident's level of care was Special Care Unit (SCU). - The resident's diagnoses included Alzheimer's dementia, chronic lymphocytic leukemia, coronary artery disease, hypertension and high cholesterol. - The resident was constantly disoriented. - The resident was ambulatory. Review of Resident #4's "Individual Service Plan (ISP)", dated 6/28/15, revealed: - Under "Special Instructions", documented "[Resident #4] is coming to the facility along with his wife from home. Please be aware that this will be an adjustment for him; please notify ALC & Wellness if resident is exit seeking or asking to go back home." - Further documented that the resident was not at risk for elopement. Interview with the 2nd Direct Care Manager (DCM), on 8/17/15 at 1:58 pm., revealed: - Resident #4 had been exit-seeking since admission to the SCU; the staff was providing 15 minute checks since the resident ' s return earlier in the day. - On 8/11/15, approximately 6 p.m., the resident was walked to his bedroom, in order to use the bathroom; he was able to toilet independently. - The staff went to the restroom herself	{D 105}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 105}	Continued From page 20 immediately after taking Resident#4 to his room. - The staff's pager indicated someone had opened the SCU exit door a few minutes later while she was still in the restroom. - As she was coming out of the restroom, she observed another staff person bringing Resident #4 back into the facility. - Staff had observed residents in the past, take the cover off the "kill switch." - Policy and Procedure was for all staff to respond when a door alarm went off. - 3 different residents had been exit-seeking on 8/11/15; and the staff stated it was possible the staff did not hear the "kill switch" alarm while attending to the exit door alarm on the opposite side of the SCU. - New policy and procedure as of 8/11/15 is that staff check and document that all alarms are properly operating at each shift change. _____ Review of the Plan of Protection provided by the E.D. with telephone addendum on 9/21/15 revealed: - Immediately, frequent checks on the SCU doors to ensure they are locked. - Door checks will be at a minimum of 2 checks on each shift. - The LCM will docuement frequent checks on each shift.	{D 105}		
{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.	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 21 This Rule is not met as evidenced by: FOLLOW UP TO THE TYPE A2 VIOLATION Based on these findings, the previous Type A2 Violation was not abated. Based on observation, interview and record review, the facility failed to ensure supervision of residents was provided in accordance with each resident's assessed need, resulting in a fall with injury for 1 of 12 sampled (#3) residents and wandering including elopement for 3 of the 12 sampled (#4, #11 and #12) residents. The findings are: 1. Review of the current FL2 for Resident #3 dated 8/13/14 revealed diagnoses that included dementia, rheumatoid arthritis, glaucoma, chronic obstructive pulmonary disease, and a history of urinary tract infections. Review of Resident #3's resident register revealed Resident #3 was admitted to the facility 9/28/11. Review of Resident #3's Individualized Service Plan, dated 11/12/14 revealed: - Resident was oriented to person and place, but required reminders throughout the day. - She required assistance to meals, as she may forget. - She was at risk for falls. Review of Progress Notes for Resident #3 revealed: - On 5/7/15 at 5:55pm Resident #3 was found on the ground outside of the activity room bleeding from the head.	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 22 - Resident was found by a family member visiting another resident. - The medication aide saw her sitting up bleeding from the right side of her head and complaining of pain in her right arm. - The medication aid called 911, the residents' family member and the Health Care Coordinator (HCC) and sent her out to the emergency room. - Resident #3 had been admitted to the hospital with the following injuries; a right arm fracture, a nose fracture a zygomatic arch (facial bones) fracture, and facial bruising. Interview with the supervisor on 8/11/15 at 3:00pm revealed: - Resident #3 had been eating dinner in the bistro. - She was found by the side of a brick wall in the courtyard outside of the activity room. - She had left her walker in the bistro. - A sitter with a resident informed her that a family member visiting another resident came up to her and told her Resident #3 was sitting on the side of the building bleeding from the face. - The visitor did not see Resident #3 fall. - Sometimes she forgets to use her walker. - This was the first time she went outside by herself. - In the morning, Resident #3 was more independent, in the afternoon she required more assistance due to sun downing. - Resident #3 was a little unsteady and the supervisor did not think the resident was strong enough to open the door leading out into the courtyard. - Resident #3 was not at high risk for falls. Interview with a personal care aide (PCA) on 8/11/15 at 1:10pm revealed: - Resident #3's gait was unpredictable, she	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 23 was a fall risk. - She would either walk with her walker or use a wheelchair, staff assist with both. - She was confused sometimes, staff had to direct her to the dining room area. - Resident #3 used to go out of the dining area by herself, but not so much recently. - She would get UTI's frequently and because of her symptoms with a UTI, the resident needed extra supervision. Interview with the Resident Care Director on 8/11/15 at 1:40pm revealed; - Resident #3 has dementia. - She was at risk for falls. - She ambulated with a wheelchair and walker, but needed staff assistance. - On 5/7/15 Resident #3 was eating in the second floor bistro. - She required staff assistance going to the bistro from the third floor and staff had to assist her back to her room. - A family member of one of the residents was either inside or outside of the activity room and found Resident #3 lying on the ground bleeding, and he went to call for help. Interview with a visiting family member on 8/17/15 at 9:46am revealed: - The family member had had dinner with the resident in the bistro on the night of 5/7/15. - About 20 - 30 minutes after dinner the family member wheeler the resident out to the patio outside of the activity room. He did not recall the time. - He looked around and found Resident #3 sitting on the ground, bleeding. - He went and found a staff person and reported Resident #3 being outside on the ground.	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 24 - He did not remember seeing Resident #3 even if she was in the bistro. - There were 3-4 staff feeding other residents in the bistro. Review of a statement written by a medication aide on 5/12/15 revealed: - On 5/7/15 she was in the bistro feeding 2 residents at the dinner meal. - When she finished feeding the residents she took one of the residents to their room and the other resident to the activity room. - She left the bistro by 5:20pm because she had to administer a medication that was due at 5:30pm in the special care unit. - When she left the bistro, there were 2 other medication aides left in the bistro along with the rest of the residents. - She communicated with the other medication aides that she was leaving the bistro. Interview with the family of Resident #3 on 9/3/15 at 4:35pm revealed: - Prior to the fall, the facility had started feeding Resident #3 in the bistro, rather than the dining room. - Resident #3 required to be prompted to eat and the bistro was where residents requiring assistance and feeding received their meals, so they could be assisted. - She did not feel she was being properly hydrated, and once when she went to visit, there was feces all over the room and the staff agreed with her that Resident #3 had not been checked on. - Resident #3 sat many times in the dining room after everyone else had left. She would have to wait until someone would take her to her room. - She received a call on 5/7/15 at 6:04pm from	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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}		

the supervisor at the facility, informing her of an incident involving her family member.
- She was informed her family member had eaten in the bistro where she had been taken for dinner.
- Her loved family member had been found lying outside on the ground outside of the activity room and there was a lot of blood.
- The supervisor did not know what happened and no one at the facility saw what happened.
- Her family member was being transported to the emergency room by emergency medical service (EMS).
- She does not think Resident #3 was found right away, when she was called at 6:04pm, they had just found her.
- They don't know for sure how long she was out there on the ground.
- Her family member was treated for a fractured humerus, fractured nose and several facial bones were broken.
- She was informed by the doctor, her family member would not be a candidate for surgery due to her age, and she would require skilled nursing for the rest of her life.
- Resident #3 always required assistance to and from meals and activities
- The only times she would attempt to get up and go alone was when she had a UTI. She's pretty sure she had a UTI at the time of the incident. Staff or another resident would catch her when she stood up to walk away.
- Resident #3 was constantly disoriented to person, place and time at the time of the fall.

Interview with floor supervisor on 9/3/15 at 5:15pm revealed:
- She had not been in the dining room helping during the dinner meal on 5/7/15.
- There had been 2 or 3 medication aides

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 26	{D 270}		

helping out in the bistro.
- Resident #3 had been the last resident in the bistro that evening, no other residents or staff.
- She was not sure if they were taking other residents back to their room.
- Resident #3 was getting to the point where she would sun down in the evenings.
- Sometimes on first shift staff would let her go to her room alone.
- Staff did not allow her to go to her room alone at the dinner meal.
- Resident #3 would usually wait for staff to take her back to her room.
- She needed to be redirected, she would start walking in the wrong direction, instead of going toward the elevator to the third floor where her room was she would head in the other direction.
- She was the first staff person on the scene when the sitter informed her of Resident #3 being on the ground.

Interview with the Executive Director on 9/3/15 at 6:10pm revealed:
- Resident #3 typically would not get out of her chair, and she normally would not wander outside.
- Resident #3 was not identified as being at risk for falls.
- She had been informed Resident #3 had been sitting in the bistro alone for 10-15minutes.
- The personal care aides (PCAs) assigned to assist her were busy taking other residents back to their rooms.
- During the time they were gone, Resident #3 got up without her walker and walked out of the bistro, across the hallway and went through the activity room and out of the activity room door, onto the patio where she was found by a relative of another resident.
- She was not aware of the exact time frame,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 27	{D 270}		

but it was after the dinner meal and she believes it was with in 5 - 10 minutes, before she was found.
- The 2 medication aides that had been assisting in the bistro went on break after feeding residents and Resident #3 was left in the bistro alone.
- The 2 medication aides that were responsible for getting Resident #3 back to her room that evening were both gone at the same time.
- After the incident, the medication aides were instructed not to leave the bistro until the PCAs have gotten all of the resident back to their rooms.

A second interview with the executive Director on 9/4/15 at 9:30am revealed:
- The medication aides should not have left Resident #3 in the bistro alone.
- The medication aides did not follow protocol.

Interview with the Resident Care Director on 9/4/15 at 10:40am revealed:
- Resident #3 was assisted with eating in the bistro.
- The last 2 residents in the bistro on the evening of 5/7/15 were Resident #3. The other resident and a visitor found Resident #3 on the ground.
- Dinner started in the bistro around 4:30pm and they usually finished around 5:30pm.
- When the residents finish eating the medication aides usually start taking the residents back to their rooms.
- One of the medication aides left the bistro to administer medication to a resident on the third floor.
- The last 2 medication aides left the resident in the bistro, because they knew the PCAs would come and take her back to her room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 28 - Resident #3 had finished eating and was awaiting to be picked up. Interview with the Assisted Living Coordinator on 9/4/15 at 11:20am revealed: - She had just started working at the facility prior to the incident on 5/7/15. - She had not worked on the floor with the resident and staff until 5/11/15. Interview with a medication aide on 9/4/15 at 2:05pm revealed: - She was feeding residents in the bistro on the evening of 5/7/15. - Resident #3 was eating in the bistro because she needed constant reminders to eat, she would forget she was eating and just look around without staff there to give her cues. - When she and the other medication aide finished feeding the residents they took the residents in wheelchairs to their rooms. - She did not take Resident #3 back to her room because she ambulated with a walker and the PCA would come get her and take her back to her room. - She did not normally take Resident #3 back to her room. - Normally Resident #3 would sit there and wait for them. - Resident #3 was in the bistro for about 15 minutes waiting for the PCA to take her back to her room. - She and the other medication aide went to clock out for their break. - When she returned from break she learned the PCA never came to get Resident #3 and she learned of the rsident's fall. Interview with a second medication aide on 9/4/15 at 2:15pm revealed:	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 29 - She was in the bistro assisting with feeding residents on the evening of 5/7/15. - When she left the bistro, Resident #3 and one other resident and visitor was in the bistro. - She and the other medication aides had left the bistro to take the residents with wheelchairs back to their rooms. - She went to take the cart back to the kitchen while Resident #3 was finishing up drinking in the bistro. - After she took the carts back to the kitchen she walked by the bistro and did not see anyone in there, so she thought the PCAs had taken Resident #3 back to her room that was between 5:30pm and 6:00pm. - She then took another resident up to the third floor to their room, and from there she went and clocked out for break. - After her break she heard Resident #3 had fallen. Interview with Resident #3's Physician Assistant on 9/4/15 at 11:40am revealed: - Resident #3 was confused and disoriented. - She was oriented to self only. - She would go to the dining room and be assisted back to her room. - She could ambulate back to her room with her walker in the mornings unassisted, he had seen her do that before. - He had not been at the facility during the dinner meal. 2. Review of Resident #4's records revealed: - The resident was admitted to the facility's assisted living unit (ALU) on 6/25/15 and transferred to a special care unit (SCU) on 7/28/15, after an elopement incident. - The resident's spouse was also admitted to the facility's ALU on 6/25/15 with the resident.	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 30 - The resident had 3 elopement incidents, once from the ALU, on 7/23/15, and twice from the SCU, on 8/11/15 and on 8/19/15. - The resident moved to another facility's SCU on 8/20/15. Review of Resident #4's Accident/Incident Report, dated, 7/23/15 at 1:30 p.m., revealed: - The resident went down the stairwell and went out to the front parking lot. - The resident was looking for his car and mail box. - The family and the resident's physician were notified. Review of Resident #4's pre-admission assessment "Service Evaluation & Health Assessment (SEHA)" dated 6/20/15, revealed: - The assessment was for the Assisted Living placement. - Under "Memory & Cognition" documented, "Remembers family names, oriented to person and requires assistance." - Under "Elopement Risk" was documented, "The resident didn't have a history of wandering, was not a wanderer, needed assistance finding his way around in the community and was not at risk for elopement." - Under "Special Instructions" was documented, "Notify ALC & Wellness if resident is exit seeking or asking to go back home." Review of Resident #4's FL-2, dated 6/17/15, revealed: - The resident's level of care was domiciliary. - The resident's diagnoses included Alzheimer's, chronic lymphocytic leukemia,	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 31	{D 270}		

coronary artery disease, hypertension and high cholesterol.
- There was no information on the orientation status.
- The resident was ambulatory.

Review of Resident #4's "Individual Service Plan (ISP) " dated 6/28/15, revealed:
- Under "Special Instructions", documented that the resident was coming to the facility along with his wife from home, to be aware of his adjustment to the new environment and notify the Wellness nurses if the resident displays exit seeking or asking to go back home.
- Further documented that the resident was not an elopement risk.

Review of the care manager's 1st and 2nd shifts "Daily Assignment Sheet", in the ALU, from 7/23/15, revealed there were no special instructions for Resident #4.

Review of the facility's "Daily Log", for Resident #4, dated 7/23/15 at 2:50 pm, revealed a wander guard was placed on the resident then it was removed because he left the facility to go home with his family.

Review of Resident #4's primary care physician (PCP) visit notes, revealed:
- On 7/24/15, the patient scored 6/30 on "Saint Louis University Mental Status (SLUMS)" testing.
- The resident was recommended to move to the SCU.

Review of Resident #4's electronic progress notes, revealed:
- Dated 7/30/15 at 4:48 p.m., the resident was exit seeking and needed to be re-directed several times daily.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 32 - Dated 8/9/15 at 11:52 a.m., the facility's nurse performed suicide risk evaluation after the resident's private sitter reported to the facility that the resident threatened to harm himself with a knife. The resident's room was searched for objects that he could harm himself with. The resident also told the nursing staff that "he gets so lost he would jump off a bridge." Interview with a lead care manager (LCM) on 8/31/15 at 2:50 p.m. revealed: - The staff never had to redirect Resident #4 when he was in the ALU. - The staff didn't recall any staff that brought up to her attention regarding Resident #4's behaviors. - Resident #4's exit seeking behavior started on 7/23/15 and that was the first incident. Interview with the 1st designated care manager (DCM), on 8/31/15 at 3 p.m., revealed: - Resident #4 was very confused when he was in the ALU. - Sometimes, when the staff reminded the resident about a meal, he didn't understand what was going on so his family member had to explain to him. - Resident #4 used to get lost on the 2nd floor, where the dining room was located. Interview with the same designated care manager (DCM), on 9/1/15 at 4:25 p.m., revealed; - The staff didn't have a lot interaction with Resident #4 but when she worked with the resident, he would always ask "Where should I go?" because he didn't know where the dining room was. - Resident #4 always wandered the halls. - Resident #4 knew his room was on the 3rd floor.	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 33 Interview with the former DCM, on 9/1/15 at 3 p.m., revealed that she only worked at the facility for a month so didn't recall Resident #4. Interview with Resident #4's family member (FM), on 8/31/15 at 11:19 a.m. and 9/2/15 at 3:15 p.m., revealed; - When Resident #4 and a family member moved into the facility, both lived in the ALU. - Resident #4 had dementia but he was not a wanderer. - On 7/23/15, facility wanted to move Resident #4 to the SCU after he exited a stairwell, and was brought back into the building by staff. - The family member thought that the resident was trying to go down to get to the dining room on 7/23/15. - The family was given an option to either place private sitters for 24/7 or admit the resident to the SCU. - The resident was confused, sometimes but he can take care of himself physically and his family member helped him. - The family did not agree with the concerns about the resident's disorientation and safety. Considering the SCU placement too extreme, family took the resident home until 7/28/15; they readmitted him to the SCU. - The FM was informed during the admission that the facility would provide checking the resident every 2 hours. - When the resident was in the ALU, the staff told the family that the resident got confused when going back to his room from the dining room and the staff had to assist him. Interview with the assisted living coordinator (ALC), on 8/31/15 at 4:10 p.m., revealed: - The ALC had been employed for a month in	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 34 her position before Resident #4's pre-admission assessment visit. - The ALC and the former SCC performed Resident #4's pre-admission assessment on 6/20/15. - The resident would go downstairs to the 1st floor to look for a dining room. - Even the resident's oriented family member would get lost within the community. - The resident didn't require any special supervision other than a routine 2 hour checks. - The ALC did see the resident's confusion within a month. - The ALC wasn't aware of any staff reporting exit seeking behaviors. Interview with the health care coordinator (HCC), on 8/31/15 at 12:35 p.m., revealed; - HCC heard over the radio 1st LCM responding to an exit door alarm on 7/23/15. - The 1st LCM went to the 1st floor exit door and brought back Resident #4 to the 3rd floor. - Resident #4 reported that he was "looking for his car" - The resident was confused, had no safety awareness and he was very mobile. - When HCC asked the resident's family member about him using the stairwell to go down to the 1st floor, the family member said they have taken the resident down to the 2nd floor using the stairwell by his room. - The HCC was not aware of any staff report of Resident #4's exit seeking behaviors. - Based on information from pre-admission assessment along with the resident's Alzheimer's diagnosis, the resident should have been placed in the SCU. - After 7/23/15 elopement incident, HCC felt that the SCU was appropriate placement for the resident due to sufficient supervision.	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 35 Review of Resident #4's Accident/Incident Report, dated 8/11/15 at 6:15 p.m., revealed: - The staff went out to take a break and saw Resident #4 in the parking lot. - The staff brought back to the SCU; closely monitoring. - Notified HCC & maintenance director. Interview with the 1st medication aide (MA), on 8/31/15 at 9:57 a.m. revealed: - The staff was in training at the facility; and 8/11/15 was her third day on the job. - She was working alongside facility staff on 8/11/15 in the Reminiscence Unit (SCU). - She had been advised that Resident #4 was exit-seeking; and all staff were to "keep an eye on him." - He had not displayed any exit seeking behaviors during the shifts she had worked on the Reminiscence Unit. - She had been trained about facility elopement policies and procedures before being on the floor. - On 8/11/15, approximately 6:30 p.m., residents were finishing dinner, and being taken back to their rooms for personal care. - The staff had just walked Resident # 4 down the hall to his room for the evening. - The staff member went on break outside the building. While the staff member was walking around the outside of the main entrance of the facility, she observed Resident #4 standing just outside Reminiscence Door 126, on the concrete steps down from the door to the parking lot. - She called out to, and approached Resident #4, she took his hand and he was easily redirected back into the building. - It was approximately 5 minutes between going on break and redirecting the resident back	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 36 into the facility. Interview with Resident #4, on 8/17/15 at 10:40 a.m., revealed: - The resident was confused; unable to tell his age. - The resident didn't recall the elopement incidents; didn't recall being outside. Review of Resident #4's physician communication fax, dated 8/9/15, revealed: - The resident expressed suicidal thought. - The resident' s physician ordered to increase Citalopram to 20 mg daily and remove all cords, wires from patient's room. - The physician ordered the facility to check the resident every 15 minutes when he was in the room with door closed, for 5 days. Review of Resident #4's "Suicide Risk Evaluation", dated 8/9/15, revealed: - The resident verbalized suicide ideation or intent to do self-harm; had thoughts of suicide and a plan. - Per report, the resident was going to hurt himself with a knife. - The resident had a previous history of psychiatric diagnosis, recent losses and hopelessness. - The resident was taking Celexa for depression. - The resident stated that "He gets so lost, he would jump off a bridge" - The resident stated that "he wouldn't do anything about it because his [family member] was coming to visit." Review of the facility's "Behavior Tracking Log", revealed: - On 8/10/15 at 3pm, 4pm, & 5pm, the resident	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 37 was constantly pushing the exit door in the activity room, trying to go home. - On 8/15/15 at 3pm, 3:25pm, 4pm, 5pm, 6pm & 7pm, the resident was constantly pushing exit doors in the dining room. - Both days, the staff tried to calm the resident down by explaining to him that he lived at the facility and also engages him in activity but he still wanted to go home. Review of the facility's "Daily Log" for Resident #4, dated 8/11/15 at 9 p.m., revealed: - 15 minute checks started around 2:45 p.m. - Until 5:30 pm, Resident #4 was in the dining room, eating supper; the resident went to his room to use the bathroom and at 5:45 p.m. the resident was talking to the medication aide. - At 6 p.m., the resident was taken back to his room. - At 6:08 p.m., the resident was found outside. - At 7:30 p.m., the resident had a sitter with him. Review of Resident #4's FL-2, dated 8/14/15, revealed: - The resident's level of care was Special Care Unit (SCU). - The resident's diagnoses included Alzheimer's dementia, chronic lymphocytic leukemia, coronary artery disease, hypertension and high cholesterol. - The resident was constantly disoriented. - The resident was ambulatory. - The resident had a medication order for Exelon patch 46 mg (apply once every 24 hours to skin). (Exelon patch is used to treat confusion related to Alzheimer's disease.)	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 38 Review of Resident #4's "Individual Service Plan (ISP)", dated 7/28/15, revealed: - Under "Special Instructions", documented - Under "Safety", documented the resident was at risk for elopement. - The facility's health care coordinator (HCC) added following notes on the same ISP: on 8/10/15, "[First 3rd party agency] sitter will be here 10-12 pm for companionship; on 8/11/15, "[Second 3rd party agency] sitters will be here at 7:30 pm."; sitters to decrease from 24 hours to 12 hours, 8 am-8 pm daily. Review of Resident #4's electronic progress notes, revealed: - On 8/11/15 around 2:30 pm, the resident returned to the facility with a family and his whereabouts were monitored every 15 minutes. - On 8/11/15 around 6:08 pm, a CM (care manager) went to take a break outside and saw resident in the parking lot. - The resident was re-directed and escorted back into the SCU. - A private sitter was put in place (after incident 8/11/15). - On 8/12/15 at 4:08 p.m., the facility's management team, including clinical members, had a meeting with the family regarding resident eloping. - The executive director (ED) informed family that at it would be best for the resident to stay in SCU instead of going back and forth visiting his family member in AL to allow the resident to adjust to the SCU. - Further documented that the resident would need sitters until he adjust. - Interview with the facility's health care coordinator (HCC), on 8/11/15 at 9:05 a.m. and 8/31/15 at 12:35 pm, revealed:	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 39 - Resident #4 got out of an exit door from the SCU. - The resident opened the door and it didn't alarm. - No staff heard the alarm because the exit door alarm was not activated. - The exit door alarm could be deactivated by turning off a "kill switch" next to the exit door. - The facility didn't know how long the exit door was deactivated. - When an exit door opened, the magnet strip on the top of the door was detached, and triggered an "alarm" (pager message) that went to all staff pagers alerting them which specific exit door had opened. - On 8/11/15, Resident #4 was asking staff to leave; he was following staff around. - Staff reported to HCC that the exit door wasn't working. - Resident #4 was found between 2 cars outside, the building, near an exit door (REM Door by126). Observation of the SCU exit door (REM Door by 126), on 8/17/15 at 9:15 a.m., revealed: - Resident #4's room and exit door are the last room and door on the hall. - It is approximately 38 feet from the Resident's room door to the exit door. - Outside the exit door is a concrete stoop and steps down to the facility parking lot. - The exit door alarm, when sounding, was loud enough to be heard throughout the SCU unit. - The "kill switch" alarm, when sounding, was hard to hear in the SCU dining room (approximately 100 feet), and was not loud enough to be heard throughout the facility. Observation of the immediate surroundings, from the SCU's exit door (REM Door by 126) to the	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 40 outside the building, on 8/17/15 at 4 p.m., revealed: - Exit door by 126 led out to the parking lot. - It was a 7 feet from the exit door to the top of the steps. - There were 5 steps leading down to the sidewalk. - Right below the steps, there were cars parked along the sidewalk. - The sidewalk/parking area was located next to a small secondary street which connects to a busy, 4 lane road. - The distance from the bottom of the steps from the SCU exit door by126, to the major road is about 180 ft. Interview with the 2nd DCM, on 8/17/15 at 1:58 pm., revealed: - Resident #4 had been exit-seeking since admission to the SCU; the staff was providing 15 minute checks since the resident's return earlier in the day. - On 8/11/15 at approximately 6 p.m., the resident was walked to his bedroom, in order to use the bathroom; he was able to toilet independently. - The staff went to the restroom herself immediately after taking Resident #4 to his room. - The staff's pager indicated someone had opened the SCU exit door a few minutes later while she was still in the restroom. - As she was coming out of the restroom, she observed another staff person bringing Resident #4 back into the facility. - New policy and procedure as of 8/11/15 is that staff check and document that all alarms are properly operating at each shift change. Interview with the 3rd DCM, on 9/2/15 at 10:40 a.m., revealed:	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 41 - Resident #4 frequently pushed two exit doors that led outside the building and alarm sounded but didn't recall documenting on the "Behavior Tracking Log". - There is a big " Exit" sign posted on the two exit doors and that seem to promote his behaviors to try to open them. - The resident would ask staff to take him to his family member upstairs because he was worried about her. - The resident stated "his [family member] was dying and he won't be able to say good-bye" - The resident didn't participate much with the activities especially group activities around the table like puzzles. - The resident enjoyed walking around the garden in the enclosed courtyard and planting flowers. - The resident was checked every 15 minutes but there was no documentation of them. - There is at least 1 staff in the common area to supervise the residents; the residents are encouraged not to stay in their rooms. Interview with the 4th DCM, on 9/2/15 at 10:50 a.m., revealed that she didn't recall any behaviors worth documenting on the "Behavior Tracking Log" for Resident #4 during her shift. Interview with Resident #4's family member (FM), on 8/31/15 at 11:19 a.m. and 9/2/15 at 3:15 p.m., revealed; - On 8/11/15, the facility notified the family that the resident had exited the SCU, through an exit door and was found by a staff who was outside. - The facility had put a sitter in place for 24 hours a day every day (24/7) without the FM's knowledge. - The FM was told the facility was looking into reducing the sitter hours from 24 hours a day to	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 42 12 hours a day. The facility would determine the number of hours based on the resident's behavior and assessed need for a sitter. - The family member ' s understanding was the resident would seek to exit the unit when he wanted to see his family member who lived in the assisted living side of the facility. - The family members had a meeting with the facility staff and discussed their options. - The resident was evaluated by a psychiatrist and was determined that he wasn't suicidal; he was frustrated and angry about having sitters. - The FM didn't remember about 15 minute checks. - The FM didn't know how much activities the resident did; at first, he didn't do much activities but towards the end of his stay, the facility came up with some activity plans. The ED provided a statement, on 8/31/15, explaining the actions taken after Resident #4's 8/9/15 elopement incident: - On 8/9/15, the sitters were put in place, 24/7, due to the resident's exit seeking behaviors. - On 8/15/15, the sitters' hours were reduced to 12 hours per day. - On 8/17/15, the sitters were discontinued due to the resident showing no signs of exit seeking behaviors. - A daily activity calendar was put in place for resident and he appeared to be calm and happy. Review of Resident #4's Accident/Incident Report, dated 8/19/15 at 4:05 p.m., revealed: - The staff saw the resident walking at the lobby next to the beauty shop. - The resident was a few feet outside of the special care unit, inside assisted living. - The staff asked the resident where he was going; the resident told the staff that he was lost	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 43	{D 270}		

and he was trying to get out of the building.
- The staff asked the medication aide if she knew the resident and she said "yes" and brought him back to the SCU.
- Family and physician notified.

Interview with the kitchen staff, on 8/31/15 at 1:10 p.m., revealed:
- 8/19/15 was her third day of employment with the facility as a dishwasher.
- She was walking down the main entrance hall toward the elevator, outside the SCU's main door, and observed Resident #4 coming up the hall from the SCU's main door.
- Resident #4 was walking away from the unit door, and turning into a hall that led to an outside door.
- When she saw the resident, she approached him, andhe told her he was lost, trying to get out of the building, and get to his family member (who resided in the facility).
- She did not know the resident and sought out staff assistance.
- The medication aide was coming out of the SCU main entrance and recognized Resident #4. She asked kitchen staff "Where did you find him?", and escorted the resident back into the SCU.

Review of Resident #4's physician communication fax, dated 8/19/15, revealed the resident's primary care provider ordered Lorazepam 0.5 mg (1 tab) to be taken every 8 hours for anxiety.

Observation of the immediate surroundings, from the SCU's main door to the hall in the ALU, on 8/31/15 at 1:45 p.m., revealed:
- The distance from the main door to the hall was approximately 20 ft.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 44 - There was a bathroom and an alarmed, exit door, in the hall. - An alarmed, exit door led out to the outside. Observation of the hallway outside, near the SCU's main entrance, on 8/31/15 at 2:30 p.m., revealed that the exit door opened onto a paved sloping parking lot and drive that meets a busy, four lane street approximately 30 feet from the exit door. Interview with Resident #4's private sitter agency owner, on 8/31/15 at 10:42 a.m., revealed: - Sitter services were provided to Resident #4 at the facility's request starting 8/11/15 at 7:30 p.m. - The sitter service continued 24 hours a day from 8/11//15 through 8/15/15, at 8:00 a.m. - The sitter service was provided again on 8/15/16 and 8/16/15 from 8:00 a.m. to 8 p.m. - On 8/17/15 the sitter service was provided from 8:00 a.m. until 12:30 p.m. when the facility told the agency they were no longer needed. - The sitter service was called on 8/19/15 to re-instate sitter service for Resident #4; which started at 8/19/15 at 7:15 p.m. and continued into 8/20/15 until the resident was discharged. - Agency records revealed Resident #4 was served by 4 sitters who documented 4 exit seeking behaviors while on duty. Resident #4 was observed attempting to exit Reminiscence Door 126, reporting he was "going to get the mail." Resident #4 was also observed standing in front of Reminiscence Door 126 on 3 occasions, pushing buttons on the keypad. - The resident was "easily" redirected all 4 times he displayed exit seeking behaviors. Resident did not understand why he had a sitter; but was not resistant or aggressive towards sitters.	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 45 Interview with Resident #4's family member, on 9/2/15 at 3:15 p.m., revealed: - The afternoon of 8/19/15, the facility called the family to advise that Resident #4 had gotten off of the unit and found in the hallway outside of the SCU. - The facility didn't know how he got out; they suspected that he might have gotten out during visitors comings and goings. - The FM suspected that the SCU's entrance door wasn't latching on and the resident was able to get out. - The visitors have to ring the bell to get in & out of the SCU and staff had to key in code on the keypad so the staff would have been standing by the door. - The facility advised the family that a sitter had been put in place again until the resident left the facility. - The resident was moved to a new SCU on 8/20/15. Interview with 3rd DCM, on 8/31/15 at 2:49 p.m., revealed: - Resident #4 had been agitated every day since moving to the SCU late July 2015. - The resident frequently requested to go home to see his family member (who resided in the facility), and went to doors seeking to exit. - During 2nd shift, the resident would constantly push the exit doors, sounding alarms until it's time to go to bed. - Since the resident came to the SCU, the former life enrichment manager (LEM) did one-on-one activities like walking, cleaning kitchen with staff (sometimes) or gardening (like 3 times a week) but his limit was like an hour or so and he'd look for his wife. - There were set of activities the resident was	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 46	{D 270}		

encouraged to participate in but he'd refuse to do them.
- The resident had a sitter on 8/15/15 and 8/16/15 from
8 p.m. to 8 a.m. The staff stated a sitter was not needed at night; because the resident was not active during those hours. He was most active between 8 a.m. and 8 p.m. A sitter was not working with Resident #4 after 8/16/15.
- The day of and the day before the 8/19/15 incident with Resident #4., he had paced up and down the hallway outside the SCU main exit door, and repeatedly pushed the buttons on the keypad, and then pulling on the door. He was not able to be redirected, and refused puzzles and engagement in other activities. They were monitoring resident while pacing and pushing the keypad.
- On 8/19/15 2nd shift, there were 3 staff on the SCU. She was the Lead Care manager.
- Approximately 4:00 p.m., she and one staff went to provide personal care to a resident who was a two-person assist. There are 4 residents on the SCU who are two person assist.
- The third staff was in the activity room near the main exit door, working with the rest of the residents.

Interview with 5th DCM, on 8/31/15 at 2:58 p.m. revealed:
- Resident #4 had been exit seeking daily since his move from Assisted Living to SCU. He frequently expressed the desire to see his wife and wanting to get out of the SCU to find his wife.
- The day of and the day before the 8/19/15 incident with Resident #4., he had paced up and down the hallway outside the SCU main exit door. He observed staff using the keypad to go in and out the door. He repeatedly pushed the buttons on the keypad at the main exit door, and then

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 47	{D 270}		

pushed on the door repeatedly, attempting to get it open. Resident was agitated and expressing his desire to get out to see his wife.
- He was not responsive to attempts to redirect him with games and activities, the staff kept an eye on him" while he went up and down the hall. The resident no longer had sitters on that date; she did not know why he no longer had a sitter.
- The staff was responsible for monitoring the main area and main exit door while staff were assisting a residents requiring 2 person assistance on the afternoon of 8/19/15.
- An outside staff brought a resident and her family through the door, returning her to the SCU. Resident #4 had been back and forth outside the main SCU door just before the resident and family entered. She did not see him at the door when they came in.
- She was monitoring the SCU main entrance, but was also assisting other residents in her care, and was not able to keep her attention consistently on the door. She "guessed " that Resident #4 went out the door behind whatever staff form AL opened the door for the entering family, because it was minutes later that she observed staff bringing Resident #4 from the hallway back into the unit.

Interview with HCC, on 8/31/15 at 12:35 p.m., revealed:
- The three options, per policies and procedures, for a resident in the SCU for increasing supervision were engaging the resident in programming, using a wander- guard, or hiring one-on-one (1:1) supervision.
- After Resident #4's elopement from the SCU on 8/11/15, the ALC and Administrator determined programming would not be effective as the resident's elopement attempts typically occurred approximately 6 p.m. when no specific

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 48	{D 270}		

programing was available. The major activities were at that time were dinner and getting residents back to their rooms and preparing for bed. A wander-guard would not have been effective, as it only alarms the facility's main exit doors, and would not alarm if the resident exited a SCU door.
- A 1:1 sitter was in place by the evening of 8/11/15, and was to continue 24/7 until it was determined it was no longer needed. The payment for the sitter is not facilitated or arranged by the ALC. She was not aware of those policies and procedures.
- During the time Resident #4 was in the SCU, he repeatedly expressed a desire to go home and to see his family member.
- The ALC's understanding why the sitter's hours were reduced and then stopped was due to "financial" reasons. The sitter was to have been at the SCU on 8/15/15 and 8/16/15 form 8 a.m. to 8 p.m. The order was mixed up, and the sitter came 8 p.m. to 8 a.m. on both days.

Interview with the Executive Director (ED), on 8/31/15 at 3:30 p.m., revealed:
- Resident #4 was doing well at least 4 days after 8/11/15 elopement incident.
- The ED felt that the resident needed a sitter for 24 hours.
- The ED and their clinical staff were trying to reduce his anxiety/agitation level.
- If the resident had exit seeking behaviors, they were documented on the facility's Behavior Log; he had a few documentation on the behavior log.
- The HCC and the clinical staff felt that the resident seemed to be engaged in activities and decided as a group to remove the sitter.
- On 8/19/15, the resident was very agitated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 49 3. Review of Resident #11's current FL-2 dated 6/8/15 revealed: -Resident #11 had a diagnosis of dementia. -Documented under "Disoriented" was intermittently. -Documented under "Ambulatory" was semi-ambulatory with a rolling walker. -Documented under admission date was 4/02/10 Review of Resident #11's current Care Plan dated 7/8/15 revealed: -Resident is forgetful. Please check on resident hourly at night. Resident does not sleep well at night and will get up and start wandering the community. Please redirect back to the room when you see her up wandering around the community at night. -Resident required monitoring and redirection because she wandered inside the facility. Review of the Facility's Incident Report for Resident #11 dated 6/28/15 at 11:30 p.m. revealed: -Resident #11 was still inside the facility. -Resident #11 was found in the entryway which connected the front lobby door and the outside door. -Resident #11 was trying to get back into the lobby. Review of the facility's door alarm log dated 6/28/15 from 11:30:28 p.m. to 11:30:40 p.m. (18 sec.) revealed: - Resident #11 pushed the front lobby door which triggered the alarm and opened the door. -Staff found Resident #11 in the entryway between the lobby door and the outside door. Observation of Resident #11's wrist on 9/1/15 at	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 50 10:45 a.m. revealed no placement of a Wander Guard. Interview with Resident #11 on 9/1/15 at 10:45 a.m. revealed she did not have to be supervised outside of the facility. Telephone interview with Resident #11's family member on 9/4/15 at 10:45 a.m. revealed: -She was aware that Resident #11 had been enclosed in the entry way door on 6/28/15. -Staff reported Resident #11 was requiring more redirection and becoming more confused. Interview the 1st medication aide on 9/1/15 at 11:00 a.m. revealed: -Resident #11 wandered in the facility, but not outside. -Staff monitored Resident #11 every hour. Interview with 1st personal care aide on 9/1/15 at 11:15 a.m. revealed: -Resident wandered in the hallway, but not outside. -Staff monitored Resident #11 every hour. Interview with the Health Care Coordinator (HCC) on 9/3/15 at 3:00 p.m. revealed: -She was aware of the incident report for Resident #11 dated 6/28/15 at 11:30 p.m. - Resident #11 pushed the front lobby door which triggered the alarm and opened the door. -Staff found Resident #11 in the entryway between the lobby door and the outside door. -Resident #11 was trying to get back into the building. -Staff reported Resident #11 wandered in the community at night. -The front entrance door was alarmed between the hours of 8:00 p.m. and 8:00 a.m.	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 51 -The concierge was at the front entrance desk between the hours of 8:00 a.m. and 10:00 p.m. -The staff were instructed to check on Resident #11 every hour at night. Interview with the Executive Director (ED) on 9/03/15 at 3:30 p.m. revealed: -She was aware of the incident report for Resident #11 dated 6/28/15 at 11:30 p.m. -Resident #11 was found in the front entry way doors trying to get inside the building. -The staff were instructed to check on Resident #11 every hour at night. -No specified hours were given. -The front entrance door was alarmed between the hours of 8:00 p.m. and 8:00 a.m. -The concierge was at the front entrance desk between the hours of 8:00 a.m. and 10:00 p.m. Review of Resident #11's physician's "Visit Summary" dated 9/2/15 revealed: -Dementia: continue the supportive care in the assisted living facility. -Patient with ongoing, confusion, disorientation and increased risk for wandering behaviors. -Would recommended a Wander Guard at this time and may need to consider a secured living environment in the future. Observation of Resident #11's right wrist on 9/3/15 at 10:30 a.m. revealed she had a Wander Guard placed on her wrist. Interview with Resident #11 on 9/3/15 at 10:30 a.m. revealed she did not know why a bracelet had been placed on her right wrist. Interview with 2nd medication aide on 9/3/15 at 11:00 a.m. revealed: -Resident #11 was wearing a Wander Guard.	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 52 -The Designated Care Manager was responsible for checking for the placement of the Wander Guard on Resident #11's wrist at least once a shift. -Resident #11 wandered inside the building, but not outside. -Resident #11 should be monitored every hour. Interview with 2nd personal care aide on 9/3/15 at 11:20 a.m. revealed: -Resident #11 was wearing a Wander Guard. -She checked the placement of the Wander Guard on Resident #11's wrist at least once on per shift. -She monitored Resident #11 every hour. Interview with 3rd medication aide on 9/3/15 at 3:15 p.m. revealed: -Resident #11 was wearing a Wander Guard. -The Designated Care Manager (DCM) checked the placement of the Wander Guard on Resident #11's wrist at least once per shift. -Resident #11 was monitored from 30 minutes to an hour. -Resident #11 was confused and had to be redirected. -Resident wandered in the building, but she did not go outside unsupervised. Interview 3rd personal care aide on 9/3/15 at 3:45 p.m. revealed: -Resident #11 was wearing a Wander Guard. -She checked the placement of the Wander Guard on Resident #11's wrist at least every shift. - Resident #11 was confused and disoriented. -She monitored Resident #11 at least every hour per shift. Telephone interview with Resident #11's family member on 9/4/15 at 10:45 a.m. revealed:	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 53 -Staff reported Resident #11 was requiring more redirection and becoming more confused. - She had been made aware of Resident #11 wandering in the facility. -On 9/02/15, a Wander Guard had been recommended by the team. -Eventually, Resident #11 may need a more secured unit in the facility. Interview with the Physician Assistant's (PA) on 9/4/15 at 11:30 a.m. revealed: -He had been made aware of Resident #11 wandering in the facility. -Staff reported Resident #11 was requiring more redirection. -He decided to write an order for the Wander Guard on 9/2/15 after he observed Resident #11 wandering in the hallway. -Eventually, Resident #11 may need a more secured unit in the facility. Interview with the Health Care Coordinator (HCC) on 9/4/15 at 2:00 p.m. revealed: -Resident #11 wandered inside the building. -On 9/2/15, the team just decided it was time for the placement of the wander guard on Resident #11. -There was no change in Resident #11's level of confusion. -The assigned staff was responsible for checking placement of the Wander Guard on Resident #11's wrist every shift. -The assigned staff should monitor Resident #11 every hour. Interview with the Executive Director (ED) on 9/4/15 at 3:30 p.m. revealed: -Resident #11 wandered inside the building. -On 9/2/15, the team came to the decision that Resident #11 required a Wander Guard to	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 54	{D 270}		

monitor her exit seeking behavior.
-Resident #11 had no major incidents of exit seeking behaviors.
-The assigned staff was responsible for checking placement of the Wander Guard on Resident #11's wrist.
-The assigned staff should monitor Resident #11 every hour.

4. Review of the current FL-2 dated 7/20/15 for Resident #12 revealed:
- The resident was admitted on 8/29/12.
- Diagnoses of Alzheimer's Dementia, History of paroxysmal atrial fibrillation of the heart, hypertension, osteoarthritis, and gastro-esophageal reflux disorder.
- The FL-2 listed the resident as constantly disoriented.
- The resident was listed as semi-ambulatory with a walker.
- There was no information related to wandering.

Review of the Resident Register dated 8/30/12 revealed Resident #12 had a memory assessment of being forgetful - needing reminders.

Review of Resident #12's Individualized Service Plan (ISP) / Assessment and Care Plan dated 3/20/15 included:
- Resident #12 was listed as having Alzheimer's Dementia and difficulty walking.
- The Socialization Section of the form listed the resident as having a sleep pattern of frequently being up at night because she was confused.
- The Direct Care Manager (DCM) was to orient the resident to time so the resident could rest at those times.
- The Memory Cognition and Approach Section documented:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 55 The resident was listed as needing assistance by staff for outings. Assistance was required due to "... a history of dementia which is a loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgement, and behavior." The resident was listed as oriented to person only and was only oriented to time with extensive cueing. The DCM was to orient the resident as to place and when necessary, escort Resident #12 to and from meals, activities, socials and outings. DCM was to anticipate the resident's needs because at times the resident was confused and may or may not require assistance. - The Safety Section rdocumented the resident was not at risk for elopement. Review of the facility's "Behavioral, Intermittently Confused, or Diagnosis of Dementia Residents" list dated 5/5/15 maintained at the first floor front desk entrance exit area with the concierge revealed Resident #12 was on the list. Review of physician notes dated 7/09/15 revealed the resident had been having increased distress and paranoia regarding fear of someone trying to kill her for the last several months. Review of facility Progress Notes for Resident #12 revealed an increased period of confusion due to a urinary infection: - 4/01/15 Resident seen today for more pronounced confusion. - 4/02/15 Resident became upset when asked questions and showed signs of confusion. - 4/03/15 Resident still had some confusion. - 4/04/15 Resident walking around with her normal amount of confusion. - 4/09/15 Resident was at baseline of confusion.	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 56 There were no facility notes or other documentation related to increase supervision and assistance of Resident #12 for disorientation when out of the facility according to her current assessed needs on her ISP. Interview on 9/03/15 at 9:30 a.m. with a medication aide (MA) revealed: - Resident #12 was confused and disoriented. - The resident could participate with resident activities. - The resident had a routine of going back and forth to her room (on the third floor), and on the second floor the activity room and the dining room. Observation on 9/03/15 at 9:52 a.m. of Resident #12 revealed: - The resident was out in the second floor garden area next to a row of bushes that backed up to a fence across the entire back length of the garden. - The garden area was not a secured area. - There was not a gate or fence on either end of the large garden area. - One side of the unsecured garden led to a back of the facility parking area. - The other end of the unsecured garden area led to a very busy city street. - The resident was seated in front of the bushes near the back of the garden on a large bench alone. - No staff members were observed in the living room, hallway, on the patio nor in the garden area observing Resident #12. - One staff person was observed across the hall from the living room in an eating area. - The staff member was calling a BINGO game and was surround by many residents and could not see the resident from her sitting position.	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 57 - The resident was observed to easily walk with a walker from the back of the garden and through the door of the large living room. - No door alarm sounded. Interview on 9/03/15 at 10:10 a.m. with Resident #12 revealed: - The resident was slightly hard of hearing. - The resident was spoken to with a sufficiently loud voice for her to hear and answer the questions. - The resident said she liked to sit outside in the garden. - The resident did not know what day it was nor where she was and kept asking where all the people were. - The resident was not able to be interviewed further. Observation of Resident #12 on 9/03/15 at 10:26 a.m. revealed: - Resident #12 was walking rapidly down the second floor hall to the elevator. - The resident got on the elevator and went directly to her third floor room and shut the door. - No staff were assisting/supervising the resident at this time. Observation on 9/03/15 at 4:50 p.m. of Resident #12 revealed: - The resident had come down to the second floor with no staff assisting her. - The resident was walking rapidly up the 200 hall with her walker and went to the end of the hall and around a corner to the computer area. - The resident was in the computer area for 3 - 4 minutes when a staff person redirected her to the dining room. Interview on 9/03/15 at 2:20 p.m., with the	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 58 supervisor-in-charge (SIC) on the third floor revealed: - Resident #12 can do a lot for herself with Activities of Daily Living (ADL). - The resident needed reminders for the meals; the resident can go to the dining room (2nd floor) and order meals by herself. - Resident #12 has "sundowning" behaviors, especially late in the evening like 8-9 p.m. - Resident #12 thought someone was going to hurt her; says her family member ws dead if she did not visit for awhile, but the family member comes at least once or twice a week. - Resident #12 had no wander-guard; did not have exit seeking behaviors. - The resident did not require extra supervision or checks. - All residents get every 2 hour checks. - The SIC was not aware of any incident in 2015 that Resident #12 went outside the facility building. Interview with the MA on the third floor, on 9/3/15 at 2:30 p.m. revealed: - Resident #12 was independent with ADLs like toileting, dressing, eating or grooming about 4-5 months ago, but a month ago her knee started to bother her so she required some assistance now. - Resident #12 has had confusion depending on the day. - The resident would ask "What's wrong with me? This is not old [first name] I used to be, I think I'm getting old." - The resident always knew how to get to the dining room & to the bedroom. - On some days, the resident needed reminders during meal times. - The staff checked on the residents who were declining mentally, in their rooms, at shift changes, during medication passes and hydration	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 59	{D 270}		

time.
- The staff use a "daily log" to document changes with the resident conditions; all staff can document on the log.
- The MA was not aware if the resident wore wander-guard.

Interview on 9/3/15 at 3:20 p.m. with a Wellness Nurse revealed:
- Resident #12 had been known to walk the circular paved pathway in the second floor garden about two times per week.
- The resident was known to be able to walk in and out to the garden on her own and back and up to her room on third floor without supervision.
- The resident had been known to stay on the walking path and not wander off of it while in the garden.
- The nurse did not realize the resident was observed sitting in and walking in the back of the garden near the fence that led to the two unsecured exits of the garden.
- The resident had not gotten out of the garden area on either side of the unsecured garden.
- She did not know of any supervision currently needed for this resident when out in the unsecured garden area.
- She was not aware of any disorientation in Resident #12.
- She was not aware the resident's supervision did not match her assessed needs of constantly disoriented.

Interview on 9/03/15 at 3:30 p.m. with a second floor evening shift MA revealed:
- Resident #12 was a little confused.
- The resident walked independently around on the third floor where she lived and came down to the second floor for meal times.
- She sometimes visited the first floor area and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 60	{D 270}		

sometimes followed staff around on the halls.
- She was redirected at these times but was not supervised for disorientation.
- She was not aware the resident was listed as disoriented and would need a system of supervision due to the door alarm systems at the doorways leading to the unsecured garden would not be activated until dark.

Interview on 9/03/14 at 3:40 p.m. with the Activity Director revealed:
- Resident #12 came down to the second floor alone and did not require supervision for disorientation.
- The doors from the activity living room and the enclosed patio room off of the dining room did not have door alarms.
- Resident # 12 had not been seen today and had never been noted to be on the grass in the garden, she just walked on the concrete path.

Interview on 9/3/15 at 4:20 p.m. with the Executive Director (ED) revealed:
- Resident #12 had hearing loss.
- Staff speak of the resident and her routines; she had no exit seeking behavior.
- The resident did not seem confused. She had a purpose on going out.
- Resident was known to walk a lot out back in the garden area a few times per day, morning and afternoon
- The resident "...could sign out and walk without being supervised.".
- She was not aware of supervision of Resident #12 due to disorientation when outside of the facility in areas leading to the unsecured garden and when door alarms were not active in the daytime.
- The door alarms on the patio and sunroom

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 61 doors were only alarmed at 8 p.m. - 8 a.m. and then when doors were opened it went to staff pagers and there was no alarm heard. - The ED said there was not a system of supervision for disoriented residents where door alarms were not activated leading to unsecured areas such as the garden accessed by activity room and dining room areas. - She would work out a system of supervision for when Resident #12 came down from her room on the third floor to the second floor to go out to the garden. - Resident #12 would be checked on more frequently. Interview on 9/03/15 at 5:10 p.m. with the Lead Care Manager (LCM) revealed: - Staff were to use the resident's ISP and notes in the daily log to determine how to care and supervise residents. - The LCM thought since Resident #12 had a walker she should not go out of the facility without assistance. - The resident goes down to the second floor for activities and to go out to garden area. - The resident can go to all of the floors and knew how to return to her room. - The resident was not an elopement risk, there were no signs such as trying to go to the door to go home. - She had nite time delusions and paranoia now. - The resident's mind would be "off sometimes" and she would be talking like her husband was there. - Staff would not have to watch her while outside the facility on the front porch on the first floor or the garden on the second floor. - There was no increased checks on the resident because she was listed as disoriented. - She was checked, as all residents were, every	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 62 2 hours. Attempt telephone interview on 9/04/15 at 9:13 a.m. with a family member of Resident #12's revealed they were unavailable for interview. Interview on 9/04/15 at 10:40 a.m. with the Health Care Coordinator (HCC) revealed: - The HCC was not worried about elopement for Resident #12. - The resident had a routine of going from her room to the dining room to the activity room. - Resident #12 only went on the first floor accompanied by her family or staff. - The HCC did not see Resident #12 as a person who was disoriented. - The resident appeared disoriented when spoken to because the resident was hard of hearing. - The resident had not been exit seeking. - The resident did not need a lot of supervision. - Nothing had been put in place for supervision for Resident #12. Based on observation, interview and record review, Resident #12 was not being supervised based on the resident's assessed needs when exiting to the unsecured garden area. _____ Plan of Protection, received from the Executive Director, dated 9/1/15, revealed: - To prevent falls, assess appropriate residents for therapy services. - Implement toileting schedules for appropriate residents. - In-service team for gait and transfer training. - Increase frequent checks on residents that are high risk for falls and resident with disorientation .	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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 63 - Review residents at risk for falls in morning meeting with in house therapy director and update ISP. - Behavior logs will be brought to morning meeting for daily reviews. - Prevent elopement by scheduling activities in small groups and 1 to 1. - Re-train on behavioral log tracking to identify residents with exit seeking behaviors. - Re-train team when exiting the secured unit to do a 360 turn to ensure the area is clear of residents and that the door is secured. - If a resident is wandering, a care manager or team member would notify the appropriate coordinator and document on daily log. - The team member will increase frequent checks on identified residents with disorientation and try to obtain U/A to rule out infection. - The managers will identify if the resident needs wander guard, sitters, or immediate placement to a secure neighborhood. - If there is no availability in house, we will contact our sister communities.	{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 regulations. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure each resident received care and services which were adequate, appropriate, and in compliance with relevant	{D912}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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
{D912}	Continued From page 64 federal and state laws and rules and regulations related to activation of and operating condition of door alarm systems. The findings are: 1. Based on observation, interview and record review, the facility failed to assure in homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents had the alarm alert system device activated when the door was opened for two of two sampled residents with disorientation and wandering. (#11, #12). [Refer to Tag D067 10A NCAC 13F .0305 (h) (4) (a) Physical Environment (Type B Violation)]. 2. Based on observation, interviews and record review, the facility failed to ensure the locking mechanism for 1 of 2 exit doors (REM Door by 126), in the special care unit to the outside, was maintained in a safe and operating condition resulting in 1 resident exiting the building without staff knowledge. (Resident #4). [Refer to Tag D0105 10A NCAC 13F .0311 (a) Other Requirements (Unabated 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 interview, observation, and record review the facility failed to assure residents were free from neglect as related to and personal care and supervision. The findings are:	{D914}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092108	A. BUILDING: _____ B. WING _____	R-C 09/04/2015

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
{D914}	Continued From page 65 Based on observation, interview and record review, the facility failed to ensure supervision of residents was provided in accordance with each resident's required need, resulting in a fall with injury for 1 of 12 sampled (#3) residents and wandering including elopement for 3 of the 12 sampled (#4, #11 and #12) residents. [Refer to Tag D270 10A NCAC 13F .0901(b) Personal Care and Supervision (Unabated Type A2 Violation)].	{D914}		

Sunrise Senior Living
Plan of Correction

Name of Community: Sunrise at North Hills
Address: 615 Spring Forest Road
License number: HAL-092-108
Inspection date(s): 9/1/15-9/4/15
Name and Title of Sunrise Representative Signing the Plan of Correction: Andrea Nobis Executive Director

Signature of Sunrise Representative: Andrea Nobis
Date of Submission: 10/15/15

Regulation	Target Date by Which Correction will be completed	Plan of Correction
10A NCAC 13F.0305 (h) (4) Physical Environment		**A. With respect to the specific resident/situation cited:** Residents #11 and #12 still reside in the community. Residents #11 and #12 experienced no negative outcomes while living in Assisted Living.
In homes with at least one resident who is determined by a physician or ins otherwise know to be disoriented or a wanderer, each exit door accessible by residents shall be	9/21/15 and ongoing	Second floor courtyard and dining room doors have been alarmed between 8am and 8pm. These doors are locked between 8pm and 8am. Only a staff member can disengage a locked door. In addition, the magnetic lock, which is part of the wander guard system, has been activated on the door from the activities room to the open courtyard. (POP dated 9/21) We are meeting with DHSR and the fire marshal on Tuesday October 13th to discuss locking the front door. The front door has a paging system whenever opened or closed and a wander guard system.
equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that is can be heard by all staff. If a central system of remote sounding devices is provided, the control panel for	9/2/15	Resident #11 has a wander guard and has private duty aides (PDAs) in place during the hours when resident typically or more likely exhibits wandering behavior. Resident was transferred to the SCU on October 7th. Resident # 12 is on the internal transfer list to move to the SCU, however is not exit seeking or wandering at this time.

Received and accepted 10/15/15 RN

Responses on the enclosed plan of correction do not constitute an admission or agreement of the truth of the facts alleged or the conclusion set forth in the regulatory report. The responses are prepared solely as a matter of compliance with law.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel.		
	9/18/15 and ongoing	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The Interdisciplinary Team reviewed residents who were/are at risk for potential exit seeking and/or elopement behaviors and ensured that their Individualized Service Plans (care plans) included individualized strategies and interventions to address these behaviors. Residents' primary care physicians and mental health professionals were contacted as appropriate for additional guidance, to discuss potential medication changes, and to confer regarding additional non-medicinal approaches. ISP revisions/supplements revisions are added to the care plan by the Resident Care Director and Care Coordinators, and additional guidance for the care managers is communicated by the Coordinators to the care team via daily communication venues.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		C. With respect to what systemic measures have been put into place to address the stated concern:
	9/18/15 and ongoing	Refresher training for the care team regarding the process for completing the behavioral log which is used to identify and communicate exit seeking and / or wandering behavior was conducted by the Resident Care Director and the Assisted Living Coordinator.
	9/18/15 and ongoing	The care team has been re trained on the protocol for responding to a resident demonstrating elopement exit seeking or wandering behaviors. This training was conducted by the Resident Care Director and Assisted Living Coordinator and included: • If a resident is exhibiting wandering behavior staff will notify appropriate coordinator and document. The care team will increase the frequency of checks on the residents demonstrating such behaviors. • The care team will try to obtain a U/A in accordance with a physicians order to rule out an infection. • The Care Coordinator in conjunction with RCD and ED will identify if the resident needs a wander guard, PDAs, or immediate placement in the SCU. • If there is no availability at the North Hills SCU, ED or Designee will contact our sister communities to find an appropriate opening, in partnership with family members/responsible parties and the physicians. (POP dates 9/1) The ED, the MC, and the RCD will review the front desk resident alert book on a weekly basis to ensure it is accurate and current and that there is consistency between the notebook and care plans.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
	9/23/15 and ongoing	**D. With respect to how the plan of correction will be monitored:** The ED 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 Quality Assurance /Performance Improvement Meetings and action initiated, if required.
10 NCAC 13 F .0311 (a) Other Requirements The building and all fire safety, electrical, mechanical, and plumbing equipment in adult care home shall be maintained in a safe and operating condition.	9/21/15	**A. With respect to the specific resident/situation cited:** Resident # 4 no longer resides in the community. Resident # 4 experienced no negative outcomes as a result of the incident. Doors have been alarmed between 8am and 8pm. Doors are locked between 8pm and 8am. Only a staff member can disengage a locked door. (POP dated 9/21)
	9/21/15 and ongoing	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The Lead Care Manager will check all the SCU doors (Including the door into AL, the external doors to enclosed courtyard, and doors to the outside) 2 times per shift to ensure

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		they are locked. (POP dated 9/21) Oversight of the check process performed by the Lead Care Managers will be conducted by the MC, the Care Coordinators, and the Manager on Duty, to confirm checks are occurring and identified issues are resolved.
	8/11/15 and ongoing	**C. With respect to what systemic measures have been put into place to address the stated concern:** Care Managers, Life Enrichment Managers, and Care Coordinators received refresher training regarding: • How to properly check the functionality and operation of the doors in SCU to ensure they remain locked and alarmed. • How the over - ride switch works, how to reset the switch and when it is acceptable to activate the over – ride switch. • Missing resident and elopement procedures including communication, notification protocols, and action and deployment steps. The refresher training was conducted by the Maintenance Coordinator. This training is also conducted in new team member orientation. The ED and AED are making unannounced and routine rounds to ensure compliance with pager and alarm response and door checks by Care Managers, Lead Care Managers, and Coordinators to ensure doors are in operation mode and to address and resolve any issues that may be observed. The Maintenance Coordinator is conducting walking rounds and meeting with the Coordinators and LCMs, jointly checking paging and alarm equipment two times per week, and

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		discussing the results with the ED. The ED reviews the information and makes necessary changes and/or initiates further training if necessary. Equipment is being repaired or replaced as needed by the MC and the MC is ensuring that extra pager batteries are available and accessible for the Care Managers at all times. In addition, as an ongoing means to identify residents with the potential for exit seeking or elopement behaviors, the Interdisciplinary Team meets two or three times a month to discuss residents who are at risk, and to initiate action and provide direction and guidance to team members regarding these residents. This meeting includes focused discussions regarding individual residents as needed. The discussion at Interdisciplinary Team Meetings includes a review of daily communication; concerns and observations from care managers on all shifts, Wellness Nurses, and observations gathered by the Care Coordinator; a review of any incidents that have occurred; a review of feedback and/or progress notes from medical, mental, and other health care professionals and partners; and concerns and suggestions from families.
		D. With respect to how the plan of correction will be monitored: The ED 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 Quality Assurance /Performance Improvement Meetings and action initiated, if required.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
10A NCAC 13F .0901 (b) Personal Care and Supervision Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.	9/2/15	**A. With respect to the specific resident/situation cited:** Resident # 3 no longer resides in the community and moved to a skilled nursing facility. Resident #11 has a wander guard and has private duty aides (PDAs) in place during the hours when resident typically or more likely exhibits wandering behavior.. Resident was transferred to the SCU on October 7th. Resident # 12 is on the internal transfer list to move to the SCU, however is not exit seeking or wandering at this time.
	9/18/15	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The interdisciplinary team reviews residents at risk for elopement behaviors or falls in the morning leadership meeting, which includes the therapy director. The discussion includes generating additional interventions, discussing potential assistive devices, and initiating therapy screens or assessments if needed. The ID team reviews incident reports during the meeting implements supplemental interventions, and updates ISPs. Behavioral logs and related notes are also being reviewed at this meeting (POP dated 9/1) The Interdisciplinary Team reviewed residents who were/are at risk for potential falls, exit seeking and/or elopement behaviors and ensured that their Individualized Service Plans

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		(care plans) included individualized strategies and interventions to address these issues and behaviors. Residents' primary care physicians and mental health professionals were contacted as appropriate for additional guidance, to discuss potential medication changes, and to confer regarding additional non-medicinal approaches. ISP revisions/supplements are added to the care plans by the Resident Care Director and the Care Coordinators and guidance and updated instructions are communicated by the Coordinators to the care team via daily communication venues.
	9/18/15 and ongoing	**C. With respect to what systemic measures have been put into place to address the stated concern:** Key components of the falls management program: • RCD or Care Coordinator will refer residents to be assessed for therapy services, as appropriate. • Implement individualized toileting schedules for residents as appropriate. • Set up training with Therapy Services for the Care Managers regarding assisting residents with gait issues and to demonstrate transfer techniques • Increase frequent checks on residents who are at high risk for falls. (POP dated 9/1) • Coverage in the main, satellite, and bistro areas has been reviewed, including ensuring a TM remains in the area at all times, while a resident or residents are eating. These components of the falls management program have

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		been reviewed and discussed with care managers, med techs, nurses, LEMs by the RCD, ALC, and RC. As an ongoing means to identify residents with the potential for experiencing falls /exit seeking/ elopement behaviors, the Interdisciplinary Team meets two or three times a month to discuss residents who are at risk, and to initiate action and provide direction and guidance to team members regarding these residents. This meeting includes focused discussions regarding individual residents as needed. The discussion at Interdisciplinary Team Meetings includes a review of daily communication; concerns and observations from care managers on all shifts and observations gathered by the Nurses and Care Coordinators; a review of any episodes or incidents that have occurred; a review of feedback and/or progress notes from medical and other health care professionals and partners; and concerns and suggestions from families.
		D. With respect to how the plan of correction will be monitored: The Executive Director and the RN Resident Care Director provide oversight of the admission process, the care planning process and care plan meetings; review resident behaviors, falls, and other incidents, and episodes for potential supplemental interventions; observe and interact with residents at risk, and promote the involvement of Mental Health Professionals and Primary Care Physicians as needed. The ED 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 Quality Assurance /Performance Improvement Meetings and action initiated if required.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
G.S 131D-21)2) Declaration of Residents' Rights: Every resident shall have the following rights: 2. To receive care and services which are adequate and appropriate, and in compliance with relevant federal and state laws and rules and regulations.	9/21/15 and ongoing 9/2/15	**A. With respect to the specific resident/situation cited:** Residents #11 and #12 still reside in the community. Residents #11 and #12 experienced no negative outcomes while living in Assisted Living. Second floor courtyard and dining room doors have been alarmed between 8am and 8pm. These doors are locked between 8pm and 8am. Only a staff member can disengage a locked door. In addition, the magnetic lock, which is part of the wander guard system, has been activated on the door from the activities room to the open courtyard. (POP dated 9/21) We are meeting with DHSR and the fire marshal on Tuesday October 13th to discuss locking the front door. The front door has a paging system whenever opened or closed and a wander guard system. Resident #11 has a wander guard and has private duty aides (PDAs) in place during the hours when resident typically or more likely exhibits wandering behavior. Resident was transferred to the SCU on October 7th. Resident # 12 is on the internal transfer list to move to the SCU, however is not exit seeking or wandering at this time.
	9/18/15 and ongoing	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The Interdisciplinary Team reviewed residents who were/are at risk for potential exit seeking and/or elopement behaviors and ensured that their Individualized Service Plans (care plans) included individualized strategies and interventions to address these behaviors. Residents' primary care physicians and mental health professionals were contacted as appropriate for additional

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		guidance, to discuss potential medication changes, and to confer regarding additional non-medicinal approaches. ISP revisions/supplements revisions are added to the care plan by the Resident Care Director and Care Coordinators, and additional guidance for the care managers is communicated by the Coordinators to the care team via daily communication venues.
		C. With respect to what systemic measures have been put into place to address the stated concern:
	9/18/15 and ongoing	Refresher training for the care team regarding the process for completing the behavioral log which is used to identify and communicate exit seeking and / or wandering behavior was conducted by the Resident Care Director and the Assisted Living Coordinator.
	9/18/15 and ongoing	The care team has been re trained on the protocol for responding to a resident demonstrating elopement exit seeking or wandering behaviors. This training was conducted by the Resident Care Director and Assisted Living Coordinator and included: • If a resident is exhibiting wandering behavior staff will notify appropriate coordinator and document in the daily log. • The care team will increase the frequency of checks on the residents demonstrating such behaviors. • The care team will try to obtain a U/A in accordance with a physicians order to rule out an infection.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		• The Care Coordinator in conjunction with RCD and ED will identify if the resident needs a wander guard, PDAs, or immediate placement in the SCU. • If there is no availability at the North Hills SCU, ED or Designee will contact our sister communities to find an appropriate opening, in partnership with family members/responsible parties and the physicians. (POP dates 9/1) The ED, the MC, and the RCD will review the front desk resident alert book on a weekly basis to ensure it is accurate and current and that there is consistency between the notebook and care plans.
	9/23/15 and ongoing	**D. With respect to how the plan of correction will be monitored:** The ED 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, on a weekly basis. The Executive Director or designee is responsible for ensuring the status of this Plan of Correction is reviewed and discussed at Quality Assurance /Performance Improvement Meetings and action initiated, if required. This is done on a weekly basis.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
In reference to the unabated type B violation	9/21/15 and ongoing	**A. With respect to the specific resident/situation cited:** Resident # 4 no longer resides in the community. Resident # 4 experienced no negative outcomes as a result of the incident. Doors have been alarmed between 8am and 8pm. Doors are locked between 8pm and 8am. Only a staff member can disengage a locked door. (POP dated 9/21)
	9/21/15 and ongoing	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The Lead Care Manager will check all the SCU doors (Including the door into AL, the external doors to enclosed courtyard, and doors to the outside) 2 times per shift to ensure they are locked. (POP dated 9/21) Oversight of the check process performed by the Lead Care Managers will be conducted by the MC, the Care Coordinators, and the Manager on Duty, to confirm checks are occurring and identified issues are resolved.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
	8/11/15 and ongoing	**C. With respect to what systemic measures have been put into place to address the stated concern:** Care Managers, Life Enrichment Managers, and Care Coordinators received refresher training regarding: • How to properly check the functionality and operation of the doors in SCU to ensure they remain locked and alarmed. • How the over - ride switch works, how to reset the switch and when it is acceptable to activate the over – ride switch. • Missing resident and elopement procedures including communication, notification protocols, and action and deployment steps. The refresher training was conducted by the Maintenance Coordinator. This training is also conducted in new team member orientation. The ED and AED are making unannounced and routine weekly rounds to ensure compliance with pager and alarm response and door checks by Care Managers, Lead Care Managers, and Coordinators to ensure doors are in operation mode and to address and resolve any issues that may be observed. The Maintenance Coordinator is conducting walking rounds and meeting with the Coordinators and LCMs, jointly checking paging and alarm equipment two times per week, and discussing the results with the ED. The ED reviews the information and makes necessary changes and/or initiates further training if necessary. Equipment is being repaired or replaced as needed by the MC and the MC is ensuring that extra pager batteries are available and accessible for the Care Managers at all times. In addition, as an ongoing means to identify residents with the potential for exit seeking or elopement behaviors, the Interdisciplinary Team meets two or three times a month to

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		discuss residents who are at risk, and to initiate action and provide direction and guidance to team members regarding these residents. This meeting includes focused discussions regarding individual residents as needed. The discussion at Interdisciplinary Team Meetings includes a review of daily communication; concerns and observations from care managers on all shifts, Wellness Nurses, and observations gathered by the Care Coordinator; a review of any incidents that have occurred; a review of feedback and/or progress notes from medical, mental, and other health care professionals and partners; and concerns and suggestions from families.
		D. With respect to how the plan of correction will be monitored: The ED 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, on a weekly basis. The Executive Director or designee is responsible for ensuring the status of this Plan of Correction is reviewed and discussed at Quality Assurance /Performance Improvement Meetings and action initiated, if required. This is done on a weekly basis

Regulation	Target Date by Which Correction will be completed	Plan of Correction
G.S 131D-21(4) Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.	9/2/15	**A. With respect to the specific resident/situation cited:** Resident # 3 no longer resides in the community and moved to a skilled nursing facility. Resident #11 has a wander guard and has private duty aides (PDAs) in place during the hours when resident typically or more likely exhibits wandering behavior.. Resident was transferred to the SCU on October 7th. Resident # 12 is on the internal transfer list to move to the SCU, however is not exit seeking or wandering at this time.
	9/18/15 and ongoing	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The interdisciplinary team reviews residents at risk for elopement behaviors or falls in the morning leadership meeting, which includes the therapy director. The discussion includes generating additional interventions, discussing potential assistive devices, and initiating therapy screens or assessments if needed. The ID team reviews incident reports during the meeting implements supplemental interventions, and updates ISPs. Behavioral logs and related notes are also being reviewed at this meeting (POP dated 9/18) The Interdisciplinary Team reviewed residents who were/are at risk for potential falls, exit seeking and/or elopement behaviors and ensured that their Individualized Service Plans (care plans) included individualized strategies and interventions to address these issues and behaviors. Residents' primary care physicians and mental health professionals were contacted as appropriate for additional guidance, to discuss potential medication changes, and to confer regarding additional non-medicinal approaches.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		ISP revisions/supplements are added to the care plans by the Resident Care Director and the Care Coordinators and guidance and updated instructions are communicated by the Coordinators to the care team via daily communication venues.
	9/18/15 and ongoing	**C. With respect to what systemic measures have been put into place to address the stated concern:** Key components of the falls management program: • RCD or Care Coordinator will refer residents to be assessed for therapy services, as appropriate. • Implement individualized toileting schedules for residents as appropriate. • Set up training with Therapy Services for the Care Managers regarding assisting residents with gait issues and to demonstrate transfer techniques • Increase frequent checks on residents who are at high risk for falls. (POP dated 9/1) • Coverage in the main, satellite, and bistro areas has been reviewed, including ensuring a TM remains in the area at all times, while a resident or residents are eating. These components of the falls management program have been reviewed and discussed with care managers, med techs, nurses, LEMs by the RCD, ALC, and RC. As an ongoing means to identify residents with the potential for experiencing falls /exit seeking/ elopement behaviors, the

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		Interdisciplinary Team meets two or three times a month to discuss residents who are at risk, and to initiate action and provide direction and guidance to team members regarding these residents. This meeting includes focused discussions regarding individual residents as needed. The discussion at Interdisciplinary Team Meetings includes a review of daily communication; concerns and observations from care managers on all shifts and observations gathered by the Nurses and Care Coordinators; a review of any episodes or incidents that have occurred; a review of feedback and/or progress notes from medical and other health care professionals and partners; and concerns and suggestions from families.
		D. With respect to how the plan of correction will be monitored: The Executive Director and the RN Resident Care Director provide oversight of the admission process, the care planning process and care plan meetings; review resident behaviors, falls, and other incidents, and episodes for potential supplemental interventions; observe and interact with residents at risk, and promote the involvement of Mental Health Professionals and Primary Care Physicians as needed. The ED 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 Quality Assurance /Performance Improvement Meetings and action initiated if required.

Regulation	Target Date by Which Correction will be completed	Plan of Correction

Responses on the enclosed plan of correction do not constitute an admission or agreement of the truth of the facts alleged or the conclusion set forth in the regulatory report. The responses are prepared solely as a matter of compliance with law.