Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092024	A. BUILDING: _____ B. WING _____	R 08/19/2016

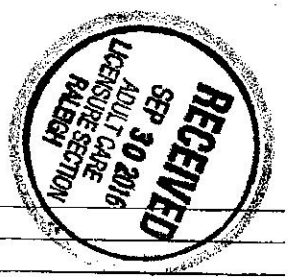
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF RALEIGH	3101 DURALEIGH ROAD RALEIGH, NC 27612

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 08/17/16 - 08/19/16.	D 000	Please see attached Plan of Correction.	
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 observations, interviews and record reviews, the facility failed to assure 2 of 2 exit gates for the special care unit (SCU) outside courtyard were equipped with a sounding device that activated when the gates were opened resulting in 2 residents (#1, #2) diagnosed with dementia exiting the SCU courtyard without staff's knowledge and the residents later being found by maintenance staff unsupervised sitting on a bench near the sidewalk located by the employee parking lot and the facility's dumpsters on 08/12/16.	D 067	RECEIVED SEP 30 2016 ADULT CARE LICENSURE SECTION RALEIGH * Refer to addendum on the attached plan of correction. W. Williams 10/10/16	

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa R. Cole — TITLE: Executive Director — (X6) DATE: 9/30/16

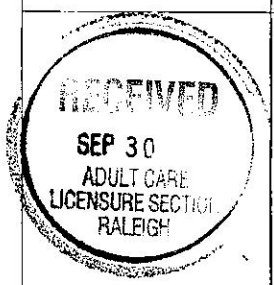
* The plan of correction with addendum was reviewed and accepted on 10/10/16. Refer to addendum on pages 1, 3, and 4 of the attached plan of correction.
W. Williams 10/10/16



Sunrise Senior Living, Inc.
Plan of Correction

Name of Community: Brighton Gardens of Raleigh
Address: 3101 Duraleigh Rd Raleigh, NC 27612
License number: HAL-092-024
Inspection date(s): 8/17/16-8/19/16
Name and Title of Sunrise Representative Signing the Plan of Correction:
Melissa Cole, Executive Director
Signature of Sunrise Representative: Melissa R. Cole, Executive Director
Date of Submission: 9/30/16

Regulation	Target Date by Which Correction will be completed	Plan of Correction
10A NCAC 13F ~~.0306 (a)(1)~~ .0305 (h)(4) Addendum per telephone with Ms. Cole on 10/7/16: Rule # corrected above.		**A. With respect to the specific resident/situation cited:**
	8/12/16	Residents #1 and #2 experienced no negative outcomes as a result of exiting the courtyard on 8/12/16.
	8/12/16	The residents in the Reminiscence program (SCU) are accompanied by a team member when outside in the gated outside courtyard.
	9/6/16	The two gate exit doors for the outside courtyard have been equipped with a sounding device that activates an alert to the team member scout phones and pagers when the gate exit doors are opened.
	8/12/16	Staff were educated on these procedures.
	8/12/16	The training was provided by the Reminiscence Coordinator.
		The Maintenance Coordinator checks the gate exit alarms at least weekly to assure they are working properly. W. Williams 10/10/16
		B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:
	9/6/16	The two gate exit doors and other perimeter doors were checked by the Maintenance Coordinator to ensure the alert devices were operating correctly. No issues were identified.
	8/17/16	The Reminiscence Coordinator or designee is completing weekly checks to confirm team members are accompanying residents when they are out in the courtyard. No issues have been identified.



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.

* The plan of correction with addendum was reviewed and accepted on 10/10/16. W. Williams 10/10/16

Regulation	Target Date by Which Correction will be completed	Plan of Correction
	8/12/16 9/6/16 8/12/16 8/17/16 9/30/16	**C. With respect to what systemic measures have been put into place to address the stated concern:** The protocol has been updated to include: The residents in the Reminiscence program (SCU) are accompanied by a team member when outside in the gated outside courtyard. The two gate exit doors for the outside courtyard have been equipped with a sounding device that activates an alert to the team member scout phones and pagers when the gate exit doors are opened. Staff were educated on these procedures by the Reminiscence Coordinator. New team members will be educated on these procedures during orientation. The Reminiscence Coordinator or designee is completing weekly checks to confirm team members are accompanying residents when they are out in the courtyard. These checks began on 8/17/16 and will continue for 3 months thereafter. The RC or designee will present the findings of the weekly audits and checks for three months at the Leadership Meetings.
	9/30/16	**D. With respect to how the plan of correction will be monitored:** The results of the weekly audits and checks will be reviewed monthly for 3 months at the Leadership Meetings. After 3 months, the Leadership Team will re-evaluate and initiate any necessary action or extend the review period.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
~~10A NCAC 13F .0407 (a) (7)~~ G.S. 131D-21(2)	8/12/16	**A. With respect to the specific resident/situation cited:** Residents #1 and #2 experienced no negative outcomes as a result of exiting the courtyard on 8/12/16.
Addendum per telephone with Ms. Cole on 10/7/16: Rule # corrected above. W. Williams 10/10/16	8/12/16 9/6/16 8/12/16 8/12/16	The residents in the Reminiscence program (SCU) are accompanied by a team member when outside in the gated outside courtyard. The two gate exit doors for the outside courtyard have been equipped with a sounding device that activates an alert to the team member scout phones and pagers when the gate exit doors are opened. Staff were educated on these procedures. The training was provided by the Reminiscence Coordinator.
	9/6/16 8/17/16	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** . The two gate exit doors and other perimeter doors were checked by the Maintenance Coordinator to ensure the alert devices were operating correctly. No issues were identified. The Reminiscence Coordinator or designee is completing weekly checks to confirm team members are accompanying residents when they are out in the courtyard. No issues have been identified.
	8/12/16 9/6/16 8/12/16	**C. With respect to what systemic measures have been put into place to address the stated concern:** The protocol has been updated to include: The residents in the Reminiscence program (SCU) are accompanied by a team member when outside in the gated outside courtyard. The two gate exit doors for the outside courtyard have been equipped with a sounding device that activates an alert to the team member scout phones and pagers when the gate exit doors are opened. Staff were educated on these procedures by the

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		Reminiscence Coordinator. New team members will be educated on these procedures during orientation.
	8/17/16	The Reminiscence Coordinator or designee is completing weekly checks to confirm team members are accompanying residents when they are out in the courtyard. These checks began on 8/17/16 and will continue for 3 months thereafter.
	9/30/16	The RC or designee will present the findings of the weekly audits and checks for three months at the Leadership Meetings.
		D. With respect to how the plan of correction will be monitored:
	9/30/16	The results of the weekly audits and checks will be reviewed monthly for 3 months at the Leadership Meetings. After 3 months, the Leadership Team will re-evaluate and initiate any necessary action or extend the review period.

Addendum per telephone with Ms. Cole on 10/7/16:

The Maintenance Coordinator checks the gate exit alarms at least weekly to assure they are working properly.

W. Williams
10/10/16

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D 067	Continued From page 1 The findings are: Review of a facility census report dated 08/17/16 revealed there were 24 residents currently residing in the special care unit (SCU) of the facility which was referred to as the Reminiscence unit. Observation of the SCU during tour of the facility on 08/17/16 at 12:08 p.m. revealed: -There was an exit door in the dining room that led outside into a fenced in courtyard. -There was a keypad and an emergency egress button with clear plastic cover on the wall to the left of the exit door. -The exit door was locked and staff had to enter a code to let surveyor outside. -The SCU courtyard had two gates that each had a keypad and an an emergency egress button with a clear plastic cover mounted beside the gates. -The emergency egress device was green with the words, "IN CASE OF EMERGENCY LIFT COVER - PUSH BUTTON". -There was a red octagon shaped button in the center of the green box with the word "PUSH" in white writing on the red button. -The word above the red button was "EXIT" and the words below the red button read, "TURN TO RESET". -The green box with red emergency egress button had a clear plastic cover with the words "LIFT HERE" on a tab at the bottom of the cover. -Both gates were locked when pushed. -One gate was located and the end of the facility connected to a sidewalk that went around to the side and front of the building near a major intersection with multiple lanes. -The second gate was located at the end of the	D 067		

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D 067	Continued From page 2	D 067		

facility connected to a sidewalk near the employee parking lot and the facility's dumpsters which eventually led around to the front of the building from the opposite side.

1. Review of Resident #1's current FL-2 dated 08/04/16 revealed:
-The resident's diagnoses included dementia, hypothyroidism, osteoporosis, history of breast cancer, Vitamin B12 deficiency, and Vitamin D deficiency.
-The resident was ambulatory.
-The resident was constantly disoriented.

Review of a service evaluation and health initial assessment (prescreening) dated 08/01/16 for Resident #1 revealed:
-The resident was noted to be independent with ambulation and transfers.
-The resident "tends to wander" and "tends to elope".
-The resident would need staff intervention or monitoring.

Review of Resident #1's Resident Register dated 08/04/16 revealed:
-The resident was admitted to the facility on 08/04/16.
-The resident was forgetful and needed reminders.
-The resident needed assistance with orientation to time and place.

Review of Resident #1's Individualized Service Plan dated 08/09/16 revealed:
-Resident #1 was independent with ambulation and transfers.
-She needed reminders for eating, toileting, dressing, and grooming.
-She needed standby assistance for bathing.

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D 067	Continued From page 3 -The resident needed to be observed for anxiety and wandering. Review of facility progress notes for Resident #1 revealed: -08/05/16 at 4:14 p.m. - Resident #1 was noted to be agitated this afternoon and has packed her belongings to go home. The resident was given a "prn" (as needed) Lorazepam (for agitation). -08/12/16 at 1:27 p.m. - Resident #1 was walking around the fenced SCU courtyard with another resident before lunch, when they unlocked the gate and both left the secured area and went to another courtyard and sat on a bench. A staff person saw the residents and brought them back inside the secured area. No agitation or signs and symptoms of discomfort were noted at that time. Both residents came in and proceeded to eat their lunch. The resident denied discomfort and is calm and pleasant. -08/12/16 1:50 p.m. - Updated safety section of service plan to have staff with resident anytime she is outside of the SCU including the SCU courtyard. Staff trained on this plan. -08/13/16 at 2:54 p.m. - No elopement attempts by resident made today. -08/14/16 at 1:50 p.m. - No elopement attempts made this shift. -08/15/16 at 3:02 p.m. - Staff continues to report that resident packs her personal belongings stating she is ready to leave. She is redirected without any incident. Review of an accident / incident report for Resident #1 dated 08/12/16 revealed: -The documented date of incident was 08/12/16 and the documented time was 11:45 a.m. -Resident #1 and another special care unit (SCU) resident were found sitting on a park bench outside of the secured SCU courtyard.	D 067		

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D 067	Continued From page 4 -The resident exited the courtyard by engaging the emergency egress button. -The facility's nurse performed a head-to-toe assessment of the residents and completed vital signs. -The primary care physician and family were notified. -The facility implemented an intervention that a staff person must accompany SCU residents while they are in the courtyard. -The resident's individualized service care plan was updated with the intervention. Review of vital signs documented for Resident #1 on 08/12/16 revealed: -The blood pressure was 140/78. -The heart rate was 70. -The respiration rate was 17. -The temperature was 97.5 degrees F. Review of Resident #1's medication administration record revealed the resident was administered Lorazepam 0.5mg at 11:30 a.m. on 08/12/16 for anxiety and it was noted to be effective at 12:00 noon. Observation and interview of Resident #1 on 08/17/16 at 1:10 p.m. revealed: -Resident #1 was walking around in the hallway wearing a hat and carrying a pocket book. -Resident #1 wanted to go to her room to talk. -Resident #1 stated she went outside to the courtyard last week to work on flowers. -She stated there were about 3 of them (referring to residents) outside. -The gate "happened to be opened" and she and another "lady" (did not know her name) walked around the sidewalk and found a white bench. -They were going to clean the bench but they could not get it clean because they did not have	D 067		

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D 067	Continued From page 5	D 067		

any bleach.
-They were going to find a man to help them move the bench because it was sitting in the sun.
-They were "out all afternoon" but could not give a timeframe.
-There were no staff outside with the residents.
-The resident walked out of her room during the interview across the hall to the "quiet" room.
-The resident pointed to the second gate of the SCU courtyard and said that was where she went out of the courtyard.

Interview with the Special Care Coordinator (SCC) on 08/17/16 at 1:55 p.m. revealed:
-When she came out of a meeting on 08/12/16, the Lead Care Manager (LCM) on duty in the SCU told her about the elopement of Resident #1 and another resident.
-The SCC took Resident #1 back outside in the SCU courtyard and Resident #1 immediately lifted the clear plastic cover to the emergency egress button and said, "yeah this is how you do it".
-Resident #1 was intermittently disoriented but "pretty sound" at times.
-Resident #1 was a new resident admitted on 08/04/16.
-Resident #1 would pack her belongings and want to leave the facility.

Telephone interview with the guardian for Resident #1 on 08/19/16 at 12:40 p.m. revealed:
-The facility staff notified the guardian that Resident #1 got out of the secured courtyard on 08/12/16.
-The resident was new at the facility and had lived independently prior to being admitted to the facility.
-The resident was leaving her apartment late at night and was found at a construction site climbing a ladder prior to being admitted to the

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D 067	Continued From page 6	D 067		

facility.
-The facility was aware of the resident's history of wandering.

Telephone interview with the primary physician's assistant (PA) on 08/19/16 at 3:45 p.m. revealed:
-Resident #1 was a new resident at the facility.
-The PA did an initial visit with the resident to establish care when the resident was first admitted to the facility.
-The facility staff notified the PA's office on 08/12/16 about the resident's elopement.
-The PA had spoken with Resident #1's family member who reported prior to coming to the facility the family had to take Resident #1's car away because the resident would leave on the car or walk in the neighborhood and not remember how to get home.
-The PA had another visit with Resident #1 on 08/18/16.
-The resident had no injuries resulting from the elopement on 08/12/16.
-Resident #1 should not be left unsupervised outside.

Refer to interview with a SCU medication aide/care manager on 08/17/16 at 12:31 p.m.

Refer to interview with a SCU care manager on 08/17/16 at 1:03 p.m.

Refer to interview with the Co-Life Enrichment Manager on 08/17/16 at 1:40 p.m.

Refer to interview with the Special Care Coordinator (SCC) on 08/17/16 at 1:55 p.m.

Refer to interview with the Administrator on 08/17/16 at 4:53 p.m.

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D 067	Continued From page 7 Refer to interview with the Maintenance Coordinator (MC) on 08/17/16 at 5:40 p.m. Refer to interview with the Maintenance Assistant (MA) on 08/18/16 at 3:16 p.m. Refer to interview with a second SCU medication aide/care manager on 08/18/16 at 1:40 p.m. Refer to interview with a SCU Lead Care Manager (LCM) on 08/18/16 at 4:45 p.m. Refer to interview with the facility's Wellness Nurse (WN) on 08/19/16 at 12:30 p.m. Refer to interview with a third SCU medication aide/care manager on 08/19/16 at 4:30 p.m. Refer to interview with the Administrator on 08/19/16 at 2:10 p.m. Refer to interview with the Maintenance Coordinator (MC) on 08/19/16 at 5:00 p.m. 2. Review of Resident #2's current FL-2 dated 08/16/16 revealed: -The resident's diagnoses included advanced dementia, anxiety, depression, insomnia, back pain, and history of urinary tract infection. -The resident was ambulatory. -The resident was intermittently disoriented. Review of Resident #2's Resident Register dated 07/29/14 revealed: -The resident was admitted to the facility on 07/29/14. -The resident had significant memory loss and must be redirected. -The resident needed assistance with orientation	D 067		

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D 067	Continued From page 8 to time and place. Review of Resident #2's Individualized Service Plan dated 07/05/16 revealed: -Resident #2 was independent with dressing, transferring, toileting, bathing, and ambulation. -She needed reminders for eating and standby assistance for grooming. -The resident needed to be observed for anxiety and wandering. Review of facility progress notes for Resident #2 revealed: -06/14/16 at 6:29 p.m. - Resident up at 2am today walking around and eventually went back to her room. -06/24/16 at 5:07 p.m. - Met with family to discuss how resident is doing. Mentioned some anxiety, talking about going home, and some sleep pattern changes. -08/12/16 at 1:36 p.m. - Resident #2 was walking around in the SCU courtyard with another resident when they unlocked the gate and exited the secured area to another courtyard and sat on a bench. A staff person brought the resident back in the secured area. The resident denied pain or discomfort. The resident proceeded to eat lunch. No agitation, discomfort, or anxiety were noted. Updated safety section of service plan to have staff with resident anytime she is outside of the SCU including the SCU courtyard. Staff trained on this plan. -08/13/16 at 2:54 p.m. - No elopement attempts by resident made today. -08/14/16 at 1:49 p.m. - No elopement attempts made this shift. Review of an accident / incident report for Resident #2 dated 08/12/16 revealed: -The documented date of incident was 08/12/16	D 067		

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D 067	Continued From page 9 and the documented time was 11:45 a.m. -Resident #2 and another special care unit (SCU) resident were found sitting on a park bench outside of the secured SCU courtyard. -The resident exited the courtyard by engaging the emergency egress button. -The facility's nurse performed a head-to-toe assessment of the residents and completed vital signs. -The primary care physician and family were notified. -The facility implemented an intervention that a staff person must accompany SCU residents while they are in the courtyard. -The resident's individualized service care plan was updated with the intervention. Review of vital signs documented for Resident #2 on 08/12/16 revealed: -The blood pressure was 130/76. -The heart rate was 70. -The respiration rate was 16. -The temperature was 97.4 degrees F. Observation and interview of Resident #2 on 08/17/16 at 12:23 p.m. revealed: -Resident #2 had come out of the dining room and was walking around in the living room and common hallway area near the entrance of the SCU. -The resident was wearing a thick sweater and indicated her hands were cold. -The resident stated she had not been outside lately but she liked the warmth outside. -The resident stated she had not heard from her family in a while and she wanted them to come and get her. Interview with the Special Care Coordinator (SCC) on 08/17/16 at 1:55 p.m. revealed:	D 067		

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D 067	Continued From page 10 -When she came out of a meeting on 08/12/16, the Lead Care Manager (LCM) on duty in the SCU told her about the elopement of Resident #2 and another resident. -Resident #2's spouse lived upstairs in the assisted living part of the facility and Resident #2 would look around the SCU for her husband. -Resident #2 had been outside in the SCU courtyard by herself with other residents many times and there had never been any issues with her trying to leave the courtyard. -Resident #2 was more confused than the other resident. Telephone interview with Resident #2's power of attorney on 08/19/16 at 12:05 p.m. revealed: -The facility notified her of the elopement of Resident #2 on the day it occurred, 08/12/16. -Resident #2 had a history of wandering from her home prior to be admitted to the facility. -Resident #2 had been found by her neighbors in a parking lot of a shopping center prior to the resident being admitted to the facility. Telephone interview with Resident #2's primary physician's assistant (PA) on 08/19/16 at 3:45 p.m. revealed: -Resident #2 was at risk for wandering which was why she lived in the SCU. -The facility staff notified the PA's office on 08/12/16 about the resident's elopement. -The resident had no injuries resulting from the elopement on 08/12/16. -Resident #2 would need supervision when outside, "staff needs to monitor her". Refer to interview with a SCU medication aide/care manager on 08/17/16 at 12:31 p.m. Refer to interview with a SCU care manager on	D 067		

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D 067	Continued From page 11 08/17/16 at 1:03 p.m. Refer to interview with the Co-Life Enrichment Manager on 08/17/16 at 1:40 p.m. Refer to interview with the Special Care Coordinator (SCC) on 08/17/16 at 1:55 p.m. Refer to interview with the Administrator on 08/17/16 at 4:53 p.m. Refer to interview with the Maintenance Coordinator (MC) on 08/17/16 at 5:40 p.m. Refer to interview with the Maintenance Assistant (MA) on 08/18/16 at 3:16 p.m. Refer to interview with a second SCU medication aide/care manager on 08/18/16 at 1:40 p.m. Refer to interview with a SCU Lead Care Manager (LCM) on 08/18/16 at 4:45 p.m. Refer to interview with the facility's Wellness Nurse (WN) on 08/19/16 at 12:30 p.m. Refer to interview with a third SCU medication aide/care manager on 08/19/16 at 4:30 p.m. Refer to interview with the Administrator on 08/19/16 at 2:10 p.m. Refer to interview with the Maintenance Coordinator (MC) on 08/19/16 at 5:00 p.m. --- Interview with a SCU medication aide/care manager on 08/17/16 at 12:31 p.m. revealed: -She was working as a care manager on the floor on 08/12/16.	D 067		

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D 067	Continued From page 12 -She had let Resident #1 and Resident #2 out of the exit door in the dining room into the outside courtyard sometime between 10:00 a.m. and 11:00 a.m. -No other residents were in the courtyard at that time to her knowledge. -Staff were not required to go outside with the SCU residents while they were in the courtyard. -There was usually a staff person in the living room or dining room and the residents would knock on the door when they were ready to come back in. -She did not check Resident #1 and Resident #2 after she let them outside. -She did not realize the two residents had gotten out of the SCU courtyard until a maintenance staff person brought the residents back in the facility just before lunch. -Lunch was usually served around 11:30 a.m. -She thought the residents hit the emergency button to unlock the gate. -Staff were now required to go outside with any residents that go into the SCU courtyard and stay with them. Interview with a SCU care manager on 08/17/16 at 1:03 p.m. revealed: -She was working on 08/12/16 when Resident #1 and Resident #2 eloped. -She had gone on break but heard that the residents were found by maintenance staff sitting on a bench outside near the beauty parlor. -Another staff person had let the residents out into the courtyard but she did not know when or how long the residents were outside. -Staff thought Resident #1 had figured out how to hit the emergency button to open the gate. -Both residents seemed fine when they were brought back inside. -There was always usually at least one staff in the	D 067		

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living room area and they could check on residents outside in the courtyard by looking out the windows.
-Since the incident, staff now have to go outside with all SCU residents.

Interview with the Co-Life Enrichment Manager on 08/17/16 at 1:40 p.m. revealed:
-She usually worked with activities in the SCU.
-She did not know how long Resident #1 and Resident #2 were outside when they eloped on 08/12/16.
-When the residents came back inside, they were laughing and Resident #1 said she was trying to sunbathe.
-Before the incident, SCU residents could go outside without staff because the residents would usually just sit on the porch.
-Staff were always close by to let the residents back in the facility.
-Now staff have to go outside with the residents.

Interview with the Special Care Coordinator (SCC) on 08/17/16 at 1:55 p.m. revealed:
-When she came out of a meeting on 08/12/16, the Lead Care Manager (LCM) on duty in the SCU told her about the elopement of Resident #1 and Resident #2.
-She was told a care manager had let the two residents outside to the courtyard via the dining room exit door around 11:00 a.m.
-The residents were found on a bench in a courtyard near the beauty salon hall exit door on the assisted living side of the building.
-The residents were sitting on a bench talking.
-The Maintenance Coordinator and the Maintenance Assistant had brought the two residents back to the SCU around 11:30 a.m.
-The SCU staff thought the residents were still in the SCU courtyard and did not realize the

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residents had left the courtyard.
-The gate on the left side of the SCU courtyard was unlocked and the emergency egress button was pushed in.
-The maintenance staff reset the button and locked the gate.
-The residents' vital signs were checked and the residents were okay.
-It was warmer outside that day but the residents were assessed by a nurse and were okay.
-The SCC was aware there was no alarm on the cover to the emergency egress button.
-The covers on the emergency buttons inside the building had a "screamer" alarm on them.
-Even if the cover outside had an alarm, staff would not be able to hear it from the inside of the building.
-The policy in the SCU was staff were required to stay with residents in the living room at all times mainly because of fall risks.
-Prior to the elopement, SCU residents who could ambulate independently were allowed to go outside into the SCU courtyard without staff.
-Staff would check on the residents but there was no set time intervals for checks.
-She was aware the cover to the emergency egress button on the gates in the courtyard would not alarm but there was no system to supervise the SCU residents in the SCU courtyard prior to the incident on 08/12/16.
-If it was extremely hot, staff would discourage residents from going outside.
-Since the incident on 08/12/16, there had to be at least one staff person outside with any SCU residents that go into the courtyard.
-There have been no other elopements from the SCU since started working at the facility in October 2013.
-The Maintenance Coordinator was working on contacting the fire marshall so they could come

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D 067	Continued From page 15 up with some type of alarm system for the outside exit gates in the SCU courtyard. Interview with the Administrator on 08/17/16 at 4:53 p.m. revealed: -She had just started working at the facility on Monday, 08/15/16. -The previous Administrator was working at the facility on 08/12/16 when two residents eloped from the SCU. -The elopement incident was reported to her when started working at the facility on 08/15/16. -It was reported that Resident #1 had pushed the emergency egress button for a gate in the SCU courtyard and Resident #2 followed Resident #1 outside of the secured SCU courtyard sometime before noon. -She was not familiar with the facility's supervision protocol prior to the elopement but since the incident, SCU staff were required to go outside and supervise any SCU residents while in the courtyard. -She was not aware there were no alarms for the exit gates in the SCU courtyard. -The Maintenance Coordinator was communicating with the fire marshall about the exit gates in the SCU courtyard. Interview with the Maintenance Coordinator (MC) on 08/17/16 at 5:40 p.m. revealed: -Sometime between 11:00 a.m. and 12:00 noon on 08/12/16, the Maintenance Assistant (MA) had gone outside to the side of the building to throw away some cardboard boxes in the facility dumpsters. -The MA saw two SCU residents sitting on a bench by a light pole near the dumpsters and employee parking area. -The MA came back into the facility and asked the MC if the SCU residents were allowed to be	D 067		

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D 067	Continued From page 16 alone without staff. -The MC and the MA went outside and the two residents were still sitting on the bench and the residents told the MC and the MA that they had wiped down the bench. -The MC estimated the bench was about 100 feet from the gate of the SCU courtyard. -The MC and the MA walked the two residents down the sidewalk and back to the gate of the SCU courtyard. -The gate was unlocked and the emergency egress button was pushed in. -The MC twisted the button to reset it and it popped out and the MC pushed on the gate to make sure it was locked. -The MC and MA took the residents back inside the SCU. -SCU staff did not know the residents had gotten outside of the secured SCU courtyard. -The facility had installed a new mag lock system in the SCU about 2 to 3 years ago. -It had been checked by the fire marshall and had passed inspection. -The facility was aware when the system was installed that the cover on the emergency egress button did not alarm when lifted and the gate would unlock if the egress button was pushed in. -The MC thought SCU staff usually went outside with the residents in the SCU. -They had not any problems with elopements in the SCU prior to the incident on 08/12/16. -After the elopement, she moved the bench to the other side of the sidewalk so it could not be seen from the SCU courtyard. -The MC had left a voice message for the fire marshall to find out if they could do away with the emergency egress button in the SCU courtyard but she had not heard back from him yet. Interview with the Maintenance Assistant (MA) on	D 067		

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D 067	Continued From page 17 08/18/16 at 3:16 p.m. revealed: -Sometime between 11:20 a.m. and 11:25 a.m. on 08/12/16, the MA walked outside to the dumpsters to empty some trash. -The MA recognized two SCU residents sitting on a bench near the employee parking lot and the dumpsters but he did not see any staff with the residents. -The MC estimated the bench was about 50 feet from the gate of the SCU courtyard. -The MA contacted the MC and they went outside to the residients. -The two residents were very content and had wiped off the bench with a tissue. -It was about 90 degrees outside at that time but the residents were just talking and did not seem to be in any distress. -The MA and the MC asked the two residents if they could show them the garden and walked the residents back to the SCU courtyard. -The gate was unlocked and the emergency egress button was pushed in. -The MA and the MC took the residents inside the SCU and the SCU staff did not know the residents had eloped. Interview with a second SCU medication aide/care manager on 08/18/16 at 1:40 p.m. revealed: -She was working on the medication cart on 08/12/16 when the two residents eloped from the facility. -She usually started her medication pass about 11:00 a.m. and it usually took about 15 minutes to finish that medication pass because it was a small one. -She had just finished passing medications on 08/12/16 when she came out of the medication room and saw the MC and the MA had two residents with them walking in the SCU courtyard.	D 067		

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D 067	Continued From page 18 -She had never seen the MC and the MA walking around with the SCU residents and she thought it was sweet and did not realize anything was wrong. -She heard about the elopement later. -One of the care managers had let the two residents out in the SCU courtyard on their own. -Residents usually stayed out in the SCU courtyard about 10 minutes at a time and they would usually come back in . -Prior to the elopement on 08/12/16, staff were not required to go outside with the SCU residents while they were in the courtyard. -Since the incident, staff are required to go outside with the residents. -Resident #1 and Resident #2 talk about wanting to go home. -Resident #1 was new at the facility and they were still learning her. -Staff did not know that Resident #1 could read and follow the directions on the egress button. -She was not aware of any other elopements. Telephone interview with a SCU Lead Care Manager (LCM) on 08/18/16 at 4:45 p.m. revealed: -She was working as the LCM in the SCU on 08/12/16. -Sometime a little after 11:00 a.m. on 08/12/16, she was in the "quiet" room with a resident who was acting out. -While in the "quiet" room she saw Resident #1 and Resident #2 through the window in the SCU courtyard looking at flowers. -She got the resident in the quiet room calmed down and went to the dining room and was helping prepare for lunch. -She estimated about 10 minutes later she looked up and saw the two residents in the SCU courtyard talking with maintenance staff.	D 067		

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D 067	Continued From page 19 -Maintenance staff brought the residents back inside the facility and reported they had found the two residents sitting on a bench outside of the SCU courtyard. -The LCM reported it to the Administrator and he instructed the LCM to fill out an incident report and have the Wellness Nurse come to the SCU to check the residents. -The time she wrote on the incident reports (11:45 a.m.) was actually the time she filled out the report. -Prior to the incident, the higher functioning SCU residents were allowed to got outside in the SCU courtyard without staff. -Staff who let the residents out into the courtyard were supposed to check on the residents periodically about every 5 to 10 minutes. -Since the incident, all SCU residents must be accompanied by staff for supervision. -She was not aware of any other elopements from the SCU. Interview with the facility's Wellness Nurse (WN) on 08/19/16 at 12:30 p.m. revealed: -The WN got a call from the lead care manager (LCM) on duty in the SCU on 08/12/16. -The LCM told the WN that two residents had went out of the SCU. -The WN did a physical assessment on both residents. -The residents were not sweating and had no injuries. -The residents' vital signs were in normal range for both residents. -The WN did not know how long the residents were outside. -Prior to the two residents eloping from the secured SCU courtyard, the WN thought staff was accompanying SCU residents while outside in the secured courtyard.	D 067		

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D 067	Continued From page 20 -The WN did not realize SCU residents were being allowed outside in the SCU courtyard without staff supervision. -She was not aware of any other elopements from the SCU. Interview with a third SCU medication aide/care manager on 08/19/16 at 4:30 p.m. revealed: -She was not working on 08/12/16 when the residents eloped from the SCU. -Prior to the elopement on 08/12/16, staff were supposed to check the gates and make sure they were locked before they let any residents into the SCU courtyard. -Since the elopement on 08/12/16, staff now has to stay with any SCU residents that go outside into the courtyard. Interview with the Administrator on 08/19/16 at 2:10 p.m. revealed: -The fire marshall had just come to the facility and looked at the gates in the SCU courtyard per facility request. -They can not change the emergency egress button for fire safety reasons. -They can add an alarm to the cover and to the gate. -She would still require the SCU staff to supervise any SCU residents when outside in the courtyard. Interview with the Maintenance Coordinator on 08/19/16 at 5:00 p.m. revealed: -The fire marshall had just left the facility this afternoon after coming to look at the gates in the SCU courtyard per facility request. -The egress buttons were required for fire safety reasons. -The facility was going to check into possibly wiring the gates to connect with an alert system inside the building.	D 067		

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D 067	Continued From page 21 -This would be in addition to the keypad already required to enter a code to unlock the gates in the SCU courtyard. Review of the facility's plan of protection dated 08/17/16 revealed: -The two residents involved in the elopement were assessed by a nurse and their care plans were updated with interventions. -All SCU residents that want to go outside must be supervised by a staff member while outside and until returning inside. -Staff education has been provided on this new procedure. -A staff member must input code for exit door in order resident to go outside and come back inside. -This procedure will remain in effect until the facility has reached a permanent solution for the exit gates with fire marshall approval. -The facility will continue to do routine monitoring with every 2 to 3 hour checks on SCU residents. -The SCC will check weekly for staff compliance to procedure. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 3, 2016.	D 067		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	D912		

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BRIGHTON GARDENS OF RALEIGH	3101 DURALEIGH ROAD RALEIGH, NC 27612

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D912	Continued From page 22 This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to physical environment. The findings are: Based on observations, interviews and record reviews, the facility failed to assure 2 of 2 exit gates for the special care unit (SCU) outside courtyard were equipped with a sounding device that activated when the gates were opened resulting in 2 residents (#1, #2) diagnosed with dementia exiting the SCU courtyard without staff's knowledge and the residents later being found by maintenance staff unsupervised sitting on a bench near the sidewalk located by the employee parking lot and the facility's dumpsters on 08/12/16. [Refer to Tag D067 10A NCAC 13F .0305(h)(4) Physical Environment (Type B Violation).]	D912		