

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL092218	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 03/12/2025
NAME OF PROVIDER OR SUPPLIER SUNRISE AT NORTH HILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 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
{C 000}	Initial Comments Report of a Biennial Follow Up Construction Survey by Suzanna Fay conducted on March 12, 2025. There is one deficiency from the Biennial Construction Survey that remains to be corrected.	{C 000}		
{C 199}	Exhaust Ventilation SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (g) The spaces listed in this Paragraph shall be provided with exhaust ventilation at the rate of two cubic feet per minute per square foot. This requirement does not apply to facilities licensed before April 1, 1984, with natural ventilation in these specified spaces: (1) soiled linen storage; (2) soil utility room; (3) bathrooms and toilet rooms; (4) housekeeping closets; and (5) laundry area. (k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities. This Rule is not met as evidenced by: 1. Observations revealed that the facility did not maintain exhaust ventilation in specified spaces. Lack of ventilation allows for the build up humidity that can cause mildew and slick areas and prevents the dissipation of odors. Findings on March 12, 2025: i. First Floor Main Laundry - there does not appear to be a working exhaust fan in the main area. Fans were possibly identified in the dryer area, but they did not appear to be pulling at the	{C 199}		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL092218	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 03/12/2025
NAME OF PROVIDER OR SUPPLIER SUNRISE AT NORTH HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
{C 199}	Continued From page 1 time of survey.	{C 199}			