PRINTED: 06/27/2018 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE S COMPLI		
		FCL032121	B. WING		05/31/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET AC	DDRESS, CITY, STAT	TE, ZIP CODE		
PRESTIGE	E ESTATES ASSISTED L	IVING	LT SCHOOL ROA I, NC 27704	AD.		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
C 000	Initial Comments		C 000			
	The Adult Care Liceninitial survey on May	sure Section conducted an 30-31, 2018.				
C 140	10A NCAC 13G .0409 Tuberculosis	5(a)(b) Test For	C 140			
	(a) Upon employmer home, the administral live-in non-residents of tuberculosis disease measures adopted by Services as specified including subsequent Copies of the rule are contacting the Depart Services. Tuberculos Mail Service Center, (b) There shall be do home that the adminiany live-in non-reside	5 Test For Tuberculosis nt or living in a family care tor, all other staff and any shall be tested for in compliance with control y the Commission for Health I in 10A NCAC 41A .0205 a amendments and editions. e available at no charge by tment of Health and Human is Control Program, 1902 Raleigh, NC 27699-1902. coumentation on file in the estrator, all other staff and ents are free of tuberculosis direct threat to the health or				
	facility failed to assure	as evidenced by: ews and interviews, the e 1 of 3 sampled staff (Staff ire for Tuberculosis (TB)				
	The findings are:					
	record revealed: -She was hired to wo	Administrator, personnel rk at the facility on 01/31/18. Itation of a TB skin test				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

placed on 02/23/12 and read as negative on

(X6) DATE TITLE

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		FCL032121	B. WING	B. WING		5/31/2018
	ROVIDER OR SUPPLIER E ESTATES ASSISTED LI	VING 4120 HO	DDRESS, CITY, STATE LT SCHOOL ROAL 1, NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 140	test placed on 06/05/05/08/12. Interview with the Adr 4:45 p.m. revealed: -The facility's license -An initial license was -The Administrator the TB skin test she had -The Administrator did have 2 step TB skin ther rehire date of 01/2-The Administrator did she would have a TB Interview with the Adr 2:00 pm revealed: -The 1st TB skin test -The employee was rethat she had a 1st stern -The employee was rethat she had a 2nd st within 2-3 weeks of h-The Administrator wo	tation of another TB skin 12 and read as negative on ministrator on 05/30/18 at had expired on 12/31/17. sissued on 01/31/18. bught that she could use the completed prior to 12/31/17. d not know she needed to ests completed because of 31/18. d not give a timeframe when skin test completed. ministrator on 05/31/18 at for staff was prior to hire. esponsible for making sure ep TB skin test prior to hire. for staff was 2-3 weeks esponsible for making sure ep TB skin test completed	C 140			
C 145	(a) Each staff person shall:(5) have no substant	6 Other Staff Qualifications of a family care home iated findings listed on the Care Personnel Registry	C 145			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	=1ED
		FCL032121	B. WING		05/3	1/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
PDESTIO		4120 HOL	SCHOOL ROA	AD		
PRESTIGI	E ESTATES ASSISTED LI	DURHAM,	NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
C 145	Continued From page	2	C 145			
	This Rule is not met Based on interviews a facility failed to assure A and B) had no subs North Carolina Health (NCHCPR) check prior The findings are: 1.Review of Staff A's, personnel record reverence was hired to work. There was no docur in Staff A's record. Interview with Staff A revealed he did not know the been completed for how the literal prior in Staff A revealed for how the literal prior in Staff A's record. Interview with the Add 2:00 pm revealed: She had completed a 05/31/18, and it had reshed in the literal prior in Staff B's record. Refer to interview with 05/31/18 at 2:00 pm. 2. Review of Staff B's personnel record revershe was hired to worthere was no docum in Staff B's record.	as evidenced by: and record reviews, the e 2 of 2 sampled staff (Staff stantiated findings on the n Care Personnel Registry or to hire. personal care aide (PCA) ealed: a at the facility on 02/20/18. mentation of a HCPR check on 05/30/18 at 12:45 pm now if a HCPR check had im. ministrator on 05/31/18 at a HCPR check for Staff A on no substantiated findings. a HCPR check had not staff A,prior to 05/31/18. th the Administrator on a, personal care aide (PCA),				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:	A. BUILDING:		FLETED	
	FCL032121	B. WING	B. WING		5/31/2018	
ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE			
ESTATES ASSISTED LI	VING		D			
(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
Continued From page	÷ 3	C 145				
Interview with the Adr 4:45pm revealed: She had completed a 05/31/18, and it had r -Staff B only worked I Refer to interview with 05/31/18 at 2:00 pm. Interview with the Adr 2:00 pm. revealed: -The Administrator was ure the HCPR check prior to hireShe did not say why were not completed p-The Administrator wi	HCPR check for Staff B on substantiated findings. PRN at the facility. In the Administrator on ministrator on 05/31/18 at as responsible for making as for staff were completed, the HCPR checks for staff prior to hire. Il audit the HCPR checks for					
10A NCAC 13G .0406(a)(7) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and G.S. 131D-40; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 2 sampled staff (Staff B) had a criminal background check prior to hire. The findings are: Review of Staff B's, personal care aide (PCA), personnel record revealed: She was rehired to work at the facility on		C 147				
	ROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENC' REGULATORY OR I Continued From page Interview with the Adr 4:45pm revealed: She had completed a 05/31/18, and it had r -Staff B only worked I Refer to interview with 05/31/18 at 2:00 pm. Interview with the Adr 2:00 pm. revealed: -The Administrator wasure the HCPR check prior to hireShe did not say why were not completed p -The Administrator wi staff within 30 days of 10A NCAC 13G .0406 Qualifications 10A NCAC 13G .0406 (a) Each staff person shall: (7) have a criminal baccordance with G.S. 131D-40; This Rule is not met Based on interviews a facility failed to assure B) had a criminal baccorder The findings are: Review of Staff B's, p personnel record rever	FCL032121 ROVIDER OR SUPPLIER STREET AL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 Interview with the Administrator on 05/30/18 at 4:45pm revealed: She had completed a HCPR check for Staff B on 05/31/18, and it had no substantiated findingsStaff B only worked PRN at the facility. Refer to interview with the Administrator on 05/31/18 at 2:00 pm. Interview with the Administrator on 05/31/18 at 2:00 pm. revealed: -The Administrator was responsible for making sure the HCPR checks for staff were completed, prior to hireShe did not say why the HCPR checks for staff were not completed prior to hireThe Administrator will audit the HCPR checks for staff within 30 days of hire. 10A NCAC 13G .0406(a)(7) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and G.S. 131D-40; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 2 sampled staff (Staff B) had a criminal background check prior to hire. The findings are: Review of Staff B's, personal care aide (PCA),	TOUR CORRECTION DENTIFICATION NUMBER: FCL032121 B. WING	TOURISECTION TOURISE CORRECTION TOURISE CONTROL TO THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) THE PROVIDER SUMMARY STATEMENT OF DEFICIENCE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) THE PROVIDER'S HAND TO THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 3 Interview with the Administrator on 05/30/18 at 4:45pm revealed: She had completed a HCPR check for Staff B on 05/31/18, and it had no substantiated findings. -Staff B only worked PRN at the facility. Refer to interview with the Administrator on 05/31/18 at 2:00 pm. Interview with the Administrator on 05/31/18 at 2:00 pm. Interview with the Administrator on 05/31/18 at 2:00 pm. Interview with the Administrator on 05/31/18 at 2:00 pm. Interview with the Administrator was responsible for making sure the HCPR checks for staff were completed, prior to hire. -She did not say why the HCPR checks for staff were not completed prior to hire. -The Administrator will audit the HCPR checks for staff within 30 days of hire. 10A NCAC 13G .0406(a)(7) Other Staff Qualifications (a) Each staff person of a family care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and G.S. 131D-40; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 2 sampled staff (Staff B) had a criminal background check prior to hire. The findings are: Review of Staff B's, personal care aide (PCA), personnel record revealed:	FCL032121 STREET ADDRESS, CITY, STATE, ZIP CODE ### STREET ASSISTED LIVING SUMMARY STATEMENT OF DEFICIENCES ### SUMMARY STATEMENT OF DEFICIENC	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL032121	B. WING		05/31/2	2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
PRESTIGE	E ESTATES ASSISTED L	IVING	T SCHOOL RO	AD		
		DURHAM	, NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 147	Continued From page	e 4	C 147			
	O1/31/18. -There was no docume consent by Staff B for check to be complete. -There was documen criminal background on 12/14/15. Staff B was unavailable. Interview with the Adr. 4:45 p.m. revealed: -The facility's license. -An initial license was. -She thought that she background check co. 12/31/17. -She did not know State another criminal back because of her rehire. -She did not give a tirt background check wo. B. -Staff B only worked Interview with the Adr. 2:00 pm revealed: -The staff were responte county criminal back hire. -The staff were response.	nentation of a signed r a criminal background d. tation of a state wide check completed for Staff B ble for interview on 05/30/18. ministrator on 05/30/18 at had expired on 12/31/17. s issued on 01/31/18. c could use the criminal mpleted for Staff B prior to aff B needed to have ground check completed date of 01/31/18. meframe when a criminal puld be completed for Staff				
	hireThe Administrator wo	ould audit the criminal or staff within 30 days of				
C 256	10A NCAC 13G .0904 Service	4(a)(1) Nutrition and Food	C 256			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL032121	B. WING		05/31/2018
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA		
PRESTIGI	E ESTATES ASSISTED LI	IVING	T SCHOOL ROA NC 27704	AD	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
C 256	Continued From page	2 5	C 256		
	(a) Food Procurement Homes:	4 Nutrition and Food Service nt and Safety in Family Care g and food storage areas y and protected from			
	failed to assure milk p	ns and interviews, the facility protected from dence by milk being served			
	The findings are:				
	on 05/30/18 at 11:30 The container of milk				
	5/30/18 at 11:30 am r -He did not know of th 05/12/18He had not been told the milk before he use -He did not know the disposed of or used b container.	ne milk's expiration date of I to check the expiration on			
		ned of the milk being spoiled			
	Interviews with 3 residuthey had never been	dents on 5/30/18 revealed served spoiled milk.			
	Interview with the Adr	ministrator on 05/30/18 at			

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:		(X3) DATE SURVEY COMPLETED
		FCL032121	B. WING		05/31/2018
	ROVIDER OR SUPPLIER E ESTATES ASSISTED LI	VING 4120 HOL	DRESS, CITY, STATI T SCHOOL ROAI , NC 27704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULING CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE
C 256	3:00 p.m. revealed: -She did not know th an expiration date of -She often brought m the freezerShe did not recall if t been frozen, prior to I -She would stop buyin buying one gallon at t -Effective 05/30/18, tl staff to look at the exp	e milk in the refrigerator had 05/12/18. ilk in bulk and put the milk in his container of milk had being used. ng milk in bulk and start the time. ne Administrator would train biration date on the	C 256		
	(d) There shall be a revariety of planned grinclude activities that physical interaction, goreative expression, ilearning of new skills. exclusively for resider exempt from this requiracility can demonstrate resident's involvement Examples of group and dancing, games, exerparties, discussion grouncil meetings, boo appreciation, review of spelling bees. This Rule is not met Based on observation failed to assure the 14.	minimum of 14 hours of a coup activities per week that promote socialization, group accomplishment, ncreased knowledge and Homes that care nts with HIV disease are uirement as long as the ate planning for each at in a variety of activities. Civities are group singing, roise classes, seasonal coups, drama, resident ok reviews, music of current events and as evidenced by: as and interviews, the facility 4 hours of planned group ere made available for the 5	0.232		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL032121	B. WING		05/31/2018
NAME OF D					1 03/31/2010
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA F SCHOOL ROA		
PRESTIGE	E ESTATES ASSISTED LI	VING	NC 27704	ער	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 292	Continued From page	÷ 7	C 292		
	The findings are:				
	11:30 a.m. revealed: -An activity calendar vroomReview of the activity documented 14 hours Review of the activity 2018 revealed: -On 05/27/18 from 9:0 School was schedule -On 05/28/18 from 10 newsgroup was schedule -On 05/29/18 from 10 Zumba was schedule -On 05/30/18 from 10 was scheduled.	:00 am-11:00 am duled. :00 am -12:00 pm balloon			
		no activities were offered to between the hours of 9:30 pm -5:30 pm.			
	05/30/18 at 12:45 pm -He used the monthly guidelineHe did activities at th weekLast week he took th -He did not know what be doing with the resitation.	e facility 2-3 times per e residents walking. ttype of activities he would			

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facility

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL032121	B. WING		05/31/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
PRESTIG	ESTATES ASSISTED LI	IVING	F SCHOOL ROA NC 27704	AD	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
C 292	-The staff did activitie times per weekThey would like to do -They watched movie and watched televisionThey had not been a preferences. Telephone interviews revealed: -They did not know hat the facilityThey came to visit 2-had not observed activeThere were 14 hours documented on the machine staff did dailyThe Administrator was sure that staff did daily accumenting daily accumenting daily accumenting daily accumenting daily accumented.	ents on 05/30/18 revealed: s at the facility one to two daily activities. s, walked around outside on (no date). sked their activity with 2 family members now often staff did activities divities at week, but they ivities at the facility. ministrator on 05/31/18 at s of group activities per week nonthly activity calendar. aff to do daily activities at the as responsible for making y activities at the facility. taff would be responsible for	C 292		
C935		ompetency Adult Care Home aining and Competency	C935		
	home is prohibited fro	ents. r 1, 2013, an adult care om allowing staff to perform dication aide duties unless			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL032121	B. WING		05/31/2018
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E. ZIP CODE	,
		4120 HOL	T SCHOOL ROA		
PRESTIGE	ESTATES ASSISTED LI	VING DURHAM	, NC 27704		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
C935	Continued From page	9	C935		
C933	that individual has premedication aide durin an adult care home of the following: (1) A five-hour training Department that incluin all of the following: a. The key principles administration. b. The federal Center Prevention guidelines applicable, safe inject procedures for monitobleeding occurs or the exists. (2) A clinical skills evan NCAC 13F .0503 and (3) Within 60 days froindividual must have a. An additional 10-hod developed by the Deptraining and instruction 1. The key principles administration. 2. The federal Center Prevention guidelines applicable, safe inject procedures for monitobleeding occurs or the exists. b. An examination deby the Division of Head accordance with substitute is not met Based on interviews as	g the previous 24 months in a successfully completed all g program developed by the des training and instruction of medication s for Disease Control and, if the potential for bleeding aluation consistent with 10A 10A NCAC 13G .0503. In the date of hire, the completed the following: our training program partment that includes in in all of the following: of medication s of Disease Control and if the potential for bleeding art the following: of medication s of Disease Control and if the potential for bleeding in which the potential for bleeding art the potential for bleeding art the potential for bleeding are potential for bleeding ar	C935		

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state approved medication administration training

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STATEMENT	OF DEFICIENCIES				DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		TED
		FCL032121	B. WING		05/31	/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
DDESTIC	E ESTATES ASSISTED LI	MING 4120 HOL	T SCHOOL ROA	AD		
PRESTIGI	ESTATES ASSISTED LI	DURHAM,	NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C935	Continued From page	e 10	C935			
		had verification of previous				
		1 sampled medication aides				
	,	I skills checklist completed				
	prior to administering	medications to residents.				
	The findings are:					
	Review of Staff C's, A	Administrator, personnel				
	record revealed:					
		rk at the facility on 01/31/18.				
	-There was documen					
		ills checklist completed on				
	10/11/11.	0				
		tation Staff C had passed				
	the written medication	1 exam on 0 1/25/12.				
	Interview with the Adr 4:45 p.m. revealed:	ministrator on 05/30/18 at				
	•	had expired on 12/31/17.				
	-An initial license was					
	-The Administrator the	ought that she could use the				
	medication clinical sk	ills checklist completed prior				
	to 12/31/17.					
		d not know she needed to				
		tion clinical skills checklist				
	completed because o 01/31/18.	i nei renire date oi				
	-The Administrator did	d not give a timeframe when				
		nedication clinical skills				
	checklist completed.					
		d not know she needed to				
	T	n of previous employment				
	form because of rehir					
		impleted a verification of				
	previous employment	torm for Staff C on				
	05/31/18.					
		as responsible for making				
	sure medication aides					
	medication clinical sk	ilis checklist and the	1		l l	

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verification of previous employment form, prior to

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	FCL032121	B. WING	05/31/2018

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

4120 HOLT SCHOOL ROAD

PRESTIGE	E ESTATES ASSISTED LIVING	DLT SCHOOL ROAD M, NC 27704			
(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	
C935	Continued From page 11	C935			
	the administration of medications.				
C992	G.S. § 131D-45 G.S. § 131D-45. Examination and screening for	C992			
	G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes.				
	(a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates				
Division of the	the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED					
		FCL032121	B. WING		05/31/2018					
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE						
PRESTIG	E ESTATES ASSISTED LI	IVING	SCHOOL ROA	AD						
	DURHAM, NC 27704									
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)								
C992	Continued From page 12		C992							
	facility failed to assure for the presence of coperformed for 1 of 2 swere hired after 10/0′. The findings are: Review of Staff B's, ppersonnel record revershe was hired to word the controlled substance completed on 12/01/1	ews and interviews, the e examination and screening ontrolled substances were sampled staff (Staff B) that 1/13. ersonal care aide (PCA), ealed: rk at the facility on 01/3118. tation Staff B had a examination and screening								
	Interview with the Adr 4:45 pm revealed: -The facility's license -An initial license was -She thought that she substance examination for Staff B prior to 12/-She did not know State controlled substance completed because of 01/31/18She did not give a tir substance examination would be completed -Staff B only worked In-The Administrator was	had expired on 12/31/17. s issued on 01/31/18. e could use the controlled on and screening completed /31/17. aff B needed another examination and screening of her rehire date of meframe when the controlled on and screening for Staff B PRN at the facility. as responsible for making olled substance examination								

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-The Administrator would audit the controlled

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STATEMENT OF DEFICIENCIES (X1) PRO AND PLAN OF CORRECTION IDEN		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE	(X3) DATE SURVEY COMPLETED					
		FCL032121	B. WING		05	/31/2018					
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE										
PRESTIGE ESTATES ASSISTED LIVING 4120 HOLT SCHOOL ROAD DURHAM, NC 27704											
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE					
C992		amination and screening	C992	DEFICIENCY)							

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