C 000 Initial Comments The Adult Care Licens	/ING 4120 HC	A. BUILDING: B. WING ADDRESS, CITY, STATE DLT SCHOOL ROAD M, NC 27704 ID PREFIX TAG	, ZIP CODE	06/	C 07/2021
(X4) ID SUMMARY STA PREFIX (EACH DEFICIENCY TAG REGULATORY OR LS C 000 Initial Comments The Adult Care Licens	STREET A 4120 HC DURHA TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ADDRESS, CITY, STATE DLT SCHOOL ROAD M, NC 27704	PROVIDER'S PLAN OF CORREC	06/	
(X4) ID SUMMARY STA PREFIX (EACH DEFICIENCY TAG REGULATORY OR LS C 000 Initial Comments The Adult Care Licens	VING 4120 HC DURHAN TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	DLT SCHOOL ROAD	PROVIDER'S PLAN OF CORREC		
(X4) ID SUMMARY STA PREFIX (EACH DEFICIENCY TAG REGULATORY OR LS C 000 Initial Comments The Adult Care Licens	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	M, NC 27704	PROVIDER'S PLAN OF CORREC		
(X4) ID SUMMARY STA PREFIX (EACH DEFICIENCY TAG REGULATORY OR LS C 000 Initial Comments The Adult Care Licens	DURHAI TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX			
C 000 Initial Comments The Adult Care Licens	MUST BE PRECEDED BY FULL	PREFIX			
The Adult Care Licens			CROSS-REFERENCED TO THE APPI DEFICIENCY)		(X5) COMPLETI DATE
		C 000			
	ure Section conducted a n on 06/07/21.				
C 007 10A NCAC 13G .0206	Capacity	C 007			
 homes have a capacit (b) The total number of exceed the number shift (c) A request for an in- adding rooms, remode modifications shall be department of social since the Division of Facility two copies of blueprint showing the existing bio of rooms and the second addition, remodeling of showing the use of ear construction, plans shift will be tied into the exist proposed changes in the (d) When licensed how designed capacity by the remodeling of the exist entire home shall meet regulations. (e) The licensee or the notify the Division of F evacuation capability of from the evacuation capability of forwarded to the Constitution of the capacity of the capacity of the forwarded to the capacity of the capacity of the forwarded to the capacity of the capacity of the capacity of the forwarded to the capacity of the capacity	31D-2(a)(5), family care y of two to six residents. of residents shall not own on the license. crease in capacity by ling or without any building made to the county ervices and submitted to Services, accompanied by ts or floor plans. One plan uilding with the current use nd plan indicating the r change in use of spaces ch room. If new all show how the addition sting building and all he structure. mes increase their the addition to or ting physical plant, the t all current fire safety e licensee's designee shall acility Services if the overall of the residents changes apability listed on the e addition of any be residing within the home. be submitted through the social services and				

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ С B. WING FCL032121 06/07/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4120 HOLT SCHOOL ROAD PRESTIGE ESTATES ASSISTED LIVING DURHAM, NC 27704 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) C 007 C 007 Continued From page 1 building. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to notify the Division of Health Service Regulation (DHSR) that resident's evacuation capabilities were different from the evacuation capabilities listed on the facility's license for 2 of 5 sampled residents (#1 and #3) who had cognitive impairments which could prevent the resident from independently evacuating the facility. The findings are: Review of the facility's current license with an effective date of 01/01/21 revealed the facility was licensed for a capacity of 6 ambulatory residents. Observations during the initial tour of the facility on 06/07/21 at 9:20am revealed a census of 4 residents. A request for fire drill logs on 06/07/21 at 9:43am, 10:48am, 11:55am and 6:37pm was made and provided on 06/08/21 at 6:58am after the exit. Interview with the Administrator on 06/07/21 at 10:01am revealed: -Resident #3 had some cognitive impairment disorders that prevented her from knowing what she was supposed to do. -Resident #3 mentally would not know that she had to exit the building without being prompted or assisted. -She was aware that Resident #3 required Division of Health Service Regulation

STATE FORM

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		BENTH IOATION NOMBER.	A. BUILDING:			
		FCL032121	B. WING		06	C 5/07/2021
NAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	, ZIP CODE		
RESTIGE	E ESTATES ASSISTED L	IVING	OLT SCHOOL ROAD M, 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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
C 007	Continued From page	e 2	C 007			
	the event of a fire or ability and supervisio -She felt Resident #1 she was able to verb sounding meant that outside; even if the re- the sofa until she ver- outside. -The Administrator co Resident #1 was able facility even though s provided many cues outside, taking up to to exit the facility. -She was aware that evacuate independen assistance but did no needing assistance. -Although, a previous must be able to amb had to be able to get own without being pr Resident #1 unable t assistance. -She was not aware be updated regarding inability to evacuate it to the facility license.	was mentally alert because ally tell that her the alarm she was supposed to go esident did not move from bally told the resident to go ontinued to insist that to independently exit the she had to be prompted and directing the resident to go 14 minutes for the resident residents should be able to ntly without coaching or of consider Resident #1 as a surveyor told residents ulate within 7 minutes and out of the building on their ompted, she did not consider to evacuate without that construction needed to g residents' status and ndependently as compared 10A NCAC 13G .0302(b)				
C 022	10A NCAC 13G .030 Construction	2 (b) Design And	C 022			
	10A NCAC 13G .030	2 Design And Construction				
	(b) Each home shall	be planned, constructed,				

STATE FORM

	OF DEFICIENCIES	Ulation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION		E SURVEY PLETED
					С	
		FCL032121	B. WING		00	6/07/2021
NAME OF PR	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
PRESTIGE	E ESTATES ASSISTED L	IVING	OLT SCHOOL ROAD M, NC 27704)		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	COMPLET
C 022	Continued From pag	e 3	C 022			
	equipped and mainta offered in the home.	ained to provide the services				
	This Rule is not met TYPE B VIOLATION	-				
	interviews, the facility residents' evacuation accordance with the on the facility's licens	n capabilities were in evacuation capability listed se for 2 of 4 sampled resident apairments and did not exit				
	The findings are:					
		's license effective 01/01/21 was licensed for a capacity of nts.				
	Review of the facility residents resided at					
	9:35am through 10:0 -There were 3 reside living room area.	e drill on 06/07/21 between 11am revealed: ents sitting in the common on one sofa, which faced the				
	was near the kitchen	sitting on a love seat that				
	after being prompted -A fourth resident wa	I to exit.				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			B. WING		С	
		FCL032121			06	/07/2021
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
PRESTIGE	E ESTATES ASSISTED L	IVING	NC 27704	,		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN) THE APPROPRIATE	COMPLET DATE
C 022	Continued From page	e 4	C 022			
	after being prompted	by the Administrator at				
	9:46am.	,				
	-At 9:30am, the Adm	inistrator sounded the alarm				
	for a fire drill.					
	-At 9:35am, the Adm	inistrator walked down the				
		arm, that was 12 feet from				
	-	ea where three residents				
	were sitting.					
		sed a broom handle to push				
		is in the hallway ceiling.				
		d piercing audio sounds that				
	-	throughout the facility, even				
	over the sound of the tele	sitting in the in the common				
		ove, they were not surprised				
	-	d sounds coming from the				
	fire alarm.					
	-The fire alarm contir	nued to sound for 14 minutes				
	and no residents mov	ved until they were asked if				
	they could identify the	e alarm and what they should				
	do when the alarm so	ounded.				
	1. Review of Resider	nt #1's current FL2 dated				
		agnoses included bipolar 1				
		order, major and neurological				
	disorder.	ormittoptly discriptor				
	-resident #1 Was Into	ermittently disoriented.				
	Review of Resident # revealed:	1's care plan dated 09/16/20				
		/mental health history				
		nt #1 was bipolar and had				
	cognitive disorder.					
		ntal illness and received				
	medications for ment	al illness.				
	-The care plan activit	ies of daily living sections				
	were not completed.					
	-There was no other	care plan in Resident #1's				
	record.					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		BERTH TO, THOM TOWERLY.	A. BUILDING:			
		FCL032121	B. WING		06	C 6/07/2021
IAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
PRESTIG	E ESTATES ASSISTED L	IVING 4120 HO	LT SCHOOL ROAD)		
		DURHAI	W, 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 ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
C 022	Continued From page	e 5	C 022			
	9:20am revealed: -Resident #1 was sitt towards her left side as if she was lightly s -Occasionally, Reside slightly moved her he -Resident #1 never m position herself to ge Administrator told her Interview with Reside revealed: -When asked what th #1 stated, "I don't kno -When asked had sho before Resident #1 s -Resident #1 continue not attempt to move. -When asked Reside	ent #1 lifted-up her head and ead. notioned or attempted to t up from the sofa until the r to do so. ent #1 on 06/07/21 at 9:50am he alarm noise was Resident ow." e ever heard that noise				
	Observation of Resid 9:35am to 9:55am re -At 9:53am, the Admi common living room a "you don't hear that a -Resident #1 said "I h was." -The Administrator st -The resident said "of sit and did not attemp -The Administrator sa "remember the smok sound what are you s -Resident #1 said get continued to sit and of the sofa.	nistrator came into the area and said to Resident #1 alarm?" hear it," "I didn't know what it ated it was the smoke alarm. kay", and then continued to bit to get up or move. aid to Resident #1 e alarm when you hear that				

STATE FORM

(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY PLETED
FCL032121	B. WING		C 06/07/2021	
STREET A	DDRESS, CITY, STATE	, ZIP CODE		
NG)		
MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL DIDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
a second time, "Oh, I do you want me to get sitting on the sofa and did ated to Resident #1 hat alarm what are you d to the Administrator with out of the building?" a third time, "okay, I didn't Administrator "do I go it entrance door to the onded "yes, go outside he Administrator's words vait." got up from the sofa and m after being prompted h Resident #1's Primary 06/07/21 at 2:47pm gnosis of neurocognitive nentia. e forgetfulness and not cility during a fire drill. d prompting and uring a fire drill. histrator on 06/07/21 at at the facility for five years o during fire drills.	C 022	DEFICIEN		
	FCL032121 NG STREET A MG L120 HO INST DF DEFICIENCIES DURHAN INST BE PRECEDED BY FULL IDENTIFYING INFORMATION: INST BY THE AND	FCL032121 B. WING STREET ADDRESS, CITY, STATE NG 4120 HOLT SCHOOL ROAD DURHAM, NC 27704 DURHAM, NC 27704 IMENT OF DEFICIENCIES ID IUST BE PRECEDED BY FULL PREFIX TAG C 022 a second time, "Oh, I do you want me to get sitting on the sofa and did at alarm what are you It to the Administrator with Dut of the building?" a third time, "okay, I didn't Administrator "do I go t entrance door to the onded "yes, go outside he Administrator's words ait." got up from the sofa and mafter being prompted h Resident #1's Primary 06/07/21 at 2:47pm nosis of neurocognitive mentia. e forgetfulness and not cillity during a fire drill. di prompting and ming a fire drill. di prompting and ming a fire drill. di prompting and ming a fire drill. ouring fire drills.	FCL032121 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE MG 120 HOLT SCHOOL ROAD DURHAM, NC 27704 MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION) ID PREFIX PREFIX PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED OF DEFICIENCIES a second time, "Oh, I do you want me to get C 022 C 022 a second time, "And idid ated to Resident #1 lat alarm what are you C 022 I to the Administrator with bout of the building?" third time, "okay, I didn't Administrator 'do I go t entrance door to the onded "yes, go outside the Administrator's words ait." got up from the sofa and m after being prompted In Resident #1's Primary 06/07/21 at 2:47pm In Resident #1's Primary 06/07/21 at 2:47pm In Resident #1's Primary 06/07/21 at 2:47pm Instrator on 06/07/21 at at the facility for five years o during fire drill. Interfacility for five years o during fire drills.	FCL032121 B. WING OG STREET ADDRESS, CITY, STATE, ZIP CODE NG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) INT OF DEFICIENCE TO THE APPROPRIATE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY C 022 Is second time, "Oh, I do you want me to get SITTEET ADDRESS SITTEET ADDRESS, CITY, STATE, ZIP CODE IS STREET ADDRESS, CITY, STATE, ZIP CODE IS SECOND TO EFICIENCY IS SECOND TO EFICIENCY IS SECOND TO THE APPROPRIATE DEFICIENCY IS SECOND TIME, NO ZOND IS SECOND TIME, NO ZOND

STATE FORM

STATEMEN	of Health Service Regu r of Deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		FCL032121	B. WING	B. WING		C 06/07/2021	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE		00	10112021	
		4120 HO					
PRESTIG	E ESTATES ASSISTED L	IVING DURHAI	M, NC 27704				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
C 022	Continued From page	e 7	C 022				
	-Resident #1 was me could verbally tell her was supposed to go o did not move from the -She had been told th was able to ambulate able to get out of the being prompted, then facility. -The Administrator in independently able to she prompted the res sounded for 14 minut -She did fire drills qua drills. -When doing drills, sh fire drill and she told -She would provide a of the day 06/07/21.	entally alert because she r the alarm meant that she outside; even if the resident e sofa. nat as along as a resident e within 7 minutes and was building on their own without n they were "okay" at the sisted that Resident #1 was o exit the facility even though sident and the alarm					
	disorder.	major neurocognitive ermittently disoriented.					
		#3's Resident Register t was admitted to the facility					
	-There was no date of plan was prepared. -The care plan was s Provider (PCP) on 04						
	included information mental health and so	nation documented regarding					

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STATEMEN	of Health Service Regu T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:			
		FCL032121	B. WING		06	C 6/07/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
PRESTIG	E ESTATES ASSISTED L	IVING	OLT SCHOOL ROAE M, NC 27704)		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 022	Continued From page 8		C 022		- ,	
	to 9:55am revealed: -Resident #3 was sitt common living room -When the fire alarm move or attempt to g -Resident #3 had her floor. -The resident looked respond or move rela -Resident #3 exited t she was prompted by Interview with the Ad 10:01am revealed: -Resident #3 had sor disorders that prever she was supposed to -Resident #3 mentall was to exit the building assisted. Based on record revin interview it was detern not interviewable. Attempted interviewable. Attempted interviewable. The facility failed to re- sampled residents' e different from the evant the license for Residents' esidents from evacu- of a fire. The facility's	sounded the resident did not et up off the sofa. • head down looking at the up several times but did not ated to the fire alarm. he facility at 9:48am after / a surveyor. ministrator on 06/07/21 at me cognitive impairment ated her from knowing what o do. y would not know that she ng without being prompted or ew, observation and mined that Resident #3 was with Resident #3's PCP on vas unsuccessful. 				

85OB11

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			SURVEY PLETED
			A. BUILDING.			С
		FCL032121	B. WING		06	/07/2021
IAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
RESTIG	E ESTATES ASSISTED L	IVING	OLT SCHOOL ROAD M, 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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
C 022	Continued From page	9	C 022			
	The facility provided a accordance with G.S this violation.	a plan of protection in . 131D-34 on 06/07/21 for				
	CORRECTION DATE VIOLATION SHALL N 2021.	E FOR THE TYPE B IOT EXCEED JULY 21,				
C 100	10A NCAC 13G .031 Disaster Plan	δ (e) Fire Safety And	C 100			
	10A NCAC 13G .031 Plan	6 Fire Safety And Disaster				
	fire evacuation plan ere rehearsals shall be m furnished to the coun services annually. The date and time of the m	least four rehearsals of the each year. Records of paintained and copies ty department of social ne records shall include the rehearsals, staff members description of what the				
	of the fire evacuation county department of rehearsals did not inc	nsure copies of rehearsals plan were furnished to the social services annually,				
	The findings are:					
		s license effective 01/01/21 /as licensed for a capacity of ts.				

		1	A. BUILDING:		COMPL	ETED
NAME OF PI		FCL032121	B. WING		C 06/07/2021	
	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			5772021
PRESTIGE	E ESTATES ASSISTED L	IVING DURHAI	M, 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	TON SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
C 100	Continued From page	e 10	C 100	DEFICIENC	, , , , , , , , , , , , , , , , , , ,	
	1.0					
	Review of the facility' residents resided at t					
	Δ request for fire drill	logs on 06/07/21 at 9:43am,				
	-	nd 6:37pm was made and				
		1 at 6:58am after the exit on				
		s fire drill logs revealed: umented fire drills for 2021.				
		mented on 01/28/21 and				
	-There was no documented time the fire drill occurred.					
	fire drill as to how lon	-				
	respond and exit the	nentation of the duration of				
	the fire drill from begi					
		e drill on 06/07/21 between				
	9:35am through 9:55 -There were three res living room area.	sidents sitting in the common				
	-	on one sofa, which faced the o the facility.				
	was near the kitchen					
		nistrator was asked to				
	sound the alarm for a -At 9:35am, the Admi	nistrator walked down the				
		rm, that was 12 feet from				
		ea where three residents				
	were sitting.					
		sed a broom handle to push				
		s in the hallway ceiling. d piercing sounds that could				
		ghout the facility, even over				

6899

	F OF DEFICIENCIES DF CORRECTION	Ation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		FCL032121	B. WING		06/07/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
PRESTIG	E ESTATES ASSISTED LI	VING	LT SCHOOL ROAD 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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
C 100	the sound of the telew -The three residents so living area did not mo startled by the loud so alarm. -The fire alarm contin and no residents move they could identify the do when the alarm so 1. Review of Resident 09/16/20 revealed dia disorder, seizure disordiand disorder, seizure disordiand disorder, seizure disordiand Review of Resident # revealed: -Resident #1's social/ documented Resident cognitive disorder. -Resident #1 had mer medications for menta -The care plan activiti were not completed. -There was no other of record. -When requested a pup provided. Observation of Resident 9:20am revealed: -Resident #1 was sittit towards her left side van as if she was lightly si -Occasionally, Resident slightly moved her her- -Resident #1 never mo	ision. sitting in the in the common ve, were not surprised or bunds coming from the fire ued to sound for 14 minutes red until they were asked if a alarm and what they should unded. t #1's current FL2 dated ignoses included bipolar 1 rder, major and neurological ermittently disoriented. 1's care plan dated 09/16/20 mental health history t #1 was bipolar and had a ntal illness and received al illness. es of daily living sections care plan in Resident #1's revious care plan was not ent #1 on 06/07/21 at ng on the sofa leaning with her head slumped over leeping. ent #1 lifted-up her head and	C 100	DEFICIEN		

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STATEMENT	of Health Service Regu	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
		FCL032121	B. WING		06	C 06/07/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
DDESTIC	E ESTATES ASSISTED LI	4120 HO	LT SCHOOL ROAD)			
FILESTIGE		DURHAN	M, NC 27704				
()())		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	DATE	
C 100	Continued From page	2 12	C 100				
	revealed: -When asked what th #1 stated, "I don't kno						
	before Resident #1 st	e ever heard that noise ated "no." ed sitting on the sofa and did					
	not attempt to move. -When asked Resider knew what that noise	nt #1 a second time if she was Resident #1 stated "no,					
		nistrator came into the area and said to Resident #1 larm?"					
	-Resident #1 said "I h was."	ear it," "I didn't know what it					
		ated it was the smoke alarm. kay", and then continued to it to get up or move.					
	-The Administrator sa						
	sound what are you s						
	-	out of the building, but she id not attempt to move off					
		ated to Resident #1 "why are "					
		d a second time, "Oh, I as, do you want me to get					
	not move.	ed sitting on the sofa and did					
		peated to Resident #1 that alarm what are you					
	-Resident #1 respond	led to the Administrator with et out of the building?"					
		d a third time, "okay, I didn't					

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STATEMEN	of Health Service Regu T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			(X3) DATE SURVEY COMPLETED	
FCL032121		B. WING		C 06/0			
	ROVIDER OR SUPPLIER	, ZIP CODE	06/07/2021				
	NONDER OR OUT LIER						
PRESTIG	E ESTATES ASSISTED L	.IVING	M, NC 27704				
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET DATE	
C 100	Continued From page	e 13	C 100				
	outside this door?" (fi facility). -The Administrator re	he Administrator "do I go ront entrance door to the esponded "yes, go outside					
	"okay, go outside and						
		ally got up from the sofa and being prompted by the am.					
		with Resident #1's primary on 06/07/21 at 2:47pm					
	-Resident #1 had a d disorder, which was o	liagnosis of neurocognitive dementia.					
		nave forgetfulness and not facility during a fire drill.					
	-Resident #1 would n reminding what to do						
	10:01am revealed:	ministrator on 06/07/21 at					
	and she knew what to	-					
	day one.	ine had been the same from					
	could verbally tell her	entally alert because she r the alarm meant that she outside; even if the resident					
	did not move from the						
	and was able to get o	ambulate within 7 minutes out of the building on their					
	at the facility.	ompted, then they were okay					
	independently able to	sisted Resident #1 was o exit the facility even though					
	she prompted the res						
sion of U.S.	alth Service Regulation						

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DAT COM	
		ECI 032121	B. WING		C 06/07/2021	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	ZIP CODE	00	10112021
		4120 HO	OLT SCHOOL ROAD			
PRESTIGE	E ESTATES ASSISTED L	IVING DURHAI	M, NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
C 100	Continued From page	e 14	C 100			
	-She did fire drills quadrills. -When doing drills, slafter drill and she told -She would provide a of the day (06/07/21) 2. Review of Resider 08/25/20 revealed dia bloodborne pathoger mellitus type I, hyper acute encephalopath Observation of Reside 9:35am to 9:50am re -Resident #2 was sitt the fire alarm was so -Resident #2 did not and watch television. Interview with Reside revealed: -When asked what w sounding, she stated -She stated she was building. -Resident #2 said "ar -The resident continu -At 9:41am, Resident she usually used to e alarm. -Resident #2 got up a exit from and then re	arterly and documented the he announced the it was a the residents to go outside. a copy of the drills by the end a copy of the				
	exit the facility, why s -Resident #2 stood u residents, "come on y	p and said to the other two				

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STATEMEN	of Health Service Regu T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
FCL032121						С
		B. WING			/07/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
PRESTIG	E ESTATES ASSISTED L	IVING	NC 27704)		
(X4) ID			ID	PROVIDER'S PLAN O		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET DATE
C 100	Continued From page	e 15	C 100			
	-Resident #2 said the	e facility had fire drills, but				
	they were usually and	nounced.				
	-The Administrator ar					
		e (SIC) verbally told residents				
	to go outside becaus					
		emember the last time the				
	-	, but thought it was sometime				
	last year.					
	3. Review of Residen	nt #3's current FL2 dated				
	04/05/21 revealed:					
	-Diagnoses included	major neurocognitive				
	disorder.					
	-Resident #3 was inte	ermittently disoriented.				
		t3's Resident Register				
	revealed Resident #3 on 03/11/21.	3 was admitted to the facility				
		t3's care plan revealed:				
	plan was prepared.	locumented when the care				
	-The care plan was s Provider (PCP) on 04	igned by the Primary Care 4/05/21.				
	-	ot completed and did not				
		regarding the resident's				
	mental health and so	-				
	the resident's activitie	nation documented regarding es of daily living.				
		lent #3 on 06/07/21 9:35am				
	to 9:55am revealed:					
		ing on the sofa in the				
	common living room area.					
		sounded the resident did not				
		et up from the sofa. ⁻ head down looking at the				
	floor.					
		up several times but did not				
	respond or move rela	aled to the life alarm.				

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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		
		B. WING	06	C 6/07/2021			
NAME OF PF	ROVIDER OR SUPPLIER	I	TADDRESS, CITY, STATE, ZIP CODE				
DESTIC		4120 HC	OLT SCHOOL ROAD	1			
RESTIGE	E ESTATES ASSISTED L	DURHA	M, 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 C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
C 100	Continued From page	e 16	C 100				
	-Resident #3 exited the she was prompted by	he facility at 9:48am after / a surveyor.					
	Attempted interview v 06/07/21 at 3:13pm v	with Resident #3's PCP on vas unsuccessful.					
	10:01am revealed: -Resident #3 had sor which prevented her supposed to do. -Resident #3 mentally	ministrator on 06/07/21 at ne impairment disorders from knowing what she was y would not know that she ng without being prompted or					
	Based on record revi interview it was deter not interviewable.	ew, observation and mined that Resident #3 was					
	4. Review of Residen 05/18/21 revealed: -Diagnoses included -Resident #3 was cor						
	9:39am revealed: -The resident was in -He got out of bed an	d started to put on his coat.					
	put his on shoes that he slide his feet into.	s to get the coat on and to were open toed slippers that got the coat on, it was					
	twisted like an X acro -Resident #4 proceed common living room.	ss the resident's back. led to walk toward the					
	room area he stopped the room at the other	eached the common living d, and then looked around residents that were still					
	sitting. -Resident #4 then tur	ned around and walked					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: FCL032121			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C	
		FCL032121	B. WING		06	/07/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STATE	, ZIP CODE		
PRESTIGI	E ESTATES ASSISTED LI	VING	T SCHOOL ROAD I, 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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 100	 "it was a fire drill," he don't worry about thin -Resident #4 came ou coat back on and prod at 9:46am. Interview with Reside 10:48am revealed: -He shook his head "h went out during a fire -He shook his head "h get up and go straigh fire alarm again. -He stated "I reckon," outside on his own if he offered no answe know the difference in alarm. Interview with the Adr 10:06am revealed: -Resident #4 heard the to get out of the bed. -She was not sure wh not go outside. -When she did a fire of fire drill and she verbaoutside. G.S. 131D-21 (2) Dectar Every resident shall h 2. To receive care an adequate, appropriate 	nounced to Resident #4 that needed to go outside and gs in his room. ut of the bathroom, put his ceed to go out the front door nt #4 on 06/07/21 at no" when asked if he always drill. no" when asked if he would to outside when he heard the when asked if he could go there were a real fire. re when asked if he would n a fire drill and a real fire ministrator on 06/07/21 at he fire alarm and proceeded by he returned to his and did drill she announced it was a ally told residents to go laration of Resident's Rights ration of Resident's Rights ration of Resident's Rights ration of Resident's Rights	C 100			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL032121		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED C		
			A. BUILDING:			
		FCL032121	B. WING		06/07/2021	
IAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
RESTIG	E ESTATES ASSISTED L	IVING	OLT SCHOOL ROAD M, NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
C 912	Continued From pag	e 18	C 912			
	review, the facility fail received care and se appropriate and in co federal and state law related to design and The findings are: Based on observation interviews, the facility residents' evacuation accordance with the on the facility's licens who had cognitive im the facility during a fi	ns, interviews and record iled to ensure residents ervices which were adequate, ompliance with relevant as and rules and regulations d construction. ns, record reviews and y failed to ensure the n capabilities were in evacuation capability listed se for 2 of 4 sampled resident opairments and did not exit re drill (#1 and #3). [Refer to C 13G .0302(b) Design and				