STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL032178	A. BUILDING: _____ B. WING _____	04/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR PROMISE CARE HOMES	4811 BAY POINT DR DURHAM, NC 27713

(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 The Adult Care Licensure Section conducted an annual survey on 04/18/23.	C 000		
C 007	10A NCAC 13G .0206 Capacity 10A NCAC 13G .0206 Capacity (a) Pursuant to G.S. 131D-2(a)(5), family care homes have a capacity of two to six residents. (b) The total number of residents shall not exceed the number shown on the license. (c) A request for an increase in capacity by adding rooms, remodeling or without any building modifications shall be made to the county department of social services and submitted to the Division of Facility Services, accompanied by two copies of blueprints or floor plans. One plan showing the existing building with the current use of rooms and the second plan indicating the addition, remodeling or change in use of spaces showing the use of each room. If new construction, plans shall show how the addition will be tied into the existing building and all proposed changes in the structure. (d) When licensed homes increase their designed capacity by the addition to or remodeling of the existing physical plant, the entire home shall meet all current fire safety regulations. (e) The licensee or the licensee's designee shall notify the Division of Facility Services if the overall evacuation capability of the residents changes from the evacuation capability listed on the homes license or of the addition of any non-resident that will be residing within the home. This information shall be submitted through the county department of social services and forwarded to the Construction Section of the Division of Facility Services for review of any possible changes that may be required to the	C 007		

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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 the resident's evacuation capabilities were different from the evacuation capabilities listed on the facility's license for 6 of 6 residents (#1, #2, #3, #4, #5 and #6) who required verbal prompting to exit the facility during a fire drill when they did not respond to the fire drill on their own. The findings are: Review of the facility's current license effective 01/01/23 revealed the facility was licensed for 6 ambulatory residents. Review of the daily census revealed 6 residents resided in the facility on 04/18/23. Review of the facility's fire rehearsal schedule revealed: -On 01/06/23 at 11:00am, the residents were seated in the living room, "fire was yelled and to evacuate" by staff, and staff got all residents out within six minutes. -On 02/03/23 at 7:30am, the residents were in their rooms, "fire was yelled" by staff, and staff got all residents out within five minutes. -On03/06/23 at 1:00pm, the residents were in the living room, "fire was yelled to leave the facility" by staff, and staff got all residents out within five minutes.	C 007		

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C 007	Continued From page 2 -On 04/04/23 at 3:00pm, some of the residents were in the living room and some were in their rooms, "fire was yelled" by staff, the residents were instructed where to go once outside, and staff got all residents out within six minutes. Interview with the Supervisor in Charge (SIC) and the Personal Care Aide (PCA) on 04/18/23 at 4:22pm revealed: -The staff always helped the residents when there was a fire drill. -The residents responded when they told them there was a fire drill and they had to go out. -They did not tell the residents ahead of time they were going to have a fire drill. -They would talk to the residents about fire drills and go over what to do during one. -During a fire drill they would tell the residents to evacuate and open the door and the residents would follow them out. -They would guide the residents out of the facility and to the meeting spot across the yard. -They did not use the sounding alarm but would yell, "fire" so the residents would know to evacuate. -They thought the residents could evacuate on their own during a fire drill, but they would always help them. -They thought they could help the residents to evacuate during a fire drill. Interview with the Administrator on 04/18/23 at 10:50am revealed: -The staff conducted monthly fire drills. -There were always two staff workig during the day from 7:00am to 7:00pm and one or two staff in the evening from 7:00pm to 7:00am. -The staff would say "fire" during a fire drill so the residents would know to exit. -They told the residents it was a fire and did not	C 007		

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C 007	Continued From page 3 use the alarm because sometimes the alarm would go off while they cooked, and they would have to tell the residents it was not a fire drill. -The residents were not told ahead of time about a fire drill because they were always a surprise. -He had sent DHSR plans for a sprinkler instalation but they had been returned by DHSR in February 2023. -He had not resubmitted anything to DHSR because he was waiting for plans for a ramp from a contractor. -He did not know the lack of the ability to exit the facility during an emergency like a fire due to cognitive impairment was considered non-ambulatory until 04/18/23. -He had not notified DHSR about resident evacuation capabilites being different from the capabilites on the facility license. Refer to Tag C0022 10A NCAC 13G .0302(b) Design and Construction.	C 007		
C 022	10A NCAC 13G .0302 (b) Design And Construction 10A NCAC 13G .0302 Design And Construction (b) Each home shall be planned, constructed, equipped and maintained to provide the services offered in the home. This Rule is not met as evidenced by: TYPE A2 VIOLATION	C 022		

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C 022	Continued From page 4	C 022		

Based on observations, interviews, and record reviews, the facility failed to ensure the residents' evacuation capabilities were in accordance with the evacuation capability listed on the facility's current license for 6 of 6 sampled residents (#1, #2, #3, #4, #5 and #6) who did not respond to the fire drill.

The findings are:

Review of the facility's current license effective 01/01/23 revealed the facility was licensed for 6 ambulatory residents.

Review of the facility's fire rehearsal schedule revealed:
-On 01/06/23 at 11:00am, the residents were seated in the living room, "fire was yelled and to evacuate" by staff, and staff got all residents out within six minutes.
-On 02/03/23 at 7:30am, the residents were in their rooms, "fire was yelled" by staff, and staff got all residents out within five minutes.
-On 03/06/23 at 1:00pm, the residents were in the living room, "fire was yelled to leave the facility" by staff, and staff got all residents out within five minutes.
-On 04/04/23 at 3:00pm, some of the residents were in the living room and some were in their rooms, "fire was yelled" by staff, the residents were instructed where to go once outside, and staff got all residents out within six minutes.

Interview with the Administrator on 04/18/23 at 10:50am revealed:
-The staff conducted monthly fire drills.
-There were always two staff working during the day from 7:00am to 7:00pm and one or two staff in the evening from 7:00pm to 7:00am.
-The staff would say "fire" during a fire drill so the

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C 022	Continued From page 5	C 022		

residents would know to exit.
-Staff yelled "fire"and did not use the alarm because sometimes the alarm would go off while they cooked, and they would have to tell the residents it was not a fire drill.
-The residents were not told ahead of time about a fire drill because they were all a surprise.
-He thought the staff could help residents out of the facility; he thought that was one of their responsibilities.
-He thought all the residents would be able to leave the facility unassisted.

Interview with the Administrator on 04/18/23 at 2:56pm revealed:
-Residents #1, #2 and #6 resided at the facility when he took over the building in August 2022; he thought they could exit without assistance because the previous owner had an all ambulatory license.
-He thought ambulitory meant the resident had to be physically able to exit on their own and not be in a wheelchair.
-He did not know the residents had to have the cognitive ability to exit the facility on their own during an emergency like a fire; he thought staff could assist.

1. Review of Resident #1's current FL-2 dated 10/13/22 revealed:
-Diagnosis included Alzheimer's disease.
-The resident was ambulatory.
-The resident was intermittently disoriented.
-The resident required assistance with bathing.

Review of Resident #1's Resident Register revealed an admission date of 08/30/22.

Review of Resident #1's assessment and care plan dated 10/06/22 revealed:

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C 022	Continued From page 6 -The resident was ambulatory with a walker. -The resident required supervision with eating, toileting, ambulation, bathing, dressing, grooming and transfers. -The resident was sometimes forgetful and needed reminders. -The resident was sometimes disoriented. Observation of the facility on 04/18/23 at various times between 8:00am-4:00pm revealed: -Resident #1 was seated on the end of the couch in the living room; sometimes she slept and sometimes she was awake. -The resident could get up from the couch and use her walker to ambulate to the dining room table for meals and to the bathroom. Observation of the facility on 04/18/23 from 3:36pm to 3:45pm revealed: -The Administrator activated the fire alarm at 3:36pm. -Resident #1 was seated on the end of the couch in the living room. -Resident #1 covered her ears and yelled "stop that noise". -She remained seated on the couch. -At 3:40pm the Administrator and two staff entered the living room and instructed the resident to leave the building. -The staff explained to the residents they were having a fire drill and they needed to leave the facility and go into the yard. -Resident #1 followed the other residents outside and down the ramp. -The residents did not know where to go once outside so the Supervisor in Charge (SIC) demonstrated where to go. -The Administrator asked Resident #1 what to do during a fire drill and she replied "leave the building".	C 022		

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C 022	Continued From page 7 Interview with Resident #1 on 04/18/23 at 4:45pm revealed: -She did not know how long she lived at the facility. -They had fire drills; the residents left when there was one. -She did not know the last time they had a fire drill; they had not had one that day. Interview with the Administrator on 04/18/23 at 5:30pm revealed he thought all the residents would exit on their own, including Resident #1. Attempted telephone interview with Resident #1's primary care provider (PCP) on 04/18/23 at 4:02pm was unsuccessful. Refer to interview with the Supervisor in Charge (SIC) on 04/18/23 at 4:22pm. Refer to interview with the Personal Care Aide (PCA) on 04/18/23 at 4:22pm. 2. Review of Resident #2's current FL-2 dated 9/15/22 revealed: -Diagnosis included Alzheimer's dementia. -The resident was semi-ambulatory. -The resident was intermittently disoriented. -The resident required assistance with bathing. Review of Resident #2's Resident Register revealed an admission date of 08/30/22. Review of Resident #2's assessment and care plan dated 10/06/22 revealed: -The resident was ambulatory with a walker. -She required supervision with eating, toileting, ambulation, bathing, dressing, grooming and transfers.	C 022		

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C 022	Continued From page 8 -The resident was sometimes forgetful and needed reminders. -The resident was sometimes disoriented. Observation of the facility on 04/18/23 at various times between 8:00am-4:00pm revealed: -Resident #2 was in her room asleep on the bed or seated in a chair in the living room. -The resident could get up on her own and used her walker to ambulate to the dining room table for meals and to the bathroom. Observation of the facility on 04/18/23 from 3:36pm to 3:45pm revealed: -The Administrator activated the fire alarm at 3:36pm. -Resident #2 came out of her room and asked "What is that? What is going on?" -Resident #2 stood in the hallway next to her bedroom door. -She did not exit the facility. -At 3:40pm, the Administrator and two staff entered the living room and instructed the residents to leave the building. -The staff explained to the residents they were having a fire drill and they needed to leave the facility and go into the yard. -Resident #2 followed the other residents and staff outside and down the ramp. -The residents did not know where to go once outside so the Supervisor in Charge (SIC) demonstrated where to go. Interview with Resident # 2 on 04/18/23 at 7:05pm revealed: -She did not recall practicing fire drills. -She did not know what to do during a fire drill. -She could not recall the last time they had practiced a fire drill; they had not had one in quite a while.	C 022		

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C 022	Continued From page 9 Interview with the Administrator on 04/18/23 at 5:30pm revealed he thought all the residents would exit on their own during a fire drill, including Resident #2. Attempted telephone interview with Resident #1's primary care provider (PCP) on 04/18/23 at 4:02pm was unsuccessful. Refer to interview with the Supervisor in Charge (SIC) on 04/18/23 at 4:22pm. Refer to interview with the Personal Care Aide (PCA) on 04/18/23 at 4:22pm. 3. Review of Resident #3's current FL-2 dated 04/06/23 revealed: -Diagnosis included major neuro cognitive disorder. -The resident was ambulatory. -The resident was constantly disoriented. -The resident wandered. -The resident required assistance with bathing. Review of Resident #3's Resident Register revealed an admission date of 04/06/23. Review of Resident #3's assessment and care plan dated 04/06/23 revealed: -The resident was ambulatory. -The resident required supervision with eating, ambulation, bathing, and transfers. -The resident required limited assistance with toileting, dressing, and grooming. -The resident required extensive assistance with bathing. -The resident was sometimes forgetful and needed reminders. -The resident was sometimes disoriented.	C 022		

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C 022	Continued From page 10 Observation of the facility on 04/18/23 at various times between 8:00am-4:00pm revealed: -Resident #3 was in the living room seated in a chair. -She could ambulate without a walker or assistance from staff. -Staff instructed her to change out of her pajamas and put on the clothes they had laid on her bed. -Resident #3 had her tooth brush and toothpaste and asked where the bathroom was. -Resident #3 asked one of the staff when her family member was coming to get her. Observation of the facility on 04/18/23 from 3:36pm to 3:45pm revealed: -The Administrator activated the fire alarm at 3:36pm. -Resident #3 came out of her room and said, "Turn that noise off, make it stop". -Resident #3 went back into her bedroom and closed the door. -She did not exit the facility. -At 3:40pm, the Administrator and two staff entered the living room and instructed the residents to leave the building. -The staff explained to the residents they were having a fire drill and they needed to leave the facility and go into the yard. -Resident #3 followed the other residents and staff outside and down the ramp. -The residents did not know where to go once outside so the Supervisor in Charge (SIC) demonstrated where to go. -The Administrator asked Resident #3 what she would do during a fire drill and she replied "leave the building". -He asked her why she did not leave when she heard the fire drill and the resident asked, 'When did we have a fire drill?"	C 022		

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C 022	Continued From page 11 Interview with Resident #3 on 04/18/23 at 5:02pm revealed: -She knew to leave during a fire drill, but the facility had never had one. -She did not have to exit the facility or go outside today, 04/18/23, for a fire drill. -She was going to leave the facility and come back tomorrow. Interview with the Administrator on 04/18/23 at 5:30pm revealed: -He thought Resident #3 would recognize the sound of the fire alarm and know to exit the facility. -Resident #3 was admitted from the facility from a memory care unit in an assisted living. Attempted telephone interview with Resident #1's primary care provider (PCP) on 04/18/23 at 4:02pm was unsuccessful. Refer to interview with the Supervisor in Charge (SIC) on 04/18/23 at 4:22pm. Refer to interview with the Personal Care Aide (PCA) on 04/18/23 at 4:22pm. 4. Review of Resident #4's current FL-2 dated 12/21/22 revealed: -Diagnosis included dementia. -The resident was ambulatory. -The resident was intermittently disoriented. Review of Resident #4's Resident Register revealed an admission date of 01/05/23. Observation of the facility on 04/18/23 at various times between 8:00am-5:02pm revealed: -Resident #4 would ask where she was and	C 022		

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C 022	Continued From page 12 where her room was located. -Resident #4 had to be directed to her room by staff; staff instructed her to look for the door with her name on it. -Resident #4 had her tooth brush and toothpaste and asked the staff where the bathroom was; staff instructed her where to go. -Resident #4 told the staff she needed to use the bathroom and asked where it was; the staff instructed her to go to the second door on the right. -Resident #4 passed the door to the bathroom; the staff told her she missed the bathroom and verbally guided her to the door. -She sat at the dining room table and asked where she was; staff told her where she was and told her where her room was. -She asked how long she had been at the facility and why she was there. -She asked where she was again, and the Administrator had to show her to her room. Observation of the facility on 04/18/23 from 3:36pm to 3:45pm revealed: -The Administrator activated the fire alarm at 3:36pm. -Resident #4 came out of her bedroom and stood in the hallway. -Resident #4 went back into her bedroom and closed the door. -She did not exit the facility. -At 3:40pm, the Administrator and two staff entered the living room and instructed the residents to leave the building. -The staff explained to the residents they were having a fire drill and they needed to leave the facility and go into the yard. -Staff went to Resident #4's room and told her to exit the facility; she followed the other residents and staff outside and down the ramp.	C 022		

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C 022	Continued From page 13 -The residents did not know where to go once outside so the Supervisor in Charge (SIC) demonstrated where to go. Interview with Resident #4 on 04/18/23 at 8:45a revealed: -She had only lived at the facility a couple of months. -She was not sure if the facility had a fire drill. -If the facility had a fire drill she would get out of the house. Interview with the Administrator on 04/18/23 at 5:30pm revealed he thought all the residents would exit on their own during a fire drill; including Resident #4. Attempted telephone interview with Resident #1's primary care provider (PCP) on 04/18/23 at 4:02pm was unsuccessful. Refer to interview with the Supervisor in Charge (SIC) on 04/18/23 at 4:22pm. Refer to interview with the Personal Care Aide (PCA) on 04/18/23 at 4:22pm. 5. Review of Resident #5's current FL-2 dated 01/30/23 revealed: -Diagnosis included Alzheimer's dementia. -The resident was semi-ambulatory. -The resident was intermittently oriented to person. -The resident was not oriented to place and time. -The resident required limited assistance with ambulation, transfers, bathing and toileting. Review of Resident #5's Resident Register revealed an admission date of 10/06/22.	C 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL032178	A. BUILDING: _____ B. WING _____	04/18/2023

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C 022	Continued From page 14 Observation of the facility on 04/18/23 at various times between 8:00am-4:00pm revealed: -Resident #5 was laying in the bed asleep. -Resident #5 had a walker and a wheelchair in her bedroom. -Staff served Resident #5 her breakfast and her lunch in her bedroom. -Resident #5 was standing beside her bed after lunch and asked to be left alone. Observation of the facility on 04/18/23 from 3:36pm to 3:45pm revealed: -The Administrator activated the fire alarm at 3:36pm. -Resident #5 did not come out of her bedroom. -She did not exit the facility. -At 3:40pm the Administrator and two staff entered the living room and instructed the residents to leave the building. -The staff explained to the residents they were having a fire drill and they needed to leave the facility and go into the yard. -Resident #5 was brought outside in a wheelchair by her family member. Interview with Resident #5's family member on 04/18/23 at 3:33pm revealed: -Resident #5 was having a "bad day" and did not recognize her. -Resident #5 would not know what to do during a fire drill. -She would have to tell Resident #5 what was going on and take her out of the facility herself. Interview with the Administrator on 04/18/23 at 5:30pm revealed: -He thought all the residents would exit on their own during a fire drill, including Resident #5. -He thought he had sufficient number of staff to assist Resident #5 if she needed the assistance.	C 022		

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C 022	Continued From page 15 Attempted telephone interview with Resident #1's primary care provider (PCP) on 04/18/23 at 4:02pm was unsuccessful. Based on observations, record reviews and interviews Resident #5 was not interviewable. Refer to interview with the Supervisor in Charge (SIC) on 04/18/23 at 4:22pm. Refer to interview with the Personal Care Aide (PCA) on 04/18/23 at 4:22pm. 6. Review of Resident #6's current FL-2 dated 11/16/22 revealed: -Diagnosis included dementia. -The resident was semi-ambulatory. -The resident was intermittently disoriented. -The resident required assistance with bathing and dressing. Review of Resident #6's Resident Register revealed an admission date of 08/06/22. Observation of the facility on 04/18/23 at various times between 8:00am-4:00pm revealed: -Resident #6 was in the living room seated on the couch and in her bedroom. -She could ambulate with a walker. Observation of the facility on 04/18/23 from 3:36pm to 3:45pm revealed: -The Administrator activated the fire alarm at 3:36pm. -Resident #6 was seated on the sofa. -She got up and walked with her walker to the kitchen; she said she was looking for staff. -She pointed to the pull station for the fire alarm	C 022		

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C 022	Continued From page 16	C 022		

and said, "That is where you turn this noise off".
-Resident #6 said she needed to be aware of something, but she did not know what.
-She did not exit the facility.
-At 3:40pm, the Administrator and two staff entered the living room and instructed the residents to leave the building.
-The staff explained to the residents they were having a fire drill and they needed to leave the facility and go into the yard.
-Resident #6 followed the other residents and staff outside and down the ramp.
-The residents did not know where to go once outside so the Supervisor in Charge (SIC) demonstrated where to go.
-The Administrator asked Resident #6 what she would do during a fire drill and she replied, "Get out of here".
-The Administrator asked her why she did not evacuate, and she said, "Because no one yelled fire and told us to leave."

Interview with Resident #6 on 04/18/23 at 6:58pm revealed:
-She did not think the facility had fire drills very often.
-She did not recall the last time there was a fire drill.
-She knew there was an alarm that sounded, and she could leave on her own.
-She helped other residents get out during a fire drill.
-Sometimes staff would tell them to get out during a fire drill.

Interview with the Administrator on 04/18/23 at 5:30pm revealed:
-He thought Resident #6 would recognize the fire alarm and exit on her own during a fire drill.
-He was very surprised when she did not know

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C 022	Continued From page 17 what to do because she knew where the shut off for the alarm was. Attempted telephone interview with Resident #1's primary care provider (PCP) on 04/18/23 at 4:02pm was unsuccessful. Refer to interview with the Supervisor in Charge (SIC) on 04/18/23 at 4:22pm. Refer to interview with the Personal Care Aide (PCA) on 04/18/23 at 4:22pm. _____ Interview with the Personal Care Aide (PCA) on 04/18/23 at 4:22pm revealed: -The staff always helped the residents when there was a fire drill. -The residents responded when staff told them there was a fire drill and they had to go out. -She told the residents they would have to evacuate and the residents would follow the staff out. -She helped to guide the residents out of the facility and to the meeting spot across the yard. -She thought it was okay for staff to help the residents to evacuate during a fire drill. Interview with the Supervisor in Charge (SIC) on 04/18/23 at 4:22pm revealed: -The staff always helped the residents when there was a fire drill. -The residents responded when staff told them there was a fire drill and they had to go out. -She did not tell the residents ahead of time they were going to have a fire drill. -She would talk about fire drills and go over what to do during one with the residents. -She would tell the residents they had to evacuate and leave the building -Staff would go out the open the door and the	C 022		

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C 022	Continued From page 18 residents would follow them out. -She would guide the residents out of the facility and to the meeting spot across the yard. -She did not use the sounding alarm but would yell "fire" so the residents would know to evacuate. -She thought all the residents would be able to evacuate on their own during a fire drill, but staff always helped them. -She thought she could help the residents to evacuate during a fire drill. _____ The failure of the facility to ensure the facility was equipped and maintained in accordance with the facility's license capacity to allow 6 of 6 residents living in the facility who had cognitive deficits to evacuate the facility independently in case of an emergency such as a fire resulted in substantial risk of death or serious injury to the residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/18/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 18, 2023.	C 022		