PRINTED: 09/23/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G170	B. WING			09/22/2020	
NAME OF F	PROVIDER OR SUPPLIER  DAD			STREET ADDRESS, CIT 515 LYNN ROAD DURHAM, NC 2770	, ,		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORR	L'S PLAN OF CORRECTION ECTIVE ACTION SHOULD ENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 004	CFR(s): 483.475(a)  The [facility] must of Federal, State and preparedness requidevelop establish a emergency prepared requirements of this.  The emergency preinclude, but not be elements:  (a) Emergency Plar and maintain an emthat must be [reviewevery 2 years. The following:  * [For hospitals at § 485.625(a):] Emer CAH] must comply State, and local emequirements. The develop and maintain emergency prepared requirements of this all-hazards approach.  * [For LTC Facilities Plan. The LTC facil an emergency prepreviewed and updated and updated and in the ESRD facilities Plan.	comply with all applicable local emergency irements. The [facility] must and maintain a comprehensive edness program that meets the section.  Exparedness program must limited to, the following  The [facility] must develop hergency preparedness plan wed], and updated at least plan must do all of the  E482.15 and CAHs at regency Plan. The [hospital or with all applicable Federal, ergency preparedness [hospital or CAH] must an a comprehensive edness program that meets the section, utilizing an	EO	04			
LABORATORY	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITL	E		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
This STANDARD is Based on record refailed to ensure the (EP) plan was revisifinding is:  The facility's EP plaupdated.  Review on 9/21/20 revealed no date or of the plan did not is update.  Interview on 9/22/2 Disabilities Profess could not be sure if reviewed and/or up EP Training Prograc CFR(s): 483.475(d)  *[For RNCHIs at §44 Hospitals at §482.1 at §484.102, "Orga OPOs at §486.360, Training program. Tollowing:  (i) Initial training policies and proceed staff, individuals program arrangement, and respected roles.  (ii) Provide emeat least every 2 year (iii) Maintain do	s not met as evidenced by: eview and interview, the facility Emergency Preparedness ewed and/or updated. The an was not reviewed or  of the facility's EP plan in the plan. Additional review include evidence of a review or  of with the Qualified Intellectual ional (QIDP) indicated she in the EP plan had not been dated. in in (1)  103.748, ASCs at §416.54, 5, ICF/IIDs at §483.475, HHAs inizations" under §485.727,  RHC/FQHCs at §491.12:] (1) The [facility] must do all of the ig in emergency preparedness lures to all new and existing involunteers, consistent with their intergency preparedness training ints. incumentation of all emergency	E 03	04			
	Continued From parthis STANDARD is Based on record refailed to ensure the (EP) plan was reviet finding is:  The facility's EP plan updated.  Review on 9/21/20 revealed no date on of the plan did not in update.  Interview on 9/22/2 Disabilities Profess could not be sure if reviewed and/or up EP Training Program CFR(s): 483.475(d)  *[For RNCHIs at §44 Hospitals at §482.1 at §484.102, "Orgamo OPOs at §486.360, Training program. Tollowing:  (i) Initial training policies and proceed staff, individuals program, and respected roles.  (ii) Provide ementate at least every 2 year (iii) Maintain do preparedness training (iv) Demonstraining pomonstraining program.	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1  This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Emergency Preparedness (EP) plan was reviewed and/or updated. The finding is:  The facility's EP plan was not reviewed or updated.  Review on 9/21/20 of the facility's EP plan revealed no date on the plan. Additional review of the plan did not include evidence of a review or update.  Interview on 9/22/20 with the Qualified Intellectual Disabilities Professional (QIDP) indicated she could not be sure if the EP plan had not been reviewed and/or updated.  EP Training Program CFR(s): 483.475(d)(1)  *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following:  (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1  This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Emergency Preparedness (EP) plan was reviewed and/or updated. The finding is:  The facility's EP plan was not reviewed or updated.  Review on 9/21/20 of the facility's EP plan revealed no date on the plan. Additional review of the plan did not include evidence of a review or update.  Interview on 9/22/20 with the Qualified Intellectual Disabilities Professional (QIDP) indicated she could not be sure if the EP plan had not been reviewed and/or updated.  EP Training Program  CFR(s): 483.475(d)(1)  *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following:  (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.  (ii) Provide emergency preparedness training at least every 2 years.  (iii) Maintain documentation of all emergency preparedness training.  (iv) Demonstrate staff knowledge of	A BUILDING  34G170  BY AGAD  STREET ADDRESS, CITY, STATE, ZIP CODE  515 LYNN ROAD  DURHAM, NC 27707  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 1  This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Emergency Preparedness (EP) plan was reviewed and/or updated. The finding is:  The facility's EP plan was not reviewed or updated.  Review on 9/21/20 of the facility's EP plan revealed no date on the plan. Additional review of the plan did not include evidence of a review or updated.  Review on 9/22/20 with the Qualified Intellectual Disabilities Professional (QIDP) indicated she could not be sure if the EP plan had not been reviewed and/or updated.  EP Training Program  CFR(s): 483.475(d)(1)  "For RNCHIs at \$403.748, ASCs at \$416.54, Hospitals at \$482.15, ICF/IIDs at \$483.475, HHAs at \$484.102, "Organizations" under \$485.727, OPOs at \$488.360, RHC/FQHCs at \$491.121 (1) Training program. The [facility] must do all of the following:  (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.  (ii) Maintain documentation of all emergency preparedness training.  (iv) Demonstrate staff knowledge of	A BUILDING B. WING 999  ROVIDER OR SUPPLIER 346370  SUMMARY STATEMENT OF DEFICIENCIES (EACH OBERCITY OF THE APPROPRIATE DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1  This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Emergency Preparedness (EP) plan was reviewed and/or updated. The finding is:  The facility's EP plan was not reviewed or updated on object on the plan had not include evidence of a review or updated.  Interview on 9/21/20 with the Qualified Intellectual Disabilities Professional (QIDP) indicated she could not be sure if the EP plan had not been reviewed and/or updated.  EP Training Program  CFR(s): 483.475(d)(1)  "[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FOHCs at §491.12; (1) Training program. The [facility] must do all of the following:  (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.  (ii) Provide emergency preparedness training at least every 2 years.  (iii) Maintain documentation of all emergency preparedness training.  (iv) Demonstrate staff knowledge of	

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E 037	and procedures are [facility] must condupolicies and procedures are shospice must do all (i) Initial training policies and procedures are expected roles.  (ii) Demonstrate emergency procedures (iii) Provide em at least every 2 years (iv) Periodically emergency prepare employees (includir special emphasis procedures necess others.  (v) Maintain dor preparedness training (vi) If the emergand procedures are hospice must condupolicies and procedures are hospice must condupolicies and procedures are staff, individuals program. The PRTI (i) Initial training policies and procedures are staff, individuals programent, and vexpected roles.	ency preparedness policies estignificantly updated, the act training on the updated dures.  418.113(d):] (1) Training. The of the following: gin emergency preparedness dures to all new and existing and individuals providing angement, consistent with their estaff knowledge of ares. The ergency preparedness training are. The ergency preparedness training are review and rehearse its edness plan with hospice and nonemployee staff), with laced on carrying out the ary to protect patients and commentation of all emergency and gency preparedness policies estignificantly updated, the act training on the updated dures.  4.1.184(d):] (1) Training must do all of the following: gin emergency preparedness dures to all new and existing oviding services under volunteers, consistent with their raining, provide emergency	EO	37			

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E 037	emergency procedu (iv) Maintain do preparedness traini (v) If the emergency procedures are PRTF must conduct policies and procedures and proc	te staff knowledge of cures.  commentation of all emergency ing. lency preparedness policies is significantly updated, the et training on the updated lures.  at §483.73(d):] (1) Training facility must do all of the gin emergency preparedness lures to all new and existing eviding services under volunteers, consistent with their ergency preparedness training extended the estaff knowledge of cures.  85.68(d):](1) Training. The estaff knowledge of training in emergency ites and procedures to all new andividuals providing ingement, and volunteers, in expected roles.  Bergency preparedness training in emergency ingement, and volunteers, in expected roles.  Bergency preparedness training in expected roles.	E 037			

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E 037	workday. The traini instruction in the los systems and signal (v) If the emer and procedures are CORF must conduct policies and procedures and procedures and procedures and procedures and procedure and procedure and where necessary personnel, and gue cooperation with authorities, to all neindividuals providing and volunteers, roles.  (ii) Provide emer at least every 2 year (iii) Maintain do (iv) Demonstrate emergency procedure (v) If the emer and procedures are CAH must conduct policies and procedures are CAH must providing preparedness policies and existing staff, in under arrangement with their expected	chin 2 weeks of their first and program must include cation and use of alarm and firefighting equipment. It is igency preparedness policies a significantly updated, the cat training on the updated dures.  6.625(d):] (1) Training program. Call of the following: It is including prompt guishing of fires, protection, and firefighting and disaster and existing staff, it is grevices under arrangement, consistent with their expected ergency preparedness training in the staff knowledge of the staff knowledge	EO	37		

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E 037	procedures. There emergency prepare years. This STANDARD is Based on record refacility failed to ension the facility's Emeplan. The finding is All staff had not been plan. Review on 9/21/20	nowledge of emergency after, the CMHC must provide adness training at least every 2 as not met as evidenced by: eview and interviews, the ure all new staff were trained ergency Preparedness (EP) is:  en trained on the facility's EP plan (no te any new or existing staff	E 0	37		
E 039	B) revealed they hat the home after the COVID-19. The state some EP training with program but not in the During an interview Intellectual Disability indicated no documbe located for any SEP Testing Require CFR(s): 483.475(d)  *[For RNCHI at §400 HHAs at §484.102, "Organizations" und §485.920, RHC/FQ Facilities at §494.62	on 9/22/20, the Qualified ies Professional (QIDP) entation of EP training could staff working in the home. ments (2) 3.748, ASCs at §416.54, CORFs at §485.68, OPO, der §485.727, CMHC at HC at §491.12, ESRD	E 0	39		

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E 039	to test the emergen must do all of the formust do accessible, con exercise every 2  (B) If the [formatural or man-more activation of the emis exempt from engon community-based of functional exercise the actual event.  (ii) Conduct an every 2 years, opportunctional exercise this section is conduct in the actual event.  (ii) Conduct an every 2 years, opportunctional exercise this section is conduct in the formust do activational exercise;  (B) A mock (C) A tablet is led by a facilitation discussion using a clinically-releval set of problem state prepared questions emergency plan.  (iii) Analyzemaintain document exercises, and emerevise the [facility's]  *[For Hospices at 4 (2) Testing for hospices for the problem is the facility of the problem is the facility's]	locy plan annually. The [facility] collowing: In a full-scale exercise that is every 2 years; or a community-based exercise is duct a facility-based functional years; or accility] experiences an actual de emergency that requires be regency plan, the [facility] aging in its next required or individual, facility-based exercise following the onset of additional exercise at least exercise following the onset of under paragraph (d)(2)(i) of acted, that may include, but is allowing: Individual, facility-based or disaster drill; or cop exercise or workshop that is and includes a group marrated, and ements, directed messages, or designed to challenge an extending the facility's] response to and attending exercise, and emergency events, and emergency plan, as needed.	EO	39		

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E 039	annually. The hos  (i) Participate community based (A) When a  (A) When a  not accessible, corbased functional exities  (B) If the horman-made eme of the emergency pexempt from engages cale community-befacility-based the onset of the emergency exempt from engages cale community-based the onset of the emergency pears, opposite the functional exercise this section is conducted in the formal functional exercise that the formal exercise or  (B) A mode (C) A table is led by a facilitate discussion using a clinically-relevance of problem states of prob	pice must do the following: in a full-scale exercise that is every 2 years; or a community based exercise is induct an individual facility exercise every 2 years; or ospice experiences a natural regency that requires activation plan, the hospital is ging in its next required full eased exercise or individual functional exercise following in additional exercise every 2 eyear the full-scale or under paragraph (d) (2)(i) of flucted, that may include, but is plowing: and full-scale exercise that is or a facility based functional exercise that is or a facility based functional exercise or workshop that or and includes a group narrated, ant emergency scenario, and a ements, directed messages, or a designed to challenge an entergency plan twice per must do the following: in an annual full-scale exercise in an annual full-scale exercise	EO	39			

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E 039	not accessible, con facility-based functi  (B) If the ho or man-made emer of the emergency pexempt from engage full-scale communit functional of the emergency e (ii) Conduct and that may include, but following:  (A) A secon community-based of exercise; or  (B) A moch (C) A table by a facilitator that in using a narrated, emergency scenaristatements, directed questions desemergency plan.  (iii) Analyze the maintain document exercises, and emergency sementer the hospice's emergency emergency plan.  (iii) Analyze the maintain document exercises, and emergency plan.  (iii) Analyze the maintain document exercises, and emergency plan.  (iii) Analyze the maintain document exercises, and emergency plan.  (iii) Participate in that is community-but the following:  (i) Participate in that is community-but that the community-but that the community that the c	duct an annual individual onal exercise; or ospice experiences a natural gency that requires activation lan, the hospice is ing in its next required by based or facility-based exercise following the onset ovent.  additional annual exercise at it is not limited to the exercise or workshop led includes a group discussion clinically-relevant or, and a set of problem do messages, or prepared signed to challenge an expercise of and action of all drills, tabletop ergency events and revise gency plan, as needed.  1.184(d), Hospitals at at §485.625(d):] RTF, Hospital, CAH] must or test the emergency plan expercise exercise exercise.	EO	39			

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E 039	experiences an act emergency that recemergency plan, the engaging in its next based or functional exercise emergency event.  (ii) Conduct an and that may include following:  (A) A secons community-based functional exercises  (B) A mock (C) A table is led by a facilitate discussion, using a clinically-relevate set of problem state prepared questions emergency plan.  (iii) Analyze the maintain document exercises, and emergency plan.  (iii) Analyze the maintain document exercises, and emergency plan.  (III) Analyze the maintain document exercises, and emergency plan.  (III) Analyze the maintain document exercises, and emergency plan.  (III) Analyze the maintain document exercises, and emergency plan.  (III) Analyze the maintain document exercises, and emergency plan.  (III) Analyze the maintain document exercises, and emergency plan.  (III) Analyze the maintain document exercises, and emergency plan.  (III) Analyze the maintain document exercises, and emergency plan.  (III) Analyze the maintain document exercises, and emergency plan.  (III) Analyze the maintain document exercises, and emergency plan.  (III) Analyze the maintain document exercises, and emergency plan.  (III) Analyze the maintain document exercises, and emergency plan.  (III) Analyze the maintain document exercises, and emergency plan.  (III) Analyze the maintain document exercises, and emergency plan.  (III) Analyze the maintain document exercises, and emergency plan.  (III) Analyze the maintain document exercises, and emergency plan.  (III) Analyze the maintain document exercises, and emergency plan.  (III) Analyze the maintain document exercises, and emergency plan.  (III) Analyze the maintain document exercises, and emergency plan.  (III) Analyze the maintain document exercises, and emergency plan.  (III) Analyze the maintain document exercises, and emergency plan.	ional exercise; or PRTF, Hospital, CAH] tual natural or man-made quires activation of the ne [facility] is exempt from trequired full-scale community individual, facility-based following the onset of the [additional] annual exercise or de, but is not limited to the nd full-scale exercise that is or individual, a facility-based; or a disaster drill; or top exercise or workshop that or and includes a group a narrated, ant emergency scenario, and a ements, directed messages, or designed to challenge an exercise in an an received staff drills using the ures. The [LTC facility, ne following: in an annual full-scale exercise	E 03	39			

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E 039	an actual natural or requires activation the LTC facility is erequired a full-scale individual, facil following the onset (ii) Conduct arthat may include, brown following:  (A) A secon community-based of functional exercise  (B) A moc (C) A table is led by a facilitate using a narrated, emergency scenaristatements, directed questions defended and materials. (iii) Analyze the response to and modills, tabletop exert events, and revise emergency plan, as *[For ICF/IIDs at §2 (2) Testing. The IC to test the emerger The ICF/IID must of (i) Participate in that is community-legal (A) When a not accessible, confacility-based functions.	ional exercise.  TC facility] facility experiences of man-made emergency that of the emergency plan, empt from engaging its next of the emergency event. In additional annual exercise of the emergency event is not limited to the end full-scale exercise that is for an individual, facility based it is or an individual, facility based it is or an individual, facility based it is or an individual, facility's and a set of problem of ed messages, or prepared signed to challenge an electron exercises, and emergency the [LTC facility] facility's an intain documentation of all cises, and emergency the [LTC facility] facility's eneeded.  183.475(d)]:  F/IID must conduct exercises only plan at least twice per year. In the following:  In an annual full-scale exercise on a community-based exercise is aduct an annual individual,	EO	39			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G170	B. WING		09	09/22/2020	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 515 LYNN ROAD DURHAM, NC 27707	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
E 039	natural or man-mace activation of the emis exempt from eng full-scale communit based functions of the emergency e (ii) Conduct an may include, but is (A) A second community-based of functional exercise; (B) A mock (C) A tablet is led by a facilitate discussion, using a clinically-relevant set of problem state prepared questions emergency plan. (iii) Analyze the maintain document exercises, and emergency emergency emergency emergency emergency emergency emisted (d)(2) Testing. The to test the emergency following: (i) Conduct a part of the emission of the emission, using a emergency scenarious tatements, directly questions designed plan. If the OPO ex or man-made emergency emission is exempted to the emission of the emission o	de emergency that requires bergency plan, the ICF/IID aging in its next required cy-based or individual, facility-based or individual, facility-based or individual, facility-based or individual exercise that not limited to the following: and full-scale exercise that is or an individual, facility-based or disaster drill; or op exercise or workshop that or and includes a group narrated, and ements, directed messages, or designed to challenge an ICF/IID's response to and ation of all drills, tabletop ergency events, and revise lency plan, as needed.  6.360] OPO must conduct exercises cy plan. The OPO must do the aper-based, tabletop exercise at annually. A tabletop exercise	ΕO	39			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		34G170	B. WING		09/22/2020	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 515 LYNN ROAD DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
E 039	engaging in its next following the onset (ii) Analyze the maintain document and emergency ever and OPO's] emerged This STANDARD is Based on document facility failed to ensor tabletop exercise Preparedness (EP) potentially affected finding is:	ge 12 required testing exercise of the emergency event. OPO's response to and ation of all tabletop exercises, ents, and revise the [RNHCI's ency plan, as needed. s not met as evidenced by: nt review and interviews, the ure facility/community-based es to test their Emergency plan were conducted. This all clients in the home. The	E 0	39		
W 217	of facility/communit Review on 9/21/20 date), did not include community-based of Interview on 9/22/20 indicated he though been conducted at however, no docum INDIVIDUAL PROGUER(s): 483.440(c) The comprehensive include nutritional s  This STANDARD is Based on record refacility failed to ensign functional Assessin	y-based or tabletop exercises.  of the facility's EP plan (no le a full-scale or tabletop exercise.  O with the Administrator at a tabletop exercise had the home over the past year; antation could be located.  GRAM PLAN (3)(v)  e functional assessment must	W 2	17		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		34G170	B. WING		09/22/2020	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 515 LYNN ROAD DURHAM, NC 27707	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODER (DEFICIENCY)	JLD BE COMPLÉTION	1
W 217	Continued From pa	ge 13	W 2	17		
	Clients (#1, #4) did their nutritional state	not receive an assessment of us.				
	he had been admitt Additional review of Program Plan (IPP) nutritional assessm	of client #1's record revealed ed to the facility on 4/15/20. f the client's Individual dated 5/14/20 revealed his ent was "Pending". Further didd not include a nutritional				
	he had been admitt	of client #4's record revealed ed to the facility on 2/10/20. the client's record did not assessment.				
W 218	Disabilities Professi clients were in need however, one had r		W 2	18		
	The comprehensive include sensorimoto	e functional assessment must or development.				
	Based on record re failed to ensure clie Functional Assessn assessment of his s	s not met as evidenced by: eview and interview, the facility ent #4's Comprehensive nent (CFA) included an sensorimotor development. audit clients. The finding is:				
	Client #4's CFA did Therapy (OT) asses	not include an Occupational ssment.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		34G170	B. WING		09/	22/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 515 LYNN ROAD DURHAM, NC 27707	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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	(X5) COMPLETION DATE
W 218	Continued From pa	nge 14	W 21	3		
	he had been admitt Additional review of OT assessment.	of client #4's record revealed ted to the facility on 2/10/20. If the record did not include an				
W 249	Disabilities Profess #4 was in need of a		W 24	9		
	As soon as the inte formulated a client' each client must re treatment program interventions and s and frequency to so	erdisciplinary team has as individual program plan, ceive a continuous active consisting of needed ervices in sufficient number apport the achievement of the d in the individual program				
	Based on observarinterviews, the facilical clients (#3, #4, #5, active treatment prointerventions and significant programmeal preparation, as	s not met as evidenced by: tions, record review and ity failed to ensure 4 of 5 audit #6) received a continuous ogram consisting of needed ervices as identified in the Plan (IPP) in the areas of adaptive equipment use and stration. The findings are:				
	Clients were not participate with cool	t prompted or assisted to king tasks.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		34G170	B. WING _		09	/22/2020	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 515 LYNN ROAD DURHAM, NC 27707	•		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
W 249	During morning ob 9/22/20 from 7:05a breakfast food iten toast) without any home. During this walked in/out of the Interview on 9/22/2 behaviors, only so with meal preparat client #4 does not his attention span Additional interview home "can help" w  Review on 9/22/20 9/26/19 revealed homeal preparation". Adaptive Behavior identified needs in Review on 9/22/20 2/25/20 indicated roreparation.  Interview on 9/21/20, wear eye glasses such pouring morning and home on 9/21/20, wear eye glasses. class work on his least the second content of the properties of the propert	servations in the home on am - 7:37am, staff prepared all as (scrambled eggs, bacon, participation from clients in the time, client #3 and client #4 area unengaged.  20 with Staff B revealed due to me of the clients participate ion tasks. The staff indicated assist in the kitchen because is short and he has behaviors. In violed all other clients in the ith meal preparation.  of client #3's IPP dated e, "likes assisting staff with Additional review of his Inventory (ABI) dated 9/23/19 the area of meal preparation.  of client #4's ABI dated needs in the area of meal	W 24				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		34G170	B. WING _		09	/22/2020	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 515 LYNN ROAD DURHAM, NC 27707			
(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)	I SHOULD BE	(X5) COMPLETION DATE	
W 249	and colored/market clients were not as eye glasses.  Interview on 9/22/2 client #3 wears eye minutes at a time.  Review on 9/21/20 9/26/19 revealed a glasses as tolerate 80% verbal prompiperiods (implement review of the client be encouraged to compliment him or The plan also note occur when [Client glasses." Further exam report dated myopia, borderline prescribed to be with the encouraged to be with the color of the client glasses. Further exam report dated myopia, borderline prescribed to be with the color of the client glasses. Additional should be prompted the opportunity arise.	coked at videos on his laptop and on a sheet of paper. The esisted or encouraged to wear a comparison of client #3's IPP dated an objective to wear his eye and for up to 30 minutes with the for two consecutive review ated 12/21/19). Additional comparison of the glasses on and staff will put the glasses on and staff will an how well they look on him" and, "Other opportunities will will put the client's vision of client #4's IPP dated as wears his eye glasses "daily ional review of the client's noted, "Myopia with the comparison of the client's noted, "Myopia with the eye glasses as needed."	W 24	49			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		34G170	B. WING		09/22/2020	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 515 LYNN ROAD DURHAM, NC 27707	•	
(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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 249	During lunch obser at 12:10pm, client as protector while consisted of an on-section of a non-section at 12:10pm, client at 12:1	rvations in the home on 9/21/20 #5 utilized regular cups, a ctioned plate and a clothing issuming his meal.  20 with Staff B revealed client cups and a clothing protector at of client #5's IPP dated is adaptive dining equipment skid mat, a cup with a lid and g protector. The plan did not utilize a sectioned plate.  20 with the QIDP confirmed eve been provided his adaptive straw at lunch. The QIDP not require a sectioned plate at #4) were provided with tive dining equipment.  22/20, all six clients, with the lient at lunch, were provided positioned underneath their of client #1, client #3, and ed 5/14/20, 9/26/19 and ely) did not indicate a non-skid	W 24	49		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		34G170	B. WING _	· · · · · · · · · · · · · · · · · · ·	09/	09/22/2020	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 515 LYNN ROAD DURHAM, NC 27707	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
W 263 W 263	PROGRAM MONIT CFR(s): 483.440(f)(c) The committee sho are conducted only consent of the clien minor) or legal guar.  This STANDARD is Based on record refailed to ensure resfor 1 of 5 audit clien with the written info guardian. The findic Client #3's BSP did consent from the guardian revealed ar Review on 9/21/20 8/27/19 revealed ar Road without (0 epi behavior and physic consecutive months	ORING & CHANGE (3)(ii)  uld insure that these programs with the written informed t, parents (if the client is a rdian.  s not met as evidenced by: eview and interview, the facility trictive Behavior Support Planuts (#3) was only conducted rmed consent of the legal ngs is:  not include written informed uardian.  of client #3's BSP dated in objective to transition to Lynn sodes) display of self-injurious	W 26				
	of the record did no	t include a current written or the BSP from the client's					
W 323	Disabilities Professi written informed co		W 32	23			
		ovide or obtain annual physical ch client that at a minimum					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G170	B. WING		09/	22/2020	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 515 LYNN ROAD DURHAM, NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE	
W 323	Continued From pa includes an evaluat	ge 19 ion of vision and hearing.	W 3	323			
	Based on record refailed to ensure clie	s not met as evidenced by: eview and interview, the facility ent #1 had an evaluation of his This affected 1 of 5 audit j is:					
	Client #1 had not re vision and hearing.	eceived an evaluation of his					
	he had been admitt						
W 352	Disabilities Profess #1 had not received and hearing as of the	0 with the Qualified Intellectual ional (QIDP) confirmed client d an assessment of his vision he date of the survey.  E DENTAL DIAGNOSTIC	W 3	552			
		ntal diagnostic services amination and diagnosis annually.					
	Based on record re failed to ensure clie comprehensive der	s not met as evidenced by: eview and interview, the facility ent #1 received a ntal examination at least cted 1 of 5 audit clients. The					

AND DUAN OF CODDECTION IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	` '	TE SURVEY MPLETED		
		34G170	B. WING		09	/22/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 515 LYNN ROAD DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORF  X (EACH CORRECTIVE ACTION S  CROSS-REFERENCED TO THE AL  DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 352	Review on 9/21/20 he had been admitt Additional review of	ge 20 eceived a dental examination.  of client #1's record revealed ed to the facility on 4/15/20.  If his Individual Program Plan dental examination was	W 3	352		
W 368	"Pending".  Interview on 9/22/20 Disabilities Profess #1 had not received the date of the surv DRUG ADMINISTR CFR(s): 483.460(k) The system for drug	O with the Qualified Intellectual ional (QIDP) confirmed client d a dental examination as of ey.  AATION (1) g administration must assure dministered in compliance with	W 3	668		
	Based on observatinterview, the facility medications were a with physician's ord	s not met as evidenced by: cions, record review and y failed to ensure all dministered in accordance ers. This affected 1 of 3 ed receiving medications. The				
	Client #3's Gavilax according to physic	powder was not administered ian's orders.				
	administration in the Staff A obtained a cadded it to 4 - 6 oz client #3. The power dissolved in the gla	servations of medication e home on 9/22/20 at 7:30am, apful of Gavilax powder, of water and gave the glass to der was not stirred or ss. Client #3 consumed the medications. After drinking the				

AND DUAN OF CORRECTION IDENTIFICATION NUMBER		RIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED			
		34G170	B. WING		09/	22/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 515 LYNN ROAD DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDER OF THE APPROPRIES OF THE	JLD BE	(X5) COMPLETION DATE
W 369	Immediate interview normally does not go morning. When as powder, the staff in to be "dissolved" in Review on 9/22/20 dated 7/13/20 revea "dissolve 17gm (1 coliquid and drink"  Interview on 9/22/2 confirmed the Gavi dissolved as writter ensure it had dissolved as writter ensure it had dissolved ADMINISTR CFR(s): 483.460(k)  The system for drug that all drugs, include self-administered, as the system for drug that all drugs, include self-administered, as a self-administered, as the system for drug that all drugs, include self-administered, as the system for drug that all drugs, include self-administered, as the system for drug that all drugs, include self-administered, as the system for drug that all drugs, include self-administered, as the system for drug that all drugs, include self-administered, as the system for drug that all drugs, include self-administered, as the system for drug that all drugs, include self-administered, as the system for drug that all drugs, include self-administered, as the system for drug that all drugs, include self-administered and system for drug that all drugs, include self-administered, as the system for drug that all drugs, include self-administered and system for drug that all drugs, include self-administered and system for drug that all drugs, include self-administered and system for drug that all drugs in the system for drug that all drugs	inined amount of Gavilax to the bottom of the glass.  In with Staff A revealed she give medications in the ked about not stirring the dicated the Gavilax just needs the water.  In of client #3 physician's orders aled an order for Gavilax, capful to the line) in 4 - 8 oz of the water of the	W 3			
		servations of medication e home on 9/22/20 at 7:30am,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G170	B. WING _		09/	/22/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 515 LYNN ROAD DURHAM, NC 27707		22/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 369	added it to 4 - 6 oz client #3. The powdissolved in the gla Gavilax with other rwater, an undeterm powder remained a Immediate interview normally does not gmorning. When as powder, the staff in to be "dissolved" in Review on 9/22/20 dated 7/13/20 rever "dissolve 17gm (1 cliquid and drink"  Interview on 9/22/2 confirmed the Gavidissolved as writter ensure it had disso EVACUATION DRICFR(s): 483.470(i)0 The facility must he quarterly for each stall clients residing in all clients residing in a solution of the powdiscourse of the powdiscours	capful of Gavilax powder, of water and gave the glass to der was not stirred or ss. Client #3 consumed the medications. After drinking the nined amount of Gavilax at the bottom of the glass.  If with Staff A revealed she give medications in the ked about not stirring the dicated the Gavilax just needs the water.  If client #3 physician's orders aled an order for Gavilax, capful to the line) in 4 - 8 oz of the water with the facility's nurse lax powder should have been on the orders or stirred to lived completely.  LLS (1)	W 36			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G170	B. WING		<u> </u>	09/	09/22/2020	
NAME OF F	PROVIDER OR SUPPLIER			515 LYN	ADDRESS, CITY, STATE, ZIP CODE IN ROAD AM, NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  '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	(X5) COMPLETION DATE	
W 440	documentation for d	of facility fire drills revealed drills completed on 2/29/20 er fire drill reports were	W 4	40				
W 460	Disabilities Profess Managers were res	TION SERVICES	W 4	60				
	Each client must re well-balanced diet i specially-prescribed	ncluding modified and						
	Based on observat reviews, the facility clients (#1, #5) rece	s not met as evidenced by: ions, interviews and record failed to ensure 2 of 5 audit eived modified and d diets as indicated. The						
	Each client's (#1, #9 was not followed.	5) modified food consistency						
	9/21/20 at 12:10pm whole grilled chees The sandwich was were varied in size dinner observations	servations in the home on a client #1 consumed two e sandwiches and Cheetos. not cut up and the Cheetos up to 1 inch pieces. During in the home on 9/21/20 at consumed two whole slices of the consumed two whole slices of the consumed two whole slices of the client was a consumed two whole slices of the client was a consumed two whole slices of the client was a client						
	Interview on 9/22/20	0 with Staff B revealed client						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G170	B. WING		_   09.	/22/2020	
NAME OF PROVIDER OR SUPPLIER  LYNN ROAD				STREET ADDRESS, CITY, STATE 515 LYNN ROAD DURHAM, NC 27707	•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
W 460	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		W 4	60			