PRINTED: 06/08/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , , , , , , , , , , , , , , , , , , ,	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G050	B. WING		06	5/07/2022	
	PROVIDER OR SUPPLIER	RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6310 MOUNT HERMAN CHURCH ROAD DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ARRON DEFENDINGED TO THE ADD	OULD BE	(X5) COMPLETION DATE	
	EP Training Prograc CFR(s): 483.475(d) §403.748(d)(1), §46 §441.184(d)(1), §48 §485.68(d)(1), §48 §485.920(d)(1), §48 *[For RNCHIs at §4 Hospitals at §482.1 at §484.102, "Orga OPOs at §486.360, (1) Training prograthe following: (i) Initial training in policies and proceds staff, individuals programment, and expected roles. (ii) Provide emerge least every 2 years (iii) Maintain documpreparedness traini (iv) Demonstrate st procedures. (v) If the emergence procedures are sign must conduct traini procedures. *[For Hospices at § hospice must do al (i) Initial training in policies and procedures employees and procedures are sign must conduct traini procedures.	m (1) 16.54(d)(1), §418.113(d)(1), 60.84(d)(1), §482.15(d)(1), 3.475(d)(1), §484.102(d)(1), 5.625(d)(1), §485.727(d)(1), 60.3.748, ASCs at §416.54, 5, ICF/IIDs at §483.475, HHAs nizations" under §485.727, RHC/FQHCs at §491.12:] m. The [facility] must do all of emergency preparedness dures to all new and existing oviding services under volunteers, consistent with their incy preparedness training at enentation of all emergency ing. aff knowledge of emergency y preparedness policies and inficantly updated, the [facility] ing on the updated policies and of the following: emergency preparedness dures to all new and existing services to all new and existing ing on the updated policies and of the following: emergency preparedness dures to all new and existing services to all new and existing services and individuals providing			ROPRIATE	DATE	
AROPATOR	expected roles. (ii) Demonstrate state procedures.	angement, consistent with their aff knowledge of emergency	NATURE	TITLE		(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.

Director of Retirement Services

06/22/2022

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUC AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			COMPLETED			
		34G050	B. WING		06	5/07/2022
	PROVIDER OR SUPPLIER	C. RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 6310 MOUNT HERMAN CHURCH ROAD DURHAM, NC 27705	E	
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
E 037	least every 2 years (iv) Periodically rev emergency prepare employees (includispecial emphasis p procedures necess others. (v) Maintain docum preparedness train (vi) If the emergency procedures are sig must conduct train procedures. *[For PRTFs at §44 program. The PRT (i) Initial training in policies and proced staff, individuals pr arrangement, and expected roles. (ii) After initial train preparedness train (iii) Demonstrate sig procedures. (iv) Maintain docum preparedness train (v) If the emergency procedures are sig must conduct train procedures. *[For PACE at §460 organization must (ii) Initial training in policies and procedures and procedures.	ency preparedness training at iew and rehearse its edness plan with hospice ing nonemployee staff), with placed on carrying out the eary to protect patients and ientation of all emergency ing. The property ing its preparedness policies and inficantly updated, the hospice ing on the updated policies and if its total and if its total ing		37		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G050	B. WING		06	/07/2022	
	PROVIDER OR SUPPLIER	C. RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6310 MOUNT HERMAN CHURCH ROAD DURHAM, NC 27705			
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
E 037	arrangement, contrivolunteers, consisted (ii) Provide emerge least every 2 years (iii) Demonstrate st procedures, including what to do, where the case of an emerged (iv) Maintain document (v) If the emergency procedures are sign must conduct training procedures. *[For LTC Facilities Program. The LTC following: (i) Initial training in policies and procedures and procedures arrangement, and expected role. (ii) Provide emergency least annually. (iii) Maintain documpreparedness train (iv) Demonstrate stand procedures. *[For CORFs at §4 CORF must do all (i) Provide initial training staff, in under arrangement with their expected	ractors, participants, and ent with their expected roles. Incy preparedness training at aff knowledge of emergency in informing participants of to go, and whom to contact in incy. Inentation of all training. The preparedness policies and inficantly updated, the PACE ing on the updated policies and inficantly must do all of the emergency preparedness dures to all new and existing oviding services under volunteers, consistent with their ency preparedness training at the entation of all emergency ing. It is the following: and set \$483.73(d):] (1) Training at the entation of all emergency ing. It is the following: and procedures to all new individuals providing services to all new individuals pr	E 03	37			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED
		34G050	B. WING		06/	07/2022
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		JLD BE	(X5) COMPLETION DATE
E 037	(iii) Maintain docum (iv) Demonstrate st procedures. All new and assigned specithe CORF's emerge their first workday include instruction i alarm systems and equipment. (v) If the emergen procedures are sign must conduct training procedures. *[For CAHs at §485 The CAH must do a (i) Initial training in policies and procedures and where necessare personnel, and gue cooperation with finauthorities, to all neindividuals providing and volunteers, corroles. (ii) Provide emerge least every 2 years. (iii) Maintain docum (iv) Demonstrate st procedures. (v) If the emergen procedures are sign must conduct training procedures. *[For CMHCs at §485]	pentation of the training. aff knowledge of emergency of personnel must be oriented fic responsibilities regarding ency plan within 2 weeks of The training program must in the location and use of signals and firefighting cy preparedness policies and nificantly updated, the CORFing on the updated policies and on the updated policies and side of the following: emergency preparedness tures, including prompt guishing of fires, protection, and efighting and disaster ew and existing staff, g services under arrangement, asistent with their expected ency preparedness training at	EC	037		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6310 MOUNT HERMAN CHURCH ROAD DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 037	and existing staff, ir under arrangement with their expected documentation of the demonstrate staff k procedures. There emergency prepare years. This STANDARD is Based on documer facility failed to ensuadequately trained oprepardness (EP) procedures (EP)	les and procedures to all new individuals providing services, and volunteers, consistent roles, and maintain he training. The CMHC must nowledge of emergency after, the CMHC must provide idness training at least every 2 is not met as evidenced by: not review and interviews, the ure direct care staff were on the facility's emergency idna. The finding is: If the facility's EP manual de any information regarding on 6/7/22, the Clinical ered Nurse (CCRN) confirmed included in the EP of the staff. ments (2) 3.113(d)(2), §441.184(d)(2), 2.15(d)(2), §483.73(d)(2), 34.102(d)(2), §485.68(d)(2), 35.727(d)(2), §485.920(d)(2), 4.62(d)(2). 54, CORFs at §485.68, OPO, der §485.727, CMHCs at QHCs at §491.12, and ESRD	EO	E037: A review of the company EP will be con annually. Employees will complete annual EF training by 6/30/2022 and annually thereafter. training will be conducted by a location super administrator: Director, Clinical Coordinator R (CCRN), or Senior Direct Supports Coordinate (SDSC).	P . The visor or RN	
	(2) Testing. The [fac	cility] must conduct exercises				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6310 MOUNT HERMAN CHURCH ROAD DURHAM, NC 27705		
(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
E 039	to test the emergen must do all of the formust do accessible, conduct exercise every 2 yeth (B) If the [facility natural or man-made activation of the emexempt from engage community-based of functional exercise actual event. (ii) Conduct an add years, opposite the functional exercise this section is conduct in the formust do a section is conducted in the formust do a section is conducted functional exercise; (B) A mock disaste (C) A tabletop exercise facilitator and inclusional exercises; (B) A mock disaste (C) A tabletop exercise facilitator and inclusional exercises, and a set directed messages designed to challer (iii) Analyze the [facility's] emergence [facility's] emergence *[For Hospices at 4 (2) Testing for hospices	acy plan annually. The [facility] billowing: all-scale exercise that is every 2 years; or unity-based exercise is not a facility-based functional ars; or y] experiences an actual de emergency that requires bergency plan, the [facility] is ging in its next required or individual, facility-based following the onset of the ditional exercise at least every 2 year the full-scale or under paragraph (d)(2)(i) of ucted, that may include, but is allowing: The calculate exercise that is or individual, facility-based or ardrill; or coise or workshop that is led by udes a group discussion using y-relevant emergency of problem statements, or prepared questions are emergency plan. Sility's] response to and action of all drills, tabletop ergency events, and revise the explan, as needed.	EO	39		

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	. RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6310 MOUNT HERMAN CHURCH ROAD DURHAM, NC 27705		
(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 SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
E 039	annually. The hosp (i) Participate in a recommunity based of (A) When a community based of (A) When a community based of (A) If the hospice of (B) If the hospice of (C) A second full-second of (C) A tabletop exert (C) A tabletop exer	e emergency plan at least place must do the following: full-scale exercise that is every 2 years; or unity based exercise is not an individual facility based every 2 years; or experiences a natural or experiences a natural or experiences a natural or exercise or individual exercise or individual onal exercise following the ency event. In the hospital is exempt from the full-scale or functional exercise or functional exercise every 2 years, and full-scale or functional exercise that is exercise that is exercise that is exercise or workshop that is led by exercise o	EO	39		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 06/08/2022 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G050	B. WING			06/	07/2022
	PROVIDER OR SUPPLIER	RETIREMENT CENTER		6	TREET ADDRESS, CITY, STATE, ZIP CODE 310 MOUNT HERMAN CHURCH ROAD OURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	facility-based function (B) If the hospice examan-made emerge the emergency planengaging in its next based or facility-based following the onset (ii) Conduct an addinary include, but is (A) A second full-so community-based dexercise; or (B) A mock disaste (C) A tabletop exert facilitator that including narrated, clinically-rand a set of problem messages, or preparable and a set of problem messages, and emerge (iii) Analyze the hosmaintain documentate exercises, and emerge (iii) Analyze the hosmaintain documentate exercises, and emerge (iii) Participate in an is community-based (2) Testing. The [PF conduct exercises to twice per year. The dothe following: (i) Participate in an is community-based (A) When a community-based (A) When a community-based function (B) If the [PRTF, Hospitz of the following: (ii) Figure 1 and	conal exercise; or experiences a natural or experiences and exercise is exempt from required full-scale community sed functional exercise of the emergency event. It is experienced in the exercise that exercise that exercise that is experienced and exercise that is experienced and exercise that is experienced and exercise that is experienced exercise that is experienced exercise that is experienced exercise that experienced exercise that experienced exercise that experienced exercise to and extend exercise that experienced exercise that experienced exercise that experienced exercise is not an annual individual,	EO	039			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		34G050	B. WING			06/	07/2022
	PROVIDER OR SUPPLIER	C. RETIREMENT CENTER		6	TREET ADDRESS, CITY, STATE, ZIP CODE 310 MOUNT HERMAN CHURCH ROAD OURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	requires activation [facility] is exempt for required full-scale of facility-based functionset of the emerg (ii) Conduct are and that may include following: (A) A second full-scommunity-based of functional exercise (B) A mock (C) A tabletop of led by a facilitator addiscussion, using a emergency scenaric statements, directed questions designed plan. (iii) Analyze the maintain document exercises, and emergency scenaric statements, directed questions designed plan. (iii) Analyze the maintain document exercises, and emergency scenaric statements, directed questions designed plan. (iii) Analyze the maintain document exercises, and emergency scenaric scenaric statements, directed questions designed plan. (iii) Analyze the maintain document exercises to test the annually. The PAC following: (i) Participate in an is community-based function (B) If the PACE examinate emergency plan emergency	of the emergency plan, the from engaging in its next community based or individual, ional exercise following the ency event. [additional] annual exercise or de, but is not limited to the cale exercise that is or individual, a facility-based or individual, a facility-based or exercise or workshop that is and includes a group in narrated, clinically-relevant is and a set of problem of messages, or prepared of to challenge an emergency effacility's] response to and facility is response to and revise the corporation must conduct the emergency plan at least is organization must do the manual full-scale exercise that did or unity-based exercise is not an annual individual,		039			

Facility ID: 010376

	OF CORRECTION	IDENTIFICATION NUMBER:	, ,	IG		IPLETED
		34G050	B. WING _		06/	07/2022
	PROVIDER OR SUPPLIER	. RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6310 MOUNT HERMAN CHURCH ROAD DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	BE	(X5) COMPLETION DATE
E 039	based or individual, exercise following the event. (ii) Conduct any ears opposite the yexercise under parais conducted that me the following: (A) A second full-socommunity-based of functional exercise; (B) A mock disaste (C) A tabletop exercise a narrated, clissing a narrated, c	facility-based functional ne onset of the emergency additional exercise every 2 year the full-scale or functional agraph (d)(2)(i) of this section ay include, but is not limited to cale exercise that is r individual, a facility based or r drill; or cise or workshop that is led by udes a group discussion, nically-relevant emergency of problem statements, or prepared questions ge an emergency plan. CE's response to and ation of all drills, tabletop rgency events and revise the plan, as needed. at §483.73(d):] must conduct exercises to plan at least twice per year, ced staff drills using the res. The [LTC facility, e following: annual full-scale exercise that l; or nity-based exercise is not an annual individual,	E 03	9		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G050	B. WING		06/0	07/2022
	PROVIDER OR SUPPLIER	RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6310 MOUNT HERMAN CHURCH ROAD DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	required a full-scale individual, facility-based following the onset (ii) Conduct an add may include, but is (A) A second full-scommunity-based of functional exercise; (B) A mock disaste (C) A tabletop exert a facilitator includes narrated, clinically-rand a set of problem messages, or preparable and maintain docume exercises, and eme [LTC facility] facility facility facility facility facility facility-based functional exercises (A) When a community-based (I) Participate in an aim is community-based functional exercise facility-based functional exercise facility-based of facility-based of functional exercise facility-based functional exercise facil	e community-based or ased functional exercise of the emergency event. In the initial annual exercise that anot limited to the following: cale exercise that is an individual, facility based or a drill; or cise or workshop that is led by a group discussion, using a elevant emergency scenario, an statements, directed ared questions designed to be ency plan. C facility] facility's response to mentation of all drills, tabletop regency events, and revise the semergency plan, as needed. 83.475(d)]: If IID must conduct exercises by plan at least twice per year. To the following: annual full-scale exercise that all; or annual individual, onal exercise; or periences an actual natural or noty that requires activation of, the ICF/IID is exempt from	EO	39		

	T OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		34G050	B. WING			06/	07/2022
	PROVIDER OR SUPPLIER	RETIREMENT CENTER		6	TREET ADDRESS, CITY, STATE, ZIP CODE 310 MOUNT HERMAN CHURCH ROAD OURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	(A) A second full-so community-based of functional exercise; (B) A mock disaster (C) A tabletop exerca facilitator and inclusing a narrated, cl scenario, and a set directed messages designed to challen (iii) Analyze the ICF maintain document exercises, and emeror (iii) Analyze the ICF maintain document exercises, and emeror (For HHAs at §484 (d)(2) Testing. The to test the emergence least annually. The (i) Participate in a frommunity-based; (A) When a correct accessible, conduct facility-based function. (B) If the HHA or man-made emeror the emergency pengaging in its next community-based of functional exercise emergency event. (ii) Conduct an add opposite the year the exercise under parties conducted, that limited to the follow	rale exercise that is or an individual, facility-based or or drill; or cise or workshop that is led by udes a group discussion, inically-relevant emergency of problem statements, or prepared questions ge an emergency plan. [AllD's response to and ation of all drills, tabletop ergency events, and revise the ey plan, as needed. [AllO2] HHA must conduct exercises explan at HHA must do the following: ull-scale exercise that is or mmunity-based exercise is not an annual individual, onal exercise every 2 years; experiences an actual natural regency that requires activation plan, the HHA is exempt from a required full-scale or individual, facility based following the onset of the itional exercise every 2 years, ne full-scale or functional agraph (d)(2)(i) of this section at may include, but is not	E	039			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		34G050	B. WING			06/	07/2022
NAME OF PROVIDER OR SUPPLIER RESIDENTIAL SERVICES, INC. RETIREMENT CENTER				63	TREET ADDRESS, CITY, STATE, ZIP CODE 310 MOUNT HERMAN CHURCH ROAD DURHAM, NC 27705		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	ULD BE COMPLETIC	
E 039	community-based of functional exercise; (B) A mock disa (C) A tabletop of led by a facilitator adiscussion, using a emergency scenaristatements, directe questions designed plan. (iii) Analyze the HH documentation of a emergency events, emergency plan, as *[For OPOs at §486 (d)(2) Testing. The to test the emergency following: (i) Conduct a paper workshop at least a led by a facilitator adiscussion, using a emergency scenaristatements, directe questions designed plan. If the OPO ex man-made emerge the emergency plar engaging in its next following the onset (ii) Analyze the OPO documentation of a emergency events, OPO's] emergency *[RNCHIs at §403.	or an individual, facility-based or aster drill; or exercise or workshop that is nd includes a group narrated, clinically-relevant o, and a set of problem d messages, or prepared to challenge an emergency. A's response to and maintain II drills, tabletop exercises, and and revise the HHA's eneeded. 6.360] OPO must conduct exercises or includes a group narrated, clinically relevant o, and a set of problem d messages, or prepared to challenge an emergency periences an actual natural or ncy that requires activation of n, the OPO is exempt from a required testing exercise of the emergency event. O's response to and maintain II tabletop exercises, and and revise the [RNHCl's and plan, as needed.	EC	139			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
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NAME OF PROVIDER OR SUPPLIER RESIDENTIAL SERVICES, INC. RETIREMENT CENTER				63	STREET ADDRESS, CITY, STATE, ZIP CODE 6310 MOUNT HERMAN CHURCH ROAD DURHAM, NC 27705			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
E 039	exercises to test the must do the followir (i) Conduct a paper least annually. A talk discussion led by a clinically-relevant er of problem stateme prepared questions emergency plan. (ii) Analyze the RNH maintain document and emergency ever emergency plan, as This STANDARD is Based on documer facility failed to ensor tabletop exercise Preparedness (EP) potentially affected #6, #7, #8, #9, #10, Review on 6/6/22 or include a full-scale exercise for 2021, vin the home. During an interview Coordinator Registe the table top exercise working in the home STAFF TRAINING CFR(s): 483.430(e) The facility must proinitial and continuing employee to perfore efficiently, and com	e emergency plan. The RNHCI ng: -based, tabletop exercise at bletop exercise is a group facilitator, using a narrated, mergency scenario, and a set nts, directed messages, or designed to challenge an HCl's response to and ation of all tabletop exercises, ents, and revise the RNHCl's eneeded. In not met as evidenced by: not review and interviews, the sure facility/community-based es to test their Emergency plan were conducted. This clients #1, #2, #3, #4, #5, #5, #11 and #12. The finding is: If the facility's EP plan, did not community-based or tabletop which included all staff working on 6/7/22, the Clinical ered Nurse (CCRN) confirmed as edid not include all the staff es. PROGRAM (1) ovide each employee with g training that enables the m his or her duties effectively,	E 0		E039: A full-scale community-based or tablet emergency exercise will be conducted annua All active employees will complete a a full-scatable-top emergency exercise by 6/30/2022 a annually thereafter. The training will be cond a location supervisor or administrator: Director Clinical Coordinator RN (CCRN), or Senior D Supports Coordinator (SDSC). Attendance/participation will be documented for all active employees receiving the training.	lly. ale and ucted by or, irect		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		34G050	B. WING		06/	07/2022		
NAME OF PROVIDER OR SUPPLIER RESIDENTIAL SERVICES, INC. RETIREMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6310 MOUNT HERMAN CHURCH ROAD DURHAM, NC 27705					
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE		
W 189	Based on observation and interview, the were sufficiently the efficiently. This afthe home; #1, #2, #10, #11 and #12. During evening ob 6/6/22 at 6:51pm, a chair in the lobby one minute. Furth were three clients texting on her phoagain observed teclients in her vicinity. Review on 6/7/22 Engagement dated Professional Focus focus on their jobs devices for person to a job focus. Plework environment co-workers. Pleas call only in emerge conversations brief. Review on 6/7/22 Orientation and Trindicated, "Persna personal electronic phones should not directly supporting phones disrupts the location distract focus from the reserview on 6/7/22.	ations, documentation review facility failed to ensure all staff ained to perform their duties fected all the clients residing in #3, #4, #5, #5, #6, #7, #8, #9, The finding is: servations in the home on Staff A was observed sitting in y testing on her cell phone for er observations revealed there in the vicinity while Staff A was ne. At 7:40pm, Staff A was acting her phone while they were ty. of the facility's Professional de 2/7/22 stated, "7. s. While at work, staff must all communication is a barrier that communication is a barrier that communication is a barrier that are maintain a professional for yourself and your se ask your friends and family to ency, and make these fi." of the facility's On-Site aining-Unit 1 revised 10/18 I cell phone usage and other codevices: Personal cell to be used for personal use while individualsThe use of cell individualsThe use of cell individuals and removing your	W 189	W189: Staff A received a Report to Pe Supplemental Training on 6/7/22 as a her mobile phone multiple times throug and not being professionally engaged activities. All staff will receive an in-se by 6/30/2022 to review company polici Code of Values and Professional Concremaining professionally engaged in w while working on shift. The training will annually by a location supervisor or ad Director, Clinical Coordinator RN (CCF Direct Supports Coordinator (SDSC).	result of using ghout the shift, in work related rvice training es on RSI's duct and ork activities be conducted iministrator:			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G050	B. WING		06/	07/2022	
	PROVIDER OR SUPPLIER	C. RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6310 MOUNT HERMAN CHURCH ROAD DURHAM, NC 27705	1 00/	OTTEGE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE	(X5) COMPLETION DATE	
W 189	Employee On-Site of Schedule Checklist cellphones usage. During an interview supervisor (HS) state to staff should be puring an interview Coordinator Register.	Orientation and Training which included personal on 6/7/22, the home ted all cell phones belonging ut away while they are on duty. on 6/7/22, the Clnical ered Nurse (CCRN) confirmed on their personal cell phones	W 1	89			