PRINTED: 12/14/2022 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	
		34G143	B. WING			C 12/13/2022		
	PROVIDER OR SUPPLIER			1722	ET ADDRESS, CITY, STATE, ZIP CODE ATHENS AVENUE CHAM, NC 27707	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
E 039	CFR(s): 483.475(d) §416.54(d)(2), §418 §460.84(d)(2), §482 §483.475(d)(2), §482 §485.625(d)(2), §482 *[For ASCs at §416 "Organizations" und §485.920, RHCs/F Facilities at §494.62 (2) Testing. The [facto test the emerger must do all of the formation of the formation of the emergen exercise every 2 years) (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 formation 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 formation of the formation of the emexempt from engage community-based of functional exercise (B) A mock disaster (C) A tabletop exercise (C) A tabletop exercise exercise exercise exercise exercise (C) A tabletop exercise exerc	8.113(d)(2), §441.184(d)(2), 2.15(d)(2), §483.73(d)(2), 84.102(d)(2), §485.68(d)(2), 4.62(d)(2). 6.54, CORFs at §485.68, OPO, der §485.727, CMHCs at QHCs at §491.12, and ESRD 2]: cility] must conduct exercises acy plan annually. The [facility] bllowing: ull-scale exercise that is every 2 years; or unity-based exercise is not a facility-based functional ears; or explexed emergency that requires hergency plan, the [facility] is ging in its next required or individual, facility-based following the onset of the itional exercise at least every 2 year the full-scale or under paragraph (d)(2)(i) of ucted, that may include, but is llowing: cale exercise that is or individual, facility-based; or	EC	039	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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G143	B. WING			C 12/13/2022	
	PROVIDER OR SUPPLIER			172	EET ADDRESS, CITY, STATE, ZIP CODE 2 ATHENS AVENUE RHAM, NC 27707	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 039	a narrated, clinicall scenario, and a set directed messages designed to challer (iii) Analyze the [farmaintain document exercises, and emergencises, and emergencises, and emergencises to test than unally. The hospicises to test thannually. The hospicises in a community based (A) When a community based (A) When a community based (B) If the hospice eman-made emergency platengaging in its next community-based facility-based functionset of the emerging (ii) Conduct an adopposite the year the exercise under particular conducted, that it to the following: (A) A second full-scommunity-based exercise; or (B) A mock disaste (C) A tabletop exercises	cludes a group discussion using y-relevant emergency to for problem statements, so, or prepared questions ange an emergency plan. Collity's response to and tation of all drills, tabletop ergency events, and revise the cy plan, as needed. 118.113(d): pices that provide care in the ne hospice must conduct the emergency plan at least pice must do the following: full-scale exercise that is every 2 years; or unity based exercise is not experiences a natural or experiences a natural or experiences a natural or experiences a natural or experiences or individual ional exercise following the exercise or individual ional exercise following the ency event. In ditional exercise every 2 years, the full-scale or functional agraph (d)(2)(i) of this section may include, but is not limited exale exercise that is or a facility based functional	EC	039			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G143	B. WING				C 13/2022
	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 1722 ATHENS AVENUE DURHAM, NC 27707	121	15/2022
(X4) ID PREFIX TAG				IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	scenario, and a set directed messages designed to challent (3) Testing for hosp care directly. The hexercises to test theyear. The hospice (i) Participate in an is community-based (A) When a community-based function (B) If the hospice eman-made emergency plarengaging in its next based or facility-based following the onset (ii) Conduct an additionary include, but is (A) A second full-scommunity-based of exercise; or (B) A mock disaste (C) A tabletop exerting facilitator that including a set of problem messages, or preparental exercises, and emergency and exercises, and emergency facilitation document exercises, and emergency directly and a set of problem messages, or preparental exercises, and emergency directly and exercises, and emergency directly and exercises.	of problem statements, , or prepared questions age an emergency plan. Sices that provide inpatient hospice must conduct e emergency plan twice per must do the following: annual full-scale exercise that d; or unity-based exercise is not t an annual individual onal exercise; or experiences a natural or ency that requires activation of ency that requires activation of ency the hospice is exempt from exercise of the emergency event. Sitional annual exercise that enot limited to the following: cale exercise that is or a facility based functional er drill; or roise or workshop led by a des a group discussion using a relevant emergency scenario, en statements, directed ared questions designed to	E	039			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		34G143	B. WING		12	C 2/13/2022	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1722 ATHENS AVENUE 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	
E 039	*[For PRFTs at §44 §482.15(d), CAHs at (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 function (B) If the [PRTF, Ho actual natural or marequires activation of [facility-based functionset of the emergency (ii) Conduct an 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 at discussion, using a emergency scenari statements, directed questions designed plan. (iii) Analyze the maintain document	1.184(d), Hospitals at at §485.625(d):] RTF, Hospital, CAH] must to test the emergency plan annual full-scale exercise that d; or unity-based exercise is not annual individual, onal exercise; or ospital, CAH] experiences an an-made emergency that of the emergency plan, the rom engaging in its next community based or individual, onal exercise following the ency event. [additional] annual exercise or le, but is not limited to the cale exercise that is or individual, a facility-based or disaster drill; or exercise or workshop that is and includes a group narrated, clinically-relevant o, and a set of problem d messages, or prepared to challenge an emergency at [facility's] response to and ation of all drills, tabletop ergency events and revise the cy plan, as needed.	EO	39			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		34G143	B. WING		12	C 2/13/2022	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC 1722 ATHENS AVENUE 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 CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
E 039	(2) Testing. The PA exercises to test the annually. The PACE following: (i) Participate in an is community-based (A) When a community-based (A) When a community-based function (B) If the PACE expressible, conduction facility-based function (B) If the PACE expressible, conduction facility-based functions are made emerged the emergency plarengaging in its next based or individual, exercise following the exercise under participate is conducted that must be following: (A) A second full-second functional exercise; (B) A mock disasted (C) A tabletop exert a facilitator and inclusing a narrated, clusing a	CE organization must conduct be emergency plan at least a corganization must do the annual full-scale exercise that do containity-based exercise is not an annual individual, conal exercise; or periences an actual natural or not that requires activation of an the PACE is exempt from a required full-scale community facility-based functional the onset of the emergency additional exercise every 2 year the full-scale or functional agraph (d)(2)(i) of this section has include, but is not limited to cale exercise that is or individual, a facility based or a drill; or to compare the full-scale exercise that is or individual, a facility based or the exercise that is or individual, a facility based or the full-scale exercise that is or individual, a facility based or the following discussion, inically-relevant emergency of problem statements, or prepared questions ge an emergency plan. CE's response to and ation of all drills, tabletop ergency events and revise the plan, as needed.	EO	39			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		34G143	B. WING			C 12/13/2022		
	PROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 722 ATHENS AVENUE DURHAM, NC 27707	1 121	10/2022	
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
E 039	test the emergency including unannour emergency procedi ICF/IID] must do th (i) Participate in an is community-base (A) When a community-based (A) When a community-based function (B) If the [LTC facility-based function LTC facility is exemined a full-scale individual, facility-based following the onset (ii) Conduct an additional exercises (B) A mock disasted (C) A tabletop exercise a facilitator includes narrated, clinically-and a set of problem essages, or preparated, clinically-and a set of problem essages, or preparated, clinically-and and maintain document (iii) Analyze the [LT and maintain document (ITC facility)] facility *[For ICF/IIDs at §4 (2) Testing. The ICI to test the emerger The ICF/IID must details and maintain document (ICF/IID must details).	plan at least twice per year, need staff drills using the ures. The [LTC facility, e following: a annual full-scale exercise that d; or unity-based exercise is not an annual individual, sonal exercise. [Ity] facility experiences an en-made emergency that for the emergency plan, the ent from engaging its next end community-based or eased functional exercise of the emergency event. In the exercise that the individual exercise that end limited to the following: cale exercise that is for an individual, facility based is or er drill; or exercise or workshop that is led by a group discussion, using a relevant emergency scenario, m statements, directed exercise that exercise that is exercise or workshop that is led by a group discussion, using a relevant emergency scenario, m statements, directed exercise of ared questions designed to gency plan. [IC facility] facility's response to mentation of all drills, tabletop ergency events, and revise the 's emergency plan, as needed. [83.475(d)]: [F/IID must conduct exercises and plan at least twice per year.	E	039				

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	CENTIFICATION NUMBER.		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G143	B. WING			C 12/13/2022	
	PROVIDER OR SUPPLIER	,		172	EET ADDRESS, CITY, STATE, ZIP CODE 2 ATHENS AVENUE RHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 039	is community-base (A) When a community-based funct (B) If the ICF/IID exman-made emerge the emergency plant engaging in its nex community-based functional exercise emergency event. (ii) Conduct an add may include, but is (A) A second full-secommunity-based functional exercise (B) A mock disaste (C) A tabletop exer a facilitator and incusing a narrated, conscipled to challer (iii) Analyze the ICF maintain document exercises, and emergency event (C) and the community-based (C) and the community-based (C) and the community-based (C) (C) Testing. The to test the emergency event (C) Testing. The totest the emergency exercises annually. The (i) Participate in a foommunity-based; (A) When a conaccessible, conductive manual exercises, and emergency exercises annually. The (ii) Participate in a foommunity-based; (A) When a conaccessible, conductive manual exercises annually. The (iii) Participate in a foommunity-based; (A) When a conaccessible, conductive manual exercises annually.	d; or unity-based exercise is not an annual individual, ional exercise; or. experiences an actual natural or ency that requires activation of in, the ICF/IID is exempt from t required full-scale or individual, facility-based following the onset of the litional annual exercise that not limited to the following: cale exercise that is or an individual, facility-based ; or or drill; or cise or workshop that is led by ludes a group discussion, linically-relevant emergency t of problem statements, or or prepared questions age an emergency plan. E/IID's response to and tation of all drills, tabletop ergency events, and revise the cy plan, as needed. 4.102] HHA must conduct exercises ancy plan at HHA must do the following: full-scale exercise that is	E	039			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G143	B. WING _			C / 13/2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1722 ATHENS AVENUE 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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 039	(B) If the HHA or man-made emer of the emergency pengaging in its next community-based of functional exercise emergency event. (ii) Conduct an add opposite the year the exercise under parais conducted, that limited to the follow (A) A second functional exercise; (B) A mock disaid (C) A tabletop of led by a facilitator and discussion, using an emergency scenaristatements, directed questions designed plan. (iii) Analyze the HH documentation of an emergency events, emergency plan, as as as a *[For OPOs at §486 (d)(2) Testing. The to test the emergency events are t	experiences an actual natural gency that requires activation lan, the HHA is exempt from a required full-scale or individual, facility based following the onset of the ditional exercise every 2 years, the full-scale or functional agraph (d)(2)(i) of this section at may include, but is not ing: all-scale exercise that is or an individual, facility-based or exercise or workshop that is and 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 a needed.	E 03	9		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION NG	, ,	COMPLETED		
		34G143	B. WING_		12	C / 13/2022	
	PROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE 1722 ATHENS AVENUE DURHAM, NC 27707		10,2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
E 039	questions designed plan. If the OPO ex man-made emerge the emergency plan engaging in its next following the onset (ii) Analyze the OPO documentation of a emergency events, OPO's] emergency exercises to test the following (i) Conduct a paper least annually. A tare discussion led by a clinically-relevant e of problem statement and emergency plan. (ii) Analyze the RNI maintain document and emergency plan, as This STANDARD is Based on record refacility failed to confere emergency prepared year. This potential #3, #4, #5, and #6) Review on 12/12/22 preparedness plant neither a tabletop a community-based as	It to challenge an emergency operiences an actual natural or ency that requires activation of an, the OPO is exempt from a required testing exercise of the emergency event. O's response to and maintain all tabletop exercises, and and revise the [RNHCI's and plan, as needed. 748]: RNHCI must conduct elemergency plan. The RNHCI and plan, as needed. 748]: r-based, tabletop exercise at a group facilitator, using a narrated, mergency scenario, and a set ents, directed messages, or a designed to challenge an anticolor of all tabletop exercises, ents, and revise the RNHCI's ents, and interviews, the duct exercises to test their edness plan at least twice per ly affected all clients (#1, #2, living in the home. 2 of the emergency dated 9/22/20, revealed that activity, nor a full-scale, activity could be located.	E 03	39			
	Interview on 12/13/	22 with the Director revealed					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						(c
		34G143	B. WING			12/ ⁻	13/2022
	PROVIDER OR SUPPLIER			17	TREET ADDRESS, CITY, STATE, ZIP CODE 722 ATHENS AVENUE URHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
E 039		e to locate either a tabletop lle, community-based activity.	E (
W 125	12/13/22 for intake NC00195921. No or relation to the comp		W	125			
	The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure client (#5) was afforded dignity regarding the use of washable incontinence pads. This affected 1 of 5 audit clients. The finding is:						
	12/12 - 13/22, a wa seen in a chair whice room of the home. the incontinence patentered into the living observations reveal	s throughout the survey on shable incontinence pad was th was located in the living Further observations revealed d was visible to anyone who ng room. Additional ed client #5 was sitting in the ontinence pad was located.					
	know why the wash	on 12/13/22, Staff B did not able incontinence pad was in nt #5 was sitting on it.					
	During an interview	on 12/13/22, the Director					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION NG		COMPLETED		
		34G143	B. WING		12	C / 13/2022	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1722 ATHENS AVENUE DURHAM, NC 27707		10/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
W 125	Continued From pa	ge 10	W 1	25			
W 130	be in the chair; nor it. The Director sta seizures and will ha		W 1	30			
	Therefore, the facili treatment and care This STANDARD is Based on observatinterviews, the facil	s not met as evidenced by: ions, record review and ity failed to ensure privacy for #2, #3, #4, #5 and #6)					
	in the home on 12/2 #3, #4, and #5 rece common dining are On 12/12/22 at 5:30 were eating dinner Staff C gave clients dining table. On 12/5 Staff B gave clients medications in the obreakfast. A privacy	common dining area during screen was not used, and wed to a separate location for					
		22 with Staff B revealed that be given either "in back or in					
		22 with the Director revealed ninistration was moved from					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G143	B. WING		12	C 2/13/2022	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1722 ATHENS AVENUE DURHAM, NC 27707			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			((EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
W 130	due to Covid preca privacy could be en	back to the larger dining area utions. When asked how client issured in the common area, that they chose to be safe and the dining area.	W 1				
	The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on record reviews and interviews with staff, management failed to report an incident to the Health Care Personnel Registry (HCPR) as required. This affected 2 of 5 audit clients (#3 and #6). The finding is:						
W 249	revealed there was where she attempte The Director stated 12/8/22. Further in		W 2	49			
	formulated a client's each client must re treatment program interventions and s and frequency to su	rdisciplinary team has sindividual program plan, ceive a continuous active consisting of needed ervices in sufficient number upport the achievement of the din the individual program					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G143	B. WING _			C 13/2022
NAME OF PROVIDER OR SUPPLIER KEYWEST CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1722 ATHENS AVENUE DURHAM, NC 27707	1 12/	10,2022
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
W 249	Continued From pa plan.	ge 12	W 24	9		
	Based on observatinterviews, the facilic clients (#2, #3, #4, a continuous active trof needed intervent	s not met as evidenced by: ions, record reviews, and ty failed to ensure 5 of 6 audit #5, and #6) received a eatment program consisting ions and services as identified ogram Plan (IPP) in the area . The findings are:				
	home on 12/12/22 a involved in preparin 12/12/22 from 4:30 dinner, consisting obread, and peaches prompting to assist 12/13/22 from 6:00a prepared breakfast	s of meal preparation in the and 12/13/22, no clients were g dinner or breakfast. On om-5:10pm, Staff D prepared f ham, collards, wild rice, corn s. At no time were clients with food preparation. On am-6:30am, the Director consisting of eggs, grits, and ere clients involved in food				
W 263	that client #3 could items. When asked preparation, the Dir scheduled to make during the summer during the fall. The could use an electri		W 26	53		
	The committee sho	uld insure that these programs				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION NG	COMPLETED	
	34G143	B. WING_		12/13/2022	
NAME OF PROVIDER OR SUPPLIER KEYWEST CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1722 ATHENS AVENUE DURHAM, NC 27707	, , , , , , , , , , , , , , , , , , , ,	
(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI	D BE COMPLÉTION	
are conducted only consent of the client minor) or legal guar This STANDARD is Based on record refailed to ensure resconducted with the legal guardian. This (#3). The finding is A. Review on 12/12 Improvement Plant was last signed by Further review reversigned by Client #3's NURSING SERVIC CFR(s): 483.460(c) Nursing services mother members of the appropriate protection measures that inclutraining clients and health and hygiene This STANDARD is Based on observation interviews, nursing were adequately transks. The finding During observations home on 12/12 - 13 the home were observed interviews observations were observed on the client of th	with the written informed at, parents (if the client is a rdian. In a continuous parents) with the written informed by: eview and interview, the facility trictive programs were only written informed consent of a saffected 1 of 5 audit clients: 2/222 of client #3's Behavior (BIP) dated 2/23/22 revealed it his guardian on 11/29/19. It is guardian on 11/29/19. It is guardian. If on 12/12/22, the Director not a current BIP consent is guardian. If on 12/16/22, the Director not a current BIP consent is guardian. If significant is guardian. If significant is guardian is guardian and preventive health in the interdisciplinary team, five and preventive health inde, but are not limited to staff as needed in appropriate methods. In some the solid in the wearing of facial gis: If sthroughout the survey in the solid is throughout the survey in the solid is throughout the survey in the solid in the wearing a served not wearing a				
	Continued From pa are conducted only consent of the clien minor) or legal guar This STANDARD is Based on record refailed to ensure resconducted with the legal guardian. This (#3). The finding is A. Review on 12/12 Improvement Plan was last signed by Further review reversigned by client #3's NURSING SERVIC CFR(s): 483.460(c) Nursing services mother members of the appropriate protection measures that inclustraining clients and health and hygiene This STANDARD is Based on observations and health and hygiene This STANDARD is Based on observations and health and hygiene This STANDARD is Based on observations of the members of the appropriate protections and health and hygiene This STANDARD is Based on observations of the property of the propert	AGINATION NUMBER: 34G143 PROVIDER OR SUPPLIER ST CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 1 of 5 audit clients (#3). The finding is: A. Review on 12/12/22 of client #3's Behavior Improvement Plan (BIP) dated 2/23/22 revealed it was last signed by his guardian on 11/29/19. Further review revealed there was not a current BIP consent signed by his guardian. During an interview on 12/12/22, the Director confirmed there is not a current BIP consent signed by client #3's guardian.	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 1 of 5 audit clients (#3). The finding is: A. Review on 12/12/22 of client #3's Behavior Improvement Plan (BIP) dated 2/23/22 revealed it was last signed by his guardian on 11/29/19. Further review revealed there was not a current BIP consent signed by his guardian. During an interview on 12/12/22, the Director confirmed there is not a current BIP consent signed by client #3's guardian. NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, document review and interviews, nursing services failed to ensure staff were adequately trained in the wearing of facial masks. The finding is: During observations throughout the survey in the home on 12/12 - 13/22, staff who were working in the home were observed not wearing a	A BUILDING 34G143 BROWIDER OR SUPPLIER 31GENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1722 ATHENS AVENUE DURHAM, NC 27707 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL. REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 1 of 5 audit clients (#3). The finding is: A. Review on 12/12/22 of client #3's Behavior Improvement Plan (BIP) dated 2/23/22 revealed it was last signed by his guardian on 11/29/19. Further review revealed there was not a current BIP consent signed by his guardian. During an interview on 12/12/22, the Director confirmed there is not a current BIP consent signed by client #3's guardian. NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, document review and interviews, nursing services failed to ensure staff were adequately trained in the wearing of facial masks. The finding is: During observations throughout the survey in the home on 12/12 - 13/22, staff who were working in the home were observed not wearing a	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			C C	
		34G143	B. WING_		1	13/2022
NAME OF PROVIDER OR SUPPLIER KEYWEST CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1722 ATHENS AVENUE DURHAM, NC 27707		10,2022
(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 APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
W 340	in the kitchen cooki	ge 14 wearing their facemasks while ng, administering medications s with washing their hands.	W 34	10		
	During an interview	on 12/13/22, Staff A stated sks are to be worn by staff				
	Plan (no date) state provide, and ensure facemasks, or a hig protection. Facema	2 of the facility's COVID-19 ed, "[Name of group home] will e that employees wear gher level of respiratory asks must be worn by e nose and mouth when				
W 371		RATION	W 3	71		
	that clients are tauge medications if the indetermines that sel is an appropriate of does not specify other This STANDARD is Based on observatifialled to ensure train	s not met as evidenced by: iions and interviews, the facility ning in the area of medication of 5 audit clients (#2, #3, #4,				
	in the home on 12/2 #3, #4, #5, and #6 i	s of medication administration 12/22 and 12/13/22, clients #2, received prepared medications ng. On 12/12/22 at 5:30pm,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION NG		E SURVEY MPLETED
		34G143	B. WING			C / 13/2022
NAME OF PROVIDER OR SUPPLIER KEYWEST CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1722 ATHENS AVENUE 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 371	Staff C approached medicine cup and so Client #3 took the comedication. On 12/Staff B approached prepared cups of mare your medication by Staff cup and swallowed staff name or explainterview on 12/13/sthat staff should explain the staff should explain medication pevaluation pevaluation pevaluation pevaluation for the staff should explain medication pevaluation pevaluation drills were conditions. The clients residing in the staff should explain the staff should explai	g dinner in the dining area. I client #3 with a prepared stated, "Here's your meds". I clients #2 wallowed his 13/22 from 7:15am-7:40am, clients #2, #4, #5, and #6 with redications and stated, "Here as". Clients #2 and #4 were fed B; clients #5 and #6 took their medication. At no time did in medications to clients. 22 with the Director revealed plain medications to clients ass. LLS (1) Inditions to- Is not met as evidenced by: If fire drill reports and ity failed to ensure fire are conducted at varied his potentially affected all the home (#1, #2, #3, #4, #5 to g is: I of the fire drill reports dated dovember 2022 revealed fire and between 7:00am and the secutive months (May - 22 with the Director revealed do respond to a drill at any time are Director stated that the per shift, per quarter.	W 3	41		
555	23.12 10 14001114	and the same of the same	0			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	CON	TE SURVEY MPLETED
		34G143	B. WING _			C / 13/2022
NAME OF PROVIDER OR SUPPLIER KEYWEST CENTER				STREET ADDRESS, CITY, STATE, ZIP 1722 ATHENS AVENUE DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
W 508	staffing. (f) Standard: COV staff. The facility is policies and proced fully vaccinated for this section, staff as if it has been 2 we completed a prima COVID-19. The covaccination series as the administration multi-dose vaccine (1) Regardless of contact, the policies to the following faccare, treatment, of and/or its clients: (i) Facility employed (ii) Licensed pract (iii) Students, train (iv) Individuals whother services for under contract or (2) The policies a do not apply to the (i) Staff who exclutelemedicine serviand who do not had clients and other services for this section; and (ii) Staff who provide facility that are per the facility setting	on of Participation: Facility ID-19 Vaccination of facility must develop and implement dures to ensure that all staff are r COVID-19. For purposes of are considered fully vaccinated leks or more since they ary vaccination series for completion of a primary for COVID-19 is defined here ion of a single-dose vaccine, or of all required doses of a lead. I clinical responsibility or client less and procedures must apply cility staff, who provide any r other services for the facility lees; litioners; lees, and volunteers; and lo provide care, treatment, or lithe facility and/or its clients, loy other arrangement. Indiprocedures of this section le following facility staff: lessively provide telehealth or loss outside of the facility setting lave any direct contact with lither staff specified in paragraph (f)(1)	W 50	08		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						С	
		34G143	B. WING			12/	13/2022
NAME OF PROVIDER OR SUPPLIER KEYWEST CENTER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 722 ATHENS AVENUE DURHAM, NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / 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
W 508	a minimum, the foll (i) A process for en- paragraph (f)(1) of staff who have pend- been granted, exen- requirements of this whom COVID-19 vadelayed, as recommedinical precautions received, at a minimal vaccine, or the first vaccination series for vaccine prior to start treatment, or other its clients; (iii) A process for enditional precaution transmission and some who are not fully vaccine additional precaution transmission and some or fully vaccine and so	this section. d procedures must include, at owing components: suring all staff specified in this section (except for those ding requests for, or who have options to the vaccination is section, or those staff for accination must be temporarily mended by the CDC, due to and considerations) have mum, a single-dose COVID-19 dose of the primary for a multi-dose COVID-19 ff providing any care, services for the facility and/or ensuring the implementation of ons, intended to mitigate the pread of COVID-19, for all staff accinated for COVID-19; acking and securely OVID-19 vaccination status of paragraph (f)(1) of this exing and securely OVID-19 vaccination status of obtained any booster doses by the CDC; hich staff may request an estaff COVID-19 vaccination do on an applicable Federal law; racking and securely nation provided by those staff d, and for whom the facility emption from the staff tion requirements;	W	508			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	` ′	FIPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED	
		34G143	B. WING			C / 13/2022	
NAME OF PROVIDER OR SUPPLIER KEYWEST CENTER				STREET ADDRESS, CITY, STATE, ZIP C 1722 ATHENS AVENUE DURHAM, NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
W 508	documentation, who clinical contraindica and which supports exemptions from value and dated by a licer the individual requests acting within their as defined by, and applicable State an ensuring that such (A) All information sauthorized COVID-contraindicated for and the recognized contraindications; as (B) A statement by recommending that exempted from the vaccination require recognized clinical (ix) A process for essecure documentat staff for whom COV temporarily delayed CDC, due to clinical considerations, inclindividuals with actin COVID-19, and ind monoclonal antibod for COVID-19, and ind monoclonal antibod for COVID-19 treat (x) Contingency playaccinated for COVID-19 treat (x) Covi	ich confirms recognized ations to COVID-19 vaccines is staff requests for medical accination, has been signed insed practitioner, who is not esting the exemption, and who is respective scope of practice in accordance with, all id local laws, and for further documentation contains: specifying which of the 19 vaccines are clinically the staff member to receive clinical reasons for the authenticating practitioner in the staff member be facility's COVID-19 ments for staff based on the contraindications; insuring the tracking and ition of the vaccination must be in the precautions and uding, but not limited to, ite illness secondary to ividuals who received lies or convalescent plasma ment; and ins for staff who are not fully VID-19.	W 5	08			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G143	B. WING			C / 13/2022
NAME OF PROVIDER OR SUPPLIER KEYWEST CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 1722 ATHENS AVENUE DURHAM, NC 27707		11012022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 508	vaccination required staff for whom COV temporarily delayed CDC, due to clinical considerations; This STANDARD is Based on record refacility failed to ensistaff have been vacexemption against COVID-19 vaccinated discovered that two or approved for an open country of the very stated there are two paperwork for the very control of the very contro	ments of this section, or those /ID-19 vaccination must be I, as recommended by the I precautions and s not met as evidenced by: eview and interviews, the ture that 100 percent of their ccinated or had an approved COVID-19. The finding is: 2/13/22 of the facility's ion information, it was staff had not been vaccinated	W 5	08		