PRINTED: 07/16/2024 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION			TIPL ING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G035	B. WING			07/	02/2024
	PROVIDER OR SUPPLIER	EL HILL		1	TREET ADDRESS, CITY, STATE, ZIP CODE 11 SILO DRIVE CHAPEL HILL, NC 27514	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / 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 018	S403.748(b)(2), §42 and (v), §441.184(b) §482.15(b)(2), §485.542(b)(2), §485.542(b)(2), §485.542(b)(1), §485.5	16.54(b)(1), §418.113(b)(6)(ii) b)(2), §460.84(b)(2), 3.73(b)(2), §483.475(b)(2), 35.625(b)(2), §485.920(b)(1), 94.62(b)(1).  Decedures. The [facilities] must ment emergency preparedness lures, based on the emergency ragraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of olicies and procedures must be ted at least every 2 years acilities]. At a minimum, the lures must address the  In to track the location of meltered patients in the mag an emergency. If on-duty patients are relocated during a [facility] must document the location of the receiving facility.  11.184(b), LTC at §483.73(b), 25(b), PACE at §460.84(b):] dures. (2) A system to track the staff and sheltered residents in CF/IID or PACE] care during ency. If on-duty staff and are relocated during the RTF's, LTC, ICF/IID or PACE] a specific name and location of	EC	018	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.

Facility ID: 922576

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G	` ,	(X3) DATE SURVEY COMPLETED		
		34G035	B. WING _		07	/02/2024		
	PROVIDER OR SUPPLIER	EL HILL		STREET ADDRESS, CITY, STATE, ZIF 111 SILO DRIVE CHAPEL HILL, NC 27514		-		
(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 C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
E 018	*[For Inpatient Hos Policies and proced (ii) Safe evacuation includes consideraneeds of evacuees transportation; ider location(s) and princommunication wit assistance.  (v) A system to tracemployees' on-duty hospice's care during on-duty employees relocated during the must document the the receiving facility.  *[For CMHCs at §4 procedures. (2) Sa which includes contreatment needs of responsibilities; tracevacuation location means of communassistance.  *[For OPOs at § 48 procedures. (2) A secure and maintaneeds of the patien This STANDARD in the control of the control of the patien This STANDARD.	pice at §418.113(b)(6):] dures. In from the hospice, which tion of care and treatment is; staff responsibilities; Intification of evacuation mary and alternate means of the external sources of  The kitch location of hospice of and sheltered patients in the mg an emergency. If the mg an emergency, the hospice of emergency, the hospice of specific name and location of of or other location.  The standard form the CMHC, sideration of care and of evacuees; staff of insportation; identification of of (s); and primary and alternate of ication with external sources of  The standard form the control of the standard form the control of the standard form the control of the standard form the dialysis of the staff responsibilities, and of the staff responsibilities, and	E 01	8				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
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E 030	failed to develop a staff in the event, the (EP) plan had to be potential to effect 6 home (#1, #2, #3, # Review on 7/2/24 to 5/16/24 revealed the clients residing in the line of the working in the home. The QID computer program be retrieved, howewas no reference to within the EP plan. Names and Contact CFR(s): 483.475(c) \$403.748(c)(1), \$449.41.184(c)(1), \$449.41.184(c)(	representation on the clients in the facility's EP plan dated here were no details for the he home and current staff.  with the Home Manager (HM) he direct care professionals e, were recently hired.  with the Qualified Intellectual hional (QIDP) acknowledged information on the clients in the prevealed staff used a where the information could wer, she acknowledged there to review electronic records at Information (1), \$418.113(c)(1), 60.84(c)(1), \$481.113(c)(1), 60.84(c)(1), 60	E O			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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	PROVIDER OR SUPPLIER	L HILL	STREET ADDRESS, CITY, STATE, ZIP CODE  111 SILO DRIVE  CHAPEL HILL, NC 27514					
(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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
E 030	following:]  (1) Names and confollowing: (i) Staff. (ii) Entities providing: (iii) Patients' physic (iv) Other [facilities] (v) Volunteers.  *[For Hospitals at § §485.625(c)] The coinclude all of the fol (1) Names and confollowing: (i) Staff. (ii) Entities providing: (ii) Patients' physic (iv) Other [hospitals (v) Volunteers.  *[For RNHCIs at §4 communication plant following: (1) Names and confollowing: (i) Staff. (ii) Entities providing: (ii) Staff. (iii) Entities providing: (ii) Next of kin, gualiv) Other RNHCIs. (v) Volunteers.  *[For ASCs at §416 plan must include at (1) Names and confollowing: (i) Staff. (ii) Staff.	tact information for the g services under arrangement. ians .  482.15(c) and CAHs at communication plan must lowing: tact information for the g services under arrangement. ians and CAHs].  03.748(c):] The n must include all of the tact information for the g services under arrangement. ract information for the g services under arrangement. ract information for the	EC	30				

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E 030	(iii) Patients' physic (iv) Volunteers.  *[For Hospices at 3 communication plate following: (1) Names and confollowing: (i) Hospice employ (ii) Entities providir (iii) Patients' physic (iv) Other hospices  *[For HHAs at §48 plan must include (1) Names and confollowing: (i) Staff. (ii) Entities providir (iii) Patients' physic (iv) Volunteers.  *[For OPOs at §48 plan must include (2) Names and confollowing: (i) Staff. (ii) Entities providir (iii) Volunteers. (iv) Other OPOs. (v) Transplant and Donation Service A This STANDARD Based on record realled to develop a guardians in their eplan. This had the	S418.113(c):] The an must include all of the intact information for the vees. In grandle services under arrangement. It is a service of the following:  1.102(c):] The communication all of the following: 1.102(c):] The communication for the ing services under arrangement.  1.102(c):] The communication all of the following:	EO	30		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G035	B. WING			07/02/2024	
	PROVIDER OR SUPPLIER	EL HILL		11	REET ADDRESS, CITY, STATE, ZIP CODE  1 SILO DRIVE  HAPEL HILL, NC 27514		
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E 030	Continued From pa	ge 5 f the facility's EP plan dated	ΕO	30			
	5/16/24 revealed there were no details that listed the names of all clients and the contact information of their guardians.  Interview on 7/2/24 with the Home Manager (HM)						
revealed most of the direct care professionals working in the home, were recently hired.		e direct care professionals e, were recently hired.					
	Interview on 7/2/24 with the Qualified Intellectual Disabilities Professional (QIDP) acknowledged the EP plan lacked information on the clients and their guardians. The QIDP revealed staff used a computer program where the information could be retrieved, however, she acknowledged there was no reference to review electronic records within the EP plan.						
E 036	EP Training and Te CFR(s): 483.475(d)		E 0	36			
	§483.475(d), §484.	84(d), §482.15(d), §483.73(d), 102(d), §485.68(d), 625(d), §485.727(d),					
	Hospice at §418.11 at §460.84, Hospita §484.102, CORFs at CAHs at §486.625, 485.727, CMHCs at §486.360, and RHC Training and testing and maintain an en	103.748, ASCs at §416.54, 3, PRTFs at §441.184, PACE als at §482.15, HHAs at at §485.68, REHs at §485.542, "Organizations" under t §485.920, OPOs at C/FHQs at §491.12:] (d) g. The [facility] must develop nergency preparedness program that is based on the					

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E 036	emergency plan se section, risk assess this section, policie (b) of this section, a paragraph (c) of this testing program muleast every 2 years  *[For LTC facilities and testing. The Lamaintain an emergand testing program emergency plan se section, risk assess this section, policie (b) of this section, policie (b) of this section, aparagraph (c) of this testing program muleast annually.  *[For ICF/IIDs at §4 testing. The ICF/IIIDs at program that is baseforth in paragraph (assessment at parapolicies and processection, and the coparagraph (c) of this testing program muleast every 2 years requirements for ex §483.470(i).  *[For ESRD Facilititiesting, and orientate develop and maintails.]	et forth in paragraph (a) of this sement at paragraph (a)(1) of s and procedures at paragraph and the communication plan at its section. The training and ust be reviewed and updated at .  at §483.73(d):] (d) Training TC facility must develop and ency preparedness training in that is based on the sement at paragraph (a)(1) of s and procedures at paragraph and the communication plan at its section. The training and ust be reviewed and updated at the section at paragraph (b) of this section, risk agraph (a)(1) of this section, dures at paragraph (b) of this mmunication plan at its section. The training and ust be reviewed and updated at . The ICF/IID must meet the vacuation drills and training at es at §494.62(d):] Training, attion. The dialysis facility must	EO	036		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
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E 036	orientation program emergency plan se section, risk assess this section, policie (b) of this section, a paragraph (c) of thi and orientation program emergency plan se section, a paragraph (c) of thi and orientation program or the section program of the	a that is based on the totroth in paragraph (a) of this sment at paragraph (a)(1) of soment at paragraph (a)(1) of soment at paragraph (a)(1) of soment at paragraph (a)(1) of some and procedures at paragraph and the communication plan at some section. The training, testing gram must be evaluated and years.  Is not met as evidenced by:  Eview and interview, the facility of emergency medical records part of their emergency plan. This had the potential to residing in the home (#1, #2, The finding is:  If the facility's EP plan dated dere were no details that listed diagnoses, physician's orders be dispensed during an  with the Home Manager (HM) e direct care professionals e were recently hired.  with the Qualified Intellectual ional (QIDP) acknowledged information on the clients' and physician's orders. The fused a computer program on could be retrieved, owledged there was no electronic records within the	E 03				
E 037	EP Training Progra CFR(s): 483.475(d)		E 03	57			

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E 037	§403.748(d)(1), §44 §441.184(d)(1), §48 §483.73(d)(1), §48 §485.68(d)(1), §48 §485.727(d)(1), §48 §491.12(d)(1).  *[For RNCHIs at §4 Hospitals at §482.1 at §484.102, REHs under §485.727, Ol RHC/FQHCs at §48 (1) Training prograthe following: (i) Initial training in epolicies and procedstaff, individuals proarrangement, and expected roles. (ii) Provide emerge least every 2 years (iii) Maintain docum preparedness traini (iv) Demonstrate st procedures. (v) If the emergency procedures are sign must conduct traini procedures.  *[For Hospices at § hospice must do all (i) Initial training in epolicies and procedures employees services under arraexpected roles.	16.54(d)(1), §418.113(d)(1), 60.84(d)(1), §482.15(d)(1), 8.475(d)(1), §484.102(d)(1), 5.542(d)(1), §485.625(d)(1), 85.920(d)(1), §486.360(d)(1), 93.748, ASCs at §416.54, 5, ICF/IIDs at §483.475, HHAs at §485.542, "Organizations" POs at §486.360, 91.12:] m. The [facility] must do all of emergency preparedness tures to all new and existing oviding services under volunteers, consistent with their ency preparedness training at entation of all emergency ng. aff knowledge of emergency y preparedness policies and inficantly updated, the [facility] ng on the updated policies and 418.113(d):] (1) Training. The	E 03	37			

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E 037	least every 2 years (iv) Periodically revemergency prepare employees (includispecial emphasis procedures necessothers. (v) Maintain documpreparedness train (vi) If the emergency procedures are sigmust conduct train procedures.  *[For PRTFs at §44 program. The PRT (i) Initial training in policies and procedures are sigmust conduct train procedures.  (ii) After initial train preparedness train (iii) Demonstrate sigmocedures. (iv) Maintain documpreparedness train (v) If the emergency procedures are sigmust conduct train procedures.  *[For PACE at §460 organization must (ii) Initial training in	ency preparedness training at invited and rehearse its edness plan with hospice and nonemployee staff), with placed on carrying out the eary to protect patients and entation of all emergency ing.  The proper preparedness policies and nificantly updated, the hospice ing on the updated policies and in the p	E 03	77			

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E 037	staff, individuals pro arrangement, contr volunteers, consiste (ii) Provide emerge least every 2 years. (iii) Demonstrate st. procedures, including what to do, where the case of an emerger (iv) Maintain docum (v) If the emergency procedures are sign must conduct training procedures.  *[For LTC Facilities Program. The LTC following: (i) Initial training in the policies and procedures and procedures and procedures are sign must conduct training procedures.  (ii) Initial training in the policies and procedure staff, individuals program arrangement, and the expected role. (ii) Provide emerge least annually. (iii) Maintain documpreparedness training (iv) Demonstrate st. procedures.  *[For CORFs at §48 CORF must do all control of the provide initial training staff, in under arrangement with their expected.	oviding on-site services under actors, participants, and ent with their expected roles. Incy preparedness training at aff knowledge of emergencying informing participants of o go, and whom to contact in acy. Interest in a generation of all training. It is preparedness policies and antificantly updated, the PACE and on the updated policies and at §483.73(d):] (1) Training facility must do all of the emergency preparedness ures to all new and existing oviding services under volunteers, consistent with their ancy preparedness training at the entation of all emergency aff knowledge of emergency aff knowledge of emergency in aff knowledge of emergency in and procedures to all new and individuals providing services, and volunteers, consistent	EC	037			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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E 037	(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 traini procedures.  *[For CAHs at §485 The CAH must do a (i) Initial training in policies and procedures and where necessal personnel, and gue cooperation with finauthorities, to all neindividuals providinand 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 traini procedures.	nentation of the training. aff knowledge of emergency of personnel must be oriented ific responsibilities regarding ency plan within 2 weeks of The training program must on the location and use of signals and firefighting  cy preparedness policies and onificantly updated, the CORF ong on the updated policies and all of the following: emergency preparedness lures, including prompt guishing of fires, protection, ary, evacuation of patients, ests, fire prevention, and efighting and disaster ew and existing staff, g services under arrangement, onesistent with their expected  ncy preparedness training at	EO	37			

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E 039	CMHC must provid preparedness polic and existing staff, in under arrangement with their expected documentation of the demonstrate staff k procedures. There emergency prepare years.  This STANDARD is Based on record refailed to ensure new preparedness (EP) had the potential to the home (#1, #2, # is:  Record review on 7 training dated 5/16/evidence of the five Staff E, Staff F and receiving their initial Interview on 7/2/24 the Supervisor revehome with less than Interview on 7/2/24 Disabilities Profess home had experient the year and both the of the staff were new testing their initial of the staff were new testing their initial interview on 7/2/24 Disabilities Profess home had experient the year and both the staff were new testing to the staff were new testing the staff were new testing to the staff were new testing testing the staff were new testing t	e initial training in emergency ies and procedures to all new adividuals providing services and volunteers, consistent roles, and maintain he training. The CMHC must anowledge of emergency after, the CMHC must provide edness training at least every 2 as not met as evidenced by: eview and interview, the facility as staff received emergency plan training upon hire. This effect 6 of 6 clients residing in 43, #4, #5 and #6). The finding at least every 2 eview and interview, the facility as a staff received emergency plan training upon hire. This effect 6 of 6 clients residing in 43, #4, #5 and #6). The finding are well as a staff (Staff A, Staff C, Staff G working in the home, and the least they had new staff in the analysis and a staff in the analysis and a staff in the analysis and the least turnover with staffing over the Home Manager and most with the Qualified Intellectual in	ΕO			

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	PROVIDER OR SUPPLIER	L HILL		1	STREET ADDRESS, CITY, STATE, ZIP CODE I11 SILO DRIVE CHAPEL HILL, NC 27514	, ,	
(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 APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
E 039	§416.54(d)(2), §418 §460.84(d)(2), §482 §483.475(d)(2), §48 §485.542(d)(2), §48 §485.542(d)(2), §48 *[For ASCs at §416 at §485.542, OPO, §485.727, CMHCs §491.12, and ESRI (2) Testing. The [facto test the emergen must do all of the formal of the formal of the formal exercise every 2 years (B) If the [facilit natural or man-manal 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 intending the formal exercise (B) A second full-second full-s	3.113(d)(2), §441.184(d)(2), 2.15(d)(2), §483.73(d)(2), 34.102(d)(2), §485.68(d)(2), 35.625(d)(2), §485.727(d)(2), 31.12(d)(2), §494.62(d)(2).  .54, CORFs at §485.68, REHs "Organizations" under at §485.920, RHCs/FQHCs at D Facilities at §494.62]:  cility] must conduct exercises be recyplan annually. The [facility] ollowing:  all-scale exercise that is every 2 years; or unity-based exercise is not at a facility-based functional ars; or y] experiences an actual deemergency that requires hergency plan, the [facility] is jung 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 allowing: tale exercise that is or individual, facility-based or	E	)39			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G035	B. WING			07	/02/2024
	PROVIDER OR SUPPLIER	EL HILL		111 SILO DRI	RESS, CITY, STATE, ZIP CODE IVE LL, NC 27514	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EAC	ROVIDER'S PLAN OF CORRE CH CORRECTIVE ACTION SH: S-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
E 039	scenario, and a set directed messages designed to challer (iii) Analyze the [fac maintain document exercises, and eme [facility's] emergence *[For Hospices at 4 (2) Testing for hospatient's home. The exercises to test the annually. The hospice in a community based of (A) When a community based of (A) When a community based of (B) If the hospice eman-made emergency planengaging in its next community-based of facility-based functionset of the emerging (ii) Conduct an addroposite the year the exercise under particles conducted, that in to the following:  (A) A second full-scommunity-based of exercise; or  (B) A mock disasted (C) A tabletop exercise a facilitator and incommunity-based of the emerging (C) A tabletop exercise a facilitator and incommunity-based of the emergency planent is conducted, that in the following:  (A) A second full-scommunity-based of the emergency planent is conducted, that in the following:  (A) A second full-scommunity-based of the emergency planent is conducted, that in the following:  (B) A mock disasted (C) A tabletop exercise; or	y-relevant emergency to of problem statements, to of an emergency plan. to tation of all drills, tabletop tergency events, and revise the to plan, as needed.  18.113(d):] pices that provide care in the the hospice must conduct the emergency plan at least to occupate that is to emergency plan at least to occupate that is to emergency plan at least to occupate that is to emergency plan at least to occupate that is to emergency plan at least to occupate that is to emergency plan at least to occupate that is to emergency plan at least to occupate that is to emergency plan at least to occupate that is to emergency plan the hospice that is to emergency plan the hospice that is to emergency plan the hospice that is to emergency plan the top occupate the top occupat	EC	39			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		34G035	B. WING			07/0	02/2024
	PROVIDER OR SUPPLIER	L HILL		111	REET ADDRESS, CITY, STATE, ZIP CODE SILO DRIVE APEL HILL, NC 27514	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	scenario, and a set directed messages designed to challen (3) Testing for hosp care directly. The hexercises to test the year. The hospice (i) Participate in an is community-based (A) When a community-based functi (B) If the hospice eman-made emerge the emergency plarengaging in its next based or facility-based following the onset (ii) Conduct an add may include, but is (A) A second full-scommunity-based of exercise; or (B) A mock disasted (C) A tabletop exerticalitator that including a set of problem essages, or preparentallenge an emerging (iii) Analyze the homaintain document exercises, and emergency is a set of problem essages, and emergency is emergency in the problem	of problem statements, , or prepared questions age an emergency plan.  vices 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 ncy that requires activation of the hospice is exempt from trequired full-scale community sed functional exercise of the emergency event. ditional annual exercise that not limited to the following: cale exercise that is or a facility based functional  er drill; or recise or workshop led by a des a group discussion using a relevant emergency scenario, m statements, directed ared questions designed to gency plan. spice's response to and ation of all drills, tabletop ergency events and revise the	EO	39			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G035	B. WING		<u> </u>	07/	02/2024
	ROVIDER OR SUPPLIER  VE FACILITY-CHAPE	L HILL		111	EET ADDRESS, CITY, STATE, ZIP CODE SILO DRIVE APEL HILL, NC 27514	•	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	conduct exercises to twice per year. The do the following: (i) Participate in an is community-based (A) When a community-based function (B) If the [PRTF, Ho actual natural or ma requires activation of [facility] is exempt for the emergency of the emergency (ii) Conduct an and that may include following: (A) A second full-scale of the emergency (B) A mock (C) A tabletop of the functional exercise; (B) A mock (C) A tabletop of the emergency scenarious tatements, directed questions designed plan.  (iii) Analyze the maintain document exercises, and emergency scenarious facility's] emergency  *[For PACE at §460]	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 an 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 not includes a group narrated, clinically-relevant o, and a set of problem d messages, or prepared to challenge an emergency  [facility's] response to and ation of all drills, tabletop ergency events and revise the cy plan, as needed.	EO	39			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		34G035	B. WING_		07	/02/2024
	PROVIDER OR SUPPLIER	L HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 111 SILO DRIVE CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
E 039	exercises to test the annually. The PACE following:  (i) Participate in an is community-based (A) When a community-based function (B) If the PACE expressible, conduct facility-based function (B) If the PACE expressible, conduct facility-based function (B) If the PACE expressible, conducted that make the emergency plarengaging in its next based or individual, exercise following the exercise following the exercise under participate is conducted that make the following:  (A) A second full-second full-second exercise; (B) A mock disasted (C) A tabletop exert a facilitator and inclusing a narrated, clusted messages designed to challen (iii) Analyze the PAM maintain document exercises, and emerpace's emergency  *[For LTC Facilities (2) The [LTC facility following in a community-based community	e emergency plan at least corganization must do the annual full-scale exercise that d; or unity-based exercise is not an annual individual, onal exercise; or periences an actual natural or necy 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 that is not limited to cale exercise that is or individual, a facility based or er drill; or the cise or workshop that is led by undes a group discussion, inically-relevant emergency of problem statements, or prepared questions ge an emergency plan. CE's response to and action of all drills, tabletop ergency events and revise the aplan, as needed.	E 03	39		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	EL HILL		STREET ADDRESS, CITY, STATE, ZIP CODE  111 SILO DRIVE  CHAPEL HILL, NC 27514		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
E 039	emergency proced ICF/IID] must do the (i) Participate in an is community-based (A) When a community-based (A) When a community-based functional extra actual natural or morequires activation LTC facility is exemorequired a full-scalindividual, facility-befollowing the onset (ii) Conduct an admay include, but is (A) A second full-scommunity-based functional exercises (B) A mock disasted (C) A tabletop exemple a facilitator include narrated, clinically-and a set of problemessages, or prepichallenge an emer (iii) Analyze the [LTC facility] facility  *[For ICF/IIDs at §4 (2) Testing. The IC to test the emerger The ICF/IID must of the community-based functional exercises, and emer (iii) Analyze the [LTC facility] facility	nced staff drills using the ures. The [LTC facility, be following: an annual full-scale exercise that d; or unity-based exercise is not st an annual individual, ional exercise. ity] facility experiences an an-made emergency that of the emergency plan, the apt from engaging its next ecommunity-based or ased functional exercise of the emergency event. ditional annual exercise that not limited to the following: cale exercise that is or an individual, facility based; or er drill; or roise or workshop that is led by a group discussion, using a relevant emergency scenario, m statements, directed ared questions designed to gency plan. TC facility] facility's response to mentation of all drills, tabletop ergency events, and revise the d's emergency plan, as needed.  483.475(d)]: F/IID must conduct exercises not plan at least twice per year. Ito the following: annual full-scale exercise that	E 03	9		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		34G035	B. WING _		07	/02/2024	
	PROVIDER OR SUPPLIER	EL HILL		STREET ADDRESS, CITY, STATE, ZIP 111 SILO DRIVE CHAPEL HILL, NC 27514			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
E 039	accessible, conduct facility-based functional emergency plar engaging in its next community-based of functional exercise emergency event.  (ii) Conduct an add may include, but is (A) A second full-so community-based of functional exercise; (B) A mock disaste (C) A tabletop exercise a facilitator and inclusing a narrated, cl scenario, and a set directed messages designed to challent (iii) Analyze the ICF maintain document exercises, and emerical exercises, and emerical exercises, and emerical exercises, and emerical exercises and emerical exercises. The to test the emergence is a functional exercise (A) When a con accessible, conduct facility-based function.	unity-based exercise is not tan annual individual, onal exercise; or. speriences an actual natural or ncy that requires activation of n, the ICF/IID is exempt from a required full-scale or individual, facility-based following the onset of the ditional annual exercise that not limited to the following: sale exercise that is or an individual, facility-based or ar 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. [IID's response to and ation of all drills, tabletop ergency events, and revise the explan, as needed.  [Incomplete the transport of the state	E 03	39			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	EL HILL		STREET ADDRESS, CITY, STATE, ZIP O 111 SILO DRIVE CHAPEL HILL, NC 27514			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
E 039	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 fucommunity-based of functional exercise; (B) A mock disa (C) A tabletop of led by a facilitator ad discussion, using a emergency scenaristatements, directed 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 emerger following:  (i) Conduct a paper workshop at least as led by a facilitator ad discussion, using a emergency scenaristatements, directed statements, dir	rigency that requires activation alan, 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 is needed.	E 03	9			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		34G035	B. WING		07	/02/2024
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 111 SILO DRIVE CHAPEL HILL, NC 27514	•	
(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 CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
E 039	plan. If the OPO exman-made emerge the emergency platengaging in its next following the onset (ii) Analyze the OP documentation of a emergency events OPO's] emergency events OPO's] emergency exercises to test through the exercises to test through	experiences an actual natural or ency that requires activation of in, the OPO is exempt from it 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 the emergency plan. The RNHCI ing:  r-based, tabletop exercise at abletop exercise is a group a facilitator, using a narrated, emergency scenario, and a set ents, directed messages, or is designed to challenge an ents, and revise the RNHCI's response to and tation of all tabletop exercises, ents, and revise the RNHCI's is needed.  is not met as evidenced by:  eview and interview, the facility table top exercise and/or est their emergency  plan. This had the potential to a residing in the home (#1, #2, and the facility) and a pandemic entity implemented it when the facility in the service of disaster in	EO	39		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		34G035	B. WING_		07	/02/2024
	PROVIDER OR SUPPLIER	EL HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 111 SILO DRIVE CHAPEL HILL, NC 27514	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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	Continued From pa	ge 22	E 03	39		
W 249	the Supervisor reversible promoted to their prince in conducting exercises. Interview on 7/2/24 Disabilities Profess	MENTATION	W 24	19		
	As soon as the interpretation formulated a client each client must restreatment program interventions and sand frequency to su	rdisciplinary team has s 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 observatinterview, the facilit clients (#1, #2, #3, continuous active to fineeded intervent assisting with meal administration; enc	s not met as evidenced by: tions, record review and y failed to ensure 6 of 6 audit #4, #5 and #6) received a reatment program consisting tions and services regarding preparation and medication ouragement for family style at meals and clearing dishes.				
	Staff B was in the k	ne home on 7/1/24 at 4:08pm, itchen with client #4 who sat in counter. During the				

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	PROVIDER OR SUPPLIER	EL HILL		STREET ADDRESS, CITY, STATE, ZIP OF 111 SILO DRIVE CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
W 249	kitchen, sat down in cooked. Staff B was from the cabinets a can opener to open a pot on the stove. The trash can, remove the trash can, remove the trash can, remove the trash can, remove to the trash can, remove the trash can, remove the trash can, remove the trash can, remove the trash can be a cabinet to line the best ware not encour preparation.  B. Observation in the client #1 brought diplaced them in the plate, rinsed it off a for client #1.  C. Observation in the plate, rinsed it off a for client #1.  C. Observation in the plate, rinsed it off a for client #1.  C. Observation in the plate, rinsed it off a for client #1.  C. Observation in the plate, rinsed it off a for client #2 and each client. There is the table, to give client in the table, to give c	#1 and #2 came to the chairs and watched Staff B is observed to remove food and refrigerator before using a can of corn and empty it in Staff B placed all garbage in oved a baking sheet from a took aluminum foil out of taking sheet. Clients #1, #2 or raged to participate in the meal one home on 7/1/24 at 5:10pm, rty dishes to the table and sink. Staff D took the dirty and loaded it in the dishwasher one home on 7/1/24 between the home on 7/1/24 between the home on 7/1/24 between the home on 7/1/24 between to the table to serve to over no pitchers present on the ents the opportunity to pour to pass the pitcher to others. The home on 7/2/24 between Staff F poured cups of water and #5 who were getting of #2/2/24 of client #3's Direct (DSE) from 5/9/23 revealed at with eating and drinking.	W 24	19		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		34G035	B. WING		07	//02/2024		
NAME OF PROVIDER OR SUPPLIER  SILO DRIVE FACILITY-CHAPEL HILL			STREET ADDRESS, CITY, S 111 SILO DRIVE CHAPEL HILL, NC 275	TATE, ZIP CODE				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	( (EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
W 249	revealed staff had a and clients should be acknowledged client meals and client #4 hand participation. clients should be githeir drinks and to le liter drinks been a turnove manager four times assessments not be acknowledged the comeal preparation and possible. The QIDF beverage pitchers to pouring. The QIDF of client #4 having the however, the direct followed, to assist version to liter drinks and growth, development client. This STANDARD is Based on observation interviews, the facility maintained positive affected 2 of 6 audifindings are:  A. During dinner observations and client drinks and client drinks are:	with the Home Manager (HM) a "bad habit of serving clients" be able to participate. The HM at #1 liked to help prepare could assist with hand over The HM also revealed the ven the opportunity to pour oad the dishwasher.  with the qualified intellectual onal (QIDP) revealed there is and that it affected their eing done. The QIDP clients should participate with and family style dining, when it revealed the facility has small to assist the clients with revealed she was not aware trouble with scooping his food, ions for placement should be with independent feeding.	W 2					
		sweet potatoes, corn and a						

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
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W 268	pasta salad for dinr was not eating his f saying to client #6, If you do not like it,  B. During morning of 7/2/24 at 8:39am, the sasembled in the lift the day program. Of Staff A about working overheard saying to on a lawn mower, yhave to take oriental training on "Our Values "we care aborelationships." Staff training on "Our Values" were new staff world Staff B was on of the support professional have to take oriental client rights, where promoted.  Interview on 7/2/24 Disabilities Profess	rier. Staff B noticed client #6 rish. Staff B was observed "I cooked what's on the menu. that's on you."  Observations in the home on the clients and staff had ving getting ready to leave for lient #1 was conversing with the on a lawn crew. Staff A was to client #1, "You cannot work to u do not have a brain." Client aff A, "Why you pick on me?".  October 2/2/24 of Minutes from the ting on 3/6/24 revealed the M) discussing with staff, their tout people" and "we build B had recently completed	W 2	68			
W 340	it was not acceptab matter that was obs NURSING SERVIC CFR(s): 483.460(c)	le to talk to clients in the served. ES	W 3	40			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
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	NAME OF PROVIDER OR SUPPLIER  SILO DRIVE FACILITY-CHAPEL HILL			STREET ADDRESS, CITY, STATE, ZIP CO 111 SILO DRIVE CHAPEL HILL, NC 27514		, <b>v = . v = .</b>		
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
W 340	other members of appropriate protect measures that including clients and health and hygiened. This STANDARD Based on observations failed to ensure stackient privacy while and that staff were in the presence of of audited clients (are:  A. Observations in revealed Staff A profor client #2 who we medication room. Stothe porch, where medications to ing.  An additional obset at 7:51am, revealed walker to head to the Staff F wanted client at the was taking him prepared medication to Staff F client #2 he was taking him prepared medications to the client walker to the door, without knock to the client was taking him prepared medications to the client was taking him prepared medications to the client was taking him prepared medications. The dock of the client was taking the client was taki	the interdisciplinary team, tive and preventive health ude, but are not limited to I staff as needed in appropriate e methods. is not met as evidenced by: ations and interviews, the facility aff were trained to afford each administering medications; a trained to prepare medications the client. This affected 3 of 6 #2, #3 and #6). The findings  the home on 7/1/24 at 3:05pm epared a cup of medications ras not present in the Staff A left the home and went e client #2 sat and gave him	W 34	40				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  IG	, ,	COMPLETED		
		34G035	B. WING _		07	/02/2024		
	PROVIDER OR SUPPLIER	EL HILL	STREET ADDRESS, CITY, STATE, ZIP COD 111 SILO DRIVE CHAPEL HILL, NC 27514					
(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 A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
W 340	nostril. Staff F did r his mouth after usi medication room w medications were of C. Observations in revealed Staff F pr client #2 with the d room. Client #5, wh medication, returned with Staff F. Client ask Staff F a quest D. Observations in 8:28am, Staff F we client #4 sat with of transportation to w medication up his re-	not prompt client #3 to rinse out ing the inhaler. The door to the ras left ajar while the given.  the home on 7/2/24 at 7:55am reparing medications to give to oor left open to the medication no had just received his red to the room to "hang out" #1 also entered the room to rion.  the home on 7/2/24 at rette to the living room, where ther clients waiting for ork, and sprayed his nose.  A on 7/1/24 revealed he takes to #2 instead of asking him to action because he was not	W 34	.0				
	prepared medication present because the not want to wait to Staff F also revealed so he received his revealed because medication 30 minus he takes the medical Interview with the Frevealed she was the 2024 on medication During her certification.	F on 7/2/24 revealed he ons without the clients being ney become inpatient and do pop the pills out of the back. The client #2 wants to sleep in medications last. Staff F also client #2 needs to take his utes before eating breakfast, eation to him in the bathroom.  Home Manager (HM) on 7/2/24 rained by the nurse in May administration practices. Ition, the home was D-19 and they did not require						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G035	B. WING		07/02/2024		
NAME OF PROVIDER OR SUPPLIER  SILO DRIVE FACILITY-CHAPEL HILL			111	REET ADDRESS, CITY, STATE, ZIP CODE SILO DRIVE IAPEL HILL, NC 27514		-	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)			BE	(X5) COMPLETION DATE
W 440	revealed she traine administration and client #2 his medicaroom, including the Interview with the CProfessional (QIDP working in the home certified to pass meacknowledged whe morning she had earnedication room to revealed clients she medication and the medications while CEVACUATION DRICER(s): 483.470(i) at least quarterly for This STANDARD in Based on record refacility failed to ensign at least quarterly for potential to affect 6 #4, #5 and #6). The Record review on 7 log from September the following:  On 9/18/23 at 10:48 On 9/28/23 at 6:00 On 3/21/24 at 4:45 On 3/27/24 at 4:19 On 3/30/24 at 12:30 O	he medication room. The HM d Staff A on medication gave him clearance to give ation outside of the medication bathroom.  Qualified Intellectual Disabilities by revealed most of the staff e were new and recently edications. The QIDP in she gave medications in the each client come to the take them. The QIDP also ould have privacy when getting re was no reason to give clients sat on toilet.  LLS (1)  It each shift of personnel. In the each shift of personnel is not met as evidenced by: eview and staff interview, the each shift. This had the of 6 audit clients (#1, #2, #3, as finding is:  It // 2/24 of the facility's fire drills in the each shift. The facility is fire drills in the each shift. The facility is fire drills in the each shift. The facility is fire drills in the each shift. The facility is fire drills in the each shift. The facility is fire drills in the each shift in the each shif	W 3				
	IIILEI VIEW UII 1/2/24	with Staff A revealed he was					

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	34G035	B. WING			07/0	02/2024
NAME OF PROVIDER OR SUPPLIER  SILO DRIVE FACILITY-CHAPEL HILL			11	11 SILO DRIVE		
(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
a new employee whas not participated.  Interview on 7/2/24 revealed she starte and has not conduct.  Interview on 7/2/24 Disabilities Profess were behind with the staff in the home.  INFECTION CONT CFR(s): 483.470(I)()  The facility must proto avoid sources and the staff in the home.  Based on observation interviews, the facil environment in the to effect 6 of 6 audit of the properties of the survey on July 1-2, urine odor in the live medication room. To stains on the furnis appeared to be inconsecred Review on Meeting Minutes from the started of the staff o	with the Home Manager d her position in April 2024 cted fire drills for the home.  with the Qualified Intellectual ional (QIDP) revealed they leir fire drills due to turnover of ROL (1)  ovide a sanitary environment and transmission of infections.  Is not met as evidenced by: tions, record review and staff ity failed to maintain a sanitary home. This had the potential t clients. The finding is:  Is in the home, during the 2024, there was a noticeable ing room, half bathroom and there were no noticeable hings and none of the clients on tinent, creating the odor.					
Interview on 7/2/24	with the Qualified Intellectual					
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LETTE CONTINUED FROM PARTICIPATE OF LETTE PARTICIPATE OF LE	TOURTH CORRECTION  34G035  PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 29  a new employee who started a month ago and has not participated in a fire drill.  Interview on 7/2/24 with the Home Manager revealed she started her position in April 2024 and has not conducted fire drills for the home.  Interview on 7/2/24 with the Qualified Intellectual Disabilities Professional (QIDP) revealed they were behind with their fire drills due to turnover of	A BUILD  34G035  B. WING  PROVIDER OR SUPPLIER  WE FACILITY-CHAPEL HILL  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 29  a new employee who started a month ago and has not participated in a fire drill.  Interview on 7/2/24 with the Home Manager revealed she started her position in April 2024 and has not conducted fire drills for the home.  Interview on 7/2/24 with the Qualified Intellectual Disabilities Professional (QIDP) revealed they were behind with their fire drills due to turnover of staff in the home.  INFECTION CONTROL CFR(s): 483.470(I)(1)  The facility must provide a sanitary environment to avoid sources and transmission of infections.  This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to maintain a sanitary environment in the home. This had the potential to effect 6 of 6 audit clients. The finding is:  During observations in the home, during the survey on July 1-2, 2024, there was a noticeable urine odor in the living room, half bathroom and medication room. There were no noticeable stains on the furnishings and none of the clients appeared to be incontinent, creating the odor.  Record Review on 7/2/24 of the home's Team Meeting Minutes from 3/6/24 revealed third shift staff were expected to deep clean the common areas, which included mopping up spills.  Interview on 7/2/24 with the Qualified Intellectual	A BUILDING  34G035  B. WING  BROVIDER OR SUPPLIER  WE FACILITY-CHAPEL HILL  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 29  a new employee who started a month ago and has not participated in a fire drill.  Interview on 7/2/24 with the Home Manager revealed she started her position in April 2024 and has not conducted fire drills for the home.  Interview on 7/2/24 with the Qualified Intellectual Disabilities Professional (QIDP) revealed they were behind with their fire drills due to turnover of staff in the home.  INFECTION CONTROL CFR(s): 483.470(I)(1)  The facility must provide a sanitary environment to avoid sources and transmission of infections.  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WING O7//  **ROVIDER OR SUPPLIER**  **VE FACILITY-CHAPEL HILL**  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MST 16 PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  **CONTINUED From page 29 a new employee who started a month ago and has not participated in a fire drill.*  Interview on 7/2/24 with the Home Manager revealed she started her position in April 2024 and has not conducted fire drills for the home. Interview on 7/2/24 with the Qualified Intellectual Disabilities Professional (QIDP) revealed they were behind with their fire drills due to turnover of staff in the home.  INFECTION CONTROL CFR(s): 483.470(I)(1)  The facility must provide a sanitary environment to avoid sources and transmission of infections.  This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to maintain a sanitary environment in the home. That dhe potential to effect 6 of 6 audit clients. 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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		34G035	B. WING _		07.	/02/2024		
	PROVIDER OR SUPPLIER	EL HILL		STREET ADDRESS, CITY, STATE, ZIP 111 SILO DRIVE CHAPEL HILL, NC 27514	•			
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
W 454	room furniture beca detected an odor in	age 30 ome, she wipes down the living ause she had previously the room. The QIDP odors may originate in the	W 45	54				
W 473	MEAL SERVICES CFR(s): 483.480(b Food must be serv This STANDARD Based on observa interview, the facility	ed at appropriate temperature. is not met as evidenced by: tions, record review and staff ty failed to ensure food was er temperature for 1 of 6 audit	W 47	73				
	7/2/24 at 7:30am, salad and turkey lir were coming to the getting their medical observation at 8:00 uncovered plate ar The side of the cof surveyor and it was 7:50am, client #2 to to leted, took his madressed before cor 8:55am to eat his to reheat his food. drink half of his cof Record review on and Environment of handling and storal prevent food-bornes.							
		with the Qualified Intellectual ional (QIDP) revealed staff						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	34G035	B. WING		07/02/2024		
NAME OF PROVIDER OR SUPPLIER  SILO DRIVE FACILITY-CHAPEL HILL			STREET ADDRESS, CITY, STATE, ZIP COD 111 SILO DRIVE CHAPEL HILL, NC 27514			
PRÉFIX (EACH DEFICIEI	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 473 Continued From should keep the client is ready to	food on a heat source until the	W	473			