DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G035	A. BUILDING ______ B. WING ______	R 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILO DRIVE FACILITY-CHAPEL HILL	**111 SILO DRIVE CHAPEL HILL, NC 27514**

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E 000	Initial Comments A revisit was conducted on September 10, 2024 for all previous deficiencies cited on July 2, 2024. Some of the deficiencies were corrected: E0030, E0036, E0039, W249, W268, W340, W440 and W473. Some deficiencies continue to need correction with an area of new non-compliance found.	E 000		
{E 018}	Procedures for Tracking of Staff and Patients CFR(s): 483.475(b)(2) §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.542(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b),	{E 018}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 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.

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{E 018}	Continued From page 1 ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical	{E 018}		

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documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.

*[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.
This STANDARD is not met as evidenced by:
Based on record review and interview, the facility failed to develop a system to track clients and staff in the event, their emergency preparedness (EP) plan had to be implemented. This had the potential to effect 6 of 6 clients residing in the home (#1, #2, #3, #4, #5 and #6). The finding is:

Review on 7/2/24 of the facility's EP plan dated 5/16/24 revealed there were no details for the clients residing in the home and current staff.

Interview on 7/2/24 with the Home Manager (HM) revealed most of the direct care professionals working in the home, were recently hired.

Interview on 7/2/24 with the Qualified Intellectual Disabilities Professional (QIDP) acknowledged the EP plan lacked information on the clients in the home. 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.

A follow-up visit was conducted on 9/10/24.

Record review of the facility's EP plan, last revised 5/16/24 continued to lack details on tracking clients in the event of an emergency.

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Interview on 9/10/24 with Staff H revealed she was given materials for their plan of correction, that she made available for review.

Interview on 9/10/24 with Staff I revealed none of the management staff were available to provide any information on additional materials to review. Staff I was unable to provide any information.

{E 037} EP Training Program {E 037}
CFR(s): 483.475(d)(1)

§403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).

*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:]
(1) Training program. The [facility] must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.
(v) If the emergency preparedness policies and

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procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.

*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least every 2 years.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.
(v) Maintain documentation of all emergency preparedness training.
(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training every 2 years.
(iii) Demonstrate staff knowledge of emergency

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procedures.
(iv) Maintain documentation of all emergency preparedness training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency

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{E 037}	Continued From page 6 preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected	{E 037}		

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{E 037}	Continued From page 7 roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure new staff received emergency preparedness (EP) plan training upon hire. This had the potential to effect 6 of 6 clients residing in the home (#1, #2, #3, #4, #5 and #6). The finding is: Record review on 7/2/24 of the facility's EP plan training dated 5/16/24 revealed there was no evidence of the five new staff (Staff A, Staff C, Staff E, Staff F and Staff G working in the home, receiving their initial EP plan training. Interview on 7/2/24 with the Home Manager and the Supervisor revealed they had new staff in the home with less than 30 days experience.	{E 037}		

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{E 037}	Continued From page 8 Interview on 7/2/24 with the Qualified Intellectual Disabilities Professional (QIDP) revealed the home had experienced turnover with staffing over the year and both the Home Manager and most of the staff were new in their roles. The QIDP revealed they hoped to get back on track now that vacancies have been filled. A follow-up visit was conducted on 9/10/24. Review of the EP plan, last revised on 5/16/24 did not include any evidence of Staff H, Staff I or Staff J working in the home, receiving EP plan training. Interview on 9/10/24 with Staff I revealed none of the management staff were available to provide any information on additional materials to review.	{E 037}		
W 000	INITIAL COMMENTS	W 000		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure medication was secure in the absence of staff. This affected 1 of 2 audit clients (#4). The finding is: During observation in the home on 9/10/24 at 3:05pm, Staff J brought client #4 to the medication room to take a pill. Staff J popped the pill out of the package, placed in pill cup and left	W 382		

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W 382	Continued From page 9 on the table next to client #4. Staff J realized he did not have water in the pitcher, locked the door to the medication closet, before leaving the surveyor in the room with client #4 with his medication on the table. Staff J returned at 3:08pm and gave client #4 his pill to swallow with water. In addition, Staff J left the medication room at 3:09pm to get client #4 a tissue, per his request. Staff J left the package of multi-vitamin with the surveyor, when he exited the room for 2 minutes. Interview on 9/10/24 with Staff J acknowledged he did not secure the medication when leaving the room twice. Staff J replied he made a "bad judgment call" not getting the pitcher filled before starting giving meds.	W 382		
{W 454}	INFECTION CONTROL CFR(s): 483.470(l)(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	{W 454}		

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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 Disabilities Professional (QIDP) revealed when she works in the home, she wipes down the living room furniture because she had previously detected an odor in the room. The QIDP acknowledged the odors may originate in the carpet.

A follow-up visit was conducted on 9/10/24.

During observations in the home on 9/10/24 from 2:30-4:00pm a faint urine odor remained in the carpeted living room area.

Record review on 9/10/24 revealed the Home Manager sent an email on 8/23/24 to an employee requesting an update to replace the facility's carpet and/or to shampoo the rug, since the urine odor was still present. There was no response from the facility if the request had been approved.

An attempt was made to interview staff on 9/10/24 however per staff, the management team was unavailable.