DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				F	ORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB	NO. 0938-0391
-	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í			· · · ·	ATE SURVEY OMPLETED
		34G036	B. WING				12/13/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SEVEN O	AKS ROAD-DURHAM				614 SEVEN OAKS ROAD		
0212110					DURHAM, NC 27704		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 004	CFR(s): 483.475(a) [The [facility] must comply with all applicable			004	4		
	Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.] * [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.						
	include, but not be lin elements:] (a) Emergency Plan. and maintain an eme	aredness program must hited to, the following The [facility] must develop rgency preparedness plan d], and updated at least					
	Plan. The ESRD facil maintain an emergen must be [evaluated], a annually. This STANDARD is r Based on record revi failed to ensure the E	cy preparedness plan that and updated at least not met as evidenced by: ew and interview, the facility mergency Preparedmess ed and updated at least					
	The facility's EP plan updated annually.	WAS NOT REVIEWED OF	2F		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.

PRINTED: 12/17/2018

		D HUMAN SERVICES MEDICAID SERVICES			FORM	M APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		34G036	B. WING		12/	/13/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SEVEN OA	AKS ROAD-DURHAM			614 SEVEN OAKS ROAD DURHAM, NC 27704		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
E 004	Continued From page	91	E 00	04		
E 006	revealed the plan had 7/21/17. Additional re "This emergency plan updated at least annu plan did not include e Interview on 12/13/18 Intellectual Disabilities revealed he was not a been reviewed or upd Plan Based on All Haz CFR(s): 483.475(a)(1 [(a) Emergency Plan. and maintain an emer that must be reviewed annually. The plan mu (1) Be based on and if facility-based and con assessment, utilizing *[For LTC facilities at on and include a docu community-based risk all-hazards approach, all-hazards approach,	eview of the plan indicated, in must be reviewed and hally." Further review of the vidence of an annual review. with the Qualified is Professional (QIDP) aware if the EP plan had lated after 7/21/17. zards Risk Assessment)-(2) The [facility] must develop rgency preparedness plan d, and updated at least ust do the following:] include a documented, inmunity-based risk an all-hazards approach.* §483.73(a)(1):] (1) Be based umented, facility-based and a assessment, utilizing an including missing residents.	EO	26		
	events identified by th	o for addressing emergency ne risk assessment. 18.113(a)(2):] (2) Include				

If continuation sheet Page 2 of 16

PRINTED: 12/17/2018

		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 12/17/20 RM APPROVE IO. 0938-039
TATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		34G036	B. WING		1:	2/13/2018
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	ΡE	
	AKS ROAD-DURHAM			614 SEVEN OAKS ROAD		
				DURHAM, NC 27704		
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
E 006	Continued From page	e 2	E OC	06		
		sing emergency events				
	-	assessment, including the				
		onsequences of power sters, and other emergencies				
		hospice's ability to provide				
	care.					
		not met as evidenced by: iew and interview, the facility				
		Emergency Preparedness				
		nd based upon a community				
	and facility-based risl all-hazards approach	< assessment, utilizing an . The finding is:				
	The facility did not ha based upon risk asse	ive an emergency plan essments.				
	plan dated 7/21/17 re provide specific inform facility-based and con assessment using an including flood, fire, to	of the facility's current EP evealed the plan did not mation in regards to a mmunity-based risk all-hazards approach ornadoes, hurricanes, winter missing clients or other				
E 037	confirmed no EP risk completed utilizing ar	s Professional (QIDP) assessment had been n all-hazards approach.	E 03	37		
	ASCs, PACE organiz	The [facility, except CAHs, ations, PRTFs, Hospices, must do all of the following:				
		nergency preparedness res to all new and existing				

Facility ID: 922555

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 12/17/2018 APPROVED 0. 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _			(X3) DATE SURVEY COMPLETED		
		34G036	B. WING		_	12/	13/2018	
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE			
SEVEN OA	AKS ROAD-DURHAM			14 SEVEN OAKS ROAD OURHAM, NC 27704				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
E 037	expected role. (ii) Provide emergence least annually. (iii) Maintain documer (iv) Demonstrate staff procedures. *[For Hospitals at §48 at §491.12:] (1) Traini or RHC/FQHC] must of (i) Initial training in em- policies and procedure staff, individuals provi arrangement, and volue expected roles. (ii) Provide emergence least annually. (iii) Maintain documer (iv) Demonstrate staff procedures. *[For Hospices at §41 hospice must do all of (i) Initial training in em- policies and procedure hospice employees, a services under arrange expected roles. (ii) Demonstrate staff procedures. (ii) Demonstrate staff procedures. (iii) Provide emergence least annually. (iv) Periodically review emergency preparedr employees (including special emphasis place	ding services under unteers, consistent with their y preparedness training at natation of the training. knowledge of emergency 2.15(d) and RHCs/FQHCs ng program. The [Hospital do all of the following: nergency preparedness es to all new and existing ding on-site services under unteers, consistent with their y preparedness training at natation of the training. knowledge of emergency 8.113(d):] (1) Training. The i the following: nergency preparedness es to all new and existing ind individuals providing uement, consistent with their knowledge of emergency cy preparedness training at	E 037					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 12/17/2018 1 APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		34G036	B. WING		_	12/	13/2018
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
SEVEN O	AKS ROAD-DURHAM		-	14 SEVEN OAKS ROAD URHAM, NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 037	Continued From page others.	2 4	E 037				
	 (i) Initial training in enpolicies and procedur staff, individuals provi arrangement, and vol expected roles. (ii) After initial training preparedness training (iii) Demonstrate staff procedures. (iv) Maintain document preparedness training *[For PACE at §460.8] organization must do (i) Initial training in enpolicies and procedur staff, individuals provi arrangement, contract volunteers, consistent (ii) Provide emergence least annually. (iii) Demonstrate staff procedures, including what to do, where to g case of an emergence (iv) Maintain document *[For CORFs at §485 CORF must do all of (i) Provide initial training preparedness policies and existing staff, ind 	nust do all of the following: hergency preparedness res to all new and existing iding services under unteers, consistent with their g, provide emergency g at least annually. Fix nowledge of emergency thation of all emergency g. (4(d):] (1) The PACE all of the following: hergency preparedness res to all new and existing iding on-site services under tors, participants, and t with their expected roles. By preparedness training at Fix nowledge of emergency informing participants of go, and whom to contact in y. hation of all training. (68(d):](1) Training. The the following: ing in emergency s and procedures to all new ividuals providing services and volunteers, consistent					

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	MENT OF HEALTH AN S FOR MEDICARE & I						FORM): 12/17/2018 APPROVED). 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		34G036	B. WING			_	12/13/2018		
NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-		
SEVEN O	AKS ROAD-DURHAM				14 SEVEN OAKS ROAD DURHAM, NC 27704				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
E 037	 (ii) Provide emergence least annually. (iii) Maintain documerent (iv) Demonstrate staff procedures. All new pand assigned specific the CORF's emergence their first workday. The include instruction in the alarm systems and signed equipment. *[For CAHs at §485.6 The CAH must do all (i) Initial training in empolicies and procedure reporting and extingui and where necessary personnel, and guests cooperation with firefing authorities, to all new individuals providing sand volunteers, consist roles. (ii) Provide emergence least annually. (iii) Maintain documerent (iv) Demonstrate staff procedures. *[For CMHCs at §485 CMHC must provide i preparedness policies and existing staff, indi- under arrangement, a with their expected ro 	y preparedness training at tation of the training. knowledge of emergency ersonnel must be oriented responsibilities regarding cy plan within 2 weeks of e training program must he location and use of gnals and firefighting 25(d):] (1) Training program. of the following: hergency preparedness es, including prompt shing of fires, protection, , evacuation of patients, s, fire prevention, and ghting and disaster and existing staff, services under arrangement, stent with their expected y preparedness training at tation of the training. knowledge of emergency 920(d):] (1) Training. The nitial training in emergency and procedures to all new viduals providing services nd volunteers, consistent les, and maintain training. The CMHC must	E	037					

Facility ID: 922555

If continuation sheet Page 6 of 16

	OF DEFICIENCIES	MEDICAID SERVICES		E CONSTRUCTION		10. 0938-039
	F CORRECTION	IDENTIFICATION NUMBER:	. ,		· · · ·	MPLETED
		34G036	B. WING		1	2/13/2018
NAME OF P	ROVIDER OR SUPPLIER		Ş	STREET ADDRESS, CITY, STATE, ZIP CODE	E	
SEVEN O	AKS ROAD-DURHAM			14 SEVEN OAKS ROAD DURHAM, NC 27704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
E 037	Continued From page	e 6	E 037			
	procedures. Thereaft emergency prepared annually.	er, the CMHC must provide ness training at least				
	Based on record revi facility failed to ensur	not met as evidenced by: iew and interviews, the e direct care staff were s Emergency Preparedness g is:				
	Staff had not been tra plan.	ained on the facility's EP				
		of the facility's EP plan dated le any information regarding				
	Intellectual Disabilitie revealed there was no	n 12/13/18, the Qualified s Professional (QIDP) o documentation to indicate een trained on the facility's				
E 039			E 039			
	RNHCIs and OPOs] r test the emergency p	ity, except for LTC facilities, must conduct exercises to lan at least annually. The NHCIs and OPOs] must do				
	The LTC facility must the emergency plan a unannounced staff dr	t §483.73(d):] (2) Testing. conduct exercises to test at least annually, including ills using the emergency facility must do all of the				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER SEVEN OAKS ROAD-DURHAM			. ,	NG	E CONSTRUCTION		PRINTED: 12/17/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 12/13/2018		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		DURHAM, NC 27704 PROVIDER'S P	PLAN OF CORRECTION		(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		CROSS-REFERENC	TIVE ACTION SHOULD BE CED TO THE APPROPRIA FICIENCY)		COMPLETION DATE	
E 039	exercise is not access facility-based. If the [i actual natural or man- requires activation of [facility] is exempt from community-based or i full-scale exercise for the actual event. (ii) Conduct an addition include, but is not limi (A) A second full-sc community-based or i (B) A tabletop exerce discussion led by a fa clinically-relevant emet of problem statements prepared questions da emergency plan. (iii) Analyze the [facilitit maintain documentati exercises, and emerg [facility's] emergency *[For RNHCIs at §403 §486.360] (d)(2) Testi must conduct exercise plan. The [RNHCI and following: (i) Conduct a paper-b least annually. A table discussion led by a fa clinically relevant emet of problem statements prepared questions da emergency plan.	escale exercise that is when a community-based sible, an individual, facility] experiences an -made emergency that the emergency plan, the m engaging in a ndividual, facility-based 1 year following the onset of onal exercise that may ted to the following: cale exercise that is ndividual, facility-based. cise that includes a group cilitator, using a narrated, ergency scenario, and a set s, directed messages, or esigned to challenge an ty's] response to and on of all drills, tabletop ency events, and revise the plan, as needed. 8.748 and OPOs at ng. The [RNHCI and OPO] es to test the emergency	E	039					

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 12/17/2018 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		34G036	B. WING				12/	13/2018
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP COD	E		
SEVEN O	AKS ROAD-DURHAM			-	14 SEVEN OAKS ROAD DURHAM, NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
E 039 W 137	to and maintain docur exercises, and emerg [RNHCI's and OPO's] needed. This STANDARD is r Based on document facility failed to ensure or tabletop exercise w emergency plan. The The facility's Emerger did not include comple facility/community-base exercise. Review on 12/12/18 of 7/21/17 did not includ community-based or i exercise or a tabletop emergency plan. Interview on 12/13/18 Intellectual Disabilities confirmed the facility full-scale facility/comm tabletop exercise to te current emergency pla PROTECTION OF CI CFR(s): 483.420(a)(1) The facility must ensu Therefore, the facility have the right to retail personal possessions This STANDARD is r	mentation of all tabletop lency events, and revise the lemergency plan, as not met as evidenced by: review and interview, the e a facility/community-based vas conducted to test their e finding is: ncy Preparedness (EP) plan etion of sed exercise or tabletop of the facility's EP plan dated e a full-scale individual facility-based o exercise to test their e with the Qualified s Professional (QIDP) has not conducted a nunity-based exercise or a est the effectiveness of their an. LIENTS RIGHTS 2) ure the rights of all clients. must ensure that clients n and use appropriate		039				

Facility ID: 922555

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 12/17/2018 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G036	B. WING			12/	13/2018
NAME OF PI	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STA	TE, ZIP CODE		
SEVEN O	AKS ROAD-DURHAM		-	14 SEVEN OAKS ROAD DURHAM, NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
W 137	the right to access he This affected 1 of 3 at Client #2 did not have During observations in survey on 12/12 - 12/ was kept locked in a h key to obtain various as needed. Staff interviews (2) or revealed client #2's clibecause she will throw room or urinate on the indicated the client wi and throw furniture or Review on 12/13/18 clibecause the need for a restricted. Interview on 12/13/18 clibecause indicate the need for a restricted. Interview on 12/13/18 Intellectual Disabilities revealed he was not a were being kept locket INDIVIDUAL PROGR CFR(s): 483.440(c)(4 The objectives of the	ed to ensure client #2 had r personal possessions. udit clients. The finding is: access to her clothing. In the home throughout the 13/18, client #2's clothing nall closet. Staff retrieved a clothing items for the client 12/12/18 and 12/13/18 othes are kept locked w her clothes around the em. Additional interview II destroy dresser drawers clothing in the hallway. of client #2's record did not access to her clothing to be with the Qualified s Professional (QIDP) aware client #2's clothes ed. AM PLAN	W 137				
		not met as evidenced by: ew and interview, the facility					

Facility ID: 922555

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(X3) DATE SURVEY COMPLETED		
3/2018		
(X5) COMPLETION DATE		
13		

Facility ID: 922555

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 12/17/2018 1 APPROVED). 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		34G036	B. WING			_	12/13/2018		
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE			
SEVEN OA	AKS ROAD-DURHAM			-	14 SEVEN OAKS ROAD DURHAM, NC 27704				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID			PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		CROSS-REFEREN	CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
W 257	Continued From page	9 11	w	257					
	Based on record revi failed to ensure client Plan (IPP) was revise towards identified obje audit clients. The find Client #3's IPP was no progress towards 3 of Review on 12/12/18 of 5/24/18 revealed obje place them into the co independence for 12 of after each meal with 4 months and to identify independence for 12 of objectives were imple	ot revised after he failed to 7 objectives. of client #3's IPP dated our extreme to sort coins and prect basket with 45% months, to brush his teeth 45% independence for 12 y safety signs with 45% months. The plan noted the mented on 5/24/18. bjective's progress notes g: dence dence dence							
	07/18 - 5% Independe 08/18 - No note 09/18 - 5% Independe	ence							

Event ID: EQUE11

Facility ID: 922555

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 12/17/2018 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		34G036	B. WING				12/13/2018	
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		_	
SEVEN OAKS ROAD-DURHAM			614 SEVEN OAKS ROAD DURHAM, NC 27704					
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
W 257	Continued From page Safety signs		W	257				
	06/18 - 100% Gesture 07/18 - 100% Gesture 08/18 - No note 09/18 - 100% Gesture 10/18 - 100% Gesture	es es						
W 263	Interview on 12/13/18 Intellectual Disabilities confirmed the objectiv considered for revisio PROGRAM MONITO CFR(s): 483.440(f)(3)	s Professional (QIDP) /es had not been ns. RING & CHANGE	w	263				
	The committee should are conducted only w	d insure that these programs ith the written informed parents (if the client is a						
	Based on record revi failed to ensure a rest program (BSP) was o written informed cons	not met as evidenced by: ew and interview, the facility trictive behavior support only conducted with the ent of a legal guardian. udit clients (#2, #3). The						
		l not include a current ent from her legal guardian.						
	a BSP dated 11/6/17. inappropriate verbaliz toileting, failure to coo	ations, inappropriate operate, falling to the floor d to depression. Additional						

Facility ID: 922555

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 12/17/2018 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G036	B. WING				12/	13/2018
NAME OF P	ROVIDER OR SUPPLIER			Ş	STREET ADDRESS, CITY, STATE, ZIP C	ODE		
SEVEN OAKS ROAD-DURHAM					614 SEVEN OAKS ROAD DURHAM, NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD B		(X5) COMPLETION DATE
W 263	Neurontin, Exelon, Di Zyprexa, Namenda ar inappropriate behavior record revealed the g consent dated 12/6/12 consent form noted, " authorization will expi exceed one year from authorization." The re current written informed guardian. Interview on 12/13/18 Intellectual Disabilities confirmed the consen current written informed obtained from client # 2. Client #3's BSP did informed consent from Review on 12/12/18 c a BSP dated 5/24/18. inappropriate touching behaviors. Additional identified the use of L address inappropriate of the record revealed consent from the clien review of a BSP cons former QIDP and Psy "Plans containing rest have written consent months." The record of written informed cons	valproex, Risperdone, nd Melatonin to address ors. Further review of the uardian had signed a 7. Additional review of the 1 understand that this ire on 11/6/18 and will not in the date of my original cord did not include a ed consent signed by the 8 with the Qualified is Professional (QIDP) at had expired and no ed consent had been 42's guardian. d not include a written in his legal guardian. of client #3's record revealed . The BSP addressed g and self-injurious review of the record .amictal and Ativan to behaviors. Further review d no signed written informed int's guardian. Additional tent form signed by the chologist on 5/24/18 noted, trictive interventions must from all parties every 6 did not include a current tent signed by the guardian. 8 with the QIDP confirmed no ed consent had been	W	263	3			

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CENTER STATEMENT	MENT OF HEALTH AN	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION		FORM OMB NC (X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMP	LETED
		34G036	B. WING		_	12/	13/2018
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
SEVEN OAKS ROAD-DURHAM			614 SEVEN OAKS ROAD DURHAM, NC 27704				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 288	BEHAVIOR CFR(s): 483.450(b)(3 Techniques to manag behavior must never f an active treatment pr This STANDARD is r Based on observation review, the facility fail manage client #2's ina included in a formal a affected 1 of 3 audit of A technique to address use of clothing was not treatment plan. During observations in survey on 12/12 - 12/ was kept locked in a f key to obtain various as needed. Staff interviews (2) or revealed client #2's of because she will throw room or urinate on the indicated the client wi and throw furniture ar Review on 12/13/18 of a Behavior Support P The BSP included teo to cooperate, falling to toileting, inappropriate symptoms of depress) e inappropriate client be used as a substitute for ogram. not met as evidenced by: ns, interviews and record ed to ensure a technique to appropriate behavior was ctive treatment plan. This lients. The finding is: as client #2's inappropriate ot included in an active the home throughout the 13/18, client #2's clothing nall closet. Staff retrieved a clothing items for the client 12/12/18 and 12/13/18 othes are kept locked w her clothes around the em. Additional interview II destroy dresser drawers id/or clothing in the hallway of client #2's record revealed lan (BSP) dated 11/6/17. hniques to address failure o the floor, inappropriate	W 288				

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING	CTION (X3)	B NO. 0938-0391) DATE SURVEY COMPLETED
34G036 B. WING		12/13/2018
NAME OF PROVIDER OR SUPPLIER STREET ADDR	RESS, CITY, STATE, ZIP CODE	
SEVEN OAKS ROAD-DURHAM 614 SEVEN O DURHAM, N		
	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 288 Continued From page 15 W 288 client #2's clothing to address inappropriate behaviors. Interview on 12/13/18 with the Qualified W 288 Interview on 12/13/18 with the Qualified Intellectual Disabilities Professional (QIDP) W 288 revealed he was not aware of any inappropriate use of clothing behaviors being exhibited by client #2 and did not know her clothes were being kept locked. Interview Interview Interview Interview	DEFICIENCY)	

Facility ID: 922555

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