

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

PRINTED: 11/30/2018
FORM APPROVED
OMB NO. 0938-0391

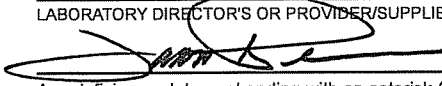
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/29/2018
NAME OF PROVIDER OR SUPPLIER BLANCHE DRIVE			STREET ADDRESS, CITY, STATE, ZIP CODE 6208 BLANCHE DRIVE RALEIGH, NC 27607	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 252}	<p>PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1)</p> <p>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure data was collected as specified in the Individual Program Plan (IPP). This affected 2 of 3 audit clients (#2, #5). The finding is:</p> <p>1. Client #2's objective data was not collected as indicated.</p> <p>Review on 11/29/18 of client #2's IPP dated 1/11/18 revealed an objective to purchase one item twice per month with verbal prompts 90% of the time for 8 consecutive months (implemented 8/1/18, data collection 2 times per month) and to evacuate the building according to task analysis with 75% verbal prompting for 12 consecutive months (implemented 9/8/17, data collection 2 times per month). Additional review of the October '18 and November '18 data sheets for each objective showed no data collection.</p> <p>Interview on 11/29/18 with the Home Manager revealed the objectives were current and data should have been collected as indicated.</p> <p>2. Client #5's objective data was not collected as indicated.</p> <p>Review on 11/29/18 of client #5's IPP dated 9/21/18 revealed an objective to participate with</p>	{W 252}	<p>The following deficiency will be corrected according to the following:</p> <p>A. All staff will be re-trained on documentation requirements.</p> <p>B. RM and/or designee will monitor daily to ensure that programming is properly ran and documented.</p> <p>C. CS will monitor weekly to ensure that programming is properly ran and documented.</p>	12/29/18

DHSR - Mental Health
DEC 21 2018
Lic. & Cert. Section

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

TITLE

(X6) DATE



Executive Director

12/17/18

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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{W 252}	Continued From page 1 matching coins (penny and nickel) according to task analysis for 2 consecutive months (implemented 9/10/17, data collection five times per month) and to stay in designated meeting area during a fire drill until staff alerts her to return to the home with verbal prompts 100% of the time for 12 consecutive months (implemented 8/1/18, data collection 3 times per month). Additional review of the October '18 and November '18 data sheets for each objective showed no data collection.	{W 252}	see page 1, W 252	
{W 255}	Interview on 11/29/18 with the Home Manager revealed the objectives were current and data should have been collected as indicated. PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(i) The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Individual Program Plan (IPP) for 2 of 3 audit clients (#4, #5) was revised after they had successfully completed objectives. The findings are: 1. Client #4 had successfully completed an objective; however, training continued. Review on 11/29/18 of client #4's IPP dated 3/1/18 revealed an objective to complete steps of self-medication tasks with verbal prompts for 75% of the time for 8 consecutive months	{W 255}	The following deficiency will be corrected according to the following: A. All prgrams will be reviewed to ensure that they appropriately address the needs and functioning capacities of each individually consumer. B. If needed, program goals will be revised to accurately reflect the current programming needs of each consumer. C. Clinical personnel will be trained and in-serviced on how to properly monitor and revise program goals when needed. D. Data associated with the progression in any particular goal area will be tracked using the data tracking form. E. Once revised, all staff will be trained on all program goals. E. CS will monitor, evaluate, and document status monthly.	12/29/18

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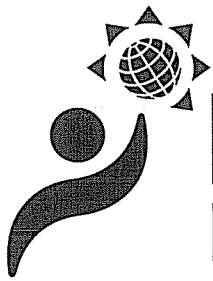
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{W 255}	Continued From page 2 (implemented 10/4/17). Additional review of progress notes for the objective revealed the following: 11/17 - 100% 12/17 - 100% 01/18 - 100% 02/18 - 100% 03/18 - 100% 04/18 - 100% 05/18 - 100% 06/18 - 100% 07/18 - 100% 08/18 - 100% 09/18 - 100% Interview on 11/29/18 with the Home Manager confirmed the objective had been completed. 2. Client #5 had successfully completed an objective; however, training continued. Review on 11/29/18 of client #5's IPP dated 9/21/18 revealed an objective to complete steps of self-medication tasks with physical prompts for 75% of the time for 8 consecutive months (implemented 3/26/16). Additional review of progress notes for the objective revealed the following: 11/17 - 100% 12/17 - 100% 01/18 - 100% 02/18 - 100% 03/18 - 100% 04/18 - 100% 05/18 - 100% 06/18 - 100% 07/18 - 100%	{W 255}	see page 2, W 255	

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{W 255}	Continued From page 3 08/18 - 100% Interview on 11/29/18 with the Home Manager confirmed the objective had been completed.	{W 255}	see page 2, W 255		



ResCare Residential Services

Community Alternatives North Carolina
1200 Navaho Drive
Raleigh, NC 27609
919.387.1011
fax: 919.387.1130
www.ResCare.com

December 17, 2018

Wilma Worsley-Diggs
Facility Survey Consultant I
Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

DHCF - Mental Health

DEC 21 2018

Lic. & Cert. Section

Re: Plan of Correction for Follow-up Survey
Blanche Drive, 6208 Blanche Drive, Raleigh, NC 27607
Provider Number: 34G083
MHL Number: MHL-092-057

Dear Mrs. Worsley-Diggs,

Thank you for your time and the feedback given during the survey you completed on November 29, 2018. We appreciate your diligence in assisting us in providing the best care possible to the consumers we serve. We look forward to making the recommended changes that will improve the services we provide.

Enclosed you will find the Plan of Correction. If you have any questions, please call me at (919) 387-1011 ext. 238. Again, thank you for your time and patience.

Sincerely,

Jason Peace, MSW
Executive Director, CANC

Enclosures

Respect and Care

Assisting People to Reach Their Highest Level of Independence