PRINTED: 12/21/2018 **DEFARTMENT OF HEALTH AND HUMAN SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A, BUILDING 34G216 B. WING 12/18/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2416 OTIS STREET **VOCA-OTIS STREET HOME** DURHAM, NC 27707 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) E 004 Develop EP Plan, Review and Update Annually E 004 E 004 CFR(s): 483.475(a) This deficiency will be corrected by the 02.19.2019 following actions [The [facility] must comply with all applicable The facility will develop and Federal, State and local emergency maintain a emergency preparedness requirements. The (facility) must preparedness plan and it will be develop establish and maintain a comprehensive reviewed and updated annually. emergency preparedness program that meets the B. A method of communicating requirements of this section.] specific needs of the people served on site will be addressed * [For hospitals at §482.15 and CAHs at C. Management will implement §485.625(a):) The (hospital or CAH) must comply D. Management will in services with all applicable Federal, State, and local staff on the community-based emergency preparedness requirements. The [hospital or CAH] must develop and maintain a strategies put in place. comprehensive emergency preparedness E. Management will have plan program that meets the requirements of this updated annually. section, utilizing an all-hazards approach, The emergency preparedness program must include, but not be limited to, the following elements:] (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually. DHSR - Mental Health * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and DEC 272018 maintain an emergency preparedness plan that must be [evaluated], and updated at least annually. Lic. & Cert. Section This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Emergency Preparedmess (EP) plan was reviewed and updated at least

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

WALLY CAN 12/26/18

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.

annually. The finding is:

updated annually.

The facility's EP plan was not reviewed or

STATEMENT OF DEFICIENCIES (X1) PR AND PLAN OF CORRECTION IDE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		. 34G216	8. WING _		12	/18/2018	
	ROVIDER OR SUPPLIER IS STREET HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2415 OTIS STREET DURHAM, NC 27707				
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	Review on 12/18/18 or revealed the plan had 7/21/17. Further revi include evidence of a Interview on 12/18/18 Intellectual Disabilitie revealed she was not been reviewed or upon EP Training Program CFR(s): 483.475(d)(1) Training program, ASCs, PACE organizand dialysis facilities] (i) Initial training in empolicies and procedures and vocapected role. (ii) Provide emergence least annually. (iii) Maintain docume (iv) Demonstrate staff procedures. *[For Hospitals at §44 at §491.12:] (1) Training RHC/FQHC) must	e 1 of the facility's EP plan I been developed on ew of the plan did not n annual review. with the Qualified s Professional (QIDP) aware if the EP plan had fated annually. The [facility, except CAHs, ations, PRTFs, Hospices, must do all of the following: nergency preparedness res to all new and existing iding services under funteers, consistent with their by preparedness training at ntation of the training. If knowledge of emergency 32.15(d) and RHCs/FQHCs ing program. The [Hospital do all of the following:	E 0	CROSS-REFERENCED TO THE APP DEFICIENCY)	eropriate elop and nocy paredness eviewed and in the dness en the will saster drills nplement	DATE.	
CODMONS	policies and procedu staff, individuals prov arrangement, and vo expected roles. (ii) Provide emergend least annually. (iii) Maintain docume	nergency preparedness res to all new and existing riding on-site services under lunteers, consistent with their by preparedness training at intation of the training.					

NAME OF PROVIDER OR SUPPLIER VOCA-OTIS STREET HOME SUMMARY STATEMENT OF DEPICIENCIES DURHAM, NO. 27707	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
VOCA-OTIS STREET HOME VOCA-OTIS STREET HOME 2415 OTIS STREET DURHAM, NO. 27707 PREPIX TAG E 037 Continued From page 2 (iv) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness policies and procedures at annually. (iv) Pomolarita staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Pariodically review and rehearse its emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Pariodically review and rehearse its emergency project annually and others. "[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. (iii) Provide emergency preparedness training at least annually. (iv) Pariodically review and rehearse its emergency proparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. "[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (ii) Initial training, provide emergency preparedness plan into the procedures of all new and existing staff, individuals, providing services under arrangement, and outsides and procedures to all new and existing staff, individuals, providing services under arrangement, and outsides, consistent with their expected roles. (iii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency preparedness training. "[For PACE at §460.84(d);] (1) The PACE			34G216	B. WING_	the second of th	12	/18/2018
PREFIX TAG RECULATORY OR LSC IDENTIFYING INFORMATION) TAGE Continued From page 2 (iv) Demonstrate staff knowledge of emergency 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) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency proparedness plan with hospice emphoyees (including nonemployee staff), with special emphasis placed on carrying out the 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 at least annually. (iii) After 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 at least annually. (iii) Demonstrate staff knowledge of emergency preparedness training. **TFOR PACE at §460.84(d):] (1) The PACE					2416 OTIS STREET		
(iv) Demonstrate staff knowledge of emergency 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 annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procadures necessary to protect patients and others. *[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 at least annually. (iii) Demonstrate staff knowledge of emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFD	((EACH CORRECTIVE ACT ORDER-REFERENCED TO	TION SHOULO BE THE APPROPRIATE	COMPLETION
organization must do all of the following: (i) Initial training in emergency preparedness	E 037	(iv) Demonstrate staff procedures. *[For Hospices at §4+hospice must do all of items in procedures in policies and procedures in policies and procedures in procedures in procedures. (ii) Demonstrate staff procedures. (iii) Provide emergen least annually. (iv) Periodically revieemergency prepared employees (including special emphasis plaprocedures necessar others. *[For PRTFs at §441 program. The PRTF (i) Initial training in empolicies and procedustaff, individuals provarrangement, and voexpected roles. (ii) After initial training preparedness training (iii) Demonstrate staff procedures. (iv) Maintain docume preparedness training in emporedness training in empolicies and procedures in procedures. (iv) Maintain docume preparedness training in preparedness training in preparedness training in procedures. (iv) Maintain docume preparedness training in pre	f knowledge of emergency 18. 113(d):] (1) Training. The if the following: nergency preparedness res to all new and existing and individuals providing gement, consistent with their knowledge of emergency cy preparedness training at w and rehearse its ness plan with hospice in nonemployee staff), with ced on carrying out the ry to protect patients and 184(d):] (1) Training must do all of the following: mergency preparedness res to all new and existing riding services under flunteers, consistent with their ing, provide emergency g at least annually. If knowledge of emergency g. 84(d):] (1) The PACE all of the following:	EC	937		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			2	STREET ADDRESS, CITY, STATE, ZIP CODE 2415 O'TIS STREET DURHAM, NC 27707		
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E 037	staff, individuals providured arrangement, contract volunteers, consisten (ii) Provide emergence least annually. (iii) Demonstrate staff procedures, including what to do, where to case of an emergence (iv) Maintain documents. *[For CORFs at §485 CORF must do all of (i) Provide initial train prepared ness policies and existing staff, induder arrangement, a with their expected rocii) Provide emergence least annually. (iii) Maintain documents to procedures. All new pand assigned specific the CORF's emergent their first workday. Thinclude instruction in alarm systems and siequipment. *[For CAHs at §485.6] The CAH must do all (i) Initial training in empolicies and procedure porting and extinguand where necessary	res to all new and existing diding on-site services under stors, participants, and it with their expected roles, by preparedness training at a few	₽	037			
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CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO	. 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1	(X2) MULTIPLE CONSTRUCTION A, BUILDING			
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
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€ 037	and volunteers, constroles. (ii) Provide emergent least annually. (iii) Maintain docume (iv) Demonstrate star procedures. *[For CMHCs at §48 CMHC must provide preparedness policies and existing staff, incurder arrangement, with their expected redocumentation of the demonstrate staff kn procedures. Thereaf emergency prepared annually. This STANDARD is Based on record refacility failed to ensutrained on the facility (EP) plan. The findinglan.	righting and disaster or and existing staff, services under arrangement, sistent with their expected by preparedness training at entation of the training. If knowledge of emergency for the initial training in emergency and procedures to all new dividuals providing services and volunteers, consistent oles, and maintain training. The CMHC must lowledge of emergency fier, the CMHC must provide these training at least the direct care staff were yes Emergency Preparedness and is:	E 03	7			
		of the facility's EP plan dated			train and controlled		

training of staff.

Staff interview on 12/18/18 revealed they had been trained on conducting fire drills; however, the staff could not provide specific information

		D HUMAN SERVICES					D: 12/21/2018 M APPROVED	
STATEMENT O	S FOR MEDICARE & DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MUL		CONSTRUCTION	(X3) DATE	O. 0938-0391 E'SURVEY PLETED	
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	ROVIDER OR SUPPLIER							
		ATPAINANT AS REPLAINANT		D	URHAM, NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENC	atement of deficiencies y must be preceded by full .9C identifying information)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
E 037	Continued From page regarding the facility's		ε	037				
•	Intellectual Disabilitie revealed there was n	n 12/18/18, the Qualified s Professional (QIDP) o documentation to indicate een trained on the facility's						
E 039	EP Testing Requirem CFR(s): 483.475(d)(2) (2) Testing. The [facil RNHCls and OPOs] itest the emergency p [facility, except for R1 all of the following: "[For LTC Facilities a The LTC facility must the emergency plan a unannounced staff diprocedures. The LTC following:] (i) Participate in a full community-based or exercise is not acces facility-based. If the actual natural or mar requires activation of [facility] is exempt frocommunity-based or full-scale exercise for the actual event.	ity, except for LTC facilities, must conduct exercises to lan at least annually. The NHCIs and OPOs] must do it §483.73(d):) (2) Testing. conduct exercises to test at least annually, including ills using the emergency facility must do all of the scale exercise that is when a community-based sible, an individual, [facility] experiences an individual, ithe emergency plan, the im engaging in a individual, facility-based of 1 year following the onset of	E		E039 This deficiency will be corrected by following actions: A. The facility will develop a maintain an emergency communication prepared plan and it will be reviewed updated annually B. A communication prepared plan will be developed. To include primary and altern communication arrangent should the primary phone unavailable in an emerge C. The communication preparedness plan will be at least annually to include scale exercise or a tableto exercise to test the plan D. Management will implemed. Management will in service staff annually	y the ind iness ed and edness o nate nents es be ency.		
	include, but is not lim	onal exercise that may nited to the following: cale exercise that is						

community-based or individual, facility-based. (B) A tabletop exercise that includes a group

AND PLAN OF CORRECTION INCOME.		1 ' '	(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED		
		34G216	B, WING			12/	18/2018
•	ROVIDER OR SUPPLIER IS STREET HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2415 OTIS STREET DURHAM, NC 27707			
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E 039	discussion led by a facilinically-relevant emof problem statement prepared questions demergency plan. (iii) Analyze the [facilimaintain documentate exercises, and emergifacility's] emergency "[For RNHCls at §40: §486.360] (d)(2) Test must conduct exercise plan, The [RNHCl and following: (i) Conduct a paper-least annually. A table discussion led by a facilinically relevant emof problem statement prepared questions demergency plan. (ii) Analyze the [RNH to and maintain document prepared questions demergency plan. (iii) Analyze the [RNH to and maintain document prepared questions demergency plan. This STANDARD is Based on document facility failed to ensure or tabletop exercises emergency plan. The facility's Emerged did not include compfacility/community-basexercise.	ciclitator, using a narrated, ergency scenario, and a set s, directed messages, or esigned to challenge an ty's) response to and ion of all drills, tabletop ency events, and revise the plan, as needed. 3.748 and OPOs at ing. The [RNHCl and OPO] es to test the emergency d OPO] must do the passed, tabletop exercise at etop exercise is a group acilitator, using a narrated, ergency scenario, and a set is, directed messages, or resigned to challenge an indiction of all tabletop ency events, and revise the pency events, and revise the pency events, and revise the pency events and interview, the re a facility/community-based was conducted to test their e finding is: not Preparedness (EP) plan	·	039			

SYATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	•	34G216	8. WING_			12	/18/2018
	OVIDER OR SUPPLIER S STREET HOME			SYREET ADDRESS, CITY, STATE, ZIP CODE 2415 OTIS STREET DURHAM, NC 277D7			
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E 039	exercise or a tabletone emergency plan. Interview on 12/18/18 Intellectual Disabilities confirmed the facility full-scale facility/comtabletop exercise to learner the emergency properties of the current emergency properties of the current emergency properties of the must be stated separated behavioral outcome. This STANDARD is Based on record revisited to ensure objective statements with the self-assessments with the self-assessments outcomes. a. Review on 12/17/14/6/18 revealed the choose and complet in the self-assessments.	le a full-scale individual facility-based o exercise to test their a with the Qualified is Professional (QIDP) has not conducted a munity-based exercise or a est the effectiveness of their lan. RAM PLAN (I)(i) individual program plan rately, in terms of a single not met as evidenced by: flew and interview, the facility brives for 3 of 3 audit clients in terms of a single The findings are: a for 2 of 3 audit clients (#3, with single behavioral 18 of client #3's IPP dated objective, "[Client #3] will a personal goals as identified int with 100% completion." 18 of client #5's IPP dated objective, "[Client #5] will		2229	W.229 This deficiency will be corrected following actions: A. All ISP'S will be reviewed revise as needed. B. All WTP will be reviewed goals will have measured outcomes. C. All WTP will have identic criteria and outcomes. D. All goals will be modified revised, or discontinues the needs of the people E. All staff will be in-serviced goals. F. Residential Manager was monitor one time a weel G. Qualified Professional was monitor one time a weel continued as well continued as we	by the d all ble flable d, to meet es served e on all ll ek. vill	02.19.2019
		e personal goals as identified					

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		B. WING		12/18/2018
NAME OF PROVIDER OR SUPPLIER VOCA-OTIS STREET HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2415 OTIS STREET DURHAM, NC 27707	
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Additional review no will learn to identity a consecutive months Interview on 12/18/1 Intellectual Disabilitic confirmed the object written with single of W 240 W 240 INDIVIDUAL PROG CFR(s): 483.440(c)() The individual progratelevant intervention toward independen This STANDARD is Based on observative, the facility fair Individual Program information to support affected 1 of 5 audit Client #3's IPP did in regarding the use of During observations day program and in soft helmet with a standard the program of the program of the program of the program and in soft helmet was not observations. Interview on 12/17/1/revealed client #3 was Additional interview	ent with 100% completion." ted an objective, "[Client #5] and write her full name for 6 with 50% independence." 8 with the Qualified es Professional (QIDP) tive statements were not utcomes. RAM PLAN 6)(i) am plan must describe as to support the individual ce. Inot met as evidenced by: ions, interviews and record siled to ensure client #3's Plan (IPP) included specific ort her independence. This clients, The finding is: not include information of an adaptive helmet. In throughout the survey at the the home, client #3 wore a trap secured under her chin. I removed during any 18 with day program staff years the helmet due to falls. In 12/18/18 with group home	W 229	W.240 This deficiency will be correfollowing actions: A. All ISP'S will be revrevise as needed to objectives of the usequipment is in plagait belt usage. B. PT will be assess the the use of adaptive. C. PT will give guidelit of equipment. D. All adaptive equipment. D. All adaptive equipment. D. All adaptive equipment. E. All adaptive equipment. HRC. F. All people served vervice on their adaptive. E. All staff will be insured equipment. G. All staff will be insured equipment. H. Vocational staff will serviced on all adaptive equipment. I. Residential Manager.	iewed and pensure. See of adaptive ace specifically are need for a equipment, and for the use a ment will be a meeting, to a ment that will be address at will be in aptive aptive. If be in potive are will be in potive.
staff indicated the c	lient wears the helmet to keep g or hitting" her head and it is	111	monitor one time a J. Qualified Professio monitor one time a	i week. nal will

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W 249	worn due to her "disa Review on 12/18/18 of 4/6/18 revealed no into of a soft helmet. Interview on 12/18/18 Infellectual Disabilities confirmed client #3's information regarding The QIDP stated, "I o PROGRAM IMPLEMI CFR(s): 483,440(d)(1) As soon as the interd formulated a client's i each client must rece treatment program co interventions and ser and frequency to sup objectives identified i plan. This STANDARD is a Based on observation reviews, the facility fe clients (#1, #2, #3, #4 active treatment plan	of client #3's IPP dated formation regarding the use with the Qualified s Professional (QIDP) IPP did not include any the use of a soft helmet. verlocked it." ENTATION) isciplinary team has adividual program plan, ive a continuous active	W 24	W.249 This deficiency will be correfollowing actions: A. All ISP'S WTP will be and revise as neede objectives of are in regarding need of a All WTP will be revior discontinued if of have been met C. ISP will be update remeet the current aneeds D. Attention will be gidietary assessment. E. All people served we service on their WT F. All staff will be in-s	e reviewed ed to ensure place tonsumer sed, updated objectives modified to assessments liven to all s. vill be in P ervice on
	Individual Program P meal preparation, fan equipment use, and s are:	vices as definition in the lan (IPP) in the areas of nily style dining, adaptive self-help skills. The findings involved in choking tasks at		their WTP objective outcomes. G. Residential Manage monitor one time a H. Qualified Profession monitor one time a	er will 1 week. nal will

	of deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
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W 249	12/18/18 from 6:50an all food items for brea encouraging clients to completed tasks such drinks, placing frozen cooking a pot of oatm dials, and placing foo Immediate interview revealed clients do no "because of the heat issue." Additional into can perform tasks su operating the microw foods to be cooked. Review on 12/18/18 Community/Home Lift revealed the client cacoking, with cooking and mixing a Additional review of the client requires physic measuring spoons of microwave, stove/ove Further review of the dated 12/5/18 noted, with meal prep" Interview on 12/18/18 Intellectual Disabilitie confirmed client #5 c and "is really good" v	rvations in the home on n - 7:30am, a staff prepared akfast without prompting or p assist. The staff in as filling pitchers with a food items onto pans, heal, operating slove/oven in dinto serving dishes. with the staff involved on assist with cooking and everythingit's a safety erview indicated client #5 ch, as preparing toast or have or assist with prepping of client #5's fe Assessment dated 12/5/17 an make food with no gout no mixing and with all with physical assistance, he assessment indicated the heal assistance for using devices, a toaster, en and coffee maker. Client's nutritional evaluation "Encourage involvement	W	249			
L	Ingue.			<u> </u>			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G216	B. WING		1	2/18/2018
	ROVIDER OR SUPPLIER IS STREET HOME			STREET ADDRESS, CITY, STATE, ZI 2415 OTIS STREET DURHAM, NG 277D7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B YAS CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 249	12/18/18 at 7:37am, splates in the kitchen a clients (#1, #2, #3) at not prompted or enco serving themselves o style dining. Interview on 12/18/18 revealed they general kitchen for those three "modified diets". a. Review on 12/18/1 assessment dated 3/8 himself with assistance the client's Communit dated 5/20/18 noted 1 passes food to others b. Review on 12/18/1 Community/Home Lift revealed, the client expassess food to other physical assistance. assessment indicated assistance for placing table. c. Review on 12/18/1 4/6/18 revealed she in completes daily living of the client's Community for the client's Community in the client's Co	ervations in the home on staff placed food items on and took the plates to three the table. The clients were uraged to assist with rother aspects of family with the staff involved and the ections because they have 8 of client #1's nutritional for the ections because they have 8 of client #1's nutritional for the eats family style and with physical assistance. 8 of client #2's e Assessment dated 3/13/18 at family dinner style and supon request with Additional review of the the client requires physical at the client requires physical	. W:	249		
		with the QIDP confirmed i) can assist with serving				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G216	B. WING		HISTORIA BURBANIA AND AND AND AND AND AND AND AND AND AN	12/	18/2018	
	ROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 415 OTIS STREET DURHAM, NC 27707		***************************************	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL)			(X5) COMPLETION DATE	
W 249	in family style dining of a Client #3's gait be ambulation. During observations I home on 12/17 - 12/1 belt secured around I ambulated throughou her to walk by holding Staff were not observed during ambulation. Staff interview on 12/belt is used "if she is run off somewhere." indicated they do not walking. Review on 12/17/18 of 4/6/18 revealed the generation and the belt properties unsteady during an Interview on 12/18/18 client #3's gait belt is assistance with ambulating waking hours.	It was not utilized during Ithroughout the survey in the 8/18, client #3 wore a gait her waist. As the client if the home, staff assisted gher arms and/or hands, red to utilize the gait belt It8/18 revealed client #3's having a behavior or tries to Additional interview use the belt when she is It client #3's IPP dated gait belt assists the client with and to minimize falls. The povides support "when she inbulation." It with the QIDP indicated used for "fall prevention and plating" and should be used Additional interview	W	249				
	with the client "at all the client #3 was not clear her place after the during breakfast observed."	prompted or assisted to breakfast. ervations in the home on staff cleared client #3's dirty						
dishes without prompting or encouraging her to							L	

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED	
•		34G216	B. WING			12/	18/2018
	SOVIDER OR SUPPLIER			24	REET ADDRESS, CITY, STATE, ZIP CODE INS OTIS STREET URHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(X6) COMPLETION DATE
W 249	help "sometimes" to de Review on 12/18/18 de Community/Home Lift date) revealed she ca kitchen independently. Interview on 12/18/18 de Collent #3 can clear he assistance. 5. Client #3 did not resupplement as indicated to eat a port At the end of the meast food items. Client #3 nutritional supplement as indicated to eat a port At the end of the meast food items. Client #3 nutritional supplement Staff interview on 12/17/18 de client at meals. Review on 12/17/18 de client should receive Plus or equivalent the meals".	nsk, 18/18 revealed client #3 will clear her place. of client #3's e Assessment (incomplete an take dirty dishes to the y.) s with the QIDP confirmed or place after meals with ecceive her dietary ted. ervations in the home on client #3 was prompted and ion of her breakfast meal. al, the client had eaten 1 of 3					
<u> </u>	l,				L		L

	of deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TE SURVEY MPLETED		
		34G216	B. WING_			12	18/2018
.,	ROVIDER OR SUPPLIER IS STREET HOME	,		2415 (et address, city, state, zip co Dtis street Ham, NG 27707	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	CXS) COMPLETION DATE
W 249	6. Client #2's adapti as indicated in the IP	ve equipment was not utilized	W 2	249			
W 252	12/17/18 at approxingiven a fruit cup for so built-up spoon. She way to the table trying Review on 12/18/18 4/5/18 revealed, "Platencourage an upright Interview with QIDP that, I tried to cue stradaptive equipment. The IPP was not foliop ROGRAM DOCUM CFR(s): 483,440(e)(CFR(s): 4	nately , client #2 was mack. Client #2 utilized a was leaning her head all the g to eat from the cup. of client #2's IPP dated at riseruse at all meals to all posture." on 12/18/18 revealed, "I saw aff to give [Client #2] the "She further acknowledged awed. MENTATION 1) omplishment of the criteria dividual program plan documented in measurable and interview, the facility is was collected as specified in am Plan (IPP). This affected #4, #5). The findings are:	W:	Th	ensure that all chas been review C. ISP/WTP will be to meet the dat. D. All WTP will be or discontinued have been met. E. All people serve service on their F. All staff will be in the serve service on the service on	ill be reviewed eeded to ensure e in place of consumer sional will data collected wed. e update modified a collected. revised, updated if objectives ed will be in with service on citives and desired mager will me a week. ssional will	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		SURVEY . PLETED
		34G216 .	B. WING_		12	18/2018
	ROVIDER OR SUPPLIER IS STREET HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2415 OTIS STREET DURHAM, NC 27707		
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 252 }	remain in his work an or less verbal prompt of the time for three or plan noted, "Docume Additional review of data sheet at the day documentation for the b. Review on 12/17/revealed a training of participate in brushin participation rate on period." The plan not week." Additional review of data sheet at the day documentation for M	ea during work time with two daily during work time 70% consecutive quarters." The nt 3 x per week." Stient #4's training objective program revealed no e year 2018. 18 of client #5's record objective, "[Client #5] will g her teeth with at least 75% each step over the review ed, "Document 3 x per client #5's training objective program revealed no ay '18 to December '18.	W 2	52		
W 257	day program reveale been missing for 2 w Interview on 12/18/1/1 Intellectual Disabilities confirmed the trainin and client #5 and she implemented and do PROGRAM MONITO CFR(s): 483.440(f)(1) The individual prograticate by the qualified professional and revibut not limited to situation for the state of the program of the state of the program of the state of the program of the state of the stat	8 with the Qualified as Professional (QIDP) gwas current for client #4 and continue to be cumented as indicated. DRING & CHANGE ()(iii)	. w:	257	·	

STATEMENT O AND PLAN OF	F DÉFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		34G216 · ·	B. WING		12/18/2018
	ROVIDER OR SUPPLIER S STREET HOME		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2415 OTIS STREET DURHAM, NG 27707	
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W 257	Based on record rev failed to ensure clien Plan (IPP) was revise towards identified ob audit clients. The fin Client #3's IPP was reprogress towards 6 of Review on 12/17/18 4/6/18 revealed objetoothbrushing process for 3 consecutive momedication administration administration independence for 6 of 75% independence for 6 of 75% participation choose and complete in the self-assessme and to purchase an ifor 6 consecutive modelications were implied to the self-assessme and to purchase an ifor 6 consecutive modelications were implied to the self-assessme and to purchase an ifor 6 consecutive modelications were implied to the self-assessme and to purchase an ifor 6 consecutive modelications were implied to the self-assessme and to purchase an ifor 6 consecutive modelications were implied to the self-assessment to purchase an ifor 6 consecutive modelications were implied to the self-assessment to purchase an ifor 6 consecutive modelications were implied to the self-assessment to purchase an ifor 6 consecutive modelications were implied to the self-assessment to purchase an ifor 6 consecutive modelications were implied to the self-assessment to purchase an ifor 6 consecutive modelications were implied to the self-assessment to purchase an ifor 6 consecutive modelication to the self-assessment to purchase and the self-assessment to the self-ass	not met as evidenced by: iew and interview, the facility i #3's Individual Program ed after he failed to progress lectives. This affected 1 of 5 ding is: not revised after he failed to if 7 objectives. of client #3's IPP dated ctives to complete is with 80% independence inths, assist in the process of ation with 50% months, wash her hands with for 6 months, was her body in for 6 consecutive months, is personal goals as identified int with 100% completion, tem with 75% independence withs. The plan noted the emented on 4/6/18, objective's progress notes ig:	W 257	This deficiency will be corrected by following actions: A. ALL ISP will be reviewed a revised as necessary. B. All WTP will be reviewed a assessed for continually cagoals will be modified and assessed for progress. C. Medication assessment wincompleted on all person selected on all person selected. E. All objectives of goals will the needs of the person be served. E. All staff will be in service onew and current WTP. F. Qualified Professional will service all people served or goals with supporting documentation of all WTP service. G. Residential Manager will monthly weekly. H. Qualified Professional will all WTP in core team montoned.	nd and are. All l l be erved. meet. eing n all in n

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0, 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		CONSTRUCTION .	(X3) DATE SURVEY COMPLETED	
		34G216	B. WING			12/	18/2018
NAME OF P	ROVIDER OR SUPPLIER	, , , , , , , , , , , , , , , , , , , ,		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-OT	IS STREET HOME		•	1	MS OTIS STREET URHAM, NC 27707		
WALES	SHMMARYST	ATEMENT OF DEFICIENCIES	iD.		PROVIDER'S PLAN OF CORRECTION	***************************************	/A/Fi
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144					\		
W 257	Continued From page	e 17	W	257			
	06/18 - 0%						
	07/18 - 0% 08/18 - 10%						
•	09/18 - 8%						
	10/18 - 8%						
	11/18 - 6%						
	Hand washing						
	06/18 - "Hand-over-h	pand"					
	07/18 - 25%	ionio					
	08/18 - 27%						
	09/18 - 23%						
	10/18 - 19%						1
	11/18 - 18%						1
	Wash her body						
	06/18 - 10%						
	07/18 - 13%						
	08/18 - 11%						1
	09/18 - 16%						
	10/18 - 16% 11/18 - 12%						
	71710 - 1270]
	Personal Goals						
	06/18 - No information						
	07/18 - No information						
	08/18 - No information				-		
	09/18 - No information						
1	11/18 - 8%	UII					
	1.11.00 070						
	Purchase an item		***************************************				
	06/18 - 0%						
<u> </u>	07/18 - 0%	A STANDARD CONTRACTOR OF THE PROPERTY OF THE P					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMP	SURVEY LETED	
		34G218	B. WING_			12/	18/2018
	ROVIDER OR SUPPLIER	,		STREET ADD 2415 OTIS S DURHAM, I			
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W 323	confirmed the objectic considered for revision PHYSICIAN SERVICIAN	s with the Qualified s Professional (QIDP) ves had not been ons. SES S)(i) vide or obtain annual physical octient that at a minimum on of vision and hearing. not met as evidenced by: liew and interview, the facility of sudit clients (#4) received of a client with a client (UA). The liew a follow UA as of client #4's record revealed of a client #4's record reve	w	This de following A. B. C.	All medical appointmer reviewed. The team will ensure appointments are scheand follow up. All the appointments we reviewed and discussed monthly core team/quarterlies/annu Options for appointments were unable to be conwill be added to meetiminutes. There will be supporting documentation for all appointments that we completed or the reason was unable to be company will review monthly company appointments that we completed or the reason was unable to be company will review monthly appointments that we completed or the reason was unable to be company will review monthly appointments that we completed or the reason was unable to be company will review monthly appointments that we completed or the reason was unable to be company will review monthly appointments.	duled vill be dat the al ISP. ents that appleted ag re on why it pleted. y vill eek. will	02.19,2019

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	,	34G216	B. WING	The second section of the second seco	12/18/2018	
	OVIDER OR SUPPLIER S STREET HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2415 OTIS STREET DURHAM, NC 27707		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
W 368	CFR(s): 483.460(k)(1) The system for drug at that all drugs are admitted physician's orders. This STANDARD is a Based on observation reviews, the facility for order was followed as clients (#5). The find Physician's orders was for client #5. During observations in the home on 12/18/18 regular teaspoon to smixed it with water for Review on 12/18/18 orders dated December a full glass (8 oz) of fivice daily." Interview on 12/18/18 technician revealed a powder with the teas Interview on 12/18/18 intellectual Disabilities confirmed the fiber pwith a specified mean FOOD AND NUTRIT CFR(s): 483.480(a)(filter)	administration must assure ninistered in compliance with s. not met as evidenced by: ns, interviews and record niled to ensure a physician's written for 1 of 5 audit ing is: ere not followed as indicated of medication administration with a 17:45am, staff used a scoop fiber powder and cr.client #5. of client #5's physician's per '18 revealed an order for, erapy, dissolve 3,4 grams in luid and drink by mouth 8 with the medication she routinely scoops the fiber poon then mixes with water. 8 with the Qualified as Professional (QIDP) powder should be scooped suring scoop. ION SERVICES 1)	W 368	W.368 This deficiency will be corrected by following actions: A. All physicians orders will be reviewed. B. There will be current order all medication in the personance records. C. The team will ensure that orders are implemented. D. All the orders will be reviewed and discussed at the monicore team/quarterlies/annish. E. There will be supporting documentation for all Orders. F. RN will review monthly. G. Residential Manager will monitor one time a week. H. Qualified Professional will monitor one time a week.	e s for all wed all wal ders	
	Each client must rec	eive a nourishing,				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		SURVEY PLETED
		34G216	B. WING		12/	18/2018
	ROVIDER OR SUPPLIER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2415 OTIS STREET DURHAM, NG 27707		
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W 460	well-balanced diet ind specially-prescribed of specially-prescribed of Based on observation review, the facility fair modified diet was proaffected 1 of 5 audit of Client #1 was not proindicated. During dinner observed 12/17/18 at 5:25pm, blend his food in a food completed, the food in with ham, cucumbers ground consistency with the staff indicated her with the staff indicated the food processor and a it resembles "baby food items which are to have liquids added Review on 12/18/18 5/28/18 and current 12/5/18 revealed her Additional review of costed in the kitchen pureed diet would be interview on 12/18/18 Intellectual Disabilities.	cluding modified and sliets. Inot met as evidenced by: ns, interviews and record led to ensure client #1's evided as indicated. This sclients. The finding is: vided a pureed diet as lations in the home on staff assisted client #1 to be processor. Once tems (peas and pasta salad and tomatoes) was a finely with visible pieces of food. With the staff who assisted receives a pureed diet. It is worth and the processor in the lating of the lating of the lating of the lating staff noted some "water based" do not need the lating staff and pureed diet. It is staff noted some "water based" do not need the lating staff noted some "water based" do not need the lating staff noted some "water based" do not need the lating staff noted some "water based" do not need the lating staff noted some indicated a "smooth with no lumps". By with the Qualified is Professional (QIDP)	W 460	W.460 This deficiency will be corrected following actions: A. All physicians (dietary) of will be reviewed. B. The dietitian will review current orders, modifying needed. C. There will be current or all nutritional services for person serve records. D. The team will ensure the orders are implemented. E. All the orders will be really and discussed at the modifier of all C. G. All person serve will recover will recover the modified or specially prescribed diets. H. RN will review monthly I. Residential Manager will monitor one time a week. J. Qualified Professional view monitor one time a week.	orders / all ng as ders for or the at all di viewed onthly nnual g Orders zeive a pporting y - ill ek. vill	2.19.2019
	Based on observation review, the facility fair modified diet was progressed and the control of 5 audit of o	ns, interviews and record led to ensure client #1's vided as indicated. This clients. The finding is: vided a pureed diet as ations in the home on staff assisted client #1 to od processor. Once tems (peas and pasta salad and tomatoes) was a finely with visible pieces of food. with the staff who assisted receives a pureed diet, y obtain that consistency, by grind up his food in the add liquid such as broth until od". The staff noted some "water based" do not need to only sician's orders dated ingests a regular pureed diet. Socuments and pictures of the home indicated a "smooth with no lumps".		current orders, modifyir needed. C. There will be current or all nutritional services for person serve records. D. The team will ensure the orders are implemented. E. All the orders will be recorded at the modified or all C. G. All person serve will recorded diet – supporting the modified or specially prescribed diets. H. RN will review monthly I. Residential Manager will monitor one time a weed.	ng as rders for for the lat all di viewed bothly annual g Orders ceive a pporting y -	

PRIN.	TED:	12/21/2018	•
FC)RM	APPROVED	
OMB	NO.	0938-0391	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DAYE	SURVEY PLETED
		34G216	B. WNG		12	18/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2416 O'HS SYREET DURHAM, NC 27707		
(X4) IĎ PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 460	his food should reser	nble "baby food" and "real acknowledged more training	W 4	60		
		·				

December 26, 2018

Wilma Worsley-Diggs
Facility Survey Consultant I
Mental Health Licensure and Certification section
NC Division of Health Services Regulations
27 18 Mail Service Center
Raleigh NC 27699-27118
919.855.3795 office
919.715.8078 fax

RE: Plan of Correction for Annual Survey conducted: December 17th 18th ,2018 VOCA-Otis Street Home 2415 Otis St. Durham NC 27707 Provider Number 34G216 MHL# 032-068

Dear Ms. Worsley-Diggs

We appreciate the courtesy extended by you while surveying the VOCA-Otis Street Home, North Carolina.

As indicated on the Plan of Correction, we will have the Deficiencies corrected for, the Annual survey conducted On December 17th-18th, 2018 it will be completed February 15, 2019.

We are committed to providing the highest possible care for the people we serve at VOCA-Otis Street Home.

If you have questions, please contact JerMaine Kearney, Program Manager 984,205,2630 ext 403

Sincerely,

Marika Whack, Executive Director

Community Alternatives North Carolina-Southeast Region

1001 Navaho Drive suite 101 Raleigh, North Carolina, 27609

Maule Whas

919.827.2790 cell

984.205.2630 etx. 405

mawhack@rescare.com

Community Alternatives – NC Southeast Region 1001 Navaho Drive Suite 101 Raleigh, NC 27609

Phone: 984-205-2630 **FAX:** 984-205-2643



TO: WURSLEY -	D1990 Fr	om: J. Keuny
Fax: 9/97/5	8078 Pa	ages: 24
Phone:	Di	ate: 12/24/18.
Re:	Co	C:
Urgent For Rev	iew Please Comment	Please Reply Please Recycle
Comments:	Jeasons	Greety

DHSR - Mental Health DEC 27 2018

Lic. & Cert. Section



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