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

PRINTED: 12/21/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G216	A. BUILDING _____ B. WING _____	12/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-OTIS STREET HOME	2416 OTIS STREET DURHAM, NC 27707

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E 004	Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) [The [facility] must comply with all applicable 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. 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. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least annually. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Emergency Preparedness (EP) plan was reviewed and updated at least annually. The finding is: The facility's EP plan was not reviewed or updated annually.	E 004	E 004 This deficiency will be corrected by the following actions A. The facility will develop and maintain a emergency preparedness plan and it will be reviewed and updated annually. B. A method of communicating specific needs of the people served on site will be addressed C. Management will implement D. Management will in services staff on the community-based strategies put in place. E. Management will have plan updated annually. DHSR - Mental Health DEC 27 2018 Lic. & Cert. Section	02.19.2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Marika Whack NP | Executive Director | 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.

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E 004	Continued From page 1 Review on 12/18/18 of the facility's EP plan revealed the plan had been developed on 7/21/17. Further review of the plan did not include evidence of an annual review. Interview on 12/18/18 with the Qualified Intellectual Disabilities Professional (QIDP) revealed she was not aware if the EP plan had been reviewed or updated annually.	E 004		
E 037	EP Training Program CFR(s): 483.475(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] 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 the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] 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, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training.	E 037	E037 This deficiency will be corrected by the following actions: A. The facility will develop and maintain an emergency communication preparedness plan and it will be reviewed and updated annually B. Staff will in-service on the emergency preparedness manual C. Staff will in-service on the will conduct monthly disaster drills D. Management will implement annually E. Management will in services staff annually	02.19.2019

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E 037	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) 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 procedures 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 procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness	E 037		

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E 037	Continued From page 3 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 annually. (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. *[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 annually. (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. *[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	E 037		

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E 037	Continued From page 4 cooperation with firefighting and disaster authorities, 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 annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency 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 annually. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure direct care staff were trained on the facility's Emergency Preparedness (EP) plan. The finding is: Staff had not been trained on the facility's EP plan. Review on 12/18/18 of the facility's EP plan dated 7/21/17 did not include any information regarding 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	E 037		

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E 037	Continued From page 5 regarding the facility's EP plan. During an interview on 12/18/18, the Qualified Intellectual Disabilities Professional (QIDP) revealed there was no documentation to indicate if or when staff had been trained on the facility's EP plan	E 037		
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: "[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group	E 039	E039 This deficiency will be corrected by the following actions: A. The facility will develop and maintain an emergency communication preparedness plan and it will be reviewed and updated annually B. A communication preparedness plan will be developed. To include primary and alternate communication arrangements should the primary phones be unavailable in an emergency. C. The communication preparedness plan will be tested at least annually to include a full scale exercise or a tabletop exercise to test the plan D. Management will implement E. Management will in services staff annually	02.19.2019

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E 039	Continued From page 6 discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. "[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure a facility/community-based or tabletop exercise was conducted to test their emergency plan. The finding is: The facility's Emergency Preparedness (EP) plan did not include completion of facility/community-based exercise or tabletop exercise. Review on 12/18/18 of the facility's EP plan dated	E 039		

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E 039	Continued From page 7 7/21/17 did not include a full-scale community-based or individual facility-based exercise or a tabletop exercise to test their emergency plan. Interview on 12/18/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the facility has not conducted a full-scale facility/community-based exercise or a tabletop exercise to test the effectiveness of their current emergency plan.	E 039		
W 229	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4)(i) The objectives of the individual program plan must be stated separately, in terms of a single behavioral outcome. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure objectives for 3 of 3 audit clients (#3, #5) were written in terms of a single behavioral outcome. The findings are: Objective statements for 2 of 3 audit clients (#3, #5) were not written with single behavioral outcomes. a. Review on 12/17/18 of client #3's IPP dated 4/6/18 revealed the objective, "[Client #3] will choose and complete personal goals as identified in the self-assessment with 100% completion." b. Review on 12/17/18 of client #5's IPP dated 12/1318 revealed the objective, "[Client #5] will choose and complete personal goals as identified	W 229	W.229 This deficiency will be corrected by the following actions: A. All ISP'S will be reviewed and revise as needed. B. All WTP will be reviewed all goals will have measurable outcomes. C. All WTP will have identifiable criteria and outcomes D. All goals will be modified, revised, or discontinues to meet the needs of the peoples served E. All staff will be in-service on all goals. F. Residential Manager will monitor one time a week. G. Qualified Professional will monitor one time a week	02.19.2019

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W 229	Continued From page 8 in the self-assesement with 100% completion." Additional review noted an objective, "[Client #5] will learn to identity and write her full name for 6 consecutive months with 50% independence." Interview on 12/18/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the objective statements were not written with single outcomes.	W 229		
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure client #3's Individual Program Plan (IPP) included specific information to support her independence. This affected 1 of 5 audit clients. The finding is: Client #3's IPP did not include information regarding the use of an adaptive helmet. During observations throughout the survey at the day program and in the home, client #3 wore a soft helmet with a strap secured under her chin. The helmet was not removed during any observations. Interview on 12/17/18 with day program staff revealed client #3 wears the helmet due to falls. Additional interview on 12/18/18 with group home staff indicated the client wears the helmet to keep her from "scratching or hitting" her head and it is	W 240	W.240 This deficiency will be corrected by the following actions: A. All ISP'S will be reviewed and revise as needed to ensure. objectives of the use of adaptive equipment is in place specifically gait belt usage. B. PT will be assess the need for the use of adaptive equipment. C. PT will give guideline for the use of equipment D. All adaptive equipment will be discussed in a team meeting, to include day program E. All adaptive equipment that will be a restriction will be address at HRC. F. All people served will be in service on their adaptive equipment G. All staff will be in-service on the use need and function of gait belt. H. Vocational staff will be in serviced on all adaptive equipment I. Residential Manager will monitor one time a week. J. Qualified Professional will monitor one time a week.	02.19.2019

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W 240	Continued From page 9 worn due to her "disability." Review on 12/18/18 of client #3's IPP dated 4/6/18 revealed no information regarding the use of a soft helmet. Interview on 12/18/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #3's IPP did not include any information regarding the use of a soft helmet. The QIDP stated, "I overlooked it."	W 240		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 5 of 5 audit clients (#1, #2, #3, #4, #5) received a continuous active treatment plan consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of meal preparation, family style dining, adaptive equipment use, and self-help skills. The findings are: 1. Client #5 was not involved in cooking tasks at breakfast.	W 249	W.249 This deficiency will be corrected by the following actions: A. All ISP'S WTP will be reviewed and revise as needed to ensure objectives of are in place regarding need of consumer B. All WTP will be revised, updated or discontinued if objectives have been met C. ISP will be update modified to meet the current assessments needs D. Attention will be given to all dietary assessments. E. All people served will be in service on their WTP F. All staff will be in- service on their WTP objectives and desired outcomes. G. Residential Manager will monitor one time a week. H. Qualified Professional will monitor one time a week.	02.19.2019

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W 249	Continued From page 10 During morning observations in the home on 12/18/18 from 6:50am - 7:30am, a staff prepared all food items for breakfast without prompting or encouraging clients to assist. The staff completed tasks such as filling pitchers with drinks, placing frozen food items onto pans, cooking a pot of oatmeal, operating stove/oven dials, and placing food into serving dishes. Immediate interview with the staff involved revealed clients do not assist with cooking "because of the heat and everything...it's a safety issue." Additional interview indicated client #5 can perform tasks such as preparing toast or operating the microwave or assist with prepping foods to be cooked. Review on 12/18/18 of client #5's Community/Home Life Assessment dated 12/5/17 revealed the client can make food with no cooking, with cooking but no mixing and with cooking and mixing all with physical assistance. Additional review of the assessment indicated the client requires physical assistance for using measuring spoons or devices, a toaster, microwave, stove/oven and coffee maker. Further review of the client's nutritional evaluation dated 12/5/18 noted, "Encourage involvement with meal prep..." Interview on 12/18/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #5 can "do a lot" in the kitchen and "is really good" with helping staff cook. 2. Clients (#1, #2, #3) were not prompted or assisted to participate with family style dining tasks.	W 249		

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W 249	Continued From page 11 During breakfast observations in the home on 12/18/18 at 7:37am, staff placed food items on plates in the kitchen and took the plates to three clients (#1, #2, #3) at the table. The clients were not prompted or encouraged to assist with serving themselves or other aspects of family style dining. Interview on 12/18/18 with the staff involved revealed they generally prepare the plates in the kitchen for those three clients because they have "modified diets". a. Review on 12/18/18 of client #1's nutritional assessment dated 3/5/18 revealed, "He serves himself with assistance..." Additional review of the client's Community/Home Life Assessment dated 5/20/18 noted he eats family style and passes food to others with physical assistance. b. Review on 12/18/18 of client #2's Community/Home Life Assessment dated 3/13/18 revealed, the client eat family dinner style and passess food to others upon request with physical assistance. Additional review of the assessment indicated the client requires physical assistance for placing items correctly on the table. c. Review on 12/18/18 of client #3's IPP dated 4/6/18 revealed she needs prompts to ensure she completes daily living activities. Additional review of the client's Community/Home Life Assessment (incomplete date) indicated she eats family style and passes food to others independently. Interview on 12/18/18 with the QIDP confirmed the clients (#1, #2, #3) can assist with serving	W 249		

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	34G216	A. BUILDING _____ B. WING _____	12/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-OTIS STREET HOME	2415 OTIS STREET DURHAM, NC 27707

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W 249	Continued From page 12 themselves and should be assisted to participate in family style dining during meals. 3. Client #3's gait belt was not utilized during ambulation. During observations throughout the survey in the home on 12/17 - 12/18/18, client #3 wore a gait belt secured around her waist. As the client ambulated throughout the home, staff assisted her to walk by holding her arms and/or hands. Staff were not observed to utilize the gait belt during ambulation. Staff interview on 12/18/18 revealed client #3's belt is used "if she is having a behavior or tries to run off somewhere." Additional interview indicated they do not use the belt when she is walking. Review on 12/17/18 of client #3's IPP dated 4/6/18 revealed the gait belt assists the client with maintaining balance and to minimize falls. The IPP noted the belt provides support "when she is unsteady during ambulation." Interview on 12/18/18 with the QIDP indicated client #3's gait belt is used for "fall prevention and assistance with ambulating" and should be used during waking hours. Additional interview revealed staff should use the belt when walking with the client "at all times". 4. Client #3 was not prompted or assisted to clear her place after breakfast. During breakfast observations in the home on 12/18/18 at 7:54am, staff cleared client #3's dirty dishes without prompting or encouraging her to	W 249		

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	34G216	A. BUILDING _____ B. WING _____	12/18/2018

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VOCA-OTIS STREET HOME	2415 OTIS STREET DURHAM, NC 27707

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W 249	Continued From page 13 participate with this task. Staff interview on 12/18/18 revealed client #3 will help "sometimes" to clear her place. Review on 12/18/18 of client #3's Community/Home Life Assessment (incomplete date) revealed she can take dirty dishes to the kitchen independently. Interview on 12/18/18 with the QIDP confirmed client #3 can clear her place after meals with assistance. 5. Client #3 did not receive her dietary supplement as indicated. During breakfast observations in the home on 12/18/18 at 7:40am, client #3 was prompted and assisted to eat a portion of her breakfast meal. At the end of the meal, the client had eaten 1 of 3 food items. Client #3 was not provided a nutritional supplement at the breakfast meal. Staff interview on 12/18/18 revealed dietary orders posted in the kitchen are followed for each client at meals. Review on 12/17/18 of client #3's dietary note and physician's orders dated 12/5/18 revealed the client should receive one container of Ensure Plus or equivalent three times a day, "offer with meals". Interview on 12/18/18 with the QIDP confirmed client #3 should be offered Ensure at each meal as indicated.	W 249		

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W 249	Continued From page 14 6. Client #2's adaptive equipment was not utilized as indicated in the IPP. During afternoon observations in the home on 12/17/18 at approximately , client #2 was given a fruit cup for snack. Client #2 utilized a built-up spoon. She was leaning her head all the way to the table trying to eat from the cup. Review on 12/18/18 of client #2's IPP dated 4/5/18 revealed, "Plate riser...use at all meals to encourage an upright posture." Interview with QIDP on 12/18/18 revealed, "I saw that, I tried to cue staff to give [Client #2] the adaptive equipment." She further acknowledged the IPP was not followed.	W 249		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. 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 5 audit clients (#4, #5). The findings are: Clients' (#4, #5) training objectives were not documented as indicated. a. Review on 12/17/18 of client #4's record revealed an objective,"[Client #4] will report to	W 252	W.252 This deficiency will be corrected by the following actions: A. All ISP'S WTP will be reviewed and revise as needed to ensure objectives of are in place regarding need of consumer B. Qualified Professional will ensure that all data collected has been reviewed. C. ISP/WTP will be update modified to meet the data collected. D. All WTP will be revised, updated or discontinued if objectives have been met E. All people served will be in service on their WTP F. All staff will be in- service on their WTP objectives and desired outcomes. G. Residential Manager will monitor one time a week. H. Qualified Professional will monitor one time a week.	02.19.2019

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W 252	Continued From page 15 remain in his work area during work time with two or less verbal prompt daily during work time 70% of the time for three consecutive quarters." The plan noted, "Document 3 x per week." Additional review of client #4's training objective data sheet at the day program revealed no documentation for the year 2018. b. Review on 12/17/18 of client #5's record revealed a training objective, "[Client #5] will participate in brushing her teeth with at least 75% participation rate on each step over the review period." The plan noted, "Document 3 x per week." Additional review of client #5's training objective data sheet at the day program revealed no documentation for May '18 to December '18. Interview on 12/17/18 with direct care staff at the day program revealed, client #5's toothbrush had been missing for 2 weeks. Interview on 12/18/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the training was current for client #4 and client #5 and should continue to be implemented and documented as indicated.	W 252		
W 257	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(iii) The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made.	W 257		

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W 257	Continued From page 16 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure client #3's Individual Program Plan (IPP) was revised after he failed to progress towards identified objectives. This affected 1 of 5 audit clients. The finding is: Client #3's IPP was not revised after he failed to progress towards 6 of 7 objectives. Review on 12/17/18 of client #3's IPP dated 4/6/18 revealed objectives to complete toothbrushing process with 80% independence for 3 consecutive months, assist in the process of medication administration with 50% independence for 6 months, wash her hands with 75% independence for 6 months, was her body with 75% participation for 6 consecutive months, choose and complete personal goals as identified in the self-assessment with 100% completion, and to purchase an item with 75% independence for 6 consecutive months. The plan noted the objectives were implemented on 4/6/18. Additional review of objective's progress notes indicated the following: Toothbrushing 06/18 - 12% 07/18 - 8% 08/18 - 5% 09/18 - 15% 10/18 - 15% 11/18 - 12% Medication Administration	W 257	W.257 This deficiency will be corrected by the following actions: A. ALL ISP will be reviewed and revised as necessary. B. All WTP will be reviewed and assessed for continually care. All goals will be modified and assessed for progress. C. Medication assessment will be completed on all person served. D. All objectives of goals will meet the needs of the person being served. E. All staff will be in service on all new and current WTP F. Qualified Professional will in service all people served on goals with supporting documentation of all WTP in service G. Residential Manager will monthly weekly H. Qualified Professional will monitor weekly I. Qualified Professional will assess all WTP in core team monthly	02.19.2019

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W 257	Continued From page 17 06/18 - 0% 07/18 - 0% 08/18 - 10% 09/18 - 8% 10/18 - 8% 11/18 - 6% Hand washing 06/18 - "Hand-over-hand" 07/18 - 25% 08/18 - 27% 09/18 - 23% 10/18 - 19% 11/18 - 18% Wash her body 06/18 - 10% 07/18 - 13% 08/18 - 11% 09/18 - 16% 10/18 - 16% 11/18 - 12% Personal Goals 06/18 - No information 07/18 - No information 08/18 - No information 09/18 - No information 10/18 - No information 11/18 - 8% Purchase an item 06/18 - 0% 07/18 - 0%	W 257		

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	34G218	A. BUILDING _____ B. WING _____	12/18/2018

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W 257	Continued From page 18 08/18 - 10% 09/18 - 10% 10/18 - 0% 11/18 - 8% Interview on 12/18/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the objectives had not been considered for revisions.	W 257		
W 323	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(i) The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 5 audit clients (#4) received a recommended follow up Urinalysis (UA). The finding is: Client #4 did not receive a follow UA as recommended. Review on 12/17/18 of client #4's record revealed client had been hospitalized from 8/29/18 to 9/6/18. The discharge summary noted, "Sepsis secondary to UTI...complete total of 14 days of Augumentin...Recommend repeat UA after completing antibiotics and referral to Nephrology as needed." Interview on 12/18/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the recommendation for a UA was not followed.	W 323	W.323 This deficiency will be corrected by the following actions: A. All medical appointment will be reviewed. B. The team will ensure appointments are scheduled and follow up. C. All the appointments will be reviewed and discussed at the monthly core team/quarterlies/annual ISP. Options for appointments that were unable to be completed will be added to meeting minutes. D. There will be supporting documentation for all appointments that were completed or the reason why it was unable to be completed. E. RN will review monthly F. Residential Manager will monitor one time a week. G. Qualified Professional will monitor one time a week	02.19.2019

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W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure a physician's order was followed as written for 1 of 5 audit clients (#5). The finding is: Physician's orders were not followed as indicated for client #5. During observations of medication administration in the home on 12/18/18 at 7:46am, staff used a regular teaspoon to scoop fiber powder and mixed it with water for client #5. Review on 12/18/18 of client #5's physician's orders dated December '18 revealed an order for, "Nat Fiber Powder therapy, dissolve 3.4 grams in a full glass (8 oz) of fluid and drink by mouth twice daily." Interview on 12/18/18 with the medication technician revealed she routinely scoops the fiber powder with the teaspoon then mixes with water. Interview on 12/18/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the fiber powder should be scooped with a specified measuring scoop.	W 368	W.368 This deficiency will be corrected by the following actions: A. All physicians orders will be reviewed. B. There will be current orders for all medication in the person serve records. C. The team will ensure that all orders are implemented D. All the orders will be reviewed and discussed at the monthly core team/quarterlies/annual ISP. 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	02.19.2019
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing,	W 460		

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W 460	Continued From page 20 well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure client #1's modified diet was provided as indicated. This affected 1 of 5 audit clients. The finding is: Client #1 was not provided a pureed diet as indicated. During dinner observations in the home on 12/17/18 at 5:25pm, staff assisted client #1 to blend his food in a food processor. Once completed, the food items (peas and pasta salad with ham, cucumbers and tomatoes) was a finely ground consistency with visible pieces of food. Immediate interview with the staff who assisted client #1 revealed he receives a pureed diet. When asked how they obtain that consistency, the staff indicated they grind up his food in the food processor and add liquid such as broth until it resembles "baby food". The staff noted some food items which are "water based" do not need to have liquids added. Review on 12/18/18 of client #1's IPP dated 5/28/18 and current physician's orders dated 12/5/18 revealed he ingests a regular pureed diet. Additional review of documents and pictures posted in the kitchen of the home indicated a pureed diet would be "smooth with no lumps". Interview on 12/18/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #1 consumes a pureed diet and	W 460	W.460 This deficiency will be corrected by the following actions: A. All physicians (dietary) orders will be reviewed. B. The dietitian will review all current orders, modifying as needed. C. There will be current orders for all nutritional services for the person serve records. D. The team will ensure that all orders are implemented E. All the orders will be reviewed and discussed at the monthly core team/quarterlies/annual ISP. F. There will be supporting documentation for all Orders G. All person serve will receive a well balanced diet – supporting the modified or specially-prescribed diets. H. RN will review monthly I. Residential Manager will monitor one time a week. J. Qualified Professional will monitor one time a week	02.19.2019

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W 460	Continued From page 21 his food should resemble "baby food" and "real smooth". The QIDP acknowledged more training needed to be completed.	W 460		

December 26, 2018

Wilma Worsley-Diggs
Facility Survey Consultant I
Mental Health Licensure and Certification section
NC Division of Health Services Regulations
2718 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

Marika Whack, Executive Director
Community Alternatives North Carolina- Southeast Region
1001 Navaho Drive suite 101
Raleigh, North Carolina, 27609
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FAX

To: Worsley-Diggs From: J. Kenney

Fax: 9197158078 Pages: 24

Phone: Date: 12/26/18

Re: CC:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Comments: Thank you
Seasons Greetings

DHSR - Mental Health
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ResCare Residential Services