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

PRINTED: 12/17/2018
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
	34G036	A. BUILDING _____ B. WING _____	12/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN OAKS ROAD-DURHAM	514 SEVEN OAKS ROAD DURHAM, NC 27704

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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 19 2018 Lic. & Cert. Section	02.10.2019

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

Marsha Whack PA | Executive Director | 12/18/18

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 12/12/18 of the facility's EP plan revealed the plan had been developed on 7/21/17. Additional review of the plan indicated, "This emergency plan must be reviewed and updated at least annually." Further review of the plan did not include evidence of an annual review, Interview on 12/13/18 with the Qualified Intellectual Disabilities Professional (QIDP) revealed he was not aware if the EP plan had been reviewed or updated after 7/21/17.	E 004		
E 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include	E 006	E 006 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. Risk Assessment and community based strategies will be completed C. Strategies for addressing emergency event will be identified in risk assessment. D. A method of communicating specific needs of the people served on site will be addressed E. Management will implement F. Management will in services staff on the community based strategies put in place.	02.10.2019

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E 006	Continued From page 2 strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop an Emergency Preparedness (EP) plan including and based upon a community and facility-based risk assessment, utilizing an all-hazards approach. The finding is: The facility did not have an emergency plan based upon risk assessments. Review on 12/12/18 of the facility's current EP plan dated 7/21/17 revealed the plan did not provide specific information in regards to a facility-based and community-based risk assessment using an all-hazards approach including flood, fire, tornadoes, hurricanes, winter storms, bio terrorism, missing clients or other emergency types. Interview on 12/13/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed no EP risk assessment had been completed utilizing an all-hazards approach.	E 006		
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	E 037		

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E 037	Continued From page 3 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. (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	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	02.10.2019

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E 037	Continued From page 4 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 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.	E 037		

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E 037	Continued From page 5 (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 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	E 037		

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E 037	Continued From page 6 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 12/12/18 of the facility's EP plan dated 7/21/17 did not include any information regarding training of staff. During an interview on 12/13/18, 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:]	E 039		

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E 039	Continued From page 7 (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 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	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	02.10.2019

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E 039	Continued From page 8 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 12/12/18 of the facility's EP plan dated 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 12/13/18 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 137	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(12) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observations, interviews and record	W 137		

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W 137	Continued From page 9 review, the facility failed to ensure client #2 had the right to access her personal possessions. This affected 1 of 3 audit clients. The finding is: Client #2 did not have access to her clothing. During observations in the home throughout the survey on 12/12 - 12/13/18, client #2's clothing was kept locked in a hall closet. Staff retrieved a key to obtain various clothing items for the client as needed. Staff interviews (2) on 12/12/18 and 12/13/18 revealed client #2's clothes are kept locked because she will throw her clothes around the room or urinate on them. Additional interview indicated the client will destroy dresser drawers and throw furniture or clothing in the hallway. Review on 12/13/18 of client #2's record did not indicate the need for access to her clothing to be restricted. Interview on 12/13/18 with the Qualified Intellectual Disabilities Professional (QIDP) revealed he was not aware client #2's clothes were being kept locked.	W 137	W.137 This deficiency will be corrected by the following actions: A. All ISP's will be reviewed by Qualified Professional B. All rights restriction will be reviewed C. All restriction will be reviewed at HRC. D. All personal items will be given to each person served unless restricted E. Behaviors support plan will be update regarding the removal of personal items F. Staff will be in serviced on all items being stored. G. People served will be in served on where their items will be located and how to assess them H. Residential Manager will monitor one time a week. I. Qualified Professional will monitor one time a week.	02.10.2019
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	W 229		

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W 229	Continued From page 10 failed to ensure objectives for 3 of 3 audit clients (#2, #3, #4) were written in terms of a single behavioral outcome. The findings are: Objective statements for 3 of 3 audit clients (#2, #3, #4) were not written with single behavioral outcomes. a. Review on 12/12/18 of client #2's Individual Program Plan (IPP) dated 3/15/18 revealed the objective, "[Client #2] will sort denominations of money and place them into the correct basket with 65% independence for 12 months." b. Review on 12/12/18 of client #3's IPP dated 5/24/18 revealed the objective, "[Client #3] will sort coins and place them into the correct basket with 45% independence for 12 months." c. Review on 12/12/18 of client #4's IPP dated 1/25/18 revealed the objective, "[Client #4] will sort denominations of money and place them into the correct basket with 75% independence for 12 months." Interview on 12/13/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the objective statements were not written with single outcomes.	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	02.10.2019
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 11 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 3 audit clients. The finding is: Client #3's IPP was not revised after he failed to progress towards 3 of 7 objectives. Review on 12/12/18 of client #3's IPP dated 5/24/18 revealed objectives to sort coins and place them into the correct basket with 45% independence for 12 months, to brush his teeth after each meal with 45% independence for 12 months and to identify safety signs with 45% independence for 12 months. The plan noted the objectives were implemented on 5/24/18. Additional review of objective's progress notes indicated the following: Sorting coins 06/18 - 25% Independence 07/18 - 25% Independence 08/18 - No note 09/18 - 25% Independence 10/18 - 75% Gestures Brush teeth 06/18 - 5% Independence 07/18 - 5% Independence 08/18 - No note 09/18 - 5% Independence 10/18 - 58% physical assistance	W 257	W.257 This deficiency will be corrected by the following actions: 1. ALL ISP will be reviewed and revised as necessary. 2. All WTP will be reviewed and assessed for continually care. All goals will be modified and assessed for progress. 3. All objectives of goals will meet the needs of the person being served. 4. All staff will be in service on all new and current WTP 5. Qualified Professional will in service all people served on goals with supporting documentation of all WTP in service 6. Residential Manager will monthly weekly 7. Qualified Professional will monitor weekly 8. Qualified Professional will assess all WTP in core team monthly	02.19.2019

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G036	A. BUILDING _____ B. WING _____	12/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN OAKS ROAD-DURHAM	614 SEVEN OAKS ROAD DURHAM, NC 27704

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W 257	Continued From page 12 Safety signs 06/18 - 100% Gestures 07/18 - 100% Gestures 08/18 - No note 09/18 - 100% Gestures 10/18 - 100% Gestures Interview on 12/13/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the objectives had not been considered for revisions.	W 257		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a restrictive behavior support program (BSP) was only conducted with the written informed consent of a legal guardian. This affected 2 of 3 audit clients (#2, #3). The finding is: 1. Client #2's BSP did not include a current written informed consent from her legal guardian. Review on 12/12/18 of client #2's record revealed a BSP dated 11/6/17. The BSP addressed inappropriate verbalizations, inappropriate toileting, failure to cooperate, falling to the floor and symptoms related to depression. Additional review of the record identified the use of	W 263	W.263 This deficiency will be corrected by the following actions A. All ISP'S will be reviewed and revise as needed to ensure objectives are met. B. Addendum will be added to ISP to meet the current needs of the people being served. C. All consents will be signed and in place before the implementation of plan. D. All consents will be current and updated annual or as needed for changes in plan. E. Home and community life assessment will be completed. F. Qualified Professional will monitor monthly G. Qualified Professional will update annual or as needed.	02.10.2019

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W 263	Continued From page 13 Neurontin, Exelon, Divalproex, Risperdone, Zyprexa, Namenda and Melatonin to address inappropriate behaviors. Further review of the record revealed the guardian had signed a consent dated 12/6/17. Additional review of the consent form noted, "I understand that this authorization will expire on 11/6/18 and will not exceed one year from the date of my original authorization." The record did not include a current written informed consent signed by the guardian. Interview on 12/13/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the consent had expired and no current written informed consent had been obtained from client #2's guardian. 2. Client #3's BSP did not include a written informed consent from his legal guardian. Review on 12/12/18 of client #3's record revealed a BSP dated 5/24/18. The BSP addressed inappropriate touching and self-injurious behaviors. Additional review of the record identified the use of Lamictal and Ativan to address inappropriate behaviors. Further review of the record revealed no signed written informed consent from the client's guardian. Additional review of a BSP consent form signed by the former QIDP and Psychologist on 5/24/18 noted, "Plans containing restrictive interventions must have written consent from all parties every 6 months." The record did not include a current written informed consent signed by the guardian. Interview on 12/13/18 with the QIDP confirmed no current written informed consent had been obtained from client #3's guardian.	W 263		

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W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure a technique to manage client #2's inappropriate behavior was included in a formal active treatment plan. This affected 1 of 3 audit clients. The finding is: A technique to address client #2's inappropriate use of clothing was not included in an active treatment plan. During observations in the home throughout the survey on 12/12 - 12/13/18, client #2's clothing was kept locked in a hall closet. Staff retrieved a key to obtain various clothing items for the client as needed. Staff interviews (2) on 12/12/18 and 12/13/18 revealed client #2's clothes are kept locked because she will throw her clothes around the room or urinate on them. Additional interview indicated the client will destroy dresser drawers and throw furniture and/or clothing in the hallway Review on 12/13/18 of client #2's record revealed a Behavior Support Plan (BSP) dated 11/6/17. The BSP included techniques to address failure to cooperate, falling to the floor, inappropriate toileting, inappropriate verbalizations and symptoms of depression. Additional review of the plan did not include a technique of looking away	W 288	W 288 This deficiency will be corrected by the following actions: A. All behavioral support plans will be reviewed. B. All Behavioral Support Plans will be updated to address the current needs and technique to manager inappropriate behavior C. All proper techniques will be used to manage behaviors D. Psychologist will review all plans. E. All staff will be in-service on all Behavioral Support Plans. F. Residential Manager will monitor one time a week. G. Qualified Professional will monitor one time a week	02.10.2019

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W 288	Continued From page 15 client #2's clothing to address inappropriate behaviors. Interview on 12/13/18 with the Qualified Intellectual Disabilities Professional (QIDP) revealed he was not aware of any inappropriate use of clothing behaviors being exhibited by client #2 and did not know her clothes were being kept locked.	W 288		

December 18, 2018

Wilma Worsley-Diggs M.Ed., QIDP
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 12th- 13th, 2018
VOCA–Seven Oaks
614 Seven Oaks Road, Durham NC 27707
Provider Number 34G036
MHL# 032-010

Dear Ms. Worsley-Diggs

We appreciate the courtesy extended by you while surveying the VOCA–Seven Oaks North Carolina.

As indicated on the Plan of Correction, we will have the Deficiencies corrected for, the Annual survey conducted On December 12th- 13th, 2018, it will be completed February 10, 2019

We are committed to providing the highest possible care for the people we serve at VOCA–Seven Oaks

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
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FAX

To: Wilma Wooley-Diggs **From:** J. Kearney

Fax: 919-715-8028 **Pages:** 17

Phone: 919-855-3795 **Date:**

Re: **CC:**

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Comments: Seven oaks POC

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