

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-586	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 07/16/2019
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

RECOVERY CONNECTIONS I

2203 ELMWOOD AVENUE
DURHAM, NC 27707

RECEIVED

III 29 2019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and follow survey was completed on 7/16/19. Deficiencies were cited. The facility is licensed for the following service 10A NCAC 27 G .5600E Supervised Living for Adults with Substance Abuse Dependency.	V 000		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure facility grounds were maintained in a safe, clean, attractive and orderly manner. The findings are: Observation on 7/12/19 at approximately 9:35 AM of the facility revealed the following issues: -Kitchen area-One of the cabinet doors was off the hinges. -Clients' #1 and #4 bedroom-Outside and inside portion of double pane window was cracked. There were multiple cracks in window pane. Two of the cracks were approximately twelve inches long, two of the cracks were approximately eight inches long, one crack was approximately twenty four inches long and one crack was approximately fourteen inches long. The blinds were broken.	V 736	Regarding 27G.0303(c) Facility and Grounds Maintenance under 10A NCAC 27G.0303 Location and exterior Requirements the Recovery Connections of Durham will become compliant and will ensure that it's facility grounds are maintained in a safe, clean, attractive and orderly manner. RCD will properly re-attach the cabinet door that was off of the hinges. RCD will also have the window that is cracked replaced. Additionally, RCD will replace the blinds that are broken. RCD's Program Director will ensure that these repairs are complete. RCD's Program Director will also monitor	

DHSR-MH Licensure Sect

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Division of Health Service Regulation

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

Thomas B. Bass, Jr.

TITLE

Program Director

(X6) DATE

7/22/19

STATE FORM

6899

8N0411

If continuation sheet 1 of 2

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

RECOVERY CONNECTIONS I

**2203 ELMWOOD AVENUE
DURHAM, NC 27707**

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V 736	Continued From page 1 Interview with the Program Manager on 7/12/19 revealed: -She was not aware the window in clients' #1 and #4 room was cracked. -A maintenance person was supposed to be fixing the cabinet door. -She confirmed the facility was not maintained in a safe, clean, attractive and orderly manner.	V 736	<i>RCD's facilities and grounds on a monthly basis to ensure compliance with this rule</i>	



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

ROY COOPER • Governor

MANDY COHEN, MD, MPH • Secretary

MARK PAYNE • Director, Division of Health Service Regulation

July 18, 2019

Thomas Bass, Program Director
Recovery Connections of Durham, Inc.
2913 Wadsworth Ave.
Durham, NC 27707

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JUL 29 2019

DHSR-MH Licensure Sect

Re: Annual and Follow up Survey completed July 16, 2019
Recovery Connections I, 2203 Elmwood Avenue, Durham, NC 27707
MHL # 032-586
E-mail Address: savinglives1@aol.com

Dear Mr. Thomas Bass:

Thank you for the cooperation and courtesy extended during the Annual and Follow up survey completed July 16, 2019.

As a result of the follow up survey, it was determined that all of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- All tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiencies must be **corrected** within 60 days from the exit of the survey, which is 9/14/19.

What to include in the Plan of Correction

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603
MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718
www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

July 18, 2019
Thomas Bass
Recovery Connections of Durham, Inc.

- Indicate what measures will be put in place to **correct** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to **prevent** the problem from occurring again.
- Indicate **who will monitor** the situation to ensure it will not occur again.
- Indicate **how often** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Bryson Brown at 919-855-3822.

Sincerely,



Kimberly R Sauls
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc:

DHSR@Alliancebhc.org
Pam Pridgen, Administrative Assistant

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER MHL032-586	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 7/16/2019
NAME OF FACILITY RECOVERY CONNECTIONS I		STREET ADDRESS, CITY, STATE, ZIP CODE 2203 ELMWOOD AVENUE DURHAM, NC 27707

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0105	Correction	ID Prefix V0290	Correction	ID Prefix	Correction
Reg. # 27G .0201 (A) (1-7)	Completed	Reg. # 27G .5602	Completed	Reg. #	Completed
LSC	07/16/2019	LSC	07/16/2019	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR Kimberly R Sauls	DATE 7/19/19
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 7/13/2018		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		