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FORM APPROVED
OMB NO. 0938-0391

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

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 _____	01/07/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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. 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 every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. 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. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC 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 every 2 years.	E 004	RECEIVED JAN 17 2020 DHSR-MH Licensure Sect	

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

Monica Whack | Executive Director | 1/17/2020

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 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 annually. The finding is: The facility's EP plan was not reviewed or updated annually. Review on 1/6/20 of the facility's EP plan revealed, "The information in this manual is current as of August 31, 2018. This manual will be revised and updated as necessary." Further review of the plan did not include evidence of an annual review or update. Interview on 1/7/20 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 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 plan annually* E. *Management will have the plan updated annually.*	03.06.2020
E 037	EP Training Program CFR(s): 483.475(d)(1) *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] 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) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness 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*	03.06.2020

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E 037	Continued From page 2 (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and 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 every 2 years. (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. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and 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.	E 037		

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E 037	Continued From page 3 (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility 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 all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[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 every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must	E 037		

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E 037	Continued From page 4 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. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[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 every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and 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	E 037		

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E 037	Continued From page 5 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 every 2 years. 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: All staff had not been trained on the facility's EP plan. Review on 1/6/20 of the facility's EP plan last updated 8/31/18 revealed some staff had received training on the facility's EP plan on 2/14/19. Additional review of the plan did not include training for all staff working at the home. During an interview on 1/7/20, the Qualified Intellectual Disabilities Professional (QIDP) confirmed all staff working at the home had not been trained on the facility's EP plan.	E 037		
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is	E 039		

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E 039	Continued From page 6 community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) 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 its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion 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 Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is	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. The facility/community-based or table top exercises will be conducted annually. C. The facility/community-based or table top exercises will be conducting in accordance with the emergency preparedness plan. D. Staff will be in services on the facility/community-based or table top exercises E. The facility/community-based or table top exercises will be conducted with staff. F. Management will implement G. Management will in services staff annually	03.06.2020

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E 039	Continued From page 7 community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility- based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d) (2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural	E 039		

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E 039	Continued From page 8 or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion 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 hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made	E 039		

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E 039	Continued From page 9 emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, 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 LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that	E 039		

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E 039	Continued From page 10 requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, 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 [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required	E 039		

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E 039	Continued From page 11 full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, 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 ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For OPOs at §486:360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and	E 039		

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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 _____	01/07/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 12 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 1/6/20 of the facility's EP plan (last updated 8/31/18) did not include a full-scale community-based or individual facility-based exercise or a tabletop exercise to test their emergency plan. Interview on 1/7/20 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 214	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(iii) The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure 1 of 1 legally blind client (#1) received an assessment	W 214		

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W 214	Continued From page 13 regarding services for the blind. The finding is: Client #1 did not receive an assessment from services for the blind. Throughout observations on 1/6/20 and 1/7/20, client #1 was observed to feel his way around. He was very obviously blind. Staff presented him with coloring to do on 1/2/20 at the day program and on the afternoon of 1/6/20 at home he was left sitting alone in his room with no music, no television and no activity from 3:30pm until 5:10pm (a period of 1 hour and 40 minutes.) Upon review of client #1's record on 1/6/20, client#1's individual program plan (IPP) dated 5/28/19 noted that he was legally blind. However, there was no assessment from services for the blind. Interview with the group home manager (GHM) on 1/7/20 revealed she had not known of client #1 to receive an assessment from services for the blind since she had been there (about one year). She also called the qualified intellectual disabilities professional (QIDP) who stated she had not known of client #1 to have an assessment from services of the blind since she had been there. The GHM stated that had been about five years. The GHM further acknowledged that such an assessment may help the staff work with client #1.	W 214	W.214 This deficiency will be corrected by the following actions: A. Community and home life assessment will be completed on each person served B. Each person will be assessed for their ability to increase independence especially persons served with visual impairments. . C. Clinical Supervisor will review and add WTP as needed to increase independence D. Clinical Supervisor will assess community for visual impairment services E. All staff will be in-service on WTP (if applicable) F. All staff will be in-service on family style dining G. Residential Manager will monitor one time a week. H. Qualified Professional will monitor one time a week and monthly at core team meeting	03.06.2020
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	W 249		

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W 249	Continued From page 14 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 3 of 4 audit clients (#1, #3, #6) received a continuous active treatment plan consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of adaptive equipment use, objective implementation and leisure. The findings are: 1. Client #3's adaptive foot stool was not utilized as indicated. During dinner and breakfast observations in the home on 1/6 - 1/7/20, client #3 did not utilize a foot stool while seated at the table. Interview on 1/7/20 with Staff D and Staff F revealed client #3 uses a foot stool wherever she is seated to help with positioning and because her feet do not touch the floor when seated. Review on 1/6/20 of client #3's IPP dated 10/6/19 revealed she should "use a foot stool while having her meals for stability at the table." Interview on 1/7/20 with the Home Manager (HM) confirmed client #3 should be using a foot stool postioned under her feet at meals.	W 249	W.249 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 guidelines 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 WTP will be reviewed all goals will have measurable outcomes. G. All WTP will have identifiable criteria and outcomes H. All goals will be modified, revised, or discontinue to meet the needs of the peoples served I. All consumers will be provided meaningful activities. J. All staff will be in-service on all goals. K. All people served will be in service on their adaptive equipment L. All staff will be in-service on the use need and function of gait belt. M. Vocational staff will be in serviced on all adaptive equipment N. Residential Manager will monitor one time a week. O. Qualified Professional will monitor one time a week. P. Qualified Professional will assessed monthly in core team meeting	03.06.2020

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W 249	Continued From page 15 2. Client #5's dental goal was not implemented consistently. During observations on 1/7/20, client #5 went at 7:30am to brush her teeth. She told this surveyor nobody assists her with toothbrushing. The group home manager confirmed this. Client #5 then brushed her teeth with a heaping spread of toothpaste on her brush. She brushed for a few seconds (no more than 20 seconds total time) and then was prompted to brush more a total of about 30 seconds. The group manager told her this was fine and indicated she is an independent lady. After the observation on 1/7/20, the group home manager was again asked if this was the way she usually brushed and the manager stated it was. Review on 1/7/20 of client #5's individual program plan (IPP) dated 12/12/19 revealed a goal implemented 12/13/19. This goal indicated that client #5 should get materials, brush her teeth and gums, brush her lower teeth and gums and brush her tongue. This goal should be implemented in the mornings. The goal stated staff should monitor to ensure adequate brushing for at least 3 minutes. 3. Client #1 was not provided meaningful activity choices as per his IPP. Throughout observations on 1/6/20 and 1/7/20, client #1 was observed to feel his way around. He was very obviously blind. Staff presented him with coloring to do on 1/2/20 at the day program and on the afternoon of 1/6/20 at home he was left sitting alone in his room with no music, no television and no activity from 3:30pm until	W 249		

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W 249	Continued From page 16 5:10pm (a period of 1 hour and 40 minutes.) Upon review of client #1's record on 1/6/20, client#1's individual program plan (IPP) dated 5/28/19 noted that he was legally blind. It further noted that staff should continue to provide opportunities to participate in activities he likes. It stated he enjoys musical activities, is friendly and social and likes to joke around. Interview with the group home manager on 1/7/20 confirmed that client #1 should have been offered some activity choices in the afternoon on 1/6/20.	W 249		
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, record reviews and interviews, the facility failed to assure doctor's orders were implemented as written for 1 of 4 audit clients (#5). The finding is: Client #5's Nat Fiber was not given as ordered. During observations of the medication pass on 1/7/20, client #5 did not received the Nat fiber as ordered. She received 3/4 fluid ounce or "4 Drams." Interview with staff E after the observation on 1/7/20 confirmed this is the amount they have always given client #5 for Nat Fiber and it was what they were taught to give her.	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	03.02.2020

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W 368	Continued From page 17 Review of client #5's physician orders on 1/7/20 confirmed that the doctor had ordered, "Nat Fiber 48.575." It noted staff should "dissolve 3.4 grams in a full glass of fluid." Interview with the nurse via phone on 1/7/20 confirmed that 4 "Drams" is an old measurement. In reviewing a conversion table it was found that 4 Drams is equal to 7.09 grams (asknumbers.com). This is almost double the amount ordered. Interview with the nurse via phone on 1/7/20 confirmed the conversion measurements sounded correct. Interview with the group home manager on 1/7/20 revealed they had these measuring cups for over a month. She further confirmed that staff had been using drams instead of grams since they had these measuring cups	W 368		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure all medications were administered without error. This affected 1 of 4 audit clients (#5). The finding is: Client #5's Nat Fiber was not given as ordered.	W 369		

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W 369	Continued From page 18 During observations of the medication pass on 1/7/20, client #5 did not received the Nat fiber as ordered. She received 3/4 fluid ounce or "4 Drams." Interview with staff E after the observation on 1/7/20 confirmed this is the amount they have always given client #5 for Nat Fiber and it was what they were taught to give her. Review of client #5's physician orders on 1/7/20 confirmed that the doctor had ordered, "Nat Fiber 48.575." It noted staff should "dissolve 3.4 grams in a full glass of fluid." Interview with the nurse via phone on 1/7/20 confirmed that 4 "Drams" is an old measurement. In reviewing a conversion table it was found that 4 Drams is equal to 7.09 grams (asknumbers.com). This is almost double the amount ordered. Interview with the nurse via phone on 1/7/20 confirmed the conversion measurements sounded correct. Interview with the group home manager on 1/7/20 revealed they had these measuring cups for over a month. She further confirmed that staff had been using drams instead of grams since they had these measuring cups	W 369	W.369 *This deficiency will be corrected by the following actions:* A. *RN will assess all orders.* B. *All physician orders will be reviewed for accuracy.* C. *All staff will be in service on medication procedure and following the guidelines for measuring and dispensing all medications* D. *All assessment will be reviewed and recommendations discussed in core team, quarterly, or ISP.* E. *Staff will be in service on Medication Administration procedures* F. *RN will monitor monthly* G. *Residential Manager will monitor one time a week.* H. *Qualified Professional will monitor monthly*	03.06.2020
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration.	W 382		

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W 382	Continued From page 19 This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to assure that all drugs and biologicals were kept locked except when being prepared for administration. This potentially affected all clients residing in the facility. The finding is: The medication area was left unlocked and open several times. During a medication administration observation on 1/6/19, at 4:20pm, the medication technician (staff E) walked down the hall to get a client while leaving the meds unlocked. Later at 4:35pm, she left the area again and went to the kitchen to get a client. During an interview on 1/6/20 after the observations, Staff E was asked if the process was to walk down and get the clients while leaving meds unlocked. She stated that she was taught to lock the meds that the other staff usually walked individuals to her but for some reason today they did not. Upon arrival to the group home on 1/7/20 at 6:00am, the medication closet was unlocked and open and only one client sat in the medication room. Client #5 sat in front of the unlocked and open medication closet. After about five minutes Staff F came into the room to prepare the medications. Interview with staff F on 1/7/20 after the observation revealed that she had been trained to lock the medication door when she was not there but just forgot.	W 382	W.382 This deficiency will be corrected by the following actions: A. All medications will be locked and secured unless being administered. B. No medications will be left unattended. C. Staff will be in serviced on ensuring that all medication remains locked except during administration. D. Medication Monitor Closet sheets will be completed weekly. E. Residential Manager will monitor one time a week. F. Qualified Professional will monitor one time a week.	03.06.2020

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W 382	Continued From page 20 Interview on 1/7/19 with the group home manager confirmed that all staff should keep all medications locked at all times unless they are preparing the medications.	W 382		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure modified diets were followed for 2 of 4 audit clients (#1, #3). The findings are: Clients (#1, #3) modified diets were not consistently followed at all meals. a. During lunch at the day program on 1/7/20, client #1 consumed spaghetti in what looked like a ground consistency. The beef and noodles were chunky to where one could still see short noodles and ground beef. It was thick and dry. The food; however, was consumed without issues. b. During dinner observations in the home on 1/7/20 at 5:25pm, client #1 and client #3 consumed chicken pot pie, mixed vegetables and potatoes salad. At the meal, the pot pie was very thick, dry and chunky. The mixed vegetables and potatoes salad were chunky with visible bits of food throughout. Both clients consumed their food without difficulty.	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. All diet textures will be assessed E. The team will ensure that all orders are implemented F. All the orders will be reviewed and discussed at the monthly core team/quarterlies/annual ISP. G. There will be supporting documentation for all Orders H. All person serve will receive a well balanced diet – supporting the modified or specially-prescribed diets. I. RN will review monthly J. Residential Manager will monitor one time a week. K. Qualified Professional will monitor one time a week	03.06.2020

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W 460	Continued From page 21 Review on 1/6/20 of client #3's IPP dated 10/6/19 revealed she is on a "Regular diet, Puree diet". Review on 1/6/20 of client #1's IPP dated 5/26/19 revealed he should receive a pureed diet texture at all meals. Interview on 1/7/20 with Staff C revealed client #1 and client #3 are on pureed diets which means their food should be like "baby food". Additional interview indicated their food should be soft with liquid added if necessary. Interview on 1/7/20 with the Home Manager (HM) confirmed client #1 and client #3 are on pureed diets and their food should be like "mush" and liquid should be added "if necessary". Additional interview indicated diet consistency information and pictures are posted in the kitchen.	W 460		
W 488	DINING AREAS AND SERVICE CFR(s): 483.480(d)(4) The facility must assure that each client eats in a manner consistent with his or her developmental level. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure clients ate in a manner which was not stigmatizing. This affected 1 of 4 audit clients (#3). The finding is: Client #3 was not assisted to eat in a manner which was not stigmatizing. During breakfast observations in the home on	W 488		

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W 488	Continued From page 22 1/7/20 at 7:23am after client #3 had consumed about half of her meal, Staff F secured the upper portion of the client's bib around her and the lower portion of the bib was then placed underneath her plate. No spillage was noted by client #3 while eating. Interview on 1/7/20 with Staff F revealed she had positioned the bib in this manner to keep the client's clothes from getting food on them. Review on 1/7/20 of client #3's Individual Program Plan (IPP) dated 10/6/19 did not identify the need for a bib at meals. Additional review of the client's Community/Home Life Assessment dated 9/11/19 indicated she eats neatly given verbal cues and eats messy food and remains neat usinig a napkin with physical assistance. Interview on 1/7/20 with the Home Manager (HM) confirmed client #3 should not be eating with her bib postitioned in this manner.	W 488	W.488 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. All adaptive equipment will be assess for need. C. Staff will be in serviced to increase a higher level of dignity while eating. D. Staff to be in service on client rights E. Staff to be in serviced on proper use of adaptive equipment. F. Additional bib/clothing protectors will be utilized to decrease cross contamination, increase safety and dignity of respect. A. Residential Manager will monitor one time a week. B. Qualified Professional will monitor monthly	03.06.2020

Community Alternatives – NC
Southeast Region
1001 Navaho Drive Suite 101
Raleigh, NC 27609
Phone: 984-205-2630
FAX: 984-205-2643

FAX

To: Ms. Worsley-Digg
From: Jermaine Tracy

Fax: 919 855 3795
Pages: 24

Phone: 919-715 8078
Date: 1/17/2020

Re:
CC:

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

Comments:

ResCare
Residential Services

January 17, 2020

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: January 6-7, 2020**
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 **January 6-7, 2020** iit will be completed **March 6, 2020**

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

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