DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			FORM OMB NO.	01/10/2020 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		. 34G216	B. WING			07/2020
NAME OF F	ROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE, ZIP COD	E	
VOCA-O	TIS STREET HOME	3, '		2415 OTIS STREET DURHAM, NC 27707	.′	
(X4) ID PREFIX TAG	FACH DESICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULDBE	COMPLETION DAYE
E 004	Develop EP Plan, I CFR(s): 483.475(a	Review and Update Annually	E 004	4		,
	Federal, State and preparedness requirements of the The emergency preparedness.  (a) Emergency Pland maintain an ethat must be [reviewery 2 years. The following:  * [For hospitals at §485.625(a):] Emergency Pland maintain and the emergency prepared the	irements. The [facility] must and maintain a comprehensive edness program that meets the				
	* [For LTC Facilities of the learning of the l	es at §483.73(a):] Emergency cility must develop and maintain eparedness plan that must be tated at least annually. Emergency facility must develop and repency preparedness plan that ed], and updated at least every 2	,	JAN 1 7 2020  DHSR-MH Licensure S		(X6) DATE

Any deficiency statement ending with an exterisk (\*) 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

Event ID: XYVY11

program participation.

DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES		Ĭ	PRINTE	0: 01/10/2020	
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			,	FORM	MAPPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION		0. 0938-0391 TE SURVEY
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD			CO	MPLETED
		210010					
NAME OF	PROVIDER OR SUPPLIER	34G216	B. WING			01	/07/2020
					EET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-0	OTIS STREET HOME				5 OTIS STREET RHAM, NC 27707		
(X4) ID	SUMMARY STAT	TEMENT OF DEFICIENCIES	ID	70	***************************************		7
PRÉFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL)	DBE	(X5) COMPLETION
1/10	NEODEMONT ON LO	DENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROF DEFICIENCY)	RIATE	DATE
•					DE TOLLIO I	,	
E 004	Continued From page	ge 1	FO	04 E (	004	1	1 [
	This STANDARD is	not met as evidenced by:			out his deficiency will be corrected by	the h	3.06.2020
	Based on record re	view and interview, the facility			llowing actions	the D	3,00.2020
	failed to ensure the	Emergency Preparedmess			A. The facility will develop and	a l	
	annually. The finding	wed and updated at least		, .	maintain a emergency		
	aimuany. The infolin	g is.			preparedness plan and it v		
	The facility's EP plan	n was not reviewed or			reviewed and updated ann		
	updated annually.				B. A method of communication		
					specific needs of the peopl served on site will be addre		
	Review on 1/6/20 of	the facility's EP plan mation in this manual is			C. Management will impleme		
	current as of August	31, 2018. This manual is			D. Management will in service		
	be revised and upda	ted as necessary." Further			staff on the plan annually		
	review of the plan did	d not include evidence of an			E. Management will have the	plan	
	annual review or upo	late.			updated annually.	-	
	Interview on 1/7/20 v	vith the Qualified Intellectual			<b>.</b>		
	Disabilities Profession	onal (QIDP) revealed she was					
	not aware if the EP p	lan had been reviewed or				1	1
E 007	updated annually.	To a second					
E 037	EP Training Program CFR(s): 483.475(d)(		E 03	7 EO	37		
	O17((a), 400,470(d)(	''			is deficiency will be corrected by	the o	3.06.2020
	*[For RNCHIs at §40	3.748, ASCs at §416.54,			lowing actions:		
	Hospitals at §482,15	ICF/IIDs at 6483,475, HHAs			<ol> <li>The facility will develop an</li> </ol>	d	
	at §484.102, "Organi:	zations" under §485.727,			maintain an emergency	*	
	Training program Th	RHC/FQHCs at §491.12:] (1) e [facility] must do all of the			communication preparedne		
	following:	e [lacility] must do all of the			plan and it will be reviewed updated annually	and	
-	(i) Initial training i	n emergency preparedness			B. Staff will in-service on the	and the same of th	
	policies and procedu	res to all new and existing			emergency preparedness		
	starr, individuals prov	iding services under unteers, consistent with their		,	manual		
	expected roles.	mineers, consistent with their			C. Staff will in-service on the w		
	(ii) Provide emerg	gency preparedness training			conduct monthly disaster d		
	at least every 2 years				<ul> <li>D. Management will implement annually</li> </ul>	1	
	(iii) Maintain docu	mentation of all emergency			E. Management will in service	s	
	preparedness training				staff annually		

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			ŗ		D: 01/10/2020
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					M APPROVED O. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	1/07/2020
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(X4) ID	CIMMADY CTA	TOMENT OF SECONDON			DURHAM, NC 27707		
PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) RF	COMPLETION DATE
E 037	(iv) Demonstrate emergency procedu (v) If the emerge	e staff knowledge of res. ency preparedness policies	ΕC	37	7		
	[facility] must condu policies and procedu						
	(i) Initial training policies and procedu	18.113(d):] (1) Training, The of the following: in emergency preparedness ares to all new and existing and individuals providing					
	services under arran expected roles.	gement, consistent with their staff knowledge of					
	emergency procedur (iii) Provide eme at least every 2 years (iv) Periodically r emergency prepared	res. rgency preparedness training					
	special emphasis pla procedures necessal others.	ced on carrying out the y to protect patients and imentation of all emergency					
	(vi) If the emerge	ncy preparedness policies significantly updated, the t training on the updated					
	<ul> <li>(i) Initial training i policies and procedur staff, individuals provi</li> </ul>	184(d):] (1) Training must do all of the following: n emergency preparedness es to all new and existing iding services under unteers, consistent with their					<u>.</u>

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES				PRINTE	D: 01/10/2020
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		34G216	8. WING	;			4/07/0000
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E 037	Continued From page	de 3	E	127			
	(ii) After initial tra	aining, provide emergency		137			
	preparedness trainir	ng every 2 years.					
	(iii) Demonstrate	staff knowledge of			·		
	emergency procedur	res. cumentation of all emergency			·		
	preparedness training	ng.					
	(v) If the emerge	ency preparedness policies					
	and procedures are	significantly updated, the					1 1
}	policies and procedu	training on the updated					
							1
	*[For LTC Facilities a	at §483.73(d):] (1) Training					
	Program. The LTC fa following:	acility must do all of the					
1		in emergency preparedness					
	policies and procedu	res to all new and existing		-			
- 1	statt, individuals prov	riding services under		1			1
	arrangement, and vo expected role.	lunteers, consistent with their					
		gency preparedness training					
	at least annually,	_		-			
	(iii) Maintain docu	mentation of all emergency					
	preparedness training	g. staff knowledge of					
	emergency procedure	es.					
		en e	625		,		
	For CORFs at §485	.68(d):](1) Training. The					1
1	CORF must do all of ( (i) Provide initial to	raining in emergency				1	1
	preparedness policies	and procedures to all new					į.
18	and existing staff, indi	ividuals providing					
	services under arrang consistent with their e	ement, and volunteers,					
1	(ii) Provide emera	xpected roles, lency preparedness training					
. 6	it least every 2 years.	_					
	(iii) Maintain docu	mentation of the training.					
	(iv) Demonstrate	staff knowledge of					(a)
6	meracine's braceafte	s. All new personnel must					

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			F	RINTE	D: 01/10/2020
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FOR	MAPPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MU	LTI	IPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
AND FLAN	OF CORRECTION .	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		34G216	B. WING	2			
NAME OF	PROVIDER OR SUPPLIER	0.40010	10.11110	, T	STREET ADDRESS, CITY, STATE, ZIP CODE	0	1/07/2020
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(X4) ID PREFIX TAG	(EACH DEFICIENCY)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RE	COMPLETION DATE
E 037	Continued From page	× 4					
2 00.	be oriented and ass		E	337	7		
	responsibilities i	regarding the CORF's					
	emergency plan with	nin 2 weeks of their first					
	workday. The training	g program must include ation and use of alarm					
	systems and signals	and firefighting equipment.					
	(v) If the emerc	gency preparedness policies significantly updated, the					
	CORF must conduct	t training on the updated					
	policies and procedu	ires.					
	The CAH must do al  (i) Initial training policies and procedu reporting and extingu and where necessary personnel, and guesi cooperation with authorities, to all new individuals providing and volunteers, c roles.  (ii) Provide emery at least every 2 years (iii) Maintain docu (iv) Demonstrate emergency procedure (v) If the emerge and procedures are s	in emergency preparedness res, including prompt uishing of fires, protection, y, evacuation of patients, is, fire prevention, and firefighting and disaster and existing staff, services under arrangement, consistent with their expected gency preparedness training is amentation of the training. staff knowledge of es. ency preparedness policies ignificantly updated, the gaining on the updated					
ļ	CMHC must provide i preparedness policies and existing staff, indi	.920(d):] (1) Training. The nitial training in emergency and procedures to all new viduals providing services and volunteers, consistent			÷		

PRINTED: 01/10/2020

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES 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 A. BUILDING COMPLETED 34G216 B. WING 01/07/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2415 OTIS STREET **VOCA-OTIS STREET HOME** DURHAM, NC 27707 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X6) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) E 037 Continued From page 5 E 037 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 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 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 039 **EP Testing Requirements** E 039 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

DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES			*	PRINTE	D: 01/10/20	020
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AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BÜILE		PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED	91
		34G216	B. WING	;				
NAME OF	PROVIDER OR SUPPLIER		1	8	STREET ADDRESS, CITY, STATE, ZIP CODE	01	/07/2020	-
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICENCY)	DRE	COMPLETIO DATE	W
E 039	Continued From pag							-
	community-based e		E0		E039	1	1	1
	(A) When a	community-based exercise is		!I	This deficiency will be corrected by	the 03	.06.2020	
	not accessible, cond	luct a facility-based functional		1	following actions:  A. The facility will develop an	. 1		
	exercise every 2	vears; or			maintain an emergency	2		
	natural or man-made	cility] experiences an actual emergency that requires			communication preparedne	255		
	activation of the eme	ergency plan the Ifacility			plan and it will be reviewed	and		
	is exempt from enga	iging in its next required			Updated annually	.		
	functional ex	individual, facility-based cercise following the onset of			<ul> <li>B. The facility/community-bas table top exercises will be</li> </ul>	ed or		
	the actual event.	cercise following the onset of			conducted annually.			
	(ii) Conduct an a	dditional exercise at least			C. The facility/community-bas	ed or		
	every 2 years, oppos functional exercise u	ite the year the full-scale or			table top exercises will be			
	this section is condu	nder paragraph (d)(2)(i) of cted, that may include, but is			conducting in accordance v	ith		
	not limited to the follo	owing:			the emergency preparednes	2:		
« <u> </u>	(A) A second	full-scale exercise that is			D. Staff will be in services on th	e		
ĺ	community-based or functional exercise; or	individual, facility-based			facility/community-based or	_		
	(B) A mock d	isaster drill; or			table top exercises  E. The facility/community-base			
	(C) A tabletor	exercise or workshop that		'	<ul> <li>E. The facility/community-base table top exercises will be</li> </ul>	d or		
1	is led by a facilitator a	and includes a group			conducted with staff.			
	discussion using a na	emergency scenario, and a			F. Management will implement	:		
	set of problem statem	ients, directed messages or			<ul> <li>G. Management will in services</li> </ul>			
1	prepared questions	designed to challenge an		١,	staff annually	1,		1
	emergency plan.					-		
	maintain documentati	ne [facility's] response to and on of all drills, tabletop						
	exercises, and emerg	ency events and						
	revise the [facility's] er	mergency plan, as needed.						
	*[For Hospices at 418	113/4)-1						
] (	(2) Testing for hospic	es that provide care in the						
11	patient's home. The h	ospice must conduct				ļ		
1	exercises to test the e	mergency plan at least				-		
1	(i) Participate in a	e must do the following: full-scale exercise that is				-		
	() ashering HIM	TO SOUR CANTOIS HIGH IS					i	

DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES				PRINTE	D: 01/10/2020	
I MAN FLAN OF CORRECTION I IDENTIFICATION NUMBER					PLE CONSTRUCTION	OMB NO. 0938-039		
		34G216	B. WING	_		01/07/2020		
	PROVIDER OR SUPPLIER OTIS STREET HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2415 OTIS STREET	1 0	1/0//2020	
		***************************************			DURHAM, NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DRE	(X5) COMPLETION DATE	
E 039	community based e (A) When a not accessible, cond based functional exi (B) If the ho or man-made emerge of the emergency ple exempt from engagiscale community-ba facility-based for the onset of the emergency of the onset of the emergency (ii) Conduct an years, opposite the year (B) A mock (C) A tableto is led by a facilitator of discussion using a naclinically-relevant set of problem staten prepared questions emergency plan.  (3) Testing for hospic care directly. The ho exercises to test the eyear. The hospice m (i) Participate in that is community-based function accessible, condutacility-based function	very 2 years; or community based exercise is duct an individual facility ercise every 2 years; or spice experiences a natural gency that requires activation an, the hospital is ng in its next required full sed exercise or individual unctional exercise following ergency event. additional exercise every 2 year the full-scale or inder paragraph (d) (2)(i) of cted, that may include, but is a facility based functional disaster drill; or op exercise or workshop that and includes a group arrated, the emergency scenario, and a nents, directed messages, or designed to challenge an est that provide inpatient spice must conduct emergency plan twice per ust do the following: an annual full-scale exercise is act an annual individual	EO	)39				

DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES				PRINTE	0: 01/10/20	20
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FORM	/ APPROVE	ED
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		34G216	B. WING	· _				
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(X4) ID PREFIX TAG	LEACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DAE .	COMPLETION DATE	N
E 039	Continued From pag	3e 8	E	121	0			$\dashv$
		gency that requires activation	E	JOS	9			1
	of the emergency pl	an, the hospice is						
	exempt from engagi	ing in its next required						
	full-scale community	based or facility-based				*		
	functional of the emergency ev	exercise following the onset					¥3.	
	(ii) Conduct an	additional annual exercise						1
	that may include, bu	t is not limited to the						1
	following:							1
	(A) A secon	d full-scale exercise that is						1
	exercise; or	a facility based functional			n			ľ
		disaster drill; or	No.		· ·			ı
	(C) A tableto	op exercise or workshop led				1		
	by a facilitator that in	cludes a group discussion						1
	using a narrated,	clinically-relevant				1		1
	emergency scenario,	and a set of problem				ĺ		
	questions desir	messages, or prepared gned to challenge an						
	emergency plan.	gried to challenge an						L
	(iii) Analyze the	hospice's response to and						
	maintain documentat	ion of all drills, tableton						
1	exercises, and emerg	gency events and revise			y de la constant de l			
1	the hospice's emerge	ency plan, as needed.						ı
	*[For PRFTs at §441.	184(d). Hospitals at						
1	§482.15(d), CAHs at	§485,625(d):1						
1	(2) Testing. The [PRT	F, Hospital, CAHI must						
1	conduct exercises to	test the emergency plan						
	twice per year. The [I do the following:	PRTF, Hospital, CAH] must						
		an annual full-scale exercise						
	that is community-bas	sed: or		ľ				
	(A) When a c	ommunity-based exercise is		-				
	not accessible, condu	ct an annual individual.						
1	facility-based function	al exercise; or					6	
	(B) If the [PR]	TF, Hospital, CAH]						
'	experiences an actual	natural or man-made						

DEPA	RTMENT OF HEALTH	AND HUMAN SERVICES				PRINTE	D: 01/10/20 M APPROVE	20 ED
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AND PLAI	N OF CORRECTION	IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
NAMEO	F PROVIDER OR SUPPLIER	34G216	B. WING	·		0.	1/07/2020	
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VOCA-	OTIS STREET HOME				2415 OTIS STREET			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		L	DURHAM, NC 27707			-
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DRE	COMPLETION DATE	N
E 039	Continued From pag	ge 9	-	200				٦
	emergency that requ		E	139				1
	emergency plan, the	Ifacility is exempt from						
	based or	required full-scale community individual, facility-based						
		ollowing the onset of the						
	emergency event,							
	(ii) Conduct an [and that may include	additional] annual exercise or e, but is not limited to the						
	following:	, but to not annited to the					İ	
	(A) A second	full-scale exercise that is						
	functional exercise;	individual, a facility-based						
	(B) A mock of	disaster drill; or						
	(C) A tableto	p exercise or workshop that				Î		
	discussion, using a n	and includes a group						
	clinically-relevant	emergency scenario and a		-				1
	set of problem staten	nents, directed messages, or	34					
	prepared questions emergency plan.	designed to challenge an						
u .	(iii) Analyze the If	acility's] response to and						
	maintain documentati	ion of all drills, tableton						
	the [facility's] emerge	gency events and revise						1
	901 VV 19000	1						-
	*[For LTC Facilities at	§483.73(d):]						
	test the emergency of	must conduct exercises to an at least twice per year,						
	including unannounce	ed staff drills using the						
	emergency procedure	s. The ILTC facility			545		-	
	(i) Participate in a	ollowing: an annual full-scale exercise						
	that is community-bas	ed; or						
	(A) When a co	ommunity-based exercise is						
,	not accessible, conductions facility-based functions	ct an annual individual,					. 1	
1	(B) If the [LTC	facility facility experiences			4		1	
	an actual natural or ma	an-made emergency that				-		
1		1		1		1		

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC	LTIP	LE CONSTRUCTION	(X3) D	O. 0938-039 ATE SURVEY OMPLETED	
		34G216	B. WING	·			1/07/2020	
1	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	1/0/12020	
VOGA-0	TIS STREET HOME				2415 OTIS STREET DURHAM, NC 27707	**	*	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION DATE	
	requires activation of the LTC facility is ex required a full-scale individual, facilit following the onset of (ii) Conduct and that may include, but following:  (A) A second community-based or functional exercise;  (B) A mock (C) A tablet is led by a facilitator using a narrated, emergency scenario statements, directed questions designed emergency plan.  (iii) Analyze the response to and main drills, tabletop exercise events, and revise the emergency plan, as referenced to the test the emergency plan as referenced in a facility-based function (B) If the ICF/IID must do (i) Participate in a facility-based function (B) If the ICF/IID matural or man-made activation of the emergency of the emergency of the emergency of the ICF/IID matural or man-made activation of the emergency of	of the emergency plan, sempt from engaging its next community-based or y-based functional exercise of the emergency event, additional annual exercise of the emergency event, additional annual exercise at is not limited to the ordiffer an individual, facility based or disaster drill; or ope exercise or workshop that includes a group discussion, clinically-relevant, and a set of problem messages, or prepared gned to challenge an [LTC facility] facility's intain documentation of all ses, and emergency e [LTC facility] facility's needed.  3.475(d)]:  ID must conduct exercises or plan at least twice per year, the following: an annual full-scale exercise is or ommunity-based exercise is an annual individual, all exercise; or.  IID experiences an actual emergency that requires	EO	)39				

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 01/10/2020 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 34G216 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 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (X5) COMPLETION PREFIX TAG TAG DATE DEFICIENCY E 039 Continued From page 11 E 039 full-scale community-based or individual, facilitybased 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 01/10/2020 CENTERS FOR MEDICARE & MEDICAID SERVICES **FORM APPROVED** OMB NO, 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY A. BUILDING COMPLETED 34G216 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 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) E 039 Continued From page 12 E 039 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. W 214 INDIVIDUAL PROGRAM PLAN W 214 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

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STATEME	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CON	STRUCTION	(X3) DA	D. 0938-0391 TE SURVEY MPLETED
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NAME O	F PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE		/07/2020
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W 214	regarding services for Client #1 did not reciservices for the blind.  Throughout observation the was very obvious with coloring to do o and on the afternoor left sitting alone in hit television and no act 5:10pm (a period of Upon review of client #1's individual point #1's individual p	cor the blind. The finding is: delive an assessment from d. d. ditions on 1/6/20 and 1/7/20, red to feel his way around. Sly blind. Staff presented him in 1/2/20 at the day program in of 1/6/20 at home he was is room with no music, no divity from 3:30pm until 1 hour and 40 minutes.)  If #1's record on 1/6/20, program plan (IPP) dated be was legally blind. However, ment from services for the legant from services of the blind since she GHM stated that had been as GHM further acknowledged ment may help the staff work entation.	W 2	A.  B.  C.  D.  E.  F.  G.  H.		e eted sed for liview to mand	3.06,2020
	As soon as the interdiformulated a client's in each client must rece	isciplinary team has ndividual program plan, ive a continuous active					

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CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 34G216 01/07/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **VOCA-OTIS STREET HOME** 2415 OTIS STREET DURHAM, NC 27707 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) W.249 03.06.2020 This deficiency will be corrected by the W 249 Continued From page 14 W 249 following actions: treatment program consisting of needed A. All ISP'S will be reviewed and revise interventions and services in sufficient number and frequency to support the achievement of the as needed to ensure objectives of the objectives identified in the individual program use of adaptive equipment is in place plan. specifically gait belt usage. PT will be assess the need for the use of adaptive equipment. C. PT will give guidelines for the use of This STANDARD is not met as evidenced by: Based on observations, interviews and record equipment D. All adaptive equipment will be reviews, the facility failed to ensure 3 of 4 audit clients (#1, #3, #6) received a continuous active discussed in a team meeting, to treatment plan consisting of needed interventions include day program and services as identified in the Individual All adaptive equipment that will be a Program Plan (IPP) in the areas of adaptive restriction will be address at HRC. equipment use, objective implementation and F. All WTP will be reviewed all goals will leisure. The findings are: have measurable outcomes. G. All WTP will have identifiable criteria 1. Client #3's adaptive foot stool was not utilized as indicated. and outcomes H. All goals will be modified, revised, or During dinner and breakfast observations in the discontinue to meet the needs of the home on 1/6 - 1/7/20, client #3 did not utilize a peoples served foot stool while seated at the table. All consumers will be provided meaningful activities. Interview on 1/7/20 with Staff D and Staff F J. All staff will be in-service on all goals. revealed client #3 uses a foot stool wherever she All people served will be in service on is seated to help with positioning and because her their adaptive equipment feet do not touch the floor when seated. All staff will be in-service on the use Review on 1/6/20 of client #3's IPP dated 10/6/19 need and function of gait belt. revealed she should "use a foot stool while M. Vocational staff will be in serviced on having her meals for stability at the table." all adaptive equipment N. Residential Manager will monitor one Interview on 1/7/20 with the Home Manager (HM) time a week. confirmed client #3 should be using a foot stool O. Qualified Professional will monitor postioned under her feet at meals. one time a week. P. Qualified Professional will assessed

monthly in core team meeting

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
		34G216	B. WING					
NAME OF	PROVIDER OR SUPPLIER			\$7	REET ADDRESS, CITY, STATE, ZIP CODE		01/07/2020	
,	TIS STREET HOME				15 OTIS STREET URHAM, NC 27797			
(X4) ID PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DRE	COMPLETION DAYE	
W 249	2. Client #5's denta consistently.  During observations 7:30am to brush her nobody assists her whome manager conforushed her teeth w toothpaste on her br	I goal was not implemented on 1/7/20, client #5 went at teeth. She told this surveyor with toothbrushing. The group irmed this. Client #5 then ith a heaping spread of ush. She brushed for a few	W 2	49				
	and then was promp about 30 seconds. This was fine and ind lady.  After the observation	nan 20 seconds total time) ted to brush more a total of The group manager told her icated she is an independent on 1/7/20, the group home						
	manager was again a usually brushed and Review on 1/7/20 of plan (IPP) dated 12/13/1 client #5 should get n and gums, brush her brush her tongue. Thimplemented in the middle of the managemented in the middle of the managemented in the middle of the managemented in the middle of the	asked if this was the way she the manager stated it was.  client #5's individual program 12/19 revealed a goal  9. This goal indicated that naterials, brush her teeth lower teeth and gums and his goal should be nornings. The goal stated or ensure adequate brushing			.*			
		provided meaningful activity						
i v s	client #1 was observe the was very obviously with coloring to do on and on the afternoon eft sitting alone in his	ons on 1/6/20 and 1/7/20, d to feel his way around. y blind. Staff presented him 1/2/20 at the day program of 1/6/20 at home he was room with no music, no rity from 3:30pm until						

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 01/10/2020 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY DENTIFICATION NUMBER: A. BUILDING COMPLETED 34G216 B. WING 01/07/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2415 OTIS STREET **VOCA-OTIS STREET HOME** DURHAM, NC 27707 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) W 249 Continued From page 16 W 249 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 368 DRUG ADMINISTRATION W 368 W.368 CFR(s): 483.460(k)(1) This deficiency will be corrected by the 03,02.2020 following actions: The system for drug administration must assure A. All physicians orders will be that all drugs are administered in compliance with reviewed. the physician's orders. B. There will be current orders for all medication in the person This STANDARD is not met as evidenced by: serve records. Based on observations, record reviews and C. The team will ensure that all interviews, the facility failed to assure doctor's orders are implemented orders were implemented as written for 1 of 4 D. All the orders will be reviewed audit clients (#5). The finding is: and discussed at the monthly core team/quarterlies/annual Client #5's Nat Fiber was not given as ordered. ISP. E. There will be supporting During observations of the medication pass on documentation for all Orders 1/7/20, client #5 did not received the Nat fiber as RN will review monthly ordered. She received 3/4 fluid ounce or "4 Residential Manager will Drams." monitor one time a week. H. Qualified Professional will Interview with staff E after the observation on monitor one time a week 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 01/10/2020 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 34G216 B. WING 01/07/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2415 OTIS STREET **VOCA-OTIS STREET HOME** DURHAM, NC 27707 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 368 Continued From page 17 W 368 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 **DRUG ADMINISTRATION** W 369. W 369 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

Client #5's Nat Fiber was not given as ordered.

is:

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER		B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE		01/07/2020		
	VOCA-OTIS STREET HOME			2415 OTIS STREET DURHAM, NC 27707			
(X4) IC PREFIX TAG	( EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DRE	(X5) COMPLETION DATE	
W 36	During observations 1/7/20, client #5 did	ons of the medication pass on Idd not received the Nat fiber as following actions:		y the	03.06.2020		
	Interview with staff E 1/7/20 confirmed this always given client # what they were tauging Review of client #5's confirmed that the double with the final full glass of fluid. Interview with the nurconfirmed that 4 "Drawn is equal to 7.0 This is almost double interview with the nurconfirmed that converse with the nurconfirmed the converse with the converse ounded correct.	physician orders on 1/7/20 octor had ordered, "Nat Fiber off should "dissolve 3.4 grams"."  I see via phone on 1/7/20 ams" is an old measurement.  I sion table it was found that 4 og grams (asknumbers.com). If the amount ordered.  I see via phone on 1/7/20 sion measurements		<ul> <li>A. RN will assess all orders.</li> <li>B. All physician orders will be reviewed for accuracy.</li> <li>C. All staff will be in service of medication procedure and following the guidelines for measuring and dispension medications.</li> <li>D. All assessment will be reviewed and recommendations distince team, quarterly, or</li> <li>E. Staff will be in service on Medication Administration procedures.</li> <li>F. RN will monitor monthly.</li> <li>G. Residential Manager will monitor one time a week.</li> <li>H. Qualified Professional will monitor monthly.</li> </ul>	on d or g all ewed cussed ISP.	3.4	
W 382	revealed they had the a month. She further been using drams ins had these measuring DRUG STORAGE AN CFR(s): 483.460(I)(2)	ID RECORDKEEPING	W 382		A THE PARTY OF THE		

DEPAR CENTE	TMENT OF HEALTH	AND HUMAN SERVICES				FOR	ED: 01/10/2020 RM APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SLIPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER		B. WING	B. WING			01/07/2020	
VOCA-OTIS STREET HOME			2415 OTIS STREET DURHAM, NC 27707				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	I O DE	COMPLETION DATE
W 382	,	¥	WS	382	W.382  This deficiency will be corrected  following actions:	by the	03.06.2020
	Based on observation failed to assure that were kept locked except locke	administration observation, the medication technician in the hall to get a client while ocked. Later at 4:35pm, she id went to the kitchen to get in 1/6/20 after the was asked if the process diget the clients while ed. She stated that she was distinct the other staff usually her but for some reason outper the medication of the unlocked and ent sat in the medication of front of the unlocked and et. After about five minutes froom to prepare the			A. All medications will be loand secured unless being administered.  B. No medications will be loan unattended.  C. Staff will be in serviced of ensuring that all medicate remains locked except doadministration.  D. Medication Monitor Closs sheets will be completed.  E. Residential Manager will monitor one time a week.  F. Qualified Professional will monitor one time a week.	eft n ion uring et weekly.	

PRINTED: 01/10/2020 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES 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 A. BUILDING COMPLETED 34G216 B. WING 01/07/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2415 OTIS STREET **VOCA-OTIS STREET HOME** DURHAM, NC 27707 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) W 382 Continued From page 20 W 382 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. FOOD AND NUTRITION SERVICES W 460 W.460 W 460 CFR(s): 483.480(a)(1) This deficiency will be corrected by the 03.06.2020 following actions: Each client must receive a nourishing, well-balanced diet including modified and A. All physicians (dietary) orders will be reviewed. specially-prescribed diets. B. The dietitian will review all current orders, modifying as This STANDARD is not met as evidenced by: needed. Based on observations, interviews and record C. There will be current orders for reviews, the facility failed to ensure modified diets all nutritional services for the were followed for 2 of 4 audit clients (#1, #3). person serve records. The findings are: D. All diet textures will be assessed The team will ensure that all Clients (#1, #3) modified diets were not orders are implemented consistently followed at all meals. All the orders will be reviewed and discussed at the monthly a. During lunch at the day program on 1/7/20. core team/quarterlies/annual client #1 consumed spaghetti in what looked like a ground consistency. The beef and noodles G. There will be supporting were chunky to where one could still see short documentation for all Orders noodles and ground beef. It was thick and dry. H. All person serve will receive a The food; however, was consumed without well balanced diet - supporting issues. the modified or specially b. During dinner observations in the home on prescribed diets. 1/7/20 at 5:25pm, client #1 and client #3 RN will review monthly consumed chicken pot pie, mixed vegetables and Residential Manager will potatoes salad. At the meal, the pot pie was very monitor one time a week. thick, dry and chunky. The mixed vegetables and Qualified Professional will potatoes salad were chunky with visible bits of monitor one time a week

food without difficulty.

food throughout. Both clients consumed their

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 01/10/2020 CENTERS FOR MEDICARE & MEDICAID SERVICES **FORM APPROVED** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 34G216 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 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) (D PROVIDER'S PLAN OF CORRECTION PREFIX (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY W 460 Continued From page 21 W 460 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 488 DINING AREAS AND SERVICE W 488 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FOR	D: 01/10/2020 MAPPROVED O. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER		B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE			01/07/2020	
VOGA-C	VOCA-OTIS STREET HOME				2415 OTIS STREET DURHAM, NC 27707		
PREFIX TAG	LEACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENT(FYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D GE	COMPLETION DATE
W 488	1/7/20 at 7:23am aft about half of her me portion of the client's	er client #3 had consumed al, Staff F secured the upper bib around her and the	W 4	88	W.488 This deficiency will be corrected following actions:		03.06.2020
	Interview on 1/7/20 v positioned the bib in client's clothes from Review on 1/7/20 of Program Plan (IPP) of the need for a bib at the client's Communidated 9/11/19 indicat verbal cues and eats neat usinig a napkin structure.	with Staff F revealed she had this manner to keep the getting food on them.  client #3's Individual dated 10/6/19 did not identify meals. Additional review of ity/Home Life Assessment ed she eats neatly given messy food and remains with physical assistance.	1		<ul> <li>A. All ISP'S will be reviewed a revise as needed to ensure objectives are met.</li> <li>B. All adaptive equipment will assess for need.</li> <li>C. Staff will be in serviced to it a higher level of dignity will eating.</li> <li>D. Staff to be in service on click rights.</li> <li>E. Staff to be in serviced on pluse of adaptive equipment.</li> <li>F. Additional bib/clothing proviil be utilized to decrease contamination, increase sa and dignity of respect.</li> <li>A. Residential Manager will none time a week.</li> <li>B. Qualified Professional will monthly</li> </ul>	I be ncrease nile nt roper otectors cross fety	

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

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

FAX

TO: MS. WENSley-DIAP	From Immune Dear
Fax: 919 855 3795	Pages: 24
Phone: 1/19.715 8078	Date: 1/17/2020
Re:	CC:
Urgent For Review Please Commer	nt Please Reply Please Recycle
Comments:	



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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, Marilca Whack follow

. Marika Whack, Executive Director

Community Alternatives North Carolina- Southeast Region

1001 Navaho Drive suite 101 Raleigh, North Carolina, 27609

919.827.2790 cell 984.205.2630 etx. 405

mawhack@rescare.com