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

PRINTED: 11/30/2020 FORM APPROVED OMB NO. 0938-0391

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 develop and maintain a comprehensive emergency preparedness program that must be reviewed and updated at least annually. *[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 \$494.8(2(a)] Emergency Plan. The ERRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.	STATEM AND PL	MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DA	TE SURVEY MPLETED
VOCA-CREKWAY VOCA-CREKWAY PAGE SUMMARY STATEMENT OF DESCRIPTIONS (EAD TOERCICENTY NUEL THE PRECEDENCY BY THAT RESULATORY OR USE IDENTIFYING INFORMATION) E 004 Develop EP Plan, Review and Update Annually CFR(c): 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 must include, but not be limited to, the following elements: The 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 CAH\$ at \$485,825(a): Emergency preparedness program that meets the requirements. The phospital or CAHI must develop and maintain an acmprehensive emergency preparedness program that meets the requirements. The phospital or CAHI must develop and maintain a comprehensive emergency preparedness program that meets the requirements. The phospital or CAHI must develop and maintain a comprehensive emergency preparedness program that meets the requirements. The phospital or CAHI 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 program that must be reviewed and updated at least annually. *[For ESRD Facilities at §484.82(a)] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least every 2 years.			.l	B. WING		11.	/26/2020
PREFIX TAG Continue Continue		, , , , , , , , , , , , , , , , , , , ,			424 CREEKWAY DRIVE	E	
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 CAH\$ at \$485.625(a)] Emergency Plan. 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 facilities at \$484.62(a)] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least every 2 years.	PRÉF	IX (EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP	IOULD BE	(X6) COMPLETION DATE
LABORATORY DIRECTOR'S OR PROVIDER/BUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X5) DATE		CFR(s): 483.475(a) The [facility] must of Federal, State and preparedness requirements of this emergency prepare requirements of this. The emergency prepare requirements: (a) Emergency Plantand maintain an emergency 2 years. The following: * [For hospitals at §4 §485.625(a):] Emergency Plantand maintain an emergency prepared requirements. The [for equirements of this all-hazards approach all-hazards approach prepared requirements of this all-hazards approach and updated and update	comply with all applicable local emergency irements. The [facility] must and maintain a comprehensive dness program that meets the section. paredness program must imited to, the following The [facility] must develop ergency preparedness plan red], and updated at least plan must do all of the 182-15 and CAHs at the plan The [hospital or with all applicable Federal ergency preparedness hospital or CAH] must a comprehensive lness program that meets the section, utilizing an endiness plan that must be did at least annually. Is at §494.62(a):] Emergency in the plan that and updated at least every 2	TURE	This deficiency will be correct following actions: This deficiency will be correct following actions: J. The Area Supervisor vand/or update the Efficiency and/or update the Efficiency and pertinent in regarding the facility locations in the event fire, tornadoes, hurrical storms, bio terrorism, residents or other informs. K. The Area Supervisor and Supervisor will be responsively staff on the Epplan and provide documentation of doing to a member of the Admitten, or a designated representative, will monocreekway at least once through the Site Review	ed by the vill develop p plan to information s evacuation of flood, anes, winter missing rmation ind the Site onsible for e updated lg so. inistrative initor per month v process.	n r

Any deficiency statement ending with an asterisk (*) denotes adeficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 'owing 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 ways 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.

FORM CMS-2567(02-89) Previous Versions Obsolete

PRINTED: 11/30/2020 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION A BUILDING: 34G228 B. WING 11/25/2020 NAME OF PROVIDER OR SUPPLIER. STREET ADDRESS, CITY, STATE, ZIP CODE 424 CREEKWAY DRIVE **VOCA-CREEKWAY** FUQUAY VARINA, NO 27526 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ۱Ď٠ (X5) PREFIX TAG COMPLETION DATE PKEHIX TAG (EAUTI DETICIEND TIMUST RE PRECEDED BY FULL REGULATORY OR USO (DENTIFYING INFORMATION) DEFICIENCY Continued From page 1 E 004 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Emergency Preparedness: (EP) plan was reviewed and updated every two years annually. The finding is: The facility's EP plan was not reviewed or updated every two years. Review on 11/16/2020 of the facility's EP plan revealed the date of their plan was 8/14/2017. Fuffher review revealed there was not an updated plan located in the home. E 020 This deficiency will be corrected by the During an Interview on 11/16/2020, the executive following actions: director revealed she was not aware if the EP G. The Area Supervisor will update plan had been reviewed or updated every two the EP plan to include all pertinent years. E 020 Policies for Evac. and Primary/Alf. Comm. information regarding the facility's E 020 CFR(s): 483,475(b)(3) evacuation locations in the event 4. of flood, fire, tornadoes, ((b) Policies and procedures. The [facilities] must hurricanes, winter storms, blo develop and implement emergency preparedness terrorism, missing residents or policies and procedures; based on the emergency plan set forth in paragraph (a) of this section, risk other information. assessment at paragraph (a)(1) of this section. H. The Area Supervisor and the 5fte and the communication plan at paragraph (c) of Supervisor will be responsible for this section. The policies and procedures must be in-servicing staff on the updated reviewed and updated at least every 2 years. (annually for LTC). At a minimum, the policies and procedures must address the following:) EP plan and provide documentation of doing so. [(3) of (1), (2), (6)] Safe evacuation from the A member of the Administrative [facility], which includes consideration of care and team, or a designated treatment needs of evacuees; staff responsibilities; transportation; identification of representative, will monitor evacuation location(s); and primary and alternate Creekway at least once per month means of communication with external sources of through the Site Review process. assistance.

FORM CMS-2567(02-99) Previous Versions Obsoloto

Event ID WWW.11

Facility 10: 921719

If continuation sheet Page 2 of 17

DEPAI CENTI	RTMENT OF HEALTH ERS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				RINTED: 11/30/20 FORM APPROVE
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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CM		11/25/2020
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E 030	Review on 11/16/20 revealed the plan did information in regard locations in the even hurricanes, winter st residents or other en revealed there were one local high school different local they were not sure we evacuate if they need to manager (HM) confinituous accurate informational evacuate local ternate evacuate local different	20 of the facility's EP plan of not include accurate is to the facility's evacuation of flood, fire, tornadoes, orms, bio terrorism, missing nergencies. Further review instructions to relocate to it, but directions to a totally chool. In 11/16/2020, staff reported here the home would ted to during an emergency. In 11/16/2020, the home med the EP plan did not reations. Further interview information could confuse evacuate. In 11/16/2020, the executive was unaware the EP plan ite information pertaining to eations. Information pertaining to eations. Information information pertaining to eations. If the information pertaining to eations. If the information pertaining to eations. If the information plan iteral, State and local laws and updated at least every IC). The communication of the following: information for the		E 030 This deficiency will following actions: D. The Area S the EP plainformatic and containentities properties of the Area S Supervisor	Supervisor will upd in to include all per on regarding the na ct information of s oviding services, a ohysician's and leg	late tinent imes taff, s well al

DEPARTMENT OF HEALTH AND HUMAN SERVICES GENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 11/30/2020 FORMAPPROVED OMB NO. 0938-0391

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	ROVIDER OR SUPPLIER	34G228	6 Wing	STREET ADDRESS, CITY, STATE, ZIP, COL 424 CREEKWAY DRIVE FUQUAY VARINA, NG 27626	11/26/2 SE:	020	
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	§416.54(b)(2).] Safe evacuation froincludes the following includes the following including	23.748(b)(3) and ASCs at mithe [RNHC] or ASC] which ng: care needs of evacuees, ties, evacuation location(s), rhate means of external sources of BS.68(b)(1); Clinios, cies, OPT/Speech at	EO	20			

FORM CMS-2567 (02-99) Provious Versions Obsolete

Event ID: W/WNT1

Facility ID: 921719

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/30/2020 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: COMPLETED A. BUILDING 34G228 8. WING 11/25/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **424 CREEKWAY DRIVE** VOCA-CREEKWAY FUQUAY VARINA, NC 27526 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION ID PREFIX (X5) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **DEFICIENCY**) E 030 | Continued From page 4 EP plan and provide E 030 arrangement. documentation of doing so. (iii) Patients' physicians F. A member of the Administrative (iv) Other [facilities]. team, or a designated (v) Volunteers. representative, will monitor Creekway at least once per month *[For Hospitals at §482.15(c) and CAHs at §485.625(c)) The communication plan must through the Site Review process. include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement, (iii) Patients' physicians (iV) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and confact information for the following: 4. (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement, (iii) Patients' physicians. (iv) Volunteers.

FORM CMS-2567(02-98) Previous Versions Obsolete

Event ID: WVWN11

Facility ID: 921719

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PRINTED: 11/30/2020 FORMAPPROVED DEPARTMENT OF HEALTHAND HUMAN SERVICES OMB NO 0938-0391 GENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X1) PROVIDER/SUPPLIER/GLIA-(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 34G228 B. WING 11/25/2020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **424 CREEKWAY DRIVE** VOCA-CREEKWAY FUQUAY VARINA, NG 2/526 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR USC IDENTIFYING INFORMATION) COMPLETION (X4) ID PREFIX TAG JEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX DATE TAG DEFICIENCY) E 030 Continued From page 5 E 030 *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entitles providing services under arrangement. (iii) Patients! physicians. (iv) Other hospices. *[For HHAs at \$484,102(c):] The communication plan must include all of the following: (1) Names and contact information for the following). (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians Anni S. (iv) Volunteers, *(For OPOs at §486.360(c):) The communication plan must include all of the following: (2) Names and contact information for the following (i) Staff. (ii) Entities providing services underarrangement. (iii) Volunteers (iv) Other DPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure an emergency

FORM CMS-2567(02-99) Previous Versions Obsolote

preparedness (EP) communication plan was developed and maintained in compliance with Federal, State and local laws. The finding is:

Event ID: WWWN11

Facility ID: 921718

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/30/2020 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING 34G228 B. WING 11/25/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 424 CREEKWAY DRIVE **VOCA-CREEKWAY** FUQUAY VARINA, NC 27526 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG DATE TAG DEFICIENCY) E 030 Continued From page 6 E 030 The facility's EP plan did not include an updated face sheet. Review on 11/16/2020 of the facility's EP plan had the wrong contact information. Further review revealed the face sheet had the contact information for a client who was decreased. Additional review revealed a client who was admitted on 8/27/2019 information was not included. Also, the EP plan included former staff and not the new staff. E 037 This deficiency will be corrected by the During an interview on 11/16/2020, the executive following actions: director confirmed the face sheet for the facility A. The Area Supervisor and the Site contained the incorrect information. E 037 **EP Training Program** Supervisor will be responsible for E 037 CFR(s): 483.475(d)(1) the initial training/ in-servicing of all new and existing staff on the *[For RNCHIs at §403.748, ASCs at §416.54, updated EP plan and emergency Hospitals at §482.15, ICF/IIDs at §483,475, HHAs plan preparedness for the home at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12;] (1) and provide documentation of Training program. The (facility) must do all of the doing so. following: The Area Supervisor and the Site (i) Initial training in emergency preparedness Supervisor training will be policies and procedures to all new and existing staff, individuals providing services under responsible for conducting this arrangement, and volunteers, consistent with their training annually for all staff and expected roles. provide documentation of doing (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency A member of the Administrative preparedness training. team, or a designated (iv) Demonstrate staff knowledge of

emergency procedures.

(v) If the emergency preparedness policies

and procedures are significantly updated, the

representative, will monitor

Creekway at least once per month

through the Site Review process.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/30/2020 FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDENSUPPLIENCUA IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION A: BUILDING _ B. WING 34G228 11/25/2020 STREET ADDRESS CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **424 CREEKWAY DRIVE** VOGA-CREEKWAY FUQUAY VARINA, NC 27526 PRÒVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCEU TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PRECEDED BY FULL REQUILATORY OR USO IDENTIFYING INFORMATION) (X4) ID PREFIX PREFIX TAG TAG DEFICIENCY) E 037 Continued From page 7 Ifacility must conduct training on the updated policies and procedures. *(For Hospices at §418,113(d); (1) Training. The hospice must go all of the following: (I) Initial training in emergency preparedness policies and procedures to all new and existing individuals providing hospice employees, and 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 ofhers , ' (v) Majntain documentation of all emergency Garage 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 fraining in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles: (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures.

FORM CMS-2067(02-99) Previous Versions Obselete

EVENTID: WWW.11

Facility ID: 921719

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	(iv) Maintain dor	timentation of all amazzana	E 037			
	hipharchiress manni	ig. incy preparedness policies				
v.	HOU PLOCEDULES are:	Significantly undated the				
·	policies and procedu	training on the updated res.	***************************************	•	ļ.	
7	*[For LTC Facilities a	f §483.73(d)/] (1) Training	·			
	Program. The LTC fa	cility must do all of the	A THE PARTY OF THE			
	(i) Initial training	n emergency preparedness			1	
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- 1	arrangement, and voi expected role	unteers, consistent with their				
	(ii) Provide emero	lency preparedness training				
	er is got attitually.	mentation of all emergency			*	`
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	(iv) Demonstrate (mergency procedure	staff knowledge of		The second section of the second		
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C	WINE THOSE OF SHI OF SHI	38(d):](1) Training. The ne following:	40 3			, ,
1	(I) Provide initial fra	aining in emergency and procedures to all new				1
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1/37	onsistent with their ex	ment, and volunteers,	`* S	h in the state of	* .	
- 1	(ii) Provide emerge least every 2 years.	NCV Dreparedness training		and the second of the second o		··:
-	(iii) Maintain docum	entation of the training		***		
en	UV) Vemonstrate si	aff knowledge of All new personnel must		·		
be	: Viiginga and assigna	ed specific 1	ľ	,		İ
	responsibilities rega	ording the GORP's				
en	iergency plan within 2	Weeks of their first	!		Ì	ı

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PRINTED: 11/30/2020

FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X8) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER A BUILDING 11/25/2020 B. WING 34G228 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **424 CREEKWAY DRIVE** FUQUAY VARINA, NO. 27526 VOCA-CREEKWAY PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE OROSS: REFERENCED TO THE APPROPRIATE DEPICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX E 037 Continued From page 9 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 CORP 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 (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 14.6 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 with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide

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Event ID: WWWN'H

Facility ID: 921719

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CENT	RTMENT OF HEALTH ERS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES					D: 11/30/2 MAPPROV
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	PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE		/25/2020
VOCA-(PREEKWAY			424 CRE	EKWAY DRIVE Y VARINA, NC 27526		
(X4) ID PREFIX TAG	I CACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG	χ .	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO ROSS-REFERENCED TO THE APPH DEFICIENCY)	al in many states	(X5) COMPLETIC DATE
125 C Timofine to Th	emergency prepared years. This STANDARD is Based on interviews facility failed to ensur home were adequate emergency plan (EP) the clients residing in Management did not direct care staff who verseled there was a Additional review revealed there was a Additional review revealed there training. During an interview on manager (HM) confirm nave been trained in the interview revealed the rained. During an interview on irrector was not aware ave completed the EP ROTECTION OF CLIENTER (S): 483,420(a)(3) The facility must ensure the facility must ensure the facility, and as citicluding the right to file due process. Its STANDARD is not	not met as evidenced by: and record review the e direct care staff in the dy trained on the facility's . This potentially affected all the facility. The finding is: provide training for all the vork in the facility's EP plan training held on 6/24/2020. aled only four or seven staff ther review revealed there is held. 1/16/2020, the home and only four of seven staff the EP plan. Further three staff just were not 11/16/2020, the executive only four of seven staff folan training	E 0	W 125 This di follow A.		of the ct with a aire o seek ent #6. If coessing ardianship lill follow rocess has not #6 has	

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

PRINTED: 11/30/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		GOMPLETED		\cap	
		34G228	B. WING		11/2	5/2020	
NAME OF PROVIDER OR SUPPLIER VOCA-CREEKWAY				STREET ADDRESS, CITY, STATE, ZIP CODE 424 CREEKWAY DRIVE FUQUAY VARINA, NC 27526			And Advantage of the Control of the
(X4) (D ;PREFIX TAG	/EACH DEFIGIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		OBE 1	(XS) COMPLETION DATE	The state of the s
W 125	failed to ensure reg for legal guardians! This affected 1 of 4 are: Client #6 does not guardian. Review on 11/16/20 revealed there is no guardianship. Furtindividual program revealed his uncle including a behavior director stated on manager went to contincompetent are guardian. Further company was not a mangers actions. Client #6 does require him being legally dindividual program being legally dindividual program the individual program actions. Client #6 does require the individual program being legally dindividual program the individual program actions. The individual program actions toward independent this STANDARD Based on observative state of the facility that the facility is the facility that the f	parding client (#6) with a need hip appointed by the court. audit clients. The findings have documentation of a legal of the part of the p	W 1	W 240 This deficiency will be corrected	vill be client ide and regarding nence ne Site nsible for	ŧ	
Passessin;	specific information	ial program plan (IPP) included to address the usage of ence pads. The finding is:		service on the updated information.	11 115		***************************************

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/30/2020

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL/A (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING 34G228 B. WING 11/25/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE VOCA-CREEKWAY 424 CREEKWAY DRIVE FUQUAY VARINA, NC 27526 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES 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 DATE DEFICIENCY) Continued From page 12 W 240 Client #1's IPP did not include guidelines to address the usage of washable incontinence pads. During observations in the home on 9:26am, when the surveyor entered the home there where two washable incontinence pads on a couch. Further observations revealed client #1 sitting on the washable incontinence pads. Review on 11/16/2020 of client #1's IPP dated 3/13/2020 revealed there was no information in regards to the usage of washable incontinence pads. Further review revealed there was no information regarding the use of a washable incontinence pad mentioned in client #1's behavior support plan (BSP), During an interview on 11/16/2020; Staff B. revealed the use of the washable incontinence pads is part of client #1's BSP. Further interview: This deficiency will be corrected by the revealed client #1 wears disposable briefs. following actions: A. All ISP's will be reviewed and During an interview on 11/25/2020, the home manager (HM) revealed client #1 does have a revised as needed to ensure that behavior of urinating on herself. all objectives are met. W 249 PROGRAM IMPLEMENTATION W 249 Community and Home Life CFR(s): 483,440(d)(1) Assessments will be reviewed and updated for accuracy. As soon as the interdisciplinary team has formulated a client's individual program plan, C. All current goals will be assessed, each client must receive a continuous active modified, updated, or treatment program consisting of needed discontinued to meet the areas interventions and services in sufficient number identified in assessments and frequency to support the achievement of the D. Goals will be implemented after objectives identified in the individual program plan. the team meeting addressing need of the consumer

FORM CMS-2567(82-99) Previous Versions Obsolete

Event ID: WVWN11

Facility ID: 921719

If continuation sheet Page 13 of 17

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

PRINTED: 11/30/2020 FORM APPROVED OMB NO. 0938-0391

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED		
	;	34G228	B. WING _		11/25/2020	
NAME OF PROVIDER OR SUPPLIER VOCA-CREEKWAY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES				STREET ADDRESS, CITY, STAYE, ZIP CODE 424 CREEKWAY DRIVE FUQUAY VARINA, NC 27526 PROVIDER'S PLAN OF CORRECTIO	N (XS)	
(X4) ID PREFIX TAG	/FACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX : TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		
W 246	Based on observat reviews, the facility received a continuo consisting of neede identified in the indit the area of self help (#2). The finding is Client #2 was not p During observations at 4:53pm, the executed sorting are into the washing marevealed the ED puring chine and turning #2 prompted to was Review on 11/16/20 community/home litterevealed he needs measure correct and turn on washing maturn on wa	s not met as evidenced by: tions, interviews and record failed to ensure each client bus active treatment program ad interventions and services vidual program plan (IPP) in to skills for 1 of 4 audit clients rempted to wash his clothes. Is in the home on 11/16/2020 cutive director (ED) was achine. Further observations atting the detergent into the g if on. At no time was client sh his own clothes, the assessment dated 9/1/2020 verbal cues to sort his laundry, nount of soap, set dials and achine. Ton 11/25/2020, the ED ust "trying to help' client #2 PMENT	W 24	the opportunity to be independent as possible F. The Clinical Supervisor a Site Supervisor will be refor in-servicing and updated on active treatment and engagement in all activity outside of the home. G. The Site Supervisor will reform one time a week, per ship complete an observation. H. A member of the Adminities of the Adminiter fore of the Adminite	nd the sponsible sting staff client lies in and monitor ift and a sheet. istrative itor per month	

DEPAF CENTE	RTMENT OF HEALT ERS FOR MEDICAR	H AND HUMAN SERVICES RE & MEDICAID SERVICES					D: 11/30/20 MAPPROVI
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA JOENTIFICATION NUMBER:	(X2) ML A. BUIL	JLTIPLE DING	CONSTRUCTION	(X3) DA)_0938-03 TE SURVEY MPLETED
111111111111111111111111111111111111111		34G228	B. WING	;		14	/25/2020
NAME OF	PROVIDER OR SUPPLIEF		· · · · · · · · · · · · · · · · · · ·		EET ADDRESS, CITY, STATE, ZIP CODE		(<u> </u>
VOCA-0	REEKWAY				CREEKWAY DRIVE QUAY VARINA, NG 27526		
(X4) IO. PREFIX TAG	J (EACH DEFICIENCE	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	x /	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	I D BE	(X5) COMPLETIO DATE
W 436	and other devices i		W 4	1	V 436 his deficiency will be corrected ollowing actions; A. The Clinical Supervisor a	nd the	2/11/2
**************************************	Based on observatinterviews, the facilities recommended equivere furnished for 2 The findings are:	s not met as evidenced by: ions, record review and ity failed to ensure prient specifically eyeglasses t of 4 audit clients (#2, #6).			Site Supervisor will be refor ensuring that all staff served on each individual which will include the us adaptive equipment to b worn by the individual B. The Clinical Supervisor and a staff supervisor and staff supervisor and a staff supervisor and a staff supervisor a	are in- il IPP's, e of any e used o	
	their eyeglasses. 1. During observation 11/16/2020, from 9:2	ons at the home on 6am until 1:03pm and			Supervisor will be respon monitoring the implement information in everyone's regarding the use of any a equipment to be used or and this will be document	itation o ; IPP adaptive worn	
P	поgram, plan (IRP) d	0 of client #2's individual lated 9/17/2020 revealed, Eyeglasses; assist with g awake hours."	, 1.51 July 1	d .	the observation sheet as C. A member of the Administer, or a designated representative, will monit	trative	
ım	uring an interview o nanager (HM) stated 2 wore eyeglasses	n 11/24/2020, the home			Creekway at least once pe through the Site Review p	r month rocess.	,
a	uring an interview or rector (ED) stated s ore eyeglasses.	n 11/25/2020, the executive he was not aware if client #2			· · · · · · · · · · · · · · · · · · ·	Mendelle de la constante de la	
3:	During observation /16/2020, from 9:26 30pm until 7:30pm, i wear his eyeglasses	am until 1:03pm and client #6 was not promoted					
Re	view on 11/16/2020	of client #6's IPP dated	[

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

PRINTED: 11/30/2020 FORM APPROVED OMB NO. 0938-0391

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATÉ SURVEY COMPLETED	
		34G228	B. WING_		11/2	5/2020	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 424 CREEKWAY DRIVE FUQUAY VARINA, NC 27526			
(X4) ID PREFIX TAG	(FACH DEFICIENC)	(TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX YAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	() BE	COMPLETION DATE	
W 436	Eyeglasses." Addit community/Home L 7/28/2020 revealed wears independent During an interview client #6 chooses in Further interview reprompts to wear his During an interview she was not aware EVACUATION DRI CFR(s): 483.470(i). The facility must he varied conditions. This STANDARD is Based on review of the facility failed to were conducted at clients residing in the following: Review of fire drills we 3:43am, 4:10am, 4:30am,	I, "Adaptive Equipment: itional review of client #6's life Assessment dated he has eyeglasses which he ly." If on 11/16/2020, the HM stated not to wear his eyeglasses, eyealed client #6 needs verbal seyeglasses. If on 11/25/2020, the ED stated if client #6 wore eyeglasses. If on 11/25/2020, the ED stated if client #6 wore eyeglasses. It is eyeglasses. If on 11/25/2020, the ED stated if client #6 wore eyeglasses. It is eyeglasses. If on 11/25/2020, the ED stated if client #6 wore eyeglasses. It is eyeglasses. If on 11/25/2020, the ED stated if client #6 wore eyeglasses. If on 11/16/2020 revealed eyer exacuation drills waried times. This affected all ne home. The finding is: If were not conducted at varied eports on 11/16/2020 revealed ere conducted on third shift: 106am, 3:47am, 4:10am, 4am, am, 1am, and 4am. If on 11/16/2020, the executive	W 44		ted in the steed with entation, and 3rd dis	Y 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	e e
	director confirmed	the fire drills conducted on				Page 16 of 17	

If continuation sheet Page 17 of 17

PRINTED: 11/30/2020 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING 34G228 8: WING 11/25/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **424 CREEKWAY DRIVE** VOCA-CREEKWAY FUQUÂY VARINA, NO 27526 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG TAG W 441 Continued From page 16 W 441 third shift were not varied. Further interview revealed third shift hours are 11pm until 8am. FORM CMS-2567(02:59) Previous Versions Obsolete Event ID: WWWN11 Facility ID: 921719

1001 Navaho Dr., Suite 101 Raleigh, NC 27609 PHONE: (919)387-1011 FAX: (919)387-1130



Fax

To: FURANIA DAMA	From: Authin to my fire
Fax: 9/9-7/5-00795	Pages: / (including cover)
Phone: 919-8102	Date /2 / 24/2/2/
Re: Calky Dy Group Home Runa.	cc:
☐ Urgent ☐ For Review ☐ Please Comme	nt □ Please Reply □ Please Recycle

December 24, 2020

Eugenia Barnes
Facility Consultant 1
Mental Health Licensure & Certification Section
27.18 Mail Service Center
Raleigh, NC 27699-2718
919.819.8182 M
919.715.8078 F

Re: Survey Completed November 25, 2020
Survey Conducted November 16th & November 25th
Creekway Group Home
424 Creekway Drive
Fuquay Varina, NC 27526
Provider Number 34G065
MHL# -092-102

Dear Mrs. Barnes

We appreciate the courtesy extended by you while surveying the Creekway Group Home, North Carolina.

As Indicated the Plan of Correction, we have will have the deficiencies corrected for the Annual Survey Conducted on **November 25, 2020**, it will be completed by **February 1, 2021**.

.e We are committed to providing the highest possible care for the people we serve at Creekway Group Home.

If you have any questions, please contact Cynthia Bradford, Associate Executive Director at 984.205.2630 ext. 238.

Kind Regards,

, 2C.

Cynthia Bradford, Associate Executive Director

Community Alternatives North Carolina-Raleigh Region

1001 Navaho Drive, suite 101

Raleigh, NC, 27609

276.252.8193

984.205.2630 ext. 403

Cynthiabradford@rescare.com