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	(X3) DATE SURVEY COMPLETED
	34G228	A. BUILDING _____ 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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 004	Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.	E 004	E004 This deficiency will be corrected by the following actions: This deficiency will be corrected by the following actions: J. The Area Supervisor will develop and/or update the EP plan to include all pertinent information regarding the facility's evacuation locations in the event of flood, fire, tornadoes, hurricanes, winter storms, bio terrorism, missing residents or other information. K. The Area Supervisor and the Site Supervisor will be responsible for in-servicing staff on the updated EP plan and provide documentation of doing so. L. A member of the Administrative team, or a designated representative, will monitor Creekway at least once per month through the Site Review process.	2/1/21

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

ASST EXEC DIRECTOR 12/24/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 004	Continued From page 1 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Emergency 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. Further review revealed there was not an updated plan located in the home. During an interview on 11/16/2020, the executive director revealed she was not aware if the EP plan had been reviewed or updated every two years.	E 004		
E 020	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.475(b)(3) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC). At a minimum, the policies and procedures must address the following:] [(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.	E 020	E 020 This deficiency will be corrected by the following actions: G. The Area Supervisor will update the EP plan to include all pertinent information regarding the facility's evacuation locations in the event of flood, fire, tornadoes, hurricanes, winter storms, bio terrorism, missing residents or other information. H. The Area Supervisor and the Site Supervisor will be responsible for in-servicing staff on the updated EP plan and provide documentation of doing so. I. A member of the Administrative team, or a designated representative, will monitor Creekway at least once per month through the Site Review process.	2/1/21

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E 020	Continued From page 3 Review on 11/16/2020 of the facility's EP plan revealed the plan did not include accurate information in regards to the facility's evacuation locations in the event of flood, fire, tornadoes, hurricanes, winter storms, bio terrorism, missing residents or other emergencies. Further review revealed there were instructions to relocate to one local high school, but directions to a totally different local high school. During an interview on 11/16/2020, staff reported they were not sure where the home would evacuate if they needed to during an emergency. During an interview on 11/16/2020, the home manager (HM) confirmed the EP plan did not include accurate information pertaining to alternate evacuate locations. Further interview revealed the current information could confuse staff if they needed to evacuate. During an interview on 11/16/2020, the executive director revealed she was unaware the EP plan did not include accurate information pertaining to alternate evacuate locations.	E 020		
E 030	Names and Contact Information CFR(s): 483.475(c)(1) [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under	E 030	E 030 This deficiency will be corrected by the following actions: D. The Area Supervisor will update the EP plan to include all pertinent information regarding the names and contact information of staff, entities providing services, as well as clients physician's and legal representatives. E. The Area Supervisor and the Site Supervisor will be responsible for in-servicing staff on the updated	2/1/21

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E 020	Continued From page 2 *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHC] or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF, Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services, and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs, staff responsibilities and needs of the patients. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop specific policies and procedures to address emergency preparedness (EP) including evacuation locations based on a community and facility risk assessment. The finding is: The facility did not have an accurate emergency plan which included evacuation locations.	E 020		

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E 030	Continued From page 4 arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(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) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(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) 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.	E 030	EP plan and provide documentation of doing so. F. A member of the Administrative team, or a designated representative, will monitor Creekway at least once per month through the Site Review process. 2/11/21	

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E 030	Continued From page 5 *[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) Entities 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. (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 under arrangement. (iii) Volunteers. (iv) Other OPOs. (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 preparedness (EP) communication plan was developed and maintained in compliance with Federal, State and local laws. The finding is:	E 030		

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E 030	Continued From page 6 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. During an interview on 11/16/2020, the executive director confirmed the face sheet for the facility contained the incorrect information.	E 030		
E 037	EP Training Program CFR(s): 483.475(d)(1) "[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the	E 037	E 037 This deficiency will be corrected by the following actions: A. The Area Supervisor and the Site Supervisor will be responsible for the initial training/ in-servicing of all new and existing staff on the updated EP plan and emergency plan preparedness for the home and provide documentation of doing so. B. The Area Supervisor and the Site Supervisor training will be responsible for conducting this training annually for all staff and provide documentation of doing so. C. A member of the Administrative team, or a designated representative, will monitor Creekway at least once per month through the Site Review process.	2/1/21

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E 037	Continued From page 7 [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures.	E 037		

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E 037	Continued From page 8 (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include	E 037		

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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 CORF must conduct training on the updated policies and procedures. "[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. "[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide	E 037		

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E 037	Continued From page 10 emergency preparedness training at least every 2 years. This STANDARD is not met as evidenced by: Based on interviews and record review the facility failed to ensure direct care staff in the home were adequately trained on the facility's emergency plan (EP). This potentially affected all the clients residing in the facility. The finding is: Management did not provide training for all the direct care staff who work in the facility. Review on 11/16/2020 of the facility's EP plan revealed there was a training held on 6/24/2020. Additional review revealed only four or seven staff had been trained. Further review revealed there were no other trainings held. During an interview on 1/16/2020, the home manager (HM) confirmed only four of seven staff have been trained in the EP plan. Further interview revealed the three staff just were not trained. During an interview on 11/16/2020, the executive director was not aware only four of seven staff have completed the EP plan training.	E 037		
W 125	PROTECTION OF CLIENTS' RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on record review and interview, the facility	W 125	W 125 This deficiency will be corrected by the following actions: A. The Clinical Supervisor of the home will initiate contact with a family member and inquire whether he/she wants to seek legal guardianship of client #6. If not, the Clinical Supervisor of the home will initiate the processing of applying for State Guardianship for client #6. B. The Program Manager will follow up on the status of this process until the guardianship process has been completed and client #6 has been assigned an LRP to advocate for him.	2/1/21

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W 125	Continued From page 11 failed to ensure regarding client (#6) with a need for legal guardianship appointed by the court. This affected 1 of 4 audit clients. The findings are: Client #6 does not have documentation of a legal guardian. Review on 11/16/2020 of client #6's record revealed there is no documentation of guardianship. Further review of client #6's individual program plan (IPP) dated 7/28/2020 revealed his uncle has been signing his consents, including a behavior support plan (BSP). During an interview on 11/16/2020, the executive director stated on 7/17/2019 the former home manager went to court to declare client #6 was not incompetent and would not need a legal guardian. Further interview revealed the company was not aware of the former home mangers actions. Additional interview revealed client #6 does require a legal guardian, due to him being legally declared incompetent.	W 125		
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 1 of 4 audit clients (#1) individual program plan (IPP) included specific information to address the usage of washable incontinence pads. The finding is:	W 240	W 240 This deficiency will be corrected by the following actions: A. The Clinical Supervisor will be responsible for updating Client #1's IPP and BSP to include and address all information regarding the usage of the incontinence pad's for client #1. B. The Clinical Super and the Site Supervisor will be responsible for providing all staff with an in-service on the updated information.	2/1/21

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	34G228	A. BUILDING _____ 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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 240	Continued From page 12 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 revealed client #1 wears disposable briefs. During an interview on 11/25/2020, the home manager (HM) revealed client #1 does have a behavior of urinating on herself.	W 240		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.	W 249	W249 This deficiency will be corrected by the following actions: A. All ISP's will be reviewed and revised as needed to ensure that all objectives are met. B. Community and Home Life Assessments will be reviewed and updated for accuracy. C. All current goals will be assessed, modified, updated, or discontinued to meet the areas identified in assessments D. Goals will be implemented after the team meeting addressing need of the consumer	2/1/21

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W 249	Continued From page 13 This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure each client received a continuous active treatment program consisting of needed interventions and services identified in the individual program plan (IPP) in the area of self help skills for 1 of 4 audit clients (#2). The finding is: Client #2 was not prompted to wash his clothes. During observations in the home on 11/16/2020 at 4:53pm, the executive director (ED) was observed sorting and placing client #2's clothes into the washing machine. Further observations revealed the ED putting the detergent into the machine and turning it on. At no time was client #2 prompted to wash his own clothes. Review on 11/16/2020 of client #2's community/home life assessment dated 9/1/2020 revealed he needs verbal cues to sort his laundry, measure correct amount of soap, set dials and turn on washing machine. During an interview on 11/25/2020, the ED revealed she was just "trying to help' client #2 with his laundry.	W 249	F All people served will be afforded the opportunity to be independent as possible F. The Clinical Supervisor and the Site Supervisor will be responsible for in-servicing and updating staff on active treatment and client engagement in all activities in and outside of the home. G. The Site Supervisor will monitor one time a week, per shift and complete an observation sheet. H. A member of the Administrative team, or a designated representative, will monitor Creekway at least once per month through the Site Review process.	2/1/21
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces,	W 436		

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VOCA-CREEKWAY	424 CREEKWAY DRIVE FUQUAY VARINA, NC 27526

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W 436	Continued From page 14 and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure recommended equipment specifically eyeglasses were furnished for 2 of 4 audit clients (#2, #6). The findings are: A. Clients #2 and #6 were not prompted to wear their eyeglasses. 1. During observations at the home on 11/16/2020, from 9:26am until 1:03pm and 3:30pm until 7:30pm, client #2 was not prompted to wear his eyeglasses. Review on 11/16/2020 of client #2's individual program plan (IPP) dated 9/17/2020 revealed, "Adaptive Equipment: Eyeglasses; assist with vision and wear during awake hours." During an interview on 11/24/2020, the home manager (HM) stated she was not sure if client #2 wore eyeglasses. During an interview on 11/25/2020, the executive director (ED) stated she was not aware if client #2 wore eyeglasses. 2. During observations at the home on 11/16/2020, from 9:26am until 1:03pm and 3:30pm until 7:30pm, client #6 was not prompted to wear his eyeglasses. Review on 11/16/2020 of client #6's IPP dated	W 436	W 436 This deficiency will be corrected by the following actions: A. The Clinical Supervisor and the Site Supervisor will be responsible for ensuring that all staff are in-served on each individual IPP's, which will include the use of any adaptive equipment to be used or worn by the individual. B. The Clinical Supervisor and Site Supervisor will be responsible for monitoring the implementation of information in everyone's IPP regarding the use of any adaptive equipment to be used or worn and this will be documented on the observation sheet. C. A member of the Administrative team, or a designated representative, will monitor Creekway at least once per month through the Site Review process.	2/1/21

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W 436	Continued From page 15 7/28/2020 revealed, "Adaptive Equipment: Eyeglasses." Additional review of client #6's community/Home Life Assessment dated 7/28/2020 revealed he has eyeglasses which he wears independently. During an interview on 11/16/2020, the HM stated client #6 chooses not to wear his eyeglasses. Further interview revealed client #6 needs verbal prompts to wear his eyeglasses. During an interview on 11/25/2020, the ED stated she was not aware if client #6 wore eyeglasses.	W 436		
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on review of fire drill reports and interview, the facility failed to ensure fire evacuation drills were conducted at varied times. This affected all clients residing in the home. The finding is: Fire drills third shift were not conducted at varied times. Review of fire drill reports on 11/16/2020 revealed the following: Eleven fire drills were conducted on third shift: 3:43am, 4:10am, 4:06am, 3:47am, 4:10am, 4am, 3:30am, 1:30am, 4am, 1am, and 4am. During an interview on 11/16/2020, the executive director confirmed the fire drills conducted on	W 441	W 441 This deficiency will be corrected by the following actions: 2/1/21 A. Fire Drills will be conducted in the home B. Fire Drills will be conducted with the appropriate documentation, at varied times 1st, 2nd, and 3rd shifts including weekends C. Fire Drill will be conducted Monthly D. Site Supervisor will monitor one time a week E. Clinical Supervisor will monitor 1 time a week	

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W 441	Continued From page 16 third shift were not varied. Further interview revealed third shift hours are 11pm until 8am.	W 441		

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

Community Alternatives-NC

Fax

To: Eugenia Barnes **From:** Cynthia Bradford

Fax: 919-715-0878 80796 **Pages:** 19 (including cover)

Phone: 919-819-8182 **Date** 12/24/2020

Re: Cookway Group Home Survey **cc:**

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

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December 24, 2020

Eugenia Barnes
Facility Consultant 1
Mental Health Licensure & Certification Section
2718 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**.

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,

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
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