

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

PRINTED: 03/25/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G279</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/24/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>VOCA-OLIVE HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>707 EAST OLIVE STREET APEX, NC 27502</b>	
(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 263	<p><b>PROGRAM MONITORING &amp; CHANGE</b> CFR(s): 483.440(f)(3)(ii)</p> <p>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure restrictive programs were conducted with the written informed consent of a legal guardian. This affected 3 of 5 audit clients (#3, #5 and #6). The findings are:</p> <p>A. Review on 3/23/21 of client #3's behavior support plan (BSP) consents were last signed by the guardian on 3/1/19. Further review revealed client #3's behavior medications are Latuda, Cymbalta and Provelgil.</p> <p>B. Review on 3/23/21 of client #5's BSP consents were last signed by the guardian on 11/19/18. Further review revealed client #5's behavior medications are Quetiapine, Melatonin, Lorazepam, Namzaric and Methylphenidate.</p> <p>C. Review on 3/23/21 of client #6's record revealed he does not have a BSP consent signed by his guardian. Further review revealed client #6 takes the following medications for his maladaptive behaviors: Saphris, Abilify and Clonidine.</p> <p>During an interview on 3/23/21, the qualified intellectual disabilities professional (QIDP) confirmed clients #3, #5 and #6 records did not include updated BSP consents, which were signed and dated by their guardians. Further</p>	W 263	<p>W.263 This deficiency will be corrected by the following actions:</p> <ul style="list-style-type: none"> <li>A. All behavior support plans will be reviewed—for all people being served.</li> <li>B. All consent for said plans will be reviewed</li> <li>C. All consent will be current and coincide with the date of the plan.</li> <li>D. All guardians will be informed of behavior support plan</li> <li>E. All consent will be signed by the guardian before the implementation of plans</li> <li>F. Clinical personnel will review monthly in core team</li> <li>G. Plans will be updated annual or as needed to meet the need of the person being served.</li> </ul>	05.23.2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Marika Whack / M* TITLE *Executive Director* (X6) DATE *3/29/2021*

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.

**RECEIVED**

By DHSR Mental Health Licensure & Certification at 10:26 am, Mar 29, 2021

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W 263	Continued From page 1 interview revealed the facility has been waiting on client #6's BSP consents since August 2020. The QIDP stated the psychologist is the responsible person to ensure consents are done in a timely manner.	W 263		
W 340	<p><b>NURSING SERVICES</b> CFR(s): 483.460(c)(5)(i)</p> <p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record review and interview, the nursing services failed to ensure that staff were sufficiently trained in taking the temperature in regards to COVID-19 protocol. This potentially effected all clients residing in the home (#1, #2, #3, #4, #5 and #6). The finding is:</p> <p>During morning observations in the home on 3/23/21 at 9:02am, the surveyor entered the home. Further observations revealed Staff A who opened the door did not take the temperature of the surveyor. Further observations revealed Staff A did not ask the surveyor any questions regarding COVID-19 protocol.</p> <p>During morning observations in the home on 3/24/21 at 5:37am, the surveyor entered the</p>	W 340	<p>This deficiency will be corrected by the following actions:</p> <ul style="list-style-type: none"> <li>A. COVID disaster plan will be update as needed.</li> <li>B. Staff will be in-services on COVID Protocol.</li> <li>C. Consumers will be trained on the importance of face coverings.</li> <li>D. RN will Staff in services on infectious diseases</li> <li>E. RN will monitor monthly</li> <li>F. Site Supervisor will monitor three time a week.</li> <li>G. Clinical Manager will monitor two times a week</li> </ul>	05.23.2021

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W 340	Continued From page 2 home. Further observations revealed Staff B who opened the door did not take the temperature of the surveyor. Further observations revealed Staff B did not ask the surveyor any questions regarding COVID-19 protocol.  During an interview on 3/24/21, Staff B stated that everyone's temperature is taken before they enter the home. Further interview revealed all staff have been trained to ensure people entering the home take their temperature taken.  During an interview on 3/23/21, the qualified intellectual disabilities professional (QIDP) stated the staff have been trained to take the temperature of anyone entering into the home regarding COVID-19 protocols.	W 340		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1)  The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.  This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure the system of medications has been updated. This affected 3 of 5 clients (#1, #5 and #6). The findings are:  Review on 3/24/21 of client #1's physician orders revealed the last one signed by the physician was on 6/11/20. Review on 3/24/21 of client #5's physician orders revealed the last one signed by the physician was on 5/27/20. Review on 3/24/21 of client #6's physician order revealed the last one signed by the physician was on 6/11/20.	W 368	W.368 This deficiency will be corrected by the following actions:  A. All medication orders will be reviewed B. All medication will be dispensed as Prescribed C. All physicians' orders will be current and updated as needed. D. RN will ensure all orders are present E. Site Supervisor will monitor one time a week. F. Clinical Manager will monitor one time a week	05.23.2021

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W 368	Continued From page 3 Further review revealed there were no updated physician orders for clients #1, #5 and #6.  During an interview on 3/24/21, the qualified intellectual disabilities professional (QIDP) confirmed clients #1, #5 and #6 do not have updated physician orders.	W 368			
W 436	<b>SPACE AND EQUIPMENT</b> 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, 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 1 of 5 audit clients (#6). The finding is:  During observations in the home on 3/23/21, client #6 was not observed wearing his eyeglasses from 9:02am until 10:11am. Client #6 was observed playing a table top game with one of his peers. At no time was client #6 prompted to put on his eyeglasses during this time frame.  During observations in the home on 3/23/21, client #6 was not observed wearing his eyeglasses from 3:50pm until 6:18pm. Further observations revealed client #6 watching a movie on the television. At no time was client #6	W 436	W.436 This deficiency will be corrected by the following actions: A. All equipment will be maintained and in good working conditions, teaching people served on the use of said equipment B. All people severed will have full access to all equipment and encouraged to use said items C. Any equipment that is not assessable or consumer choices not to use will be address in ISP. D. If there are any rights restrictions, they will be presented to HRC. E. All people served will be in service on equipment F. All staff will be in-service on their equipment working conditions, an teaching people served on the use of said equipment G. Site Supervisor will monitor one time a week. H. Clinical Manager will monitor one time a week	05.23.2021	

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W 436	<p>Continued From page 4</p> <p>prompted to put on his eyeglasses during this time frame.</p> <p>During observations in the home on 3/24/21, client #6 was not observed wearing his eyeglasses from 6:30am until 8:45am. Further observations revealed client #6 eating breakfast and then playing a table top game with a peer. At no time was client #6 prompted to put on his eyeglasses during this time frame.</p> <p>During a review on 3/23/21 of client #6's individual program plan (IPP) dated 8/24/20 revealed, "Adaptive Equipment: Eyeglasses; assist with seeing; During awake hours."</p> <p>During a review on 3/24/21 of client #6's vision examination dated 10/23/19 revealed, "Recommendations: Continue wearing glasses."</p> <p>During an interview on 2/23/21, the qualified intellectual disabilities professional (QIDP) revealed staff should be prompting client #6 to wear his eyeglasses. Further interview revealed client #6 is to wear his eyeglasses during awake hours.</p>	W 436		
W 460	<p>FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1)</p> <p>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #2's diet was provided as prescribed. This affected 1</p>	W 460		

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W 460	<p>Continued From page 5 of 5 clients (#2). The finding is:</p> <p>During breakfast observations in the home on 3/24/21 at 7:18am, client #2 consumed five pears, which came into the table in 1/2 cut pieces. Further observations revealed Staff C asked client #2 "are those pears cut up?" Additional observations revealed Staff C did not assist client #2 with chopping up his pears. Client #2 coughed two times at 7:20am while eating the pears and 3 times at 7:22am after he finished eating them.</p> <p>During an interview on 3/24/21, Staff C revealed she should have ensured client #2's pears were chopped before he consumed them.</p> <p>Review on 2/1/21 of the homes diet list dated 2/24/21 stated client #2's food is finely chopped.</p> <p>During an interview on 3/24/21, the qualified intellectual disabilities professional (QIDP) revealed staff should ensure client #2's food is chopped before he consumes it.</p>	W 460	<p>W.460 This deficiency will be corrected by the following actions:</p> <ul style="list-style-type: none"> <li>A. Nutritionist will complete and assessment on consumers</li> <li>B. Recommendations will be added based upon assessment</li> <li>C. Nutritional assessments will be conducted to ensure proper food consistency</li> <li>D. All people served will receive a nourishing, well-balanced diet including modified and specially prescribed diets.</li> <li>E. All staff will be in service on Food consistency orders</li> <li>F. Site Supervisor will monitor one time a week.</li> <li>G. Clinical Manager will monitor one time a week</li> </ul>	05.23.2021	

March 29, 2021

Eugina Barnes, BSW QIDP  
Facility Survey Consultant I  
919.819.8182  
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: March 23<sup>rd</sup>- 24<sup>th</sup> , 2021  
VOCA-Olive Street Home  
707 East Olive Street, Apex NC 27502  
Provider Number 34G 279  
MHL# 092-121

Dear Ms. Eugina Barnes


We appreciate the courtesy extended by you while surveying the VOCA-Olive Street Home, North Carolina.

As indicated on the Plan of Correction, we will have the Deficiencies corrected for, the Annual survey conducted On March 23<sup>rd</sup>- 24<sup>th</sup> , 2021 will be completed May 23, 2021

We are committed to providing the highest possible care for the people we serve at VOCA-Olive Street Home,

If you have questions, please contact JerMaine Kearney, Program Manager  
984.205.2630 ext 218

Sincerely,



Marika Whack, Executive Director  
Community Alternatives North Carolina- Raleigh Region  
1001 Navaho Drive suite 101  
Raleigh, North Carolina, 27609  
919.827.2790 cell  
[mawhack@rescare.com](mailto:mawhack@rescare.com)

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

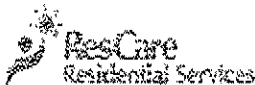
# FAX

To: Eugene Barnes From: J. Kearney  
 Fax: 919 715 8078 Pages: 7  
 Phone: 919 855 3795 Date: 3/29/2021  
 Re: \_\_\_\_\_ CC: \_\_\_\_\_

Urgent     For Review     Please Comment     Please Reply     Please Recycle

Comments: Thank you Olive Street

**RECEIVED**  
 By DHR Mental Health Licensure & Certification at 10:25 am, Mar 29, 2021



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