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 COMPLETED
	34G083	A. BUILDING _____ B. WING _____	04/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLANCHE DRIVE	6208 BLANCHE DRIVE RALEIGH, NC 27607

(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 APPRO	(X5) COMPLETION DATE
W 224	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include adaptive behaviors or independent living skills necessary for the client to be able to function in the community. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #2's Comprehensive Functional Assessment (CFA) included an accurate assessment of her meal preparation skills and abilities. This affected 1 of 4 audit clients. The finding is: During observations in the home throughout the survey on 4/12 - 4/13/21, client #2 assisted with meal preparation tasks including pouring, stirring, and mixing. The client completed various cooking tasks with physical assistance and verbal prompts from staff. Additional observations revealed client #2 setting the table with verbal prompts, clearing her dirty dishes independently and wiping the table with verbal prompts. Interview on 4/13/21 with Staff A revealed client #2 can complete cooking tasks such as pouring and mixing and will also set the table. Additional interview indicated the client can perform the tasks mainly with physical assistance and verbal prompts. Review on 4/13/21 of client #2's Community Home Life Assessment (CHLA) dated 1/12/21 revealed "Not applicable" for the client's ability to make and pack lunches, make foods with no cooking, cooking, cooking and mixing. The CHLA also noted the client was "Dependent" regarding	W 224	W 224 This deficiency will be corrected by the following actions: A. All ISP's and assessments will be reviewed and updated. B. All Assessments will be updated to address the current needs and abilities of the consumer C. All staff will be in-serviced on all ISP's, assessments, and proper documentation. D. Site Supervisor will monitor one time a week E. Qualified Professional will monitor one time a week	6/13/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ivanita Jefferson AH | TITLE: Program Manager | (X6) DATE: 4/21/2021

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.

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W 224	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include adaptive behaviors or independent living skills necessary for the client to be able to function in the community. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #2's Comprehensive Functional Assessment (CFA) included an accurate assessment of her meal preparation skills and abilities. This affected 1 of 4 audit clients. The finding is: During observations in the home throughout the survey on 4/12 - 4/13/21, client #2 assisted with meal preparation tasks including pouring, stirring, and mixing. The client completed various cooking tasks with physical assistance and verbal prompts from staff. Additional observations revealed client #2 setting the table with verbal prompts, clearing her dirty dishes independently and wiping the table with verbal prompts. Interview on 4/13/21 with Staff A revealed client #2 can complete cooking tasks such as pouring and mixing and will also set the table. Additional interview indicated the client can perform the tasks mainly with physical assistance and verbal prompts. Review on 4/13/21 of client #2's Community Home Life Assessment (CHLA) dated 1/12/21 revealed "Not applicable" for the client's ability to make and pack lunches, make foods with no cooking, cooking, cooking and mixing. The CHLA also noted the client was "Dependent" regarding	W 224	W 224 This deficiency will be corrected by the following actions: A. All ISP's and assessments will be reviewed and updated. B. All Assessments will be updated to address the current needs and abilities of the consumer C. All staff will be in-serviced on all ISP's, assessments, and proper documentation. D. Site Supervisor will monitor one time a week E. Qualified Professional will monitor one time a week	6/13/2021

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

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W 224	Continued From page 1 her ability to set the table correctly, taking dirty dishes to the kitchen and wiping the table. Additional review of the client's Individual Program Plan (IPP) dated 1/12/21 indicated, "[Client #2] requires mostly verbal prompting, as well as some hand-over-hand support to complete ADL tasks." Interview on 4/13/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #2's CHLA was not an accurate representation of her meal preparation skills.	W 224		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) 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. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 2 of 4 audit clients (#1 and #6). The findings are: A. Review on 4/12/21 of client #1's Behavior Support Plan (BSP) dated 11/1/19 revealed objectives to exhibit 1 or fewer episodes of self-injurious behavior per month for 12 consecutive months and to exhibit 0 episodes of inappropriate verbalizations per month for 12 consecutive months. The BSP incorporated the use of Paxil. Additional review of the record revealed a consent for the BSP dated 11/1/19 which had not been signed by the guardian. The	W 263	W 263 This deficiency will be corrected by the following actions: A. All behavioral support plans will be reviewed. B. All Behavioral Support Plans will be updated to address the current needs and technique to manager inappropriate behavior C. All proper techniques will be used to manage behaviors D. Psychologist will review all plans. E. Qualified Professional will review and obtain informed guardian consent for all plans before implementation F. All staff will be in-serviced on all Behavioral Support Plans and proper documentation. G. Site Supervisor will monitor one time a week H. Qualified Professional will monitor one time a week	6/13/2021

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W 263	Continued From page 2 consent noted, "I understand that this authorization will expire on 11/1/20 and will not exceed one year from the date of my original authorization." No current consent could be located. Interview on 4/13/21 with the Qualified Intellectual Disabilities Professional (QIDP) indicated no current consent was available for review. B. Review on 4/12/21 of client #6's BSP dated 11/1/19 revealed objectives to exhibit 0 episodes of non-compliance per month for 12 consecutive months, to exhibit 0 episodes of physical aggression per month for 12 consecutive months and to exhibit 3 or fewer episodes of stealing food per month for 12 consecutive months. The BSP incorporated the use of Adderall XR, Lorazepam, Melatonin and Clonazepam. Additional review of the record revealed a consent for the BSP signed by the guardian on 11/1/19. The consent noted, "I understand that this authorization will expire on 11/1/20 and will not exceed one year from the date of my original authorization." No current consent could be located. Interview on 4/13/21 with the QIDP indicated no current consent was available for review.	W 263		
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, and other devices identified by the interdisciplinary team as needed by the client.	W 436	W 436 This deficiency will be corrected by the following actions: A. All ISP's will be reviewed and updated to reflect the current needs of the consumer. B. All staff will be in-serviced on all ISP's. C. Site Supervisor will monitor one time a week D. Qualified Professional will monitor one time a week	6/13/2021

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W 436	Continued From page 3 This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #2 was furnished eye glasses as identified in the Individual Program Plan (IPP). This affected 1 of 4 audit clients. The finding is: During observations throughout the survey on 4/12 - 4/13/21, client #2 did not wear eye glasses. The client was not prompted or encouraged to wear eye glasses. Review on 4/12/21 of client #2's IPP dated 1/12/21 revealed under Adaptive Equipment, "Glasses". Additional review of the plan noted the eye glasses were used to "Improve vision" and should be used "As [Client #2] would like to". The IPP indicated, "[Client #2] does not like wearing her glasses and does not display any negative repercussions from not wearing them...her glasses will remain available for whenever she would like to use them..." Interview on 4/13/21 with the Qualified Intellectual Disabilities Professional (QIDP) and Home Manager (HM) indicated client #2 currently does not have eye glasses available for use in the home.	W 436		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.	W 460		

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W 460	Continued From page 4 This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure client #3 received a modified diet as indicated. This affected 1 of 4 audit clients. The finding is: During breakfast observations in the home on 4/13/21 at 7:18am, client #3 was assisted to serve herself oatmeal. The oatmeal was thick, dry and lumpy. The client consumed the oatmeal without difficulty. Interview on 4/13/21 with Staff A revealed client #3 consumes a pureed diet and her food should be processed in the food processor, "soft" and looks like "applesauce". The staff acknowledged client #3's oatmeal was not blended in the food processor. Review on 4/13/21 of client #3's Individual Program Plan (IPP) dated 2/18/21 revealed she consumes a regular, high fiber pureed diet. Additional review of documentation located in the kitchen of the home noted pureed food should be processed and blended and looks "like baby food." Interview on 4/13/21 with the Home Manager (HM) confirmed client #3 consumes a pureed diet and all of her food should be blended in the food processor.	W 460	W 460 This deficiency will be corrected by the following actions: A. All ISP's will be reviewed and updated to reflect the current needs of the consumer. B. All staff will be in-serviced on all ISP's to include information such as special diets and adaptive equipment. C. Site Supervisor will monitor one time a week D. Qualified Professional will monitor one time a week	6/13/2021

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

Community Alternatives-NC

Fax

To: Wilma Worsley-Diggs **From:** Juanita Jefferson
Fax: 919-715-8078 **Pages:** 7 (including cover)
Phone: 919-612-5220 **Date** 4/15/2021
Re: Blanche Drive Survey **cc:**

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

April 15, 2021

Wilma Worsley-Diggs
Facility Consultant 1
Mental Health Licensure & Certification Section
2718 Mail Service Center
Raleigh, NC 27699-2718
919.612.5220 M
919.715.8078 F

Re: Survey Completed April 13, 2021
Blanche Drive Group Home
6208 Blanche Drive
Raleigh, NC 27607
Provider Number 34G083
MHL# -092-057

Dear Mrs. Worsley-Diggs

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

As indicated the Plan of Correction, we have will have the deficiencies corrected for the Annual Survey Conducted on **April 13, 2021** it will be completed by **June 13, 2021.**

We are committed to providing the highest possible care for the people we serve at Blanche Drive 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
Cynthiabradford@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: Worsley-Diggs From: Kearney

Fax: 919 715 8078 Pages: 1

Phone: 919 612 5220 Date: 4/21/21

Re: CC:

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

Comments: Correct page - Thank You