

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-261	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER REGIS AVENUE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 4425 REGIS AVENUE DURHAM, NC 27705		
(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) COMPLETE DATE
V 000	INITIAL COMMENTS An annual survey was completed on October 6, 2021. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.	V 000	<p>DHSR - Mental Health</p> <p>OCT 28 2021</p> <p>Lic. & Cert. Section</p>	
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure facility grounds were kept free from offensive odor. The findings are: Observation on 10/6/21 at approximately 1:20 pm of the facility revealed the following issues: -Hallway area near client #3's bedroom-There was a strong urine odor. -Client #3's bedroom-There was a strong urine odor. Interview on 10/6/21 with the Division Director revealed: -The urine odor in those areas of the home was due to client #3 having issues with incontinence. -Client #3 would urinate on the bed and possibly on the floor sometimes if she couldn't make it to the bathroom in time.	V 736		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6559

PLSH11

If continuation sheet 1 of 2

Elizabeth Scott Executive Director 10/27/21

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-261	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/06/2021
NAME OF PROVIDER OR SUPPLIER REGIS AVENUE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4425 REGIS AVENUE DURHAM, NC 27705		
(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) COMPLETE DATE
V 736	Continued From page 1 -Client #3 wore diapers and still had accidents. -She thought the urine odor was now embedded in the carpet in her bedroom. -The agency had reached out to the ARC of North Carolina. -The agency put in a request to have the carpet be removed and hardwoods floors put down in certain areas of the home. -She could not remember when the agency made that request to the ARC of North Carolina. -She confirmed facility staff failed to ensure facility grounds were kept free from offensive odor.	V 736			

Durham County Community Living Programs, Inc.

Post Office Box 51159
Durham, N.C. 27717-1159
(919) 489-0682

Regis Avenue Group Home
MHL # 032-261

Plan of Correction to Survey Completed 10/06/2021

DHSR - Mental Health

OCT 28 2021

Lic. & Cert. Section

V 736 27G.0303(c) Facilities and Grounds *ES*
~~V 118 27G.0219 (C) Medication Requirements:~~

To Correct the Deficiency: The rule is not met based on a urine odor by and in bedroom #3. The consumer in bedroom #3 has incontinence issues, and wears a diaper. Staff reminds her to go to the bathroom the last thing before she goes to bed, and the first thing in the morning. We also have on-site a carpet cleaner. In addition, we have previously requested from the Arc of NC, the owner, to replace the carpeting with laminate or hard wood floors.

We are sending a copy of this report to Arc of NC to let them be aware of this citation, and to request again that the flooring be changed. We will call in a professional carpet cleaner again, and we will continue to use our own carpet cleaner in the home.

To Prevent the Deficiency from Occurring Again: As stated above, we will request that the flooring be changed to one that is more conducive to cleaning the urine. We will call in a professional carpet cleaner (we usually do this twice per year anyhow) to professionally clean the carpet. We will continue to use the home carpet cleaner to clean up between professional cleaning. In addition, we will continue to prompt the consumer to use the bathroom more frequently and as needed.

Who will Monitor: The managers who are live-in staff are responsible to monitor the situation on a daily basis, and perform carpet cleaning as needed. The Division Director (program supervisor) is responsible for monitoring the home.

How Often the Monitoring will Take Place: Monitoring by the managers will take place daily. The Division Director will monitor at least monthly, but is normally in the home multiple times per week and will monitor the odor during those visits.



Elizabeth Scott, BS, QDDP
Executive Director
October 22, 2021

Durham County Community Living Programs, Inc.

P.O. Box 51159 Durham, NC 27717-1159

(919) 489-0682

DHSR - Mental Health

OCT 28 2021

Lic. & Cert. Section

Fax

To: *Kimberly Sauts*
DHSR

From: *Elizabeth Scott*
Extension #: *24*

Fax: *919-715-8078*

Pages: *7* (including cover)

Phone: *919-855-3795*

Date: *10/22/21*

Re: *Regis Avenue Group Home* CC:

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

● Comments:

MHL-032-261

I will mail the original today.

Thank you!
Elizabeth

This fax, including any attachments, is for the sole use of the sender and intended recipient(s) and may contain confidential information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply fax or telephone and destroy all copies of the original message.

Durham County Community Living Programs, Inc.

Fax Number: (919) 493-0869

TRANSMISSION VERIFICATION REPORT

TIME : 10/22/2021 11:15
NAME : DCCLP
FAX : 9194930869
TEL : 9194890682
SER.# : BROJ1J598192

DATE, TIME	10/22 11:13
FAX NO./NAME	9197158078
DURATION	00:02:01
PAGE(S)	06
RESULT	OK
MODE	STANDARD



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

October 12, 2021

Elizabeth Scott, Executive Director
Durham County Community Living Programs, Inc.
P.O. Box 51159
Durham, NC 27717

DHSR - Mental Health

OCT 28 2021

Lic. & Cert. Section

Re: Annual Survey completed October 6, 2021
Regis Avenue Group Home, 4425 Regis Avenue, Durham, NC 27705
MHL # 032-261
E-mail Address: ewscott-dcclp@ncrrbiz.com

Dear Ms. Scott:

Thank you for the cooperation and courtesy extended during the Annual survey completed October 6, 2021.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- All tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiency must be **corrected** within 60 days from the exit of the survey, which is 12/5/21.

What to include in the Plan of Correction

- Indicate what measures will be put in place to **correct** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to **prevent** the problem from occurring again.
- Indicate **who will monitor** the situation to ensure it will not occur again.

MENTAL HEALTH LICENSURE & CERTIFICATION SECTION

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603
MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718
www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

10/12/21
Regis Avenue Group Home
Elizabeth Scott

- Indicate **how often** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Bryson Brown at 919-855-3822.

Sincerely,



Kimberly R Sauls
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc:

DHSR@Alliancebhc.org
Pam Pridgen, Administrative Assistant