

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

PRINTED: 04/29/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2022
NAME OF PROVIDER OR SUPPLIER BLANCHE DRIVE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 125	<p>PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3)</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure client #5 had the right to a legal guardian. This affected 1 of 3 audit clients. The finding is:</p> <p>Review on 4/25/22 of client #5's individual program plan (IPP) dated 9/16/21 revealed client #5 has a diagnosis that includes Profound Intellectual Disability, Unspecified Disruptive Impulse Control/Conduct Disorder, Cerebral Palsy, Quadriplegia and a Seizure Disorder. Further review of client #5's IPP revealed she does not currently have a legal guardian.</p> <p>Interview on 4/26/22 with the executive director confirmed client #5 does not currently have a legal guardian.</p>	W 125	<p>W125 This deficiency will be corrected by the following actions:</p> <ul style="list-style-type: none"> A. All community/ home assessment will be reviewed to look at all current needs of persons served. B. Core Team will address all guardianship issues. C. Qualified professional will follow up with the Department of Social Services to petition their assistance with obtaining guardianship. D. Adequate supervision will be provided for consumers to ensure all current needs are being met until a guardian has been assigned. E. Qualified Professional will monitor and complet 	06.25.2022	
W 247	<p>INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi)</p> <p>The individual program plan must include opportunities for client choice and self-management.</p> <p>This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that 1 of 3 audit clients (#4) received a choice of a nutritious meal. The finding is:</p> <p>During breakfast observations in the home on</p>	W 247			

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

Marika Whack / *JK* Executive Director 5/9/2022

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 04/29/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2022
NAME OF PROVIDER OR SUPPLIER BLANCHE DRIVE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 247	Continued From page 1 4/26/22 at 7:51am, client #4 drunk a cup of coffee and ate two cut pieces of toast. On her plate were sliced bananas and cooked oatmeal. Client #4 showed no interest in her food and never took a bite. After 15 minutes, client #4 got up and left the table. The home manager asked client #4 to return to the table to clear her dishes. The HM did not offer client #4 any food substitutions for breakfast. Interview on 4/26/22 with the HM, she acknowledged client #4 was not offered something else to eat for breakfast. Interview on 4/26/22 with the executive director revealed that he observed Staff C, Staff A and the HM not offer client #4 a breakfast alternate when she refused to eat what was served on the menu.	W 247	W247 This deficiency will be corrected by the following actions: A. All ISP'S will be reviewed and revise as needed to ensure objectives of the use of adaptive equipment is in place specifically gait belt usage. B. Nutritionist will assess all diets. C. Staff will in serviced on meal substitutions D. All staff will be in serviced on Diets of people served E. Nutritionist will in-service staff. F. Site Manager will monitor one time a week while doing home observations G. Qualified Professional will monitor one time a week while doing home observations	06.25.2022	
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. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 2 of 3 audit clients (#3 and #4) received a continuous active treatment program consisting of needed interventions and services as identified in the	W 249			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 04/29/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2022
NAME OF PROVIDER OR SUPPLIER BLANCHE DRIVE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 249	<p>Continued From page 2</p> <p>Individual Program Plan (IPP) in the areas of program implementation regarding meal guidelines; and positioning guidelines, the use of adaptive devices and foot stool. The findings are:</p> <p>A. During lunch observations in the home on 4/25/22 at 12:30pm, Staff A served bite size pieces of deli meat and vegan cheese sandwich, sliced clementine oranges, V-8 juice and water to client #4. Client #4 was 2 of 5 clients sitting at the table, who was independent with feeding. Client #4 sat at the end of the table and consumed her beverages and food rapidly, while Staff B stood with her back turned to client #4 and fed client #3; Staff A stood and faced client #2 who was assisted with eating and the home manager (HM) stood to feed client #5, faced away from client #4. None of the staff sat next to client #4 during the course of her meal. Client #4 did not consistently use her utensils and took a sandwich portion off of client #2's plate and ate it before staff could intervene.</p> <p>During dinner observations in the home on 4/25/22 at 5:10pm, the HM assisted client #4 scoop shredded baked chicken, cooked carrots, and beans on her plate for dinner. Client #4 was given a fork and spoon. Staff A stood with her back to client #4 to feed client #2, Staff D fed client #5 and the HM stood next to client #1. Client #4 did not have any staff sitting next to her at the meal. Client #4 finished her drinks before she began eating large pieces of chicken, and overstuffed her mouth, eating at a face pace. An additional observation at the conclusion of dinner, client #4 noticed client #1's spilled food on the floor. Client #4 reached down to eat a piece of food off the floor but the HM took it away. When the HM resumed assisting to clear the table,</p>	W 249	<p>W.249 This deficiency will be corrected by the following actions:</p> <ul style="list-style-type: none"> A. All ISP'S will be reviewed and revise as needed to ensure objectives are met. B. Nutritionist will assess all diets, and modify as needed. C. Nutritionist will review all diets written by physician simplifying the orders written to be better understood. (laymen terms) D. Meal assessments will be completed on all people served. E. All current goals will be assess, modified, update or discontinued to meet meal assessment needs. F. Goals will be implemented after team meeting. G. Staff will be present while consumers are eating to ensure safety during meal time H. PT will be assess the need for the use of adaptive equipment. I. PT will give guidelines for the use of equipment J. All adaptive equipment will be discussed in a team meeting, to include day program K. OT will be assess the need for the use of adaptive equipment. L. OT will give guidelines for the use of equipment M. All adaptive equipment will be discussed in a team meeting, to include day program 	06.25.2022	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 04/29/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2022
NAME OF PROVIDER OR SUPPLIER BLANCHE DRIVE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 249	<p>Continued From page 3</p> <p>client #4 reached down on the floor and picked up three more pieces of food and ate them, while no one noticed.</p> <p>Review on 4/25/22 of client #4's IPP dated 5/11/21 revealed client #4 was noted to eat too fast at meals and needed to have meat cut into bite size pieces. Staff needed to sit within arm's reach at all meals. Staff to encourage client #4 to put down her spoon after every bite.</p> <p>Interview on 4/26/22 with the HM, who acknowledged that staff did not sit next to client #4 during her meals and that she did not observe client #4 eating the other food debris off of the floor.</p> <p>B. During observations in the home at lunch and dinner on 4/25/22 and breakfast on 4/26/22, client #3 was observed sitting in a wheelchair with a chest harness. Throughout the meal time observations, client #3 was observed to lean forward and to her left side.</p> <p>Review on 4/25/22 of client #3's IPP dated 2/18/22 revealed she is supported by a wheelchair with chest harness to provide proper positioning when dining.</p> <p>Review on 4/26/22 of client #3's Positioning Guidelines dated 1/21 revealed, "secure chest harness across her chest at all four points to improve sitting position."</p> <p>Interview on 4/26/22 with Staff C revealed client #3 should be seated in an upright position when she is eating.</p> <p>Interview on 4/26/22 with the executive director</p>	W 249	<p>W.249 (continued)</p> <p>This deficiency will be corrected by the following actions:</p> <ul style="list-style-type: none"> N. All adaptive equipment that will be a restriction will be address at HRC. O. All people served will be afforded the opportunity to participate and assist in cutting food. P. All people served will be afforded the opportunity to be as independent as possible while preparing and while eating. Q. All staff will be in serviced of all diets R. All staff will be in service on active treatment - independence while eating S. Site Supervisor will monitor one time a week. T. Qualified Professional will monitor one time a week. 	06.25.2022	

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

PRINTED: 04/29/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2022
NAME OF PROVIDER OR SUPPLIER BLANCHE DRIVE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 249	<p>Continued From page 4</p> <p>confirmed client #3 should be sitting in an upright position when she is eating.</p> <p>C. During observations in the home throughout the survey on 4/25/22 - 4/26/22, client #3 was observed wearing a gait vest. Throughout the observations, client #3 was observed to ambulate in her home with staff holding her arm/elbow or by holding her fingers.</p> <p>Review on 4/25/22 of client #3's IPP dated 2/18/22 revealed client #3 is supported with a gait vest that is to be used while ambulating for the purpose of ambulation, physical redirection and to prevent/minimize falls.</p> <p>Interview on 4/26/22 with Staff C revealed staff should always assist client #3 with ambulating by holding the gait vest as she is a risk for falls.</p> <p>Interview on 4/26/22 with the executive director confirmed that when client #3 is ambulating, staff should be holding the back of the gait vest.</p> <p>D. During observations in the home throughout the survey on 4/25/22 - 4/26/22, client #3 was observed to sit in various locations in the home such as a chair on the front porch, in the living room and in the medication room. During the observations, client #3's feet did not touch the floor. A foot stool was located in the living room of the home but at no time was the foot stool provided for client #3 to put her feet on.</p> <p>Review on 4/25/22 of client #3's IPP dated 2/18/22 revealed client #3 utilizes a foot stool when sitting to assist with proper positioning.</p> <p>Interview on 4/26/22 with Staff C revealed client</p>	W 249			

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

PRINTED: 04/29/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2022
NAME OF PROVIDER OR SUPPLIER BLANCHE DRIVE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 249	Continued From page 5 #3's foot stool should be used anytime she is sitting up.	W 249			
W 262	<p>Interview on 4/26/22 with the executive director confirmed client #3 should utilize a foot stool anytime she is sitting up and her feet do not touch the floor to assist with proper positioning.</p> <p>PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i)</p> <p>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the restrictive behavior techniques for 2 of 3 audit clients (#3 and #5) was reviewed and monitored by the human rights committee (HRC). The findings are:</p> <p>A. Review on 4/25/22 of client #3's individual program plan (IPP) dated 2/18/22 revealed an objective for client #3 to display zero episodes of physical aggression and non-compliance. Review on 4/25/22 of client #3's Behavior Support Plan (BSP) dated 6/9/21 revealed no review or consent by the HRC.</p> <p>Interview on 4/26/22 with the executive director confirmed that based on the consent located in the record, client #3's BSP was not reviewed or consented to by the HRC.</p> <p>B. Review on 4/25/22 of client #5's IPP dated 9/16/21 revealed an objective for client #5 to display zero episodes of non-compliance and</p>	W 262	<p>W262 This deficiency will be corrected by the following actions:</p> <ul style="list-style-type: none"> 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 guardian consent. F. Qualified Professional will have consented BSP reviewed and signed by HRC representative G. All staff will be in-service on all Behavioral Support Plans and proper documentation. H. Site Supervisor will monitor one time a week I. Qualified Professional will monitor one time a week 	06.25.2022	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 04/29/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2022
NAME OF PROVIDER OR SUPPLIER BLANCHE DRIVE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 262	Continued From page 6 physical aggression and one or fewer episodes of inappropriate verbalizations. Review on 4/25/22 of client #5's BSP dated 6/9/21 revealed no review or consent by the HRC.	W 262			
W 263	Interview on 4/26/22 with the executive director confirmed that based on the consent located in the record, client #5's BSP was not reviewed or consented to by the HRC. 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 3 audit clients (#3 and #5). The findings are: A. Review on 4/25/22 of client #3's Individual Program Plan (IPP) dated 2/18/22 revealed client #3 is supported by co-guardians. Further review of client #3's IPP revealed an objective for client #3 to display zero episodes of physical aggression and non-compliance. Review on 4/25/22 of client #3's Behavior Support Plan (BSP) dated 6/9/21 revealed only one guardian had authorized and consented to the BSP. Interview on 4/26/22 with the executive director confirmed written informed consent for client #3's BSP had not been obtained by both co-guardians.	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 consents will have all of he legal representatives. G. All staff will be in-service on all Behavioral Support Plans and proper documentation. H. Site Supervisor will monitor one time a week I. Qualified Professional will monitor one time a week	06.25.2022	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 04/29/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2022
NAME OF PROVIDER OR SUPPLIER BLANCHE DRIVE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 263	Continued From page 7 B. Review on 4/25/22 of client #5's IPP dated 9/16/21 revealed an objective for client #5 to display zero episodes of non-compliance and physical aggression and one or fewer episodes of inappropriate verbalizations. Review on 4/25/22 of client #5's BSP dated 6/9/21 revealed no consent by a legal guardian. Interview on 4/26/22 with the executive director confirmed written informed consent for client #5's BSP had not been obtained.	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. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to furnish 1 of 3 audit clients (#3) a wheelchair in good repair. The finding is: During observations in the home at lunch and dinner on 4/25/22 and breakfast on 4/26/22, client #3 was observed sitting in a wheelchair with a chest harness. The back of the chest harness on the left side was attached to the wheelchair with a bolt/screw, while the right side of the chest harness was unattached from the screw hole and tied in a knot around the handle of the wheelchair. Throughout the meal time observations, client #3 was observed to lean	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 C. Any equipment that is not assessable 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. Residential Manager will monitor one time a week. H. Qualified Professional will monitor one time a week	06.25.2022	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 04/29/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2022
NAME OF PROVIDER OR SUPPLIER BLANCHE DRIVE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 436	Continued From page 8 forward and to her left side. Review on 4/25/22 of client #3's Individual Program Plan (IPP) dated 2/18/22 revealed she is supported by a wheelchair with chest harness to provide proper positioning when dining. Review on 4/26/22 of client #3's Positioning Guidelines dated 1/21 revealed, "secure chest harness across her chest at all four points to improve sitting position." Interview on 4/26/22 with Staff C revealed she does not know how long the chest harness strap had been broken. Staff C confirmed it is difficult to position client #3 in a proper, upright position due to the strap being broken. Interview on 4/26/22 with the home manager revealed she had noticed on 4/25/22 that the buckle of client #3's chest harness was broken, but was not sure how long the strap had been broken.	W 436			
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility did not conduct the appropriate number of fire drills, per quarter. This had the potential to affect all clients (#1, #2, #3, #4, #5 and #6). During record review on 4/26/22 of the facility's fire drill log, it revealed there was no documented fire drills during May, June and July 2021.	W 440	W.440 This deficiency will be corrected by the following actions: A. Fire drill will be conducted in the home B. Fire drills will be conducted with appropriate documentation, at varied times 1 st , 2 nd , and 3 rd shifts including weekends C. Fire drill will be conducted monthly D. Fire drill will be conducted monthly E. Disaster Drills will be conducted as scheduled throughout the year. F. Residential Manager will monitor one time a week. G. Qualified Professional will monitor one time a week	06.25.2022	

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

PRINTED: 04/29/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2022
NAME OF PROVIDER OR SUPPLIER BLANCHE DRIVE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 440	Continued From page 9 Interview on 4/26/22 with the home manager revealed she pulled the fire drills from last year and did not retain all the copies.	W 440			
W 441	Interview on 4/26/22 with the executive director (ED) stated that they needed to have a system to store the fire drills after they have been completed. EVACUATION DRILLS CFR(s): 483.470(i)(1) and under varied conditions to- This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure fire drills were conducted at varying times and conditions. This potentially affected all clients residing in the home (#1, #2, #3, #4, #5 and #6). The findings is: Review on 4/26/22 of facility's fire drill reports for July 2021-April-2022 revealed the fire drills were not conducted during varied times for all three shifts. Interview on 4/26/22 with the home manager revealed she did not know the drills had to be done at different times.	W 441	W441 This deficiency will be corrected by the following actions: A. Fire drill will be conducted in the home B. Fire drills will be conducted with appropriate documentation. C. Fire drill will be conducted monthly one per shift per month. D. Disaster Drills will be conducted as scheduled throughout the year. E. Site Supervisor will monitor one month F. Qualified Professional will monitor one time a week	06.25.2022	