DEPART	MENT OF HEALTH	AND HUMAN SERVICES			'		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			(MB NO.	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		E SURVEY IPLETED
		34G216	B. WING	;		08/	24/2022
NAME OF F	PROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-O	TIS STREET HOME				2415 OTIS STREET DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIN DEFICIENCY)) BE	(X5) COMPLETION DATE
E 039	EP Testing Require CFR(s): 483.475(d) §416.54(d)(2), §418 §460.84(d)(2), §482 §483.475(d)(2), §482 §485.625(d)(2), §48 §491.12(d)(2), §494 *[For ASCs at §416 "Organizations" und §485.920, RHCs/F0 Facilities at §494.62 (2) Testing. The [fact to test the emergen must do all of the fo (i) Participate in a for community-based of (A) When a comm accessible, conduct exercise every 2 yee (B) If the [facilit natural or man-made activation of the emergen exempt from engage community-based of functional exercise actual event. (ii) Conduct an add years, opposite the functional exercise	ements (2) 8.113(d)(2), §441.184(d)(2), 2.15(d)(2), §483.73(d)(2), 84.102(d)(2), §485.68(d)(2), 35.727(d)(2), §485.920(d)(2), 4.62(d)(2). 6.54, CORFs at §485.68, OPO, der §485.727, CMHCs at QHCs at §491.12, and ESRD 2]: cility] must conduct exercises here plan annually. The [facility] blowing: ull-scale exercise that is every 2 years; or unity-based exercise is not t a facility-based functional ears; or y] experiences an actual de emergency that requires hergency plan, the [facility] is jing in its next required following the onset of the itional exercise at least every 2 year the full-scale or under paragraph (d)(2)(i) of ucted, that may include, but is	1	; D39	DEFICIENCY)	PRIATE	DATE
	(A) A second full-sc community-based of functional exercise;(B) A mock disaster	cale exercise that is or individual, facility-based or					
LABORATOR	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	VATURE		TITLE		(X6) DATE

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.

PRINTED: 08/25/2022

		AND HUMAN SERVICES				FORM	08/25/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		34G216	B. WING	·		08/;	24/2022
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	a facilitator and incl a narrated, clinically scenario, and a set directed messages, designed to challen (iii) Analyze the [fac maintain documents exercises, and eme [facility's] emergend *[For Hospices at 4 (2) Testing for hosp patient's home. The exercises to test the annually. The hosp (i) Participate in a f community based e (A) When a commu accessible, conduct functional exercise (B) If the hospice ex- man-made emergent the emergency plan engaging in its next community-based function onset of the emerged (ii) Conduct an add opposite the year the exercise under para is conducted, that n to the following: (A) A second full-sec community-based of exercise; or (B) A mock disaste (C) A tabletop exer	udes a group discussion using y-relevant emergency of problem statements, , or prepared questions ige an emergency plan. Sility's] response to and ation of all drills, tabletop ergency events, and revise the cy plan, as needed. 18.113(d):] bices that provide care in the e hospice must conduct e emergency plan at least bice must do the following: full-scale exercise that is every 2 years; or unity based exercise is not t an individual facility based every 2 years; or xperiences a natural or ncy that requires activation of n, the hospital is exempt from t required full scale exercise or individual onal exercise following the ency event. ditional exercise every 2 years, ne full-scale or functional agraph (d)(2)(i) of this section may include, but is not limited cale exercise that is or a facility based functional	E	039			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	08/25/2022 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G216	B. WING			08/:	24/2022
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-O	OTIS STREET HOME				415 OTIS STREET DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	a narrated, clinically scenario, and a set directed messages designed to challen (3) Testing for hosp care directly. The h exercises to test the year. The hospice (i) Participate in an is community-based (A) When a commu accessible, conduct facility-based functii (B) If the hospice ex- man-made emerge the emergency plar engaging in its next based or facility-based following the onset (ii) Conduct an ador may include, but is (A) A second full-se community-based or exercise; or (B) A mock disaste (C) A tabletop exer facilitator that include narrated, clinically-r and a set of probler messages, or prepa- challenge an emerge (iii) Analyze the hos- maintain document exercises, and emerge	y-relevant emergency to f problem statements, a, or prepared questions age an emergency plan. bices that provide inpatient hospice must conduct e emergency plan twice per must do the following: a annual full-scale exercise that d; or unity-based exercise is not at an annual individual ional exercise; or experiences a natural or ency that requires activation of an, the hospice is exempt from t required full-scale community sed functional exercise of the emergency event. ditional annual exercise that not limited to the following: cale exercise that is or a facility based functional er drill; or rcise or workshop led by a des a group discussion using a relevant emergency scenario, m statements, directed ared questions designed to	EC	039			

Facility ID: 922342

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/25/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G216	B. WING			08/:	24/2022
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-O	TIS STREET HOME				415 OTIS STREET DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
E 039	§482.15(d), CAHs a (2) Testing. The [PF conduct exercises t twice per year. The do the following: (i) Participate in an is community-based (A) When a commu accessible, conduct facility-based functii (B) If the [PRTF, Ho actual natural or ma requires activation of [facility] is exempt for required full-scale of facility-based functii onset of the emerge (ii) Conduct an and that may includ following: (A) A second full-sc community-based of functional exercise; (B) A mock (C) A tabletop e led by a facilitator a discussion, using a emergency scenario statements, directe questions designed plan. (iii) Analyze the maintain document	1.184(d), Hospitals at at §485.625(d):] RTF, Hospital, CAH] must to test the emergency plan e [PRTF, Hospital, CAH] must annual full-scale exercise that d; or unity-based exercise is not t an annual individual, onal exercise; or ospital, CAH] experiences an an-made emergency that of the emergency plan, the rom engaging in its next community based or individual, onal exercise following the ency event. [additional] annual exercise or le, but is not limited to the cale exercise that is or individual, a facility-based or disaster drill; or exercise or workshop that is nd includes a group narrated, clinically-relevant o, and a set of problem d messages, or prepared to challenge an emergency [facility's] response to and ation of all drills, tabletop ergency events and revise the cy plan, as needed.	E	039			

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		AND HUMAN SERVICES				FORM	08/25/2022 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		34G216	B. WING	i		08/:	24/2022
NAME OF F	PROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-O	TIS STREET HOME				2415 OTIS STREET DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	 (2) Testing. The PAR exercises to test the annually. The PACE following: (i) Participate in an is community-based (A) When a commu accessible, conduct facility-based function (B) If the PACE exp man-made emergen the emergency plan engaging in its next based or individual, exercise following the event. (ii) Conduct an years opposite the years opposite the years is conducted that may the following: (A) A second full-sec community-based of functional exercise; (B) A mock disaster (C) A tabletop exer a facilitator and inclusing a narrated, cli scenario, and a set directed messages, designed to challen (iii) Analyze the PA maintain documenta exercises, and eme PACE's emergency 	CE organization must conduct e emergency plan at least E organization must do the annual full-scale exercise that d; or unity-based exercise is not t an annual individual, ional exercise; or periences an actual natural or ency that requires activation of n, the PACE is exempt from t required full-scale community facility-based functional he onset of the emergency additional exercise every 2 year the full-scale or functional agraph (d)(2)(i) of this section hay include, but is not limited to cale exercise that is or individual, a facility based ; or er drill; or rcise or workshop that is led by ludes a group discussion, inically-relevant emergency of problem statements, , or prepared questions age an emergency plan. ACE's response to and ation of all drills, tabletop ergency events and revise the plan, as needed.		039	ξ		

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		AND HUMAN SERVICES				FORM	08/25/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		34G216	B. WING	i		08/:	24/2022
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-O	TIS STREET HOME				2415 OTIS STREET DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 039	test the emergency including unannoun emergency procedu ICF/IID] must do the (i) Participate in an is community-based (A) When a commu accessible, conduct facility-based function (B) If the [LTC facility actual natural or marequires activation of LTC facility is exem requires activation of LTC facility is exem required a full-scale individual, facility-based following the onset (ii) Conduct an add may include, but is (A) A second full-sc community-based of functional exercise; (B) A mock disaste (C) A tabletop exer a facilitator includes narrated, clinically-r and a set of probler messages, or prepa challenge an emerg (iii) Analyze the [LT and maintain docum exercises, and eme [LTC facility] facility' *[For ICF/IIDs at §4 (2) Testing. The ICF to test the emergen The ICF/IID must do	 plan at least twice per year, need staff drills using the ures. The [LTC facility, e following: annual full-scale exercise that d; or unity-based exercise is not t an annual individual, onal exercise. ty] facility experiences an an-made emergency that of the emergency plan, the opt from engaging its next e community-based or ased functional exercise of the emergency event. ditional annual exercise that not limited to the following: cale exercise that is or an individual, facility based for a individual, facility based for a group discussion, using a relevant emergency scenario, m statements, directed ared questions designed to gency plan. C facility] facility's response to nentation of all drills, tabletop ergency events, and revise the 's emergency plan, as needed. 83.475(d)]: F/IID must conduct exercises for year. 		039			

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		AND HUMAN SERVICES				FORM	08/25/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G216	B. WING			08/2	24/2022
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-O	TIS STREET HOME				2415 OTIS STREET DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	is community-based (A) When a commu accessible, conduct facility-based function (B) If the ICF/IID ex- man-made emerged the emergency plane engaging in its next community-based of functional exercises emergency event. (ii) Conduct an addi may include, but is (A) A second full-sc community-based of functional exercise; (B) A mock disaster (C) A tabletop exerce a facilitator and incl using a narrated, cli scenario, and a set directed messages, designed to challen (iii) Analyze the ICF maintain documents exercises, and eme ICF/IID's emergence *[For HHAs at §484 (d)(2) Testing. The to test the emergen least annually. The (i) Participate in a fu community-based; of (A) When a cor accessible, conduct	d; or unity-based exercise is not t an annual individual, onal exercise; or. speriences an actual natural or ncy that requires activation of n, the ICF/IID is exempt from t required full-scale or individual, facility-based following the onset of the itional annual exercise that not limited to the following: cale exercise that is or an individual, facility-based ; or r drill; or cise or workshop that is led by ludes a group discussion, inically-relevant emergency of problem statements, , or prepared questions age an emergency plan. <i>C</i> /IID's response to and ation of all drills, tabletop ergency events, and revise the cy plan, as needed.	EC	039			

		AND HUMAN SERVICES				FORM	08/25/2022 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G216	B. WING			08/2	24/2022
NAME OF F	PROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-O	TIS STREET HOME				2415 OTIS STREET DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	 (B) If the HHA or man-made emergency pengaging in its next community-based of functional exercise emergency event. (ii) Conduct an addi opposite the year the exercise under parais conducted, that limited to the followin (A) A second functional exercise; (B) A mock disa (C) A tabletop eled by a facilitator a discussion, using a emergency scenario statements, directed questions designed plan. (iii) Analyze the HHZ documentation of al emergency plan, as *[For OPOs at §486 (d)(2) Testing. The following: (i) Conduct a paper workshop at least a led by a facilitator a discussion, using a emergency scenario following: 	experiences an actual natural rgency that requires activation blan, the HHA is exempt from t required full-scale or individual, facility based following the onset of the itional exercise every 2 years, ne full-scale or functional agraph (d)(2)(i) of this section at may include, but is not ring: ull-scale exercise that is or an individual, facility-based ; or aster drill; or exercise or workshop that is and includes a group narrated, clinically-relevant o, and a set of problem d messages, or prepared d to challenge an emergency A's response to and maintain ull drills, tabletop exercises, and and revise the HHA's is needed.	EC	039			

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		AND HUMAN SERVICES				FORM	08/25/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G216	B. WING			08/:	24/2022
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-O	TIS STREET HOME				415 OTIS STREET DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	questions designed plan. If the OPO ex man-made emerge the emergency plar engaging in its next following the onset (ii) Analyze the OPO documentation of a emergency events, OPO's] emergency *[RNCHIs at §403. (d)(2) Testing. The exercises to test the must do the followin (i) Conduct a paper least annually. A tal discussion led by a clinically-relevant en of problem stateme prepared questions emergency plan. (ii) Analyze the RNI maintain document and emergency eve emergency plan, as This STANDARD is Based on document facility failed to ension r tabletop exercise Preparedness (EP) potentially affected and #6. The finding Review on 8/23/22 include a full-scale exercise for 2021.	 d to challenge an emergency periences an actual natural or incy that requires activation of h, the OPO is exempt from t required testing exercise of the emergency event. O's response to and maintain II tabletop exercises, and and revise the [RNHCI's and plan, as needed. 748]: RNHCI must conduct e emergency plan. The RNHCI ng: based, tabletop exercise at bletop exercise is a group facilitator, using a narrated, mergency scenario, and a set ents, directed messages, or a designed to challenge an HCI's response to and tation of all tabletop exercises, ents, and revise the RNHCI's s needed. s not met as evidenced by: nt review and interviews, the ure facility/community-based es to test their Emergency plan were conducted. This clients #1, #2, #3, #4, #5, #5 	EC)39			

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DA	TE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	. ,	B		MPLETED
		34G216	B. WING		08/24/202	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-O	TIS STREET HOME			2415 OTIS STREET DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
E 039	Continued From pa	ige 9 firmed a table top exercise had	E 039			
W 227	not been completed INDIVIDUAL PROC CFR(s): 483.440(c)	d for 2021. GRAM PLAN	W 227	7		
	objectives necessa as identified by the required by paragra This STANDARD i Based on interview failed to assure the for 2 of 4 audit clier objective training to	ram plan states the specific ry to meet the client's needs, comprehensive assessment aph (c)(3) of this section. s not met as evidenced by: v and record review, the facility individual program plan (IPP) nts (#1 and #2) included o meet the client's money I preparation and self care is are:				
	6/16/22 revealed sł which included: me Further review of cl	22 of client #1's IPP dated ne had priority training needs al preparation and self care. lient #1's IPP confirmed no tified in the areas of meal lf-care.				
	disabilities professi	2 with the qualified intellectual onal (QIDP) confirmed client formal training in the areas of nd self-care.				
	5/28/22 confirmed l	22 of client #2's IPP dated he had priority training needs ing and money management.				
	disabilities professi	2 with the qualified intellectual onal (QIDP) confirmed client formal training in the areas of				

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NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-O	TIS STREET HOME				415 OTIS STREET DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 249	Continued From pa CFR(s): 483.440(d)	-	W 2	249			
	formulated a client's each client must rea treatment program interventions and se and frequency to su	rdisciplinary team has s individual program plan, ceive a continuous active consisting of needed ervices in sufficient number upport the achievement of the d in the individual program					
	Based on observat interviews, the facili received a continuo consisting of neede as identified in the I in the area of struct	s not met as evidenced by: tions, record reviews and ity failed to ensure each client ous active treatment program ed interventions and services Individual Program Plan (IPP) tured leisure activities and the ints. This affected 2 of 4 audit The findings are:					
	the facility on 8/22/2 #2, who is legally bl table with a piece or	ervations of leisure activities in 22 from 4:35pm-5:00pm client lind, was at the dining room f paper moving a crayon back per with crayons. He was not isure options.					
	8/22/22 at 5:05pm, come to the kitchen pitcher with water. A returned to the dinir crayons until 5:30pr	bservations in the facility on staff B asked client #2 to and help her fill up a water After assisting staff B, client #2 ng room table with paper and m when staff A and staff B or supper. He was not offered otions.					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		LE CONSTRUCTION		E SURVEY PLETED
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W 249	During observations breakfast at 8:00-8: paper and crayons color on the back pa getting on the van to workshop after 830 other leisure options Review on 8/22/22 5/28/22 revealed he Mood Disorder, Pro and Blindness. Interview on 8/23/22 (RM) and the qualifi- professional (QIDP) activities more appr and abilities in the fi- him during structure B. Throughout obse 8/22/22 from 4:00pr from 6:00am-8:30al work with client #1 of Review on 8/22/22 6/16/22 revealed sh on 5/2/22 after bein nursing facility after that resulted in diag and Left Hemipares Review on 8/23/22 of client #1's folder ino that is to be used w daily with the carrot her left hand slowly carrot splint and to	s in the facility on 8/23/22 after 30am staff D and E set up for client #2 to sit outside and atio until it was time to start o go out to the vocational am. He was not offered any s. of client #2's IPP dated a has the following diagnoses: of ound Intellectual Disabilities 2 with the residential manager ied intellectual disabilities) confirmed there are leisure ropriate for client #2's skills acility that can be offered to de leisure time. ervations at the facility on m-6:30pm and on 8/23/22 m staff were not observed to on using her carrot splint. of client #1's IPP dated he was admitted to the facility ig discharged from a skilled being treated from a stroke gnoses of Dysphagia, Aphasia	W 2	249			

Facility ID: 922342

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		AND HUMAN SERVICES			FORM	08/25/2022 APPROVED 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G216	B. WING _		08/2	24/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-OTIS STREET HOME				2415 OTIS STREET DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 249	onto the splint at lea increase the time da therapist could see Interviews on 8/23/2 confirmed the carro staff should be work onto the carrot splin PROGRAM MONIT CFR(s): 483.440(f)(The committee sho are conducted only consent of the clien minor) or legal guar This STANDARD is Based on record re failed to ensure rest conducted with the legal guardian. This (#2 and #3). The fin A. Review on 8/23/2 Support Plan (BSP) objective to exhibit cooperate per mont months. Additional revealed a target be Further review of th informed consent hal legal guardian since Interview on 8/23/22 disabilities professio written informed con by the legal guardian	ast one hour daily and to aily until the occupational her again to re-evaluate. 22 with the RM and the QIDP of splint is in the facility and king with client #1 on holding nt and to relax her hand daily. ORING & CHANGE (3)(ii) build insure that these programs with the written informed at, parents (if the client is a rdian. s not met as evidenced by: eview and interview, the facility trictive programs were only written informed consent of a s affected 2 of 4 audit clients ndings are: 22 of client #3's Behavior) dated 11/26/19 revealed an zero episodes of failure to th for twelve consecutive review of client #3's BSP ehavior for noncompliance. he BSP revealed written ad not been obtained by the e 12/24/19. 2 with the qualified intellectual onal (QIDP) confirmed that nsent has not been obtained	W 24	49		
	B. Review on 8/23/2	22 of client #2's BSP dated				

		AND HUMAN SERVICES				FORM	08/25/2022 APPROVED
		(X2) MULTIPLE CONSTRUCTION A. BUILDING			MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		34G216	B. WING	i		08/2	24/2022
NAME OF F	NAME OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-OTIS STREET HOME					2415 OTIS STREET DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
W 263 W 331	11/20/19 revealed a episodes of self-inju consecutive months revealed this progra Risperidone 0/25mg Review of the BSP signed by client #2's on 12/11/19 and thi would expire on 11/ Interview on 8/22/22 facility had not upda consent for client #2 guardian and the B NURSING SERVIC CFR(s): 483.460(c) The facility must pro- services in accorda This STANDARD is Based on records of facility failed to prov- accordance with the (#5) relative to ensu- orders were available Review on 8/23/22	an objective to decrease ury per month for 12 s. Further review of the BSP am incorporated the use of g and Sertraline 50 mg. consent revealed it was s legal guardian of the person s written informed consent 20/20. 2 with the QIDP confirmed the ated this written informed 2's BSP from the legal SP was still ongoing. ES ovide clients with nursing nce with their needs. s not met as evidenced by: review and interviews, the vide nursing services in e needs of 1 of 4 audit clients uring authenticated physician ole. The finding is: of quarterly physician orders and not had signed physician	W 2 W 3				
W 340	confirmed authentic client #5 were last s NURSING SERVIC CFR(s): 483.460(c) Nursing services m		W 3	340			

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		AND HUMAN SERVICES			0	FORM	08/25/2022 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY PLETED
		34G216	B. WING			08/2	24/2022
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 415 OTIS STREET		
VOCA-O	TIS STREET HOME				DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 340 W 436	appropriate protecti measures that inclu training clients and health and hygiene This STANDARD is Based on observat services failed to er sufficiently trained i of visitors in regard potentially effected and #6) residing in During observations 10:00am and 4:00p door to the home at Further observation temperature was no During an interview manager (HM) repor home must have th During an interview confirmed the surve have been taken. SPACE AND EQUID CFR(s): 483.470(g) The facility must fur and teach clients to choices about the u hearing and other of and other devices in interdisciplinary tea This STANDARD is Based on observat failed to ensure 1 o	ive and preventive health ide, but are not limited to staff as needed in appropriate methods. Is not met as evidenced by: tions and interview, nursing insure that staff were in the taking the temperature is to COVID-19 protocol. This all clients (#1, #2, #3, #4, #5 the home. The finding is: Is at the home on 8/23/22 at om, a staff person opened the ind greeted the surveyors. Is revealed surveyors' of taken. If on 8/24/22, the home orted any visitors who enter the eir temperature taken. If on 8/24/22, the facility nurse eyors' temperatures should PMENT (2) mish, maintain in good repair, o use and to make informed use of dentures, eyeglasses, communications aids, braces,	W 3				

		AND HUMAN SERVICES			FORM	08/25/2022 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		. ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G216	B. WING _		08/2	24/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-OTIS STREET HOME				2415 OTIS STREET DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 436	Continued From pa the use of glasses.	-	W 43	36		
	4:00pm-6:30pm clie crafts activity drawin wooden napkin holo	ations on 8/23/22 from ent #1 was involved in arts and ng on paper, painting a der as well as dining. During he was not observed to be ises.				
	6:00am-8:30am du	ations on 8/23/22 from ring dining and preparation to cational workshop, client #1 • eyeglasses.				
	revealed client #1 w assessment in Mar at the facility on 5/2	2 with the facility nurse vas seen for a visual ch 2022 prior to her placement 2/22. Further interview seen by the Optometrist and ear for reading.				
W 460	disabilities profession #1 does have glass formal training to to for her eyeglasses.	ITION SERVICES	W 46	50		
	Each client must re well-balanced diet i specially-prescribed	ncluding modified and				
	Based on observat	s not met as evidenced by: tions, record reviews and ity failed to ensure 3 of 4 audit #3) received their				

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		AND HUMAN SERVICES				FORM	08/25/2022 APPROVED 0938-0391
		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G216	B. WING			08/2	24/2022
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-OTIS STREET HOME					415 OTIS STREET DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 460	specially-modified of findings are: A. During observati 5:28pm, client #2 w mechanically groun tomatoes and chee serve mashed pota included juice and w During observations 6:40am, client #2 w ground waffles, unr unmodified canned beverages which in Review of client #2' 3/5/18 revealed clier regular pureed diet daily. Review on 8/23/22 dated 6/27/22 revea prescribed a regula prescribed once da Interview on 8/23/22 confirmed that clier pureed as he wears does not completely interview confirmed smooth with broth of in the mixture that i Interview on 8/23/22	diet as prescribed. The diet as prescribed. The as assisted to serve ad taco which included lettuce, as e. He was also assisted to toes and beverages which water. s of breakfast on 8/23/22 at vas served mechanically modified scrambled eggs and fruit. He was also served acluded water and juice. 's nutritional evaluation dated ent #2's diet is prescribed a with Ensure prescribed once of client #2's physician orders aled client #2's diet is ar pureed diet with Ensure	W 4	160			

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		AND HUMAN SERVICES				FORM	08/25/2022 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G216	B. WING			08/2	24/2022
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-OTIS STREET HOME					415 OTIS STREET URHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 460	 B. During observati 6:42am client #1 wawere unmodified, caunmodified and mewas also served juin Review on 8/22/22 client #1's IPP date admitted to the facil discharged from a sbeing treated from a diagnoses of Dysph Hemiparesis. Furtheshe is prescribed a times daily. Review on 8/23/22 dated 6/27/22 revealed client mechanically ground aily as she was repureed texture. Interview on 8/23/22 confirmed client #1 ground diet with all Interview on 8/23/22 confirmed client #1 Soost three times de C. During observati 5:27pm, client #3 we way mean set and set and	ons in the home on 8/23/22 at as served scrambled eggs that anned fruit that was chanically ground waffles. She ce and water. of client #1's IPP revealed d 6/16/22 revealed she was lity on 5/2/22 after being skilled nursing facility after a stroke that resulted in hagia, Aphasia and Left er review of the IPP revealed pureed diet with Boost three of client #1's physician orders aled her diet was prescribed th Boost three times daily. of a dietary note from July 27, at #1's diet was changed to ad with Boost clear three times fusing meals served at the 2 with the facility nurse is to be served a mechanically foods modified at meals. 2 with the QIDP confirmed echanically modified with	W 4	-60			

		AND HUMAN SERVICES			FORM	08/25/2022 APPROVED 0938-0391
			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G216	B. WING		08/2	24/2022
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-OTIS STREET HOME				2415 OTIS STREET DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 460	6:15am, client #3 re medications with wa 6:40am, client #3 re waffles, scrambled unmodified. Review on 8/23/22 evaluation dated 5/ supposed to receive nectar thick liquids. all foods should be consistency. Staff s process fruits and v drained before mod being a watery cons Interview on 8/24/22 #3 is supposed to b uses thickened liqu reveled client #3 is foods like jello beca Interview on 8/24/22 (HM) confirmed clie mechanically soft d liquids. MEAL SERVICES CFR(s): 483.480(b) Food must be served interviews, staff did clients (#3) received	s in the home on 8/24/22 at accived her morning ater. Further observation at accived mechanically softened eggs and canned mixed fruit of client #3's nutritional 1/20 revealed client #3 is e a mechanical soft diet with The evaluation also reveals served no thinner than nectar should make sure not to over vegetables and they should be difying to prevent them from sistency. 2 with Staff C revealed client be on mechanical soft and ids sometimes. Staff C also not supposed to have watery ause they make her cough. 2 with the home manager ent #3 is supposed to be on iet with nectar thickened	W 460 W 475			
	During dinner obse	rvations in the home on				

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	08/25/2022 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G216	B. WING		08/;	24/2022
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-O	TIS STREET HOME			2415 OTIS STREET DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 475	8/23/22 at 5:27pm, room table and was tacos and mashed of client #3 was a p plate, weighted cup During breakfast ok 8/24/22, client #3 si was served mechan scrambled eggs an the table in front of high-sided divided p angled spoon and k fed herself and ate Review on 8/23/22 Quarterly Update d needs a small marc design built up han plate raiser, weight for positioning and revealed fork use n mechanical soft die tremors client #3 co prongs.	client #3 sat at the dining s served mechanichally ground potatoes On the table in front plate raiser, high-sided divided o and built up angled fork. bservations in the home on at at the dining room table and nically ground waffles, id unmodified mixed fruit. On client #3 was a plate raiser, a plate, a weighted cup, built up built up angled fork. Client #3	W 475			

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