PRINTED: 08/25/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING			S SURVEY PLETED	
	•	34G216	8. WING			08/	24/2022
	ROVIDER OR SUPPLIER	1		2	STREET ADDRESS, CITY, STATE, ZIP COD 2415 OTIS STREET DURHAM, NO 27707	E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MIJST RE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (FACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	§460.84(a)(2), §48; §483.475(d)(2), §48; §483.475(d)(2), §49; §491.12(d)(2), §49; §491.12(d)(2), §49; §491.12(d)(2), §49; §491.12(d)(2), §49; §495.920, RHCs/F Facilities at §494.6 (2) Testing. The [facilities at §494.6 (3) Testing. The [facilities at §494.6 (4) Participate in a second accessible, conduct exercise every 2 years (B) If the [facilities activation of the enexempt from engal activation of the enexempt from engal community-based functional exercise this section is connot limited to the faceommunity-based functional exercise (A) A second full-second functional exercise (B) A mock disaste (C) A tabletop exercise (C) A tabletop exercise (C)	8.113(d)(2), §441.184(d)(2), 2.15(d)(2), §483.73(d)(2), 84.102(d)(2), §485.68(d)(2), 85.727(a)(2), §485.920(a)(2), 4.62(d)(2). 8.54, CORFs at §485.68, OPO, der §485.727, CMHCs at QHCs at §491.12, and ESRD (2): acility] must conduct exercises ncy plan annually. The [facility] following: full-scale exercise that is every 2 years; or nunity-based exercise is not ct a facility-based functional ears; or ity] experiences an actual ade emergency that requires mergency plan, the [facility] is ging in its next required or individual, facility-based e following the onset of the ditional exercise at least every 2 e year the full-scale or e under paragraph (d)(2)(i) of ducted, that may include, but is ollowing: scale exercise that is or individual, facility-based e; or er drill; or ercise or workshop that is led by)39	E039 This deficiency will be corrected following actions: A. CANC-SE will develop implement an emergen preparedness (EP) train tableton testing programs. B. The manual will contain information on the train testing of the facilities. C. Management will train emergency preparedne training and table testing. D. Documentation will be support training. E. Site Supervisor will make a month. F. Qualified Professional one time a month.	p and cy ning and in ning and/or staff. all staff on ss (EP) ng program. provided to onitor one	
LABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGN	VATURE		TITLE		(x6) DATE

09/07/2022

Marika Whack, Executive Director

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		34G216	8. WNG		08/2	4/2022	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2415 OTIS STREET DURHAM, NC 27707	CODE		
(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	(XS) COMPLETION DATE	
E 039	a narrated, clinicall scenario, and a ser directed messages designed to challer (iii) Analyze the [fa maintain document exercises, and eme [facility's] emergen *[For Hospices at 4 (2) Testing for hospatient's home. The exercises to test the annually. The hos (i) Participate in a community based (A) When a community based (A) When a community based (B) If the hospice of the emergency place emerge	dudes a group discussion using ly-relevant emergency to for problem statements, and or prepared questions age an emergency plan. cility's] response to and tation of all drills, tabletop ergency events, and revise the cy plan, as needed. 18.113(d):] spices that provide care in the needed. 18.113(d):] spices that is every 2 years; or experiences a natural or experiences a natural or experiences a natural or experiences a natural or experiences or individual tional exercise following the gency event. 18.113(d):] spices that requires activation of the nospital is exempt from the trequired full scale exercise or individual tional exercise following the gency event. 18.113(d):] spices that requires activation of the nospital is exempt from the provided full scale exercise or individual tional exercise every 2 years, the full-scale or functional ragraph (d)(2)(i) of this section may include, but is not limited scale exercise that is or a facility based functional	E 039				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G216	8. WING			08/24/2022	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 2415 OTIS STREET DURHAM, NC 27707	Œ		
(X4) ID PREFIX TAG	EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE ACTION S	HOULO BE	(X5) COMPLETION DATE	
E 039	a narrated, clinicall scenario, and a set directed messages designed to challer (3) Testing for host care directly. The exercises to test theyear. The hospice (i) Participate in aris community-based (A) When a community-based funct (B) If the hospice eman-made emergency plaengaging in its next based or facility-based or facility-based (ii) Conduct an admay include, but is (A) A second full-community-based exercise; or (B) A mock disast (C) A tabletop exercise; or (B) A mock disast (C) A tabletop exercise; or proper challenge an emer (iii) Analyze the homaintain document exercises, and emerges	ly-relevant emergency is of problem statements, is, or prepared questions inge an emergency plan. pices that provide inpatient thospice must conduct e emergency plan twice per must do the following: in annual full-scale exercise that ed; or unity-based exercise is not of an annual individual tional exercise; or experiences a natural or ency that requires activation of in, the hospice is exempt from at required full-scale community ased functional exercise to fithe emergency event. ditional annual exercise that is not limited to the following: scale exercise that is or a facility based functional er drill; or ercise or workshop led by a ides a group discussion using a -relevant emergency scenario, em statements, directed bared questions designed to	E	039			

SYATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G216	B, WING			08/2	4/2022
	PROVIDER OR SUPPLIER			24	REET ADDRESS, CITY, STATE, ZIP CODE IS OTIS STREET IRHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES ' MUST BE PRÉCEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 039	§482.15(d), CAHs (2) Testing. The [F conduct exercises twice per year. The do the following: (i) Participate in a is community-base (A) When a comm accessible, conduct facility-based funct (B) If the [PRTF, I actual natural or r requires activation [facility] is exempt required full-scale facility-based funct onset of the emer (ii) Conduct a and that may included in the community-based functional exercise (B) A more (C) A tabletor led by a facilitator discussion, using emergency scene statements, direct questions design plan. (iii) Analyze to maintain docume exercises, and er	at \$485.625(d):] PRTF, Hospital, CAH] must to test the emergency plan te [PRTF, Hospital, CAH] must an annual full-scale exercise that ed; or funity-based exercise is not cot an annual individual, stional exercise; or dospital, CAH] experiences an annual emergency plan, the from engaging in its next community based or individual, stional exercise following the gency event. In [additional] annual exercise or ude, but is not limited to the escale exercise that is dor individual, a facility-based e; or exercise or workshop that is r and includes a group a narrated, clinically-relevant ario, and a set of problem at the effective of the emergency events and revise the ency plan, as needed.		039			

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	(X3) DAY	E SURVEY
EXPLOSE SHEAR NO	e and the best describe a community		A BUILU	nn.	1	
		34G216	B. WING		_ 08	/24/2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT 2415 OTIS STREET DURHAM, NC 27707	TE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE I TO THE APPROPRIATE BIENCY)	(X5) COMPLETION DATE
E 039	exercises to test the annually. The PAC following: (i) Participate in an is community-based (A) When a community-based functional exercise following event. (ii) Conduct an years opposite the exercise under pais conducted that it the following: (A) A second full-community-based functional exercise (B) A mock disast (C) A tabletop exit a facilitator and in using a narrated, scenario, and a sed directed message designed to challed (iii) Analyze the Final maintain document exercises, and empace is emergent.	the emergency plan at least be organization must do the emergency plan at least be organization must do the en annual full-scale exercise that ed; or unity-based exercise is not et an annual individual, tional exercise; or experiences an actual natural organization of an, the PACE is exempt from at required full-scale community all, facility-based functional the onset of the emergency an additional exercise every 2 eyear the full-scale or functional ragraph (d)(2)(i) of this section may include, but is not limited to exercise or workshop that is led by cludes a group discussion, clinically-relevant emergency et of problem statements, es, or prepared questions enge an emergency plan. PACE's response to and intation of all drills, tabletop nergency events and revise the cy plan, as needed.	E	039		

Facility ID: 922342

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	TIPLE CONSTRUCTION DING		TE SURVEY MPLETED
		34G216	B. WING		O	8/24/2022
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E 039	including unannou emergency proced (CF/IID) must do the (i) Participate in actis community-based (A) When a community-based function (B) If the [LTC facility-based function actual natural or many include, but is (A) A second full-community-based functional exercises (B) A mock disast (C) A tabletop exercised, clinically and a set of problemessages, or prechallenge an eme (iii) Analyze the [Land maintain documentation of the community-based functional exercises, and emerged functional exercises (B) A mock disast (C) A tabletop exercised, clinically and a set of problemessages, or prechallenge an eme (iii) Analyze the [Land maintain documentation of the community-based functional exercises, and emerged functional exercises (B) A mock disast (C) A tabletop exercise (B) A mock di	y plan at least twice per year, need staff drills using the lures. The [LTC facility, ne following: n annual full-scale exercise that at; or unity-based exercise is not ext an annual individual, tional exercise. Iity] facility experiences an nan-made emergency plan, the mpt from engaging its next le community-based or pased functional exercise to of the emergency event. ditional annual exercise that is not limited to the following: scale exercise that is or an individual, facility based exercise or workshop that is led by ear a group discussion, using a relevant emergency scenario, am statements, directed pared questions designed to regency plan. TC facility] facility's response to unentation of all drills, tabletop nergency events, and revise the cy's emergency plan, as needed (483.475(d)): CF/IID must conduct exercises ency plan at least twice per year		039		
FORM CMS-2	567(02-99) Previous Version	is Obsotete Event ID:LWT	411	Facility ID: 922342	If continuation st	eet Page 6 of 20

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G216	B. WING		08/	24/2022	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 2415 OTIS STREET DURHAM, NC 27707	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
E 039	accessible, conduction facility-based functions are many in the emergency place many include, but is community-based functional exercise emergency event. (ii) Conduct an addinay include, but is community-based functional exercise (B) A mock disastic (C) A tabletop exercise a facilitator and in using a narrated, scenario, and a sed directed message designed to challe (iii) Analyze the IC maintain document exercises, and em ICF/IID's emerger "[For HHAs at §48 (d)(2) Testing. The totest the emergeleast annually. The (i) Participate in a community-based (A) When a chaceessible, conductive many includes the community-based (A) When a chaceessible, conductive many includes the community-based (A) When a chaceessible, conductive many includes the conductive many includes the community-based (A) When a chaceessible, conductive many includes the conductive many includes the community-based (A) When a chaceessible, conductive many includes the conductive many includes the community-based (A) When a chacees includes the conductive many includes the condu	ed; or unity-based exercise is not et an annual individual, tional exercise; or. experiences an actual natural or ency that requires activation of an, the ICF/IID is exempt from ext required full-scale or individual, facility-based e following the onset of the ditional annual exercise that e not limited to the following: escale exercise that is or an individual, facility-based e; or er drill; or ercise or workshop that is led by cludes a group discussion, clinically-relevant emergency et of problem statements, es, or prepared questions enge an emergency plan. DF/IID's response to and intation of all drills, tabletop inergency events, and revise the ency plan, as needed. 34.102] e HHA must conduct exercises ency plan at the HHA must do the following: full-scale exercise that is		039			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED (X3) DATE SURVEY	
		34G216	8. WNG			/24/2022	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
E 039	(B) If the HHA or man-made eme of the emergency engaging in its ne community-based functional exercis emergency event (ii) Conduct an ad opposite the year exercise under pa is conducted, the limited to the follor (A) A second community-based functional exercis (B) A mock di (C) A tabletop led by a facilitator discussion, using emergency scene statements, direct questions design plan. (iii) Analyze the H documentation of emergency even- emergency even- emergency plan, *[For OPOs at §4 (d)(2) Testing. The to test the emerg following: (i) Conduct a pay workshop at leas led by a facilitator discussion, using emergency scene	A experiences an actual natural ergency that requires activation plan, the HHA is exempt from xt required full-scale I or individual, facility based e following the onset of the ditional exercise every 2 years, the full-scale or functional aragraph (d)(2)(i) of this section hat may include, but is not wing: full-scale exercise that is for an individual, facility-based are; or isaster drill; or a exercise or workshop that is a rand includes a group a narrated, clinically-relevant ario, and a set of problem ated messages, or prepared ed to challenge an emergency delication and the second maintain fall drills, tabletop exercises, and text as needed.		039			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		1 ' '		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G216	B. WNG		08	/24/2022	
	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP 2415 OTIS STREET DURHAM, NC 27707	CODE		
(X4) ID PREFIX YAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFII TAG		ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DATE	
E 039	plan. If the OPO exman-made emerge the emergency planengaging in its nex following the onset (ii) Analyze the OP documentation of a emergency events OPO's] emergency events OPO's] emergency exercises to test the must do the following (i) Conduct a paper least annually. A table discussion led by a clinically-relevant of problem statement of pro	d to challenge an emergency operiences an actual natural or ency that requires activation of in, the OPO is exempt from at required testing exercise of the emergency event. O's response to and maintain all tabletop exercises, and and revise the [RNHCl's and plan, as needed. 748]: RNHCl must conduct be emergency plan. The RNHCl ing: 1-based, tabletop exercise at abletop exercise is a group a facilitator, using a narrated, emergency scenario, and a set ents, directed messages, or is designed to challenge an allHCl's response to and tation of all tabletop exercises, wents, and revise the RNHCl's is needed. Is not met as evidenced by: Int review and interviews, the sure facility/community-based sets to test their Emergency plan were conducted. This is delients #1, #2, #3, #4, #5, #5	EC	39			

STATEMENT C AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
		34G216	B. WING		08/2	4/2022
	/FACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	2	TREET ADDRESS, CITY, STATE, ZIP CODE 415 OTIS STREET FURHAM, NC 27707 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE OF CORRECTIVE)) 8E	(X5) COMPLETION DAYE
W 227	not been complete INDIVIDUAL PROCCFR(s): 483.440(c). The individual proposition objectives necessias identified by the required by paraging This STANDARD Based on interview failed to assure the for 2 of 4 audit clie objective training management, meneeds. The findin A. Review on 8/22 6/16/22 revealed which included; management formal training idepreparation and substitution of the finding and meneeds. The findin B. Review on 8/22 disabilities profess #1 currently has meal preparation. B. Review on 8/22 disabilities profess #1 currently has management included; disabilities profess #2 currently has adining and moneeds.	diffrmed a table top exercise had a for 2021. GRAM PLAN e)(4) gram plan states the specific ary to meet the client's needs, a comprehensive assessment raph (c)(3) of this section. Is not met as evidenced by: It wand record review, the facility is individual program plan (IPP) ents (#1 and #2) included to meet the client's money all preparation and self care ags are: 2/22 of client #1's IPP dated she had priority training needs heal preparation and self care. It is IPP confirmed no entified in the areas of meal self-care. 2/22 with the qualified intellectual is sional (QIDP) confirmed client no formal training in the areas of and self-care. 2/22 of client #2's IPP dated the had priority training needs lining and money management. 2/22 with the qualified intellectual sional (QIDP) confirmed client no formal training in the areas of the promote training training training training training training training training trai	ı	This deficiency will be corrected by following actions: A. All ISP's will be reviewed a modified as needed to addreobjective trainings. B. All individual served goals reviewed and modified base their objective training need. C. Active treatment will be present to all individuals served. D. Written training programs implemented based on any strategies and needs identified team. E. Qualified Professional will service all staff on individuals. F. Qualified Professional will one time a week and will a any changes in core team recommended.	will be ed off ds. ovided will be goals, fied by in- initial's imonitor ddress	10/23/2022

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X: A. BUÍLDING		(X3) DATE COME	SURVEY PLETED	
		34G216	B. WING			08/	24/2022
VOCA-O	PROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 415 OTIS STREET DURHAM, NC 27707 PROVIDER'S PLAN OF CORRECTION	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE RIATE	COMPLETION DATE
W 249	formulated a client each client must reatment program interventions and and frequency to so objectives identified plan. This STANDARD Based on observation interviews, the factoriews and received a continuous identified in the inthe area of structuse of adaptive so clients (#1 and #2 A. Throughout obthe facility on 8/22 #2, who is legally table with a piece and forth on the proffered any other. During continued 8/22/22 at 5:05pr come to the kitch pitcher with water returned to the dicrayons until 5:30	didition description of the services in sufficient number support the achievement of the ed in the individual program plan, eservices in sufficient number support the achievement of the ed in the individual program is not met as evidenced by: ations, record reviews and cility failed to ensure each client uous active treatment program ded interventions and services individual Program Plan (IPP) ctured leisure activities and the plints. This affected 2 of 4 audit 2). The findings are: servations of leisure activities in 2/22 from 4:35pm-5:00pm client blind, was at the dining room of paper moving a crayon back paper with crayons. He was not be leisure options. observations in the facility on m, staff B asked client #2 to en and help her fill up a water. After assisting staff B, client #2 ining room table with paper and opm when staff A and staff B of for supper. He was not offered		249	This deficiency will be corrected by following actions: A. ISP's will be updated and m to meet the current ADL's a adaptive equipment. B. All ISP's will be reviewed: revised as needed to ensure objectives are met to mee the current need of all individua. C. Written training plans will be implemented as need to addindividual's needs, adaptive equipment and appropriate treatment. D. All staff will be in-services individual's ISP's, adaptive equipment and active treatment the home. E. Site Supervisor will monito document weekly. F. Qualified Professional will and document weekly.	the codified round and that all ne als. on active on nent in or and	10/23/2022

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
W 249	breakfast at 8:00-8 paper and crayons color on the back p getting on the van workshop after 836 other leisure option Review on 8/22/22 5/28/22 revealed h Mood Disorder, Pr and Blindness. Interview on 8/23/2 (RM) and the qual professional (QIDI activities more app and abilities in the him during structu B. Throughout obs 8/22/22 from 4:00 from 6:00am-8:30 work with client #3 Review on 8/22/22 6/16/22 revealed s on 5/2/22 after be nursing facility after that resulted in dia and Left Hemipare Review on 8/23/23 client #1's folder in that is to be used to daily with the carr her left hand slow carrot splint and to	as in the facility on 8/23/22 after 8:30am staff D and E set up a for client #2 to sit outside and batio until it was time to start to go out to the vocational to go. He was not offered any ns. 2 of client #2's IPP dated be has the following diagnoses: refound Intellectual Disabilities are leisured intellectual disabilities. 22 with the residential manager ified intellectual disabilities. 23 with the residential manager ified intellectual disabilities. 24 with the residential manager ified intellectual disabilities. 25 confirmed there are leisure propriate for client #2's skills facility that can be offered to red leisure time. 26 servations at the facility on pm-6:30pm and on 8/23/22 am staff were not observed to don using her carrot splint. 26 of client #1's IPP dated she was admitted to the facility ing discharged from a skilled ar being treated from a stroke agnoses of Dysphagia, Aphasia		249			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILC		E CONSTRUCTION	(X3) DATE COMP	
		34G216	8. WNG			08/2	4/2022
	PROVIDER OR SUPPLIER T IS STREE T HOM E			2.	TREET ADDRESS, CITY, STATE, ZIP CODE 415 OTIS STREET URHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	8E	(X5) COMPLETION DATE
W 249	increase the time of therapist could see the time of the carristaff should be wo onto the carrot split PROGRAM MONICFR(s): 483.440(f). The committee share conducted onliconsent of the clie minor) or legal guardian or legal guardian. The conducted with the legal guardian. The coperate per momonths. Additionare vealed a target Further review of informed consent legal guardian single limiter on 8/23/ disabilities profes written informed coperate of the legal guardian single l	east one hour daily and to daily until the occupational e her again to re-evaluate. /22 with the RM and the QIDP of splint is in the facility and rking with client #1 on holding int and to relax her hand daily. TORING & CHANGE (3)(ii) ould insure that these programs y with the written informed ent, parents (if the client is a fardian. Is not met as evidenced by: eview and interview, the facility estrictive programs were only estrictive programs were only ewritten informed consent of a finis affected 2 of 4 audit clients findings are: 8/22 of client #3's Behavior (2) dated 11/26/19 revealed an it zero episodes of failure to enth for twelve consecutive fall review of client #3's BSP behavior for noncompliance, the BSP revealed written had not been obtained by the loce 12/24/19.		249	W263 This deficiency will be corrected by following actions: A. The Qualified Professional review all behavior support B. All behavior support plans address the current needs an technique to manage inapprobehavior. C. All proper techniques will be to manage behaviors. D. Psychologist will review all E. HRC approval and the properonsents will be obtained for BSP's. F. The Qualified Professional review and obtain guardian G. Qualified Professional will and document this monthly.	will plans. vill d opriate e used plans. er or all will consent. monitor	0/23/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G216	B. WNG		08/2	4/2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2415 OTIS STREET DURHAM, NC 27707		
(X4) ID PREFIX TAG	/FACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	COMPLETION DATE
W 331	episodes of self-ir consecutive mont revealed this prog Risperidone 0/25t Review of the BS signed by client # on 12/11/19 and for would expire on 1 Interview on 8/22 facility had not up consent for client guardian and the NURSING SERV CFR(s): 483.460 The facility must services in accord facility failed to p accordance with (#5) relative to el orders were availed client # orders since August Interview on 8/23/revealed client # orders since August Interview on 8/2 confirmed auther client #5 were la NURSING SER CFR(s): 483.460 Nursing service	l an objective to decrease njury per month for 12 hs. Further review of the BSP gram incorporated the use of mg and Sertraline 50 mg. P consent revealed it was 2's legal guardian of the person this written informed consent 1/20/20. (22 with the QIDP confirmed the odated this written informed #2's BSP from the legal BSP was still ongoing. ICES (c) provide clients with nursing dance with their needs. O is not met as evidenced by: s review and interviews, the rovide nursing services in the needs of 1 of 4 audit clients insuring authenticated physician illable. The finding is: 22 of quarterly physician orders is had not had signed physician gust 16, 2021. 4/22 with the facility nurse inticated physician orders for its signed August 16, 2021. VICES D(c)(5)(i)	W	W.331 This deficiency will be corrected following actions: A. All Physician orders wing reviewed by the nurse. B. All physician orders wing to the physician for revisignature. C. RN will ensure all orded present. D. RN will monitor month	II be II be given iew and rs are	10/23/2022
	other members	of the interdisciplinary team,				

PRINTED: 08/25/2022 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPL IDENTIFICATION NUMBER: A. BUILDING			NSTRUCTION	COMP	LETED
		34G216	B. WING			08/2	4/2022
	ROVIDER OR SUPPLIER			2415 (T ADDRESS, CITY, STATE, ZIP CODE DTIS STREET HAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRÉCEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	8E	(X5) COMPLETION DATE
	measures that inclutraining clients and health and hygiend This STANDARD Based on observations of visitors in regard potentially effected and #6) residing in During observation 10:00 am and 4:00 door to the home Further observation temperature was a During an intervier manager (HM) rephome must have been taken. SPACE AND EQUICER(s): 483.470(The facility must from and other and other devices interdisciplinary to This STANDARD Based on observations of the surface of the surface of the surface and other devices interdisciplinary to This STANDARD Based on observations of the surface of the surface of the surface of the surface and other devices interdisciplinary to This STANDARD Based on observations of the surface of	tive and preventive health ude, but are not limited to I staff as needed in appropriate e methods. is not met as evidenced by: tions and interview, nursing ensure that staff were in the taking the temperature ds to COVID-19 protocol. This d all clients (#1, #2, #3, #4, #5 in the home. The finding is: as at the home on 8/23/22 at pm, a staff person opened the and greeted the surveyors. and taken. w on 8/24/22, the home corted any visitors who enter the cheir temperature taken. w on 8/24/22, the facility nurse veyors' temperatures should IIPMENT g)(2) urnish, maintain in good repair, to use and to make informed use of dentures, eyeglasses, communications aids, braces,		follo A. B. C. D. E. F. G. H	s deficiency will be corrected by owing actions: Temperatures will be taken for visitors and staff in the home tenter the homes. RN will in-service all staff on Infectious diseases. COVID disaster plan will be up as needed. Staff will be in-services on COV protocol to ensure that temperare taken. Staff will be trained on the importace coverings. RN will monitor monthly. Site Supervisor will monitor to a week. Qualified Professional will montaines a week. 436 is deficiency will be corrected belowing actions: A. All adaptive equipment will discussed in a team meeting. B. All people served will be in serviced on their adaptive equipment and the importate wearing/using their adaptive equipment. C. All adaptive equipment will accessible to the person seen needing the equipment.	the all hat odated /ID atures oortance vo time itor two y the ll be g. i- nce of ye ll be	10/23/2022

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG	COMPLETED		
		34G216	B. WING _		08/24	/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2415 OTIS STREET DURHAM, NC 27707		6/6
(X4) ID PREFIX TAG	(EACH DEFICIENCY	(TEMENT OF DEFICIENCIES MUST 8E PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE C	(X5) COMPLETION DATE
W 436	4:00pm-6:30pm cli crafts activity draw wooden napkin ho this observation, s offered her eyegla Throughout observ 6:00am-8:30am de transport to her vo was not offered her	The finding is: vations on 8/23/22 from ent #1 was involved in arts and ing on paper, painting a Ider as well as dining. During he was not observed to be sses. vations on 8/23/22 from uring dining and preparation to cational workshop, client #1 er eyeglasses.	W 4	D. Formal training will be confor the use of adaptive equieyeglasses E. All people served will be a for the use of adaptive equience. F. Qualified Professional will implement a formal goal. G. All staff will be in-serviced use of adaptive equipment. H. Site Supervisor will monito time a week. I. Qualified Professional will one time a week.	ssessed ipment.	
W 460	revealed client #1 assessment in Ma at the facility on 5. revealed she was given glasses to v Interview on 8/23/ disabilities profes/ #1 does have glas formal training to for her eyeglasse FOOD AND NUTI CFR(s): 483.480(Each client must well-balanced die specially-prescrib This STANDARD Based on observ interviews, the far	22 with the qualified intellectual sional (QIDP) confirmed client uses but currently does not have colorate wearing or learn to care s. RITION SERVICES a)(1) receive a nourishing, tincluding modified and	W	W. 460 This deficiency will be corrected be following actions: A. Nutritionist will complete assessment on consumers. B. Recommendations will be based upon assessment. C. Nutritional assessments we conducted to ensure proper consistency.	added	0/23/2022

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G216	B. WNG		08/2	4/2022
NAME OF PROVIDER OR SUPPLIER VOCA-OTIS STREET HOME		2	TREET ADDRESS, CITY, STATE, ZIP CODE 415 OTIS STREET PURHAM, NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC.IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REPERENCED TO THE APPROPI DEFICIENCY)	BÉ	(%) COMPLETION DATE
W 460	A. During observa 5:28pm, client #2 mechanically grout tomatoes and che serve mashed pot included juice and During observatio 6:40am, client #2 ground waffles, ur unmodified canne beverages which Review of client #3/5/18 revealed c regular pureed die daily. Review on 8/23/2 dated 6/27/22 rev prescribed a regular pureed die daily. Review on 8/23/2 dated 6/27/22 rev prescribed once of the regular pureed interview on 8/23 confirmed that clien pureed as he were does not complete interview confirms smooth with broth in the mixture that Interview on 8/23 disabilities profess	tions in the home on 8/22/22 at was assisted to serve and taco which included lettuce, ese. He was also assisted to atoes and beverages which I water. In sof breakfast on 8/23/22 at was served mechanically amodified scrambled eggs and a fruit. He was also served included water and juice. It is nutritional evaluation dated lient #2's diet is prescribed a set with Ensure prescribed once. I of client #2's physician orders realed client #2's diet is lar pureed diet with Ensure.	W 460	 D. All people served will receive Nourishing, well-balanced of including modified and specified diets. E. All staff will be in-serviced consistency orders. F. Site Supervisor will monito time a week. G. Qualified Professional will once a week. 	liet cialty on food r one	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G216	B. WNG			/24/2022	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 2415 OTIS STREET DURHAM, NC 27707	ODE		
(X4) ID PREFIX TAG	/FACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
W 460	6:42am client #1 v were unmodified, unmodified and m was also served ju Review on 8/22/2 client #1's IPP data admitted to the far discharged from a being treated fron diagnoses of Dys Hemiparesis. Further she is prescribed times daily. Review on 8/23/2 data 6/27/22 revealed climes daily as a pureed diet v Review on 8/22/2 2022 revealed climechanically ground diet with Interview on 8/23 confirmed client in ground diet with Interview on 8/23 client #1's diet is Boost three time C. During observed.	tions in the home on 8/23/22 at was served scrambled eggs that canned fruit that was echanically ground waffles. She uice and water. 2 of client #1's IPP revealed ted 6/16/22 revealed she was cility on 5/2/22 after being a skilled nursing facility after in a stroke that resulted in phagia, Aphasia and Left ther review of the IPP revealed a pureed diet with Boost three 2 of client #1's physician orders realed her diet was prescribed with Boost three times daily. 2 of a dietary note from July 27, ent #1's diet was changed to und with Boost clear three times refusing meals served at the 8/22 with the facility nurse #1 is to be served a mechanically all foods modified at meals.	/	460			

INMIE OF PROVIDER OR SUPPLIER VOCA-OTIS STREET HOME 2415 OTIS STREET DURHAM, NC 27797 (SAUMARAY STATEMENT OF DEPICENCIES PREFIX TAG (SAUMARAY STATEMENT OF DEPICENCIES PROPERLY OF DEPICENCIES (SAUMARAY STATEMENT OF DEPICENCIES PROPERLY OF CORRECTION (SAUMARAY STATEMENT OF DEPICENCIES PROPERLY OF COMMERCE OF CROSS-REFERENCE OF CATOON SPOULD SE CROSS-REFER	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD			(X3) DATE SURVEY COMPLETED	
PACINITY STREET HOME VOCA-OTIS STREET HOME VOCA-OTIS STREET HOME VOCA-OTIS STREET HOME VOCA-OTIS STREET HOME VALUE OF SUMMARY STATEMENT OF DEPOCIENCIES (EACH DEFICIENCY MUST BE RECECED BY TRUL RESOLUTIONY OR LIST DENTIFYING INFORMATION) W 460 Continued From page 18 During observations in the home on 8/24/22 at 6:15am, client #3 received her morning medications with water. Further observation at 6:40am, client #3 received methanically softened warflies, scrambled eggs and canned mixed fruit unmodified. Review on 8/23/22 of client #3's nutritional evaluation dated 5/1/20 revealed client #3 is supposed to receive a mechanical soft diet with nectar thick liquids. The evaluation also reveals all foods should be served no thinner than nectar consistency. Staff should make sure not to over process fruits and vegetables and they should be drained before modifying to prevent them from being a watery consistency. Interview on 8/24/22 with Staff C revealed client #3 is supposed to be on mechanical soft and uses thickened liquids sometimes. Staff C also reveted client #3 is not supposed to have watery foods like jello because they make her cough. Interview on 8/24/22 with the home manager (HM) contirmed client #3 is supposed to be on mechanically soft diet with nectar thickened liquids. W 475 MEAL SERVICES CFR(s): 483.480(b)(2)(v) Food must be served with appropriate utensils. This STANDARD is not met as evidenced by. Based on observations, record review and interviews, staff did not ensure that 1 of 4 audit clients (#3) received the proper adaptive equipment will be discussed in a team meeting. C. All adaptive equipment will be accessible to the person served needing the equipment. During dinner observations in the home on			34G216	B. WING			<u> </u>	4/2022
W 460 Continued From page 18 During observations in the home on 8/24/22 at 6.15am, client #3 received her morning medications with water. Further observation at 6.40am, client #3 received mechanically softened waffles, scrambled eggs and canned mixed fruit unmodified. Review on 8/23/22 of client #3's nutritional evaluation dated 5/1/20 revealed client #3 is supposed to receive a mechanical soft dist with nectar thick liquids. The evaluation also reveals all foods should be served no thinner than nectar consistency. Staff should make sure not to over process fruits and vegetables and they should be drained before modifying to prevent them from being a watery consistency. Interview on 8/24/22 with Staff C revealed client #3 is supposed to be on mechanical soft and uses thickened liquids sometimes. Staff C also reveled client #3 is not supposed to have watery foods like jello because they make her cough. Interview on 8/24/22 with the home manager (HM) confirmed client #3 is supposed to be on mechanically soft diet with nectar thickened liquids. W 475 MEAL SERVICES CFR(s): 483 480(b)(2)(w) Food must be served with appropriate utensils. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, staff did not ensure that 1 of 4 audit clients (#3) received the proper adaptive equipment for 2 of 2 meals. The finding is: During dinner observations in the home on					241	S OTIS STREET IRHAM, NC 27707		
During observations in the home on 8/24/22 at 6:15am, client #3 received her morning medications with water. Further observation at 6:40am, client #3 received mechanically softened waffles, scrambled eggs and canned mixed fruit unmodified. Review on 8/23/22 of client #3's nutritional evaluation dated 5/1/20 revealed client #3 is supposed to receive a mechanical soft diet with nectar thick liquids. The evaluation also reveals all foods should be served no thinner than nectar consistency. Staff should make sure not to over process fruits and vegetables and they should be drained before modifying to prevent them from being a watery consistency. Interview on 8/24/22 with Staff C revealed client #3 is supposed to be on mechanical soft and uses thickened liquids sometimes. Staff C also reveled client #3 is not supposed to have watery foods like jello because they make her cough. Interview on 8/24/22 with the home manager (HM) confirmed client #3 is supposed to be on mechanical soft diet with nectar thickened liquids. W 475 This deficiency will be corrected by the W 475 following actions: A. OT will complete assessment on individuals. B. All adaptive equipment will be discussed in a team meeting. C. All adaptive equipment will be accessible to the person served needing the equipment. During dinner observations, record review and interviews, staff did not ensure that 1 of 4 audit clients (#3) received the proper adaptive equipment for 2 of 2 meals. The finding is: During dinner observations in the home on	PRÉFIX	(FACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETION
		During observation 6:15am, client #3 medications with v 6:40am, client #3 waffles, scramble unmodified. Review on 8/23/2 evaluation dated supposed to recenectar thick liquid all foods should be consistency. Staff process fruits and drained before medically a watery consistency of the second supposed to uses thickened liguidates water well and confirmed consistency. Interview on 8/24 #3 is supposed to uses thickened liguidates water w	ns in the home on 8/24/22 at received her morning water. Further observation at received mechanically softened diegs and canned mixed fruit. 2 of client #3's nutritional 5/1/20 revealed client #3 is ive a mechanical soft diet with s. The evaluation also reveals e served no thinner than nectar should make sure not to over livegetables and they should be odifying to prevent them from onsistency. //22 with Staff C revealed client to be on mechanical soft and quids sometimes. Staff C also is not supposed to have watery because they make her cough. //22 with the home manager client #3 is supposed to be on the diet with nectar thickened. S(b)(2)(iv) reved with appropriate utensils. It is not met as evidenced by: vations, record review and client ensure that 1 of 4 audit of 2 meals. The finding is:			This deficiency will be comfollowing actions: A. OT will complete a individuals. B. All adaptive equipmed discussed in a team. C. All adaptive equipmed accessible to the peneeding the equipment. D. Formal training will	ssessment on nent will be meeting, nent will be arson served nent.	10/23/2022

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		34 G216	8. WING		08/2	4/2022
NAME OF PROVIDER OR SUPPLIER VOCA-OTIS STREET HOME			I	SYREET ADDRESS, CITY, STATE, ZIP CODE 2415 OTIS STREET DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	RTEMENT 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 APPROPRIED TO THE	BE RIATE	(XS) COMPLETION DATE
W 475	room table and wa tacos and mashed of client #3 was a plate, weighted cu During breakfast of 8/24/22, client #3 was served mechaserambled eggs a the table in front of high-sided divided angled spoon and fed herself and attractive work weight for positioning and revealed fork use mechanical soft ditremors client #3 prongs. Interview with hor revealed that she	, client #3 sat at the dining is served mechanically ground potatoes. On the table in front plate raiser, high-sided divided p and built up angled fork. It is been been at the dining room table and anically ground waffles, and unmodified mixed fruit. On f client #3 was a plate raiser, a plate, a weighted cup, built up built up angled fork. Client #3	W 478	use of adaptive equipment. F. Site supervisor will monitor time a week. O. Qualified Professional will a one time a week.		