PRINTED: 11/16/2022

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

OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES AND	(X1) PROVIDER/SUPPLIER/CLIA	· (X2) MU	LTIPL	LE CONSTRUCTION	(X3) DAT	E SURVEY
PLAN OF CO		IDENTIFICATION NUMBER:	A. BUILI	DING			PLETED
							R
		34G216	B. WING			1	/04/2022
NAME OF PROVIDER OR SUPPLIER		B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	11/	0412022	
				ı	415 OTIS STREET		
VOCA-0	TIS STREET HOME	×		D	DURHAM, NC 27707		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX '	TAG	(EACH CORRECTIVE ACTION SHOULD)		COMPLETION
TAG	REGULATORY OR LS	C IDENTIFYING INFORMATION)			CROSS-REFERENCED TO THE APPROPRIATE DEF	ICIENCY)	DATE
W 000	(a)		W	000			
	INITIAL COMMEN	TS		į			
							1
		eted on 11/4/22 for all previous					
		8/24/22. Several deficincies were					
	corrected and some w						
{W 227}		560 (3) (4) (4) (4) (4) (4) (4) (4) (4) (4) (4	{W 2	27}	This deficiency will be corrected	by the	12.04.2022
	CFR(s): 483.440(c)(4	4)			following actions:		
		1			<ul> <li>A. All ISP's will be reviewed a</li> </ul>	soft Control to	
		am plan states the specific			modified as needed to ad-	dress	
		to meet the client's needs, as prehensive assessment required		-	objective trainings.	*	
	by paragraph (c)(3) of			1	<ul> <li>B. All individual served goals</li> </ul>		
<i>6</i> 77		not met as evidenced by: Based		j	be reviewed and modified	i	
		interviews with staff, the facility	٠.		based off their objective		
20		dividual program plan (IPP) for 1	*		training needs.	İ	
	of 4 audit clients (#2)				<ul> <li>C. Active treatment will be</li> </ul>		
		neet his priority training needs		-	provided to all individuals	1	
		g and money management. The		ı	served.		
8	finding is:	6			<ul> <li>D. Written training programs</li> </ul>		
	D 11/4/22 - 6	Saliant Hala IDD dated			be implemented based on		
	Review on 11/4/22 of				goals, strategies and need	S	
		ad priority training needs which noney management. Further			identified by team.		
		ealed no programs identified in		i	<ul> <li>E. Qualified Professional will</li> </ul>		
	money management of				service all staff on individu	al's	
					ISP's and goals.		
	Review on 11/4/22 of	the facility's plan of correction			F. Qualified Professional will	55	. 1
	dated 9/7/22 revealed	the following: "(A) All ISP's		Ì	monitor one time a week		~
	will be reviewed and	modified to address objective			will address any changes i	n	1
2		vidual served goals will be			core team meetings		
		d based off their objective needs					
		will be provided to all					
		Written training programs will					
	•	d on any goals, strategies and			¥	Ï	
		am Qualified Professional will					
ļ		individual's ISP's and goals (F)					1
	Qualified Professiona	I will monitor one time per week		!			1
	and						
ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE	E	7.	TITLE S	1112	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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:LWT412

Facility ID: 922342

If continuation sheet Page 1 of 4

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	***************************************	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			SUR VEY LETED
						R	
		34G216	B. WING			11/0	4/2022
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-O	TIS STREET HOME			1000	415 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	ΓAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE DE	BE	(X5) COMPLETION DATE
{W 227}			{W 2	27}			
*	Interview on 11/4/22	ges in core team meetings."  with the Program Director					u e
{W 263}	revealed there was n in the areas of mone PROGRAM MONIT CFR(s): 483.440(f)().  The committee shou conducted only with the client, parents (it guardian. This STANDARD is on record review and staff, the facility fail	ot identified training for client #2 y management and dining. FORING & CHANGE 3)(ii)  Id insure that these programs are the written informed consent of the client is a minor) or legal is not met as evidenced by: Based d confirmed by interviews with ed to ensure restrictive behavior	{W 2	63}	following actions:  A. The Qualified Professional review all behavior support B. All behavior support plans address the current needs a technique to manage inapped behavior.  C. All proper techniques will	will plans. will nd ropriate	12.04.2022
	programs were only informed consent of of 4 audit clients (#2 A. Review on support program (B) objective to decreas for 12 consecutive revealed this program Risperidone and Sertraline. Review of signed by client #2's 12/11/19 and this wexpire on 11/20/20.  B. Review on 11/26/29 revealed a of failure to cooperamonths. Additional	conducted with the written a legal guardian. This affected 2 2 and #3). The findings are:  11/4/22 of client #2's behavior SP) dated 11/20/19 revealed an elepisodes of self-injury per month nonths. Further review of this BSP mincorporated the use of the BSP consent revealed it was a guardian of the person on ritten informed consent would  11/4/22 of client #3's BSP dated in objective to exhibit zero episodes are per month for 12 consecutive review of client #3's BSP revealed orates the use of Clonazepam and		٠	to manage behaviors.  D. Psychologist will review al E. HRC approval and the proposition of BSP's.  F. The Qualified Professional review and obtain guardian consent.  G. Qualified Professional will and document this monthly	l plans. per or all will monitor	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
						R	
34G216		B. WING		11/04/2022			
NAME OF PROVIDER OR SUPPLIER  VOCA-OTIS STREET HOME		2	STREET ADDRESS, CITY, STATE, ZIP CODE 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 APPROPRIATE DE	BE	(X5) COMPLETION DATE	
{W 263}			{W 263}				
{W 436}	was obtained by the 12/24/19 and this wriexpire 11/26/20.  Review on 11/4/22 or dated 9/7/22 revealed Qualified Professions programs. (B) All be current needs and technical behavior. (C) All promanage behaviors. (I plans (E) HRC approbe obtained for all BS Professional will review (G) Qualified Professional will review on 11/4/22 confirmed the facility informed consent for SPACE AND EQUITION CFR(s): 483.470(g)(3).  The facility must furnt teach clients to use an about the use of dention other communication identified by the interthe client. This STAN	saled written informed consent guardian on itten informed consent would if the facility's plan of correction if the following: "(A)The al will review all behavior support havior support plans will address thiniques to manage inappropriate per techniques will be used to D) Psychologist will review all loval, and the proper consents will SP's (F) The Qualified iew and obtain guardian consent. Sional will monitor and document with the Program Director (had not obtained written these BSP's.  PMENT 2)  Inish, maintain in good repair, and and to make informed choices weres, eyeglasses, hearing and as aids, braces, and other devices redisciplinary team as needed by NDARD is not met as evidenced	{W 436}				
	interview the facility	ations, record review and failed to assure for 1 of 4 audit int to use and make informed of eyeglasses.					
STATEMENT PLAN OF COI	OF DEFICIENCIES AND RRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G216	B. WING			R 11/04/2022	

OMB NO. 0938-0391

	The same of the same same same same same same same sam		STREET ADDRESS, CITY, STATE, ZIP CODE				
NAME OF PROVIDER OR SUPPLIER			2415 OTIS STREET				
	TO GENERAL HOME	- 1	DURHAM, NC 27707				
OCA-O1	IS STREET HOME						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TA	FROVIDER OF COMPLETION				
(0.6)	G. C. J.F. war 2002	{W 436	This deficiency will be corrected by the 12.04.2022				
W 436}	Continued From page 3	(1	following actions:				
	Throughout observations in the facility on 11/4/22 from 7:15am-9am client #1 was not observed to wear		A. All adaptive equipment will be				
	glasses. Her glasses were not located in her bedside		discussed in a team meeting.				
	table, the medication closet or in the back pocket of		B. All people served will be in-				
	her wheelchair.		serviced on their adaptive				
	ner wheelenan.		equipment and the importance of				
	Review on 11/4/22 of a visual assessment dated March		wearing/using their adaptive				
	2022, prior to her placement on 5/2/22, client #1 was		equipment.				
	seen by an Optometrist and given a prescription to		C. All adaptive equipment will be				
	obtain reading glasses.		accessible to the person served				
			needing the equipment.				
	Review on 11/4/22 of the facility's plan of		needing the equipment.				
	correction dated 9/7/22 revealed the following: (A)	Ē.	D. Formal training will be completed				
	All adaptive equipment will be discussed in a team		for the use of adaptive equipment-				
	meeting (B) All people served will be in-service on		eyeglasses				
	their adaptive equipment and the importance of		E. All people served will be assessed				
	wearing/using their adaptive equipment (C) All		for the use of adaptive equipment.				
	adaptive equipment will be accessible to the person served needing the equipment(D) Formal training will		F. Qualified Professional will				
	be completed for the use of adaptive equipment-		implement a formal goal.				
	eyeglasses (E) All people will be assessed for the use		G. All staff will be in-serviced of the				
	of adaptive equipment (F)Qualified Professional will		use of adaptive equipment.				
	implement a formal goal (G) All staff will be in-		H. Site Supervisor will monitor one				
	serviced of the use of adaptive equipment (H) Site		time a week.				
	Supervisor will monitor one time a week (I) Qualified		I. Qualified Professional will monitor				
	Professional will monitor one time per week.		one time a week				
	Interview on 11/4/22 with the Program Director						
	revealed client #1 does not currently have glasses.						
	The state of the s		92				