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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G216	A. BUILDING ______ B. WING ______	C 03/15/2024

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A complaint survey was completed on March 15, 2024 for intake #NC00214099. The complaint was substantiated with deficiency.	W 000		
W 342	NURSING SERVICES CFR(s): 483.460(c)(5)(iii) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff were competent to recognize signs and symptoms of new conditions to be reported to the nurse. This affected 1 of 1 audit clients (#5). The finding is: Record review on 3/15/24 revealed client #5 initially injured her finger in a French door in the home and required emergency room treatment. Client #5 was instructed to wear a sling on right hand and to elevate arm to reduce swelling. On 1/17/24, while unsupervised in her room, client #5 admitted to applying nail polish on her injured right ring finger, that led to an infection. Staff transported client #5 to the emergency room, where the finger was treated and placed in a cast for two weeks. Staff were reporting client #5 would remove the dressing on hand and had to be verbally prompted often to not "dig in her purse" with injured hand, but was not easily redirected.	W 342		

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

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W 342	Continued From page 1 Record review on 3/15/24 of client #5's daily body audits forms revealed on 2/23/24, 2/24/24 and 2/25/24 staff had recorded a "pin in skin" on hand on the form. There was no record the nurse was notified to triage the condition until 2/27/24. On the 2/27/24 Triage call, client #5's finger was described as swollen and it looked like the pin was trying to come through. Record review on 3/15/24 of client #5's hospital admission summary records on 2/27/24 revealed she presented with pain, swelling and purulent drainage. There were findings and concerns for severe infection to the K wire placement as well as osteomyelitis. A decision was made upon further exam to partially amputate the right ring finger to the mid-middle phalanx. Client #5 was discharged from the hospital on 2/29/24. Interview on 3/15/24 with the house manager (HM) revealed client #5 did not tolerate wearing the sling and dressing on injured right finger and would remove them. The HM revealed client #5 liked to use cosmetics and purchased nail polish or was given polish at the day program. The HM added that client #5 liked to carry a large pocketbook and would carry a lot of contents in it and would dig around in her purse, even with injured hand. The HM stressed she had to insist the doctor use a cast on client #5's hand after the 2nd injury to finger in January, 2024 because of risks of reinjure finger. Interview on 3/15/24 with the guardian revealed client #5 liked to wear cosmetics that were sometimes given to her and she expected her to be supervised to prevent new injuries. The guardian revealed she might have spoken to a nurse in the home on 2/22/24 who had examined	W 342		

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W 342	Continued From page 2 client #5's injured finger and it looked fine. The guardian revealed concerns if the finger's condition deteriorated after the visit, why staff did not contact the nurse again, which might have prevented part of the finger being amputated on 2/27/24. Interview on 3/15/24 with the Program Director (PD) revealed at the time of the injury to client #5's right middle finger, the facility did not employ a full-time nurse. Instead, the facility contracted with virtual nursing services, who staff would contact and have the nurse triage the clients' conditions. The PD acknowledged she had a record of all of the calls made to the virtual nurse. The PD confirmed she examined client #5's finger on 2/21/24 and it "looked fine" and that there was no record of any calls to the virtual nurse in February 2024 until 2/27/24.	W 342		