STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G225	A. BUILDING _____ B. WING _____	05/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-GENTRY	2219 GENTRY DRIVE DURHAM, NC 27705

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E 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to develop specific facility-based risk assessment strategies relative to client information as part of their emergency plan. The finding is: The facility failed to develop specific risk	E 006		

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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E 006	Continued From page 1 assessment strategies to address possible hazards specific to the facility's location. Review on 5/2/18 of the facility's Emergency Management Program (EMP) revealed the EMP to contain a thorough risk assessment and community-based strategies. However, further review of the EMP revealed no method of communicating the specific needs of the clients in the group home. Interview on 5/2/18 with the Program Manager and the Executive Director revealed the facility had not completed an all hazards risk assessment as of the date of the survey.	E 006		
E 020	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.475(b)(3) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):]	E 020		

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E 020	Continued From page 2 Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop specific policies and procedures to address emergency preparedness including evacuation locations based on a community and facility risk assessment. The finding is: The facility failed to develop a specific plan for possible evacuation of the clients in the facility in the event of an emergency. Review on 5/2/18 of the facility's Emergency Management Plan (EMP) revealed there were no	E 020		

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E 020	Continued From page 3 evacuation locations for the clients listed in this plan. There were no contracts or agreements with shelters, hotels, alternate locations should it become necessary for the clients to evacuate from the facility. Interview on 5/2/18 with the Program Director and the Executive Director revealed the facility had not identified alternate locations for the clients should it become necessary to evacuate from the facility. Additional interview revealed this had been discussed at the management level but no formal plan had been developed.	E 020		
E 032	Primary/Alternate Means for Communication CFR(s): 483.475(c)(3) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to develop a plan for alternate communication with facility staff and guardians for clients should phones become inoperable in an	E 032		

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E 032	Continued From page 4 emergency. The finding is: The facility failed to develop a specific plan for alternate communication with guardians and facility staff should phones become inoperable in a facility emergency. Review on 5/2/18 of the facility's emergency management plan (EMP) revealed there was no alternate arrangement for communication should primary phones be unavailable in an emergency. Interview on 5/2/18 with the Program Director and the Executive Director revealed there was no alternate communication plan should primary communication become inoperable.	E 032		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record/document reviews and interview, the facility failed to ensure data relative to the accomplishment of objectives was documented in measurable terms. This effected 1 of 3 audit clients #3 The finding is: Facility staff failed to collect data as prescribed in client #3's individual program plan (IPP). Review on 5/3/18 of client #3's IPP dated 3/27/18 revealed several written training programs to be	W 252		

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W 252	Continued From page 5 implemented in April 2018 which included: a) Participating in flossing his teeth with 80% compliance for 3 consecutive months. b) Will identify the number 5 when prompted with numbered coins with 85% for 2 consecutive months. c) Will monitor toileting needs every 2 hours throught all shifts. d) Will complete task of exercise with 75% participation for 3 consecutive months Interview on 5/3/18 with the Residential Manager revealed direct care staff are training client #3 on these programs. Further interview revealed the Qualified Intellectual Disabilities Professional (QIDP) had not assembled client #3's program book so data could be collected in one central location. Interview on 5/3/18 with the Program Director revealed the QIDP has been out and she had not assembled client #3's program book. He confirmed client #3's programs are being implemented. Additional interview revealed the QIDP usually assembles hte program book so direct care staff can collect program data in one central location.	W 252		
W 255	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(i) The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has	W 255		

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W 255	Continued From page 6 successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and interview, the Qualified Intellectual Disabilities Professional (QIDP) failed to ensure the individual program plan (IPP) for 1 of 3 audit clients (#1) was reviewed after she completed written training objectives. The findings are: The QIDP failed to consider additional training for client #1 after she met criteria for completion for 2 of 5 written training objectives. Review on 5/3/18 of client #1's IPP dated 5/19/17 revealed two written training objectives to complete toothbrushing and washing her hands that were implemented on 5/19/17. Summary of the data for these objectives is as follows: a) Will complete toothbrushing process with 80% independence for 3 consecutive months. November 2017: 88% December 2017: 95% January 2018: 88% met criteria for 3 consecutive months February 2018: 88% b) Will wash hands with 75% Independence for 6 consecutive months. June 2017: 80% July 2017: 80% August 2017: no data September 2017: no data October 2017: 83% November 2017: 92% December 2017: 100%	W 255		

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W 255	Continued From page 7 January 2018: 92% met criteria for 6 consecutive months February 2018: 30% Interview on 5/3/18 with the Residential Manager confirmed both of these programs are trained as total task objectives, training all steps of these objectives when they are implemented. Interview on 5/3/18 with the Program Director revealed client #1 had met criteria for completion for both of these formal programs however, she had not been considered for additional training.	W 255		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the system for drug administration failed to assure all drugs were administered in compliance with physician's orders for 1 of 3 audit clients (#1). The finding is: Staff failed to administer medications as ordered by the physician for client #1. Observation on 5/2/18 of the medication administration pass on 5/2/18 revealed client #1 received Carvedilol 12.5 mg. at 4:10pm. This medication was taken with water. Observation on 5/2/18 of the supper meal revealed client #1 began eating at 5:50pm.	W 368		

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W 368	Continued From page 8 Review on 5/2/18 of client #1's physician orders dated 2/6/18 revealed, "Carvedilol 12.5. mg. Give 1 tablet by mouth twice daily at 7am and 5pm. Take medication with meals." Interview on 5/3/18 with the direct care staff who administered medications on 5/2/18 revealed she was instructed by the Facility Nurse if there are instructions during the medication pass to "Give with meals" to offer pudding, applesauce, crackers, etc. if medications are given outside of 30 minutes of a meal. She confirmed this was not followed on 5/2/18 at 4:10pm with client #1. Interview on 5/3/18 with the Program Director revealed staff should follow specific instructions by the Facility nurse when administering medications.	W 368		