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
	34G282	A. BUILDING _____ B. WING _____	05/02/2018

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VOCA-LAUREL WOOD	200 LAUREL WOOD DR SMITHFIELD, NC 27577

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E 013	Development of EP Policies and Procedures CFR(s): 483.475(b) (b) Policies and procedures. [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. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization 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 address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility 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. These	E 013	To correct this citation the following will be done: 1. Regional QA Manager will revise and or develop new policy and procedure which addresses a. the communication plan implemented in crisis that includes how home's information will be shared between homes, offices, and stakeholders and guardians/families. b. Use of the risk assessment in development of emergency procedures and inclusion of risk assessment in the Emergency Plan c. Specific information that will be contained in the Emergency Plan and how this informaiton will be maintained in the Emergency Preparedness Manual 2. RQAM will send New/Revised policies to Executive Directors to be implemented upon receipt 3. ED will review policy with managers and give copy of policy to each home for the Emergency Preparedness Manual. 4. Residential Managers will train staff on the policy as well as the procedures contained in the Emergency Preparedness Manual 5. During monthly site visits, the ED or designee will review the Emergency Preparedness Manual to ensure that all information is current. 6. Annually the Emergency Preparedness Manual will be reviewed/updated as needed. 7. Annually the RQAM, Regional Manager and Executive Directors will review and update Emergency Policies as needed. RECEIVED MAY 16 2018 DHSR-MH Licensure Sect	6/30/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Executive Director 5/11/18

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 013	Continued From page 1 emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure policies and procedures were developed and implemented based the facility's emergency preparedness (EP) plan. The finding is: The facility's EP plan did not include relevant policies and procedures. Review on 5/1/18 of the facility's EP plan dated 9/21/17 did not include any specific policies and procedures regarding the emergency plan, risk assessment and communication plan. Interview on 5/2/18 with the Qualified Intellectual Disabilities Professional (QIDP) indicated the facility was in the process of developing policies and procedures for their EP plan; however, none had been completed as of the date of the survey.	E 013		
E 037	EP Training Program CFR(s): 483.475(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at	E 037		

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E 037	Continued From page 2 least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:	E 037	To correct this citation the following will be done: 1. All new hires completing orientation will take on line training for FIRE SAFETY; and WORKPLACE EMERGENCIES AND NATURAL DISASTERS: AN OVERVIEW 2. All new hires will receive training from his/her Supervisor/trainer on the Emergency Preparedness Manual for his/her assigned work site. 3. Staff must successfully pass a test on their knowledge of the Emergency Plan. 4. A certificate of training completion will be done by the Supervisor/trainer and place in the staff Training File along with the test. 4. Annually all staff will receive refresher training, completing a knowledge test of the Emergency Plan. The test and a certificate will be place in the staff training file.	6/30/18

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E 037	Continued From page 3 (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency	E 037		

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E 037	Continued From page 4 procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This STANDARD is not met as evidenced by:	E 037		

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E 037	Continued From page 5 Based on interview and record review, the facility failed to ensure direct care staff were adequately trained regarding the facility's emergency preparedness (EP) plan. The finding is: Staff had not received EP training as indicated. Review on 5/1/18 of the facility's EP plan dated 9/21/17 revealed no specific training for direct care staff. Staff interviews (2) on 5/2/18 revealed they have been trained regarding monthly fire/disaster drills; however, the staff could not provide specific details regarding the facility's EP program. Additional interview on 5/1/18 with the Qualified Intellectual Disabilities Professional (QIDP) and the facility's home manager revealed staff have not received training on the facility's most current EP plan and no training documentation was provided. Further interview on 5/2/18 with the QIDP revealed they were preparing to train direct care staff on the facility's most current emergency plan; however, the training was not complete.	E 037		
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test	E 039		

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E 039	Continued From page 6 the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated,	E 039	The following will be done to correct this citation: 1. The ED or designee will contact the City of Smithfield and or Johnston County Emergency Management to inquire about city/county wide Disaster Drills 2. If possible, the home will participate in the drill 3. If a community wide drill is not held before July, the ED and RQAM will design a disaster senario and run an individual, facility based drill. 4. A copy of the drill senario will be attached to the Disaster Drill report. 5. Going forward Disaster Drill Reports will include information about the senario run or discussed in a table top activity 6. Results of drills will be reviewed by the Residential Manager and QP, and by the Safety Committee 7. Individual specific issues will be addressed by the Treatment Team and training put in place as needed.	6/30/18

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E 039	Continued From page 7 clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure facility/community-based or tabletop exercises to test their emergency plan were conducted. The finding is: The facility's emergency preparedness (EP) plan did not include completion of facility/community-based exercises or tabletop exercises. Review on 5/1/18 of the facility's EP plan dated 9/21/17 did not include a full-scale community-based or individual facility-based exercise or a tabletop exercise to test their emergency plan. Interview on 5/2/18 with the Qualified Intellectual Disabilities Professional (QIDP) indicated the facility has not conducted a full-scale facility/community-based exercise or a tabletop exercise to test the effectiveness of their current emergency plan.	E 039		
W 120	SERVICES PROVIDED WITH OUTSIDE SOURCES CFR(s): 483.410(d)(3) The facility must assure that outside services meet the needs of each client.	W 120		

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W 120	Continued From page 8 This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure day program staff were sufficiently trained to use latex gloves appropriately. This affected 2 of 3 audit clients. (#3, #6). The finding is: Day program staff were not adequately trained to wear gloves appropriately. During observations at the day program on 5/1/18 from 11:01am - 12:05pm, three staff wore latex gloves while preparing food for each client. The staff continued to wear gloves while touching various items such as the refrigerator door handle, handle/buttons on the microwave, handles on a wheelchair, lunch bags, training books and surfaces of tables. One staff continued to wear the same gloves while feeding client #3 his lunch. Another staff prepared client #6's food and drink items on her plate while wearing the same gloves. Interviews on 5/1/18 with day program staff (2) revealed they had been trained to wear gloves while preparing food for "sanitary" reasons. During the interview, the staff acknowledged once other surfaces and items were touched, the gloves could be contaminated. Interview on 5/1/18 with the day program supervisor revealed the staff had been trained regarding universal precautions including the use of gloves when exposure to bodily fluids was likely or while toileting clients. Additional interview indicated gloves would only be worn when feeding a client, depending on the needs of	W 120	To correct this citation the following will be done: 1. Director of Wake Enterprises to inform staff of correct use of gloves during meal prep and assisting individuals with meal 2. CANC Nurse to inservice Wake Enterprises staff regarding cross contamination and proper use of gloves 3. Residential Manager to randomly monitor Meal times at Wake Enterprises bi-weekly to ensure appropriate use of PPE/gloves 4. QP will randomly monitor Wake Enterprises staff monthly for appropriate use of PPE/ gloves. 5. RM and QP will inform the QP at Wake Enterprises of any issues observed.	7/3/18

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W 120	Continued From page 9 that client. Further interview noted staff were likely wearing gloves during lunch preparation based on "personal preferences". During an interview on 5/2/18, the facility's nurse acknowledged gloves can be easily contaminated and staff should practice good handwashing. Interview on 5/2/18 with the home manager revealed staff had not been observed wearing gloves during visits to the day program and she was not sure why they would be wearing them during food preparation.	W 120		
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure client #6's individual support plan (ISP) included specific information to support her independence. This affected 1 of 3 audit clients. The finding is: Client #6's ISP did not include specific instructions regarding the use of a foot stool. During observations in the home throughout the survey on 5/1 - 5/2/18, a foot stool was located near where client #6 was seated while in the living and at the dining room table. During observations on 5/2/18, client #6 was seated at a table in the living room. Even though the foot stool was located under the table, client #6 was	W 240	This citation will be corrected by the following actions: 1. ED or designee will arrange for OT consult on recommendations for best chair to meet needs of the individual 2. Current chair will be replaced by an more appropriate chair, per OT recommendation 3. Staff will be inserviced on use of appropriate seating for individual 4. Residential Manager will utilized IPP monitoring form weekly to ensure all individuals have appropriate seating. 5. QP will monitor monthly to ensure all individuals have appropriate seating. Any concerns for seating will be referred to OT or PT as appropriate.	

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W 240	Continued From page 10 not prompted or assisted to position her feet on the stool. At breakfast on 5/2/18, client #6 was seated at the table while consuming her meal; however, her feet were not positioned on the foot stool located underneath the table. Staff interview on 5/2/18 revealed client #6 should have her feet positioned on the foot stool any time she is seated at the activity table or dining room table. Review on 5/2/18 of client #6's ISP dated 2/14/18 did not include any information regarding the use of a foot stool for the client. Interview on 5/2/18 with the home manager (HM) and Qualified Intellectual Disabilities Professional (QIDP) indicated client #6 should have her feet positioned on the foot stool when she is seated to prevent her feet from dangling. Additional interview confirmed the use of the foot stool should be included in the client's ISP; however, it had been omitted.	W 240	This citation will be corrected by the following: 1. Residential Manager will retrain all staff on food preparation and diet consistencies. 2. Staff will perform return demonstration and documentation will be placed in staff training record 3. QP will inservice staff on Active Treatment and family style dining 4. Core Team will review needs/abilities of each individual and reassess mealtime goals 5. QP will inservice staff on client specific training needs, especially as they relate to mealtime goals/guidelines/assistance 6. Residential Manager will monitor meals twice a week to ensure meals are served per diet order with approriate consistency 7 RM will also monitor to ensure mealtime guidelines and goals are being followed, and individuals are encouraged to be as involved in meal prep and during mealtime as possible 8. QP will monitior meals once a week	
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by:	W 249		7/3/18

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W 249	Continued From page 11 Based on observations, interviews and record review, the facility failed to ensure a pattern of interactions between clients and staff supported the implementation of individual support plan (ISP) in the areas of food consistency and dining skills. This affected 1 of 3 audit clients (#3). The finding is: 1. Client #3's food was not prepared to the appropriate consistency. During breakfast observations in the home on 5/2/18 at 6:45am, client #3 was served oatmeal. The oatmeal was very thick, lumpy and dry. Client #3 was fed the oatmeal by staff. Staff interview on 5/2/18 revealed client #3 should receive a pureed diet. Review on 5/2/18 of client #3's ISP dated 3/27/18 revealed, "Regular diet pureed consistency with nectar thickened liquids." Interview on 5/2/18 with the home manager (HM) confirmed client #3's food should be prepared to a pureed consistency which would be smooth and without lumps. 2. Client #3 was not encouraged to participate with dining tasks. During breakfast obnservations in the home on 5/2/18 from 6:45am - 7:08am, staff fed client #3 his meal and held his adaptive cup for him. Client #3 was not afforded the opporunity to participate with these tasks. Staff interview on 5/2/18 revealed client #3's "hands can't really open up". The staff stated, "If	W 249		

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VOCA-LAURELWOOD	200 LAURELWOOD DR SMITHFIELD, NC 27577

(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 249	Continued From page 12 he resists hand-over-hand, we just feed him." Review on 5/2/18 of client #3's ISP dated 3/27/18 revealed, "Maximize independence with meals and assist as needed." Additional review of the plan identified an objective to accept hand over hand assistance to hold his cup for 80% of the time for 6 consecutive months. Further review of the client's Occupational Therapy (OT) evaluation dated 3/25/18 noted, "Staff should offer hand over hand assistance to help pt scoop and bring the loaded spoon to his mouth. If pt resists hand over hand assistand then staff should passively feed pt with the maroon spoon. Encourage pt to hold cup in L hand and bring it to mouth." Interview on 5/2/18 with the HM revealed staff should be following the instructions from the OT evaluation regarding client #3's assistance with eating and drinking.	W 249		
W 312	DRUG USAGE CFR(s): 483.450(e)(2) Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure a medication used for behavior management was not ordered on a PRN basis. This affected 1 of 3 audit clients (#5). The finding is:	W 312	This citation will be corrected by the following: 1. RN will review all medication orders monthly to ensure prn psychotropic medications are not ordered 2. If a prn medication is ordered the QP or RN will contact the prescribing doctor to have the order discontinued. 3. For individual #5 the psychitrist and psychologist were notified of need to discontinue prn medication 4. QP or designee will train staff on the ICF regulation regading use of prn medications 5. Psychologist will revise the BSP for Individual #5 to remove use of prn meds 6. Staff accompaning individuals to psych appointments will inform psychiatrist that no prn psychotropic meds may be used, if the psychiatrist discusses prescribing prn 's for the individual	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G282	A. BUILDING _____ B. WING _____	05/02/2018

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W 312	Continued From page 13 Client #5's Seroquel, used for behavior management, was ordered on a PRN basis. Review on 5/2/18 of client #5's Behavior Support Plan (BSP) dated 3/26/18 revealed an objective to address inappropriate behaviors of noncompliance, agitation, inappropriately pulling up her dress, self-injurious behaviors (SIB) and physical aggression. Additional review of the plan identified the use of Seroquel as a PRN medication. Further review of client #5's PRN physician's orders dated 51/18 included Quetiapine (Seroquel) 25 mg to be taken by mouth every 8 hours as needed for agitation or anxiety. Interview on 5/2/18 with the home manager (HM) confirmed client #5 receives Seroquel on a PRN basis to address agitation. The HM indicated the client has not needed the PRN medication for a while and redirection to address behaviors has worked well.	W 312		