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	34G181	A. BUILDING _____ B. WING _____	05/30/2019

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VOCA-MEADOWOOD DRIVE GROUP HOME	401 MEADOWOOD STREET GREENSBORO, NC 27409

(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
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 record review and interview, the facility failed to develop specific facility-based strategies as part of their emergency plan. The finding is: Review of the facility's Emergency Plan (EP) on 5/29/19 revealed the EP did not contain a thorough risk assessment or community-based	E 006		

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

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E 006	Continued From page 1 strategies. Further review of the EP, and substantiated by interview with the facility administrator, revealed that the EP was written in a more general way to accommodate the needs for all of the group homes and day program owned by the facility. Continued review of the EP and interview with the administrator revealed some additional facility-based information needed to be developed to address the specific needs of the clients in the group home. For example: A. Review of the facility's EP revealed information regarding the residents of the group home was limited to the general information contained on an information face sheet. Further review of the EP and interview with the qualified intellectual disability professional (QIDP) revealed no information regarding the specific needs of the 5 residents of the group home to assist anyone unfamiliar with the residents working with them in an emergency situation. B. Review of the EP substantiated by interview with the QIDP and administrator revealed during emergencies one of the highest needs would be food and water. Observations conducted in the group home, substantiated by interview with the group home manager, revealed an inadequate supply of food and water designated for use by staff and clients during an emergency was available to meet subsistence needs.	E 006		
E 009	Local, State, Tribal Collaboration Process CFR(s): 483.475(a)(4) [(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:]	E 009		

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E 009	Continued From page 2 (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This STANDARD is not met as evidenced by: The facility failed to develop an Emergency Preparedness Plan (EP) which included a process for cooperation and collaboration with local, state and federal emergency preparedness officials' efforts of an integrated emergency response or documentation of the facility's efforts to contact such officials as evidenced by interview and record verification. The finding is: Review on 5/29/19 of the facility's EP revealed a document from a local health club stating the group home has permission to use the facility for shelter needs during an emergency evacuation.	E 009		

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E 009	Continued From page 3 Interview on 5/30/19 with the qualified intellectual disabilities professional (QIDP) and substantiated by the facility administrator revealed that although a designated location was identified for evacuation if needed, no contact had been made with local emergency management resources to determine what is available locally in case evacuation is not possible. Interview with the facility administrator on 5/30/19 substantiated the facility's EP did not include documentation of efforts for ensuring cooperation and collaboration with local, tribal, regional, state, and federal emergency preparedness officials for an integrated response during a disaster or emergency situation.	E 009		
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	E 013		

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E 013	Continued From page 4 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 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 review of facility documents and staff interviews, the facility failed to ensure policies and procedures were developed and updated based on the facility's emergency preparedness (EP) plan. The finding is: Review conducted on 5/30/19 of the facility's EP included general information for emergency preparedness. The EP plan did not include current policies and procedures regarding the emergency plan, risk assessment or the communication plan. Interviews conducted on 5/29/19 and 5/30/19 with the qualified intellectual disabilities professional	E 013		

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E 013	Continued From page 5 and the administrator on 5/30/19 verified the EP plan did not include current policies and procedures relative to the facility's emergency response plan.	E 013		
E 029	Development of Communication Plan CFR(s): 483.475(c) (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. This STANDARD is not met as evidenced by: Based on review of facility documents and staff interviews, the facility failed to ensure policies and procedures were developed and updated based on the facility's emergency preparedness (EP) plan. The finding is: Review conducted on 5/30/19 of the facility's EP included general information for emergency preparedness; however, the EP did not include current policies and procedures regarding the emergency plan, risk assessment and the communication plan. Interviews conducted on 5/29/19 and 5/30/19 with the qualified intellectual disabilities professional and the administrator on 5/30/19 verified the EP plan did not include current policies and procedures relative to the facility's emergency response plan.	E 029		
E 036	EP Training and Testing CFR(s): 483.475(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is	E 036		

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E 036	Continued From page 6 based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure direct care staff were adequately trained on the facility's emergency preparedness plan (EP). The finding is:	E 036		

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E 036	Continued From page 7 Review on 5/29/19 of the facility's EP revealed no documentation of consistent staff training or annual staff training related to the EP. Interview on 5/29/19 conducted in the group home with staff D revealed staff had been trained regarding fire drills and disaster drills, that clients would evacuate to a nearby health club in the event of an emergency or disaster. Staff D could not provide specific details regarding the facility's EP program. Interviews on 5/30/19 conducted with the qualified intellectual disabilities professional (QIDP) and administrator revealed the EP was mentioned in regards to the fire drill and disaster drills during staff meetings in the home. Further interview verified no specific EP training such as tabletop exercises, mock evacuations or testing to evaluate what staff may or may not know regarding the facility EP goals and processes had been conducted.	E 036		
W 148	COMMUNICATION WITH CLIENTS, PARENTS & CFR(s): 483.420(c)(6) The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: The facility failed to show evidence guardians were promptly notified of an investigation involving 3 of 3 sampled clients (#2, #3, #4) and	W 148		

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W 148	Continued From page 8 2 of 2 non-sampled clients (#1, #5) for 1 of 1 investigations reviewed as evidenced by interview and review of records. The finding is: Review on 5/30/19 of the facility investigation reports for abuse/neglect revealed an investigation that began on 3/16/19 where it was reported staff P left the facility at the end of night shift (11pm-7am) before staff arrived for day shift (7am-3pm) leaving clients alone and unattended. The investigation was substantiated and the staff P was terminated. Additional review of the investigation report revealed no evidence the Department of Social Services (DSS) for Guilford County or the guardians for all 5 clients residing in the home were notified of the abuse/neglect incident/investigation. Review of the facility policy and procedure manual revealed "The investigator will be responsible for ...follow up reports and calls to the DFS". "The family/guardian and advocate should be informed within 24 hours of the investigation's initiation." Interview on 5/30/19 with the investigator that conducted the internal investigation revealed he did not contact DSS. Interview on 5/30/19 with the qualified intellectual disabilities professional (QIDP) revealed the guardians for all 5 clients that reside in the home were not notified. Further interview with the QIDP revealed the guardians for all 5 clients should have been notified. Therefore, the facility failed to show evidence DSS and guardians were notified promptly of any possible abuse or neglect of the residents.	W 148		
W 369	DRUG ADMINISTRATION	W 369		

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W 369	Continued From page 9 CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all medications were administered without error for 1 of 3 audit clients (#2). The finding is: During morning observations of medication administration on 5/30/19 at 7:30 AM, staff D administered client #2 medications to include oral and topical medications. Continued observations of client #2's medication administration revealed Tea Tree Oil was applied topically to both his feet in no apparent dosing quantity specification by staff D. Review on 5/30/19 of client #2's current physician's orders dated 5/13/19 and signed by the physician 5/15/19 revealed "Tea Tree Oil Apply twice daily to affected area(s) of feet after soaking in warm water and Pumice" with time directions to administer daily at 8:00 AM and at 8:00 PM. During an interview on 5/30/19 staff D revealed they apply enough Tea Tree Oil to both of client #2's feet. Continued interview revealed client #2's feet are soaked in warm water during his morning bath routine and the pumice is used afterwards. During an interview on 5/30/19, the qualified intellectual disabilities professional (QIDP) confirmed client #2's current physician's orders does not have the amount of Tea Tree Oil	W 369		

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W 369	Continued From page 10 to be applied to both of his feet.	W 369		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: The facility failed to assure all drugs and biologicals were kept locked except when being prepared for administration as evidenced by observation and interview. The finding is: During observations of morning medication administration in the home on 5/30/19, staff D left the medication room at 7:30 AM and at 8:00 AM with client #2 still in the room. During this time, pill packs of client #2's medications were left out on a desk in the medication room. Further observations revealed the facility's controlled medications box was left unlocked and open on a desk in the medication room. Continued observations revealed the medication closet contained within the medication room was left unlocked and open. In addition, the medication keys were left out on a desk in the medication room. During ongoing observations of morning medications in the home on 5/30/19, staff D left the medication room at 8:03 AM to take client #2 to the bathroom to wash his hair. During this time, the medication room area was left unlocked and open. Subsequent observations at 8:06 AM revealed staff D left the medication room area unlocked and open.	W 382		

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W 382	Continued From page 11 Interview on 5/30/19 at 8:30 AM with staff D revealed she should not have left the medications unsecured, the medication room area unlocked and open. Further interview revealed they have been trained to ensure the medications are locked and secured before leaving the area. Interview on 5/30/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed medication technicians have been trained to ensure access to the medication room area is secured and medications are locked before leaving the area during medication administration.	W 382		
W 383	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) Only authorized persons may have access to the keys to the drug storage area. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure the medication keys were not accessible to unauthorized individuals. The finding is: During observations of morning medication administration in the home on 5/30/19 at 7:30 AM and 8:00 AM, staff D left the medication keys on a desk in the medication room along with client #2's medications and the unlocked box of controlled medications. This allowed anyone to have access to the medications without staff supervision. Clients and other staff were observed to be near the medication room area during the time the medication room and medications were unlocked.	W 383		

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W 383	Continued From page 12 During an interview on 5/30/19, staff D confirmed medication keys were not to be left unsupervised. Further interview revealed they have been trained to ensure medications are locked and secured before leaving the area and possession of medication keys are retained at all times by the staff member administering medications. Interview on 5/30/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed medication technicians have been trained to ensure access to the medication room area is secured and medications are locked before leaving the area during medication administration.	W 383		
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure infection control prevention procedures were carried out to promote client health and to prevent possible cross-contamination. While this affected clients (#2 and #3) it potentially affects all clients residing in the home. The findings are: A. Client #2's adaptive equipment (helmet) was placed on the floor during the breakfast meal. Morning observations on 5/30/19 at 6:45 AM in the home revealed client #2 to sit in a chair at the dining room table consuming his pureed breakfast meal. Continued observations revealed client #2's helmet to be located on the dining	W 455		

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W 455	Continued From page 13	W 455		

room floor nearby him. Subsequent observations revealed client #2's mittens to be located on a living room chair. Ongoing observations revealed at 7:10 AM staff D retrieved client #2's helmet from the floor and placed his helmet on him.

Review on 5/30/19 of client #2's individual support plan (ISP) dated 1/10/19 revealed a behavior support plan (BSP) with a revision date of 1/12/19. Continued review revealed "[Client #2] still utilizes a helmet for protection from SIB, gloves for his hands to prevent injury during SIB..." Subsequent review of client #2's ISP revealed his medical diagnoses to include Renal Insufficiency, Diabetes Insipidus, and new onset Atrial Fibrillation.

Interview on 5/30/19 with staff D at 7:35 AM revealed client #2 has a self-injurious behavior (SIB) and his helmet is placed on the floor nearby client #2 during meals. Continued interview with staff D confirmed the floor may not be the ideal location to place client #2's helmet due to possible infection control and cross-contamination concerns. Interview on 5/30/19 with the qualified intellectual disabilities professional (QIDP) confirmed client #2's helmet should not go on the floor and the floor is unsanitary.

B. Client #3's adaptive equipment (helmet and mittens) was placed on the floor during the breakfast meal.

Morning observations on 5/30/19 from 6:45 AM to 7:21 AM in the home revealed client #3 seated at the dining room table consuming his pureed breakfast meal. Continued observations revealed client #3's helmet and mittens to remain placed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G181	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-MEADOWOOD DRIVE GROUP HOME	401 MEADOWOOD STREET GREENSBORO, NC 27409

(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 455	Continued From page 14 on the floor nearby him for this time period. Subsequent observations revealed at 7:21 AM staff D retrieved client #3's helmet and mittens from the floor and placed the helmet and mittens on client #3. Review on 5/30/19 of client #3's ISP dated 12/11/18 revealed the following for his adaptive equipment, "Mittens" for "Behavior Intervention" used "daily" for "BSP in place." Continued review revealed "Helmet" for "protection" used "daily" for "BSP in place." Interview on 5/30/19 with staff D at 7:35 AM revealed client #3 has a self-injurious behavior (SIB) and his helmet and mittens are placed on the floor nearby client #3 during meals. Continued interview with staff D confirmed the floor may not be the ideal location to place client #3's helmet and mittens due to possible infection control and cross-contamination concerns. Interview on 5/30/19 with the QIDP confirmed client #3's helmet and mittens should not go on the floor as the floor is unsanitary for placement of adaptive equipment.	W 455		