STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G218	A. BUILDING _____ B. WING _____	07/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-OBIE	322 OBIE DRIVE DURHAM, NC 27713

(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 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure privacy for 2 of 5 (#2, #5) audit clients. The findings are: Clients #2 and #5 were not afforded privacy while using the bathroom. a. During evening observations in the home on 7/16/19 at 5:17pm, client #2 opened the door of the bathroom while another client was standing in the bathroom with his pants and underwear down to his knees. Client #2 proceeded to void in the toilet. Further observations revealed the bathroom door remained open. At no time was client #2 prompted to exit the bathroom while the other client was in the bathroom. Review on 7/17/19 of client #2's community/home life assessment dated 6/9/18 he needs verbal cues when it comes to observing privacy. During an interview on 7/17/19, the home manager (HM) revealed client #2 needs to be encouraged to knock on doors before entering into the bathroom. During an interview on 7/17/19, the qualified intellectual disabilities professional (QIDP) revealed client #2 can independently knock on the bathroom door.	W 130		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G218	A. BUILDING _____ B. WING _____	07/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-OBIE	322 OBIE DRIVE DURHAM, NC 27713

(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 130	Continued From page 1 b. During evening observations in the home on 7/16/19 at 5:17 pm, client #5 left the bathroom door open while urinating. Review on 7/17/19 of client #1's individual program plan dated 2/7/19 revealed that he should be monitored when spending time in the bathroom. During an interview with the residential manager on 7/17/19 revealed that he expected staff to monitor clients going to the bathroom to make sure privacy was protected. During an interview with the QIDP on 7/17/19 revealed that staff should prompt clients to close the door, to ensure privacy.	W 130		
W 192	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure that all staff were sufficiently trained to properly apply medication patches, initiate communication with the nurse for any medication errors and to ensure clients receive necessary medical treatment for 1 of 5 audited clients (#1). The finding is: Staff were not sufficiently trained to recognize med errors, to initiate meds replacement or how to document the incidents of med errors.	W 192		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G218	A. BUILDING _____ B. WING _____	07/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-OBIE	322 OBIE DRIVE DURHAM, NC 27713

(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 192	Continued From page 2 During an observation of medication administration on 7/17/19 at 7:00 am, client #1 was missing an Exelon patch from 7/16/19 when staff A applied a new patch on 7/17/19. Review of June 2019 physician orders for client #1 on 7/17/19 revealed that client #1 should have an Exelon patch applied daily. The manufacturer's instructions, enclosed in the box of medication instructed the user "every 24 hours remove the old patch and apply a new patch. Press down firmly for 30 seconds until the edges stick well when applying to clean, dry, hairless, intact skin in a place that will not be rubbed up against by tight clothing. If a patch falls off or if a dose is missed, apply a new patch immediately and then replace this patch at the usual application time." In an addition, the Exelon Patch Administration Record for July 2019 was reviewed. In the column that indicated the old patch was removed, by staff's initials, there were four blanks (7/1/19, 7/2/19, 7/3/19 and 7/17/19) and on 7/9/19 and 7/13/19 N/A was recorded. There was a diagram to instruct user where to apply the patch each date. The patch applied on 7/16/19 by staff A should have been intact on client #1's lower back, right side, the morning of 7/17/19. During an interview with staff A on 7/17/19 revealed that he had discovered client #1's patch on the floor in his room, in his bed or seen it off in the shower, on numerous occasions while working third shift (10 pm-10 am). He had not reported to the nurse that the patch had a pattern of falling off. During an interview with staff B on 7/17/19	W 192		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G218	A. BUILDING _____ B. WING _____	07/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-OBIE	322 OBIE DRIVE DURHAM, NC 27713

(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 192	Continued From page 3 revealed that when he assisted client #1 with showering this morning, before medication administration, there was no Exelon patch on client #1. Staff B commented that sometimes client #1 became incontinent during the night and it was possible the patch could come off then. Staff B had not witnessed client #1 tamper with the patch, since it was always placed in places out of reach on his back. During an interview with the home manager (HM) on 7/17/19 acknowledged that he was aware that the Exelon patch was coming off and shared that ultimately, it was a medication error. HM stated that they should be contacting the nurse because it was the same as dropping a pill. During an interview with the registered nurse on 7/17/19 revealed that she must be contacted by group home staff whenever the Exelon patch for client #1 was found off so that she could instruct staff on re-application. The nurse shared that she was unaware that it was coming off and that staff could have used tape to keep it adhered to the skin. During an interview with the qualified individual professional (QIDP) on 7/17/19 revealed that staff needed to make sure the Exelon patch stayed on client #1 and that he was not aware of incidents of it falling off.	W 192		
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	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G218	A. BUILDING _____ B. WING _____	07/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-OBIE	322 OBIE DRIVE DURHAM, NC 27713

(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 4 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: Based on observation, interviews and record reviews, the facility failed to ensure each client received a continuous active treatment plan consisting of needed interventions and services identified in the individual program plan (IPP) in the areas of personal hygiene, self help skills, toothbrushing and eyeglasses. This affected 5 of 5 audit clients (#1, #2, #3, #4, #5). The findings are: 1. Client #2 was not prompted to wash his hands after toileting. During evening observations in the home on 7/16/19 at 5:17 pm, client #2 voided in the toilet. Client #2 exited the bathroom at 5:19 pm and did not wash his hands. At no time was client #2 prompted to wash his hands. Review on 7/17/19 of client #2's community/home life assessment dated 6/9/18 revealed he is independent with washing his hands. During an interview on 7/17/19, the home manager (HM) revealed client #2 needs to be encouraged to wash his hands after toileting. During an interview on 7/17/19, the qualified intellectual disabilities professional (QIDP) needs a verbal cue to wash his hands after toileting.	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G218	A. BUILDING _____ B. WING _____	07/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-OBIE	322 OBIE DRIVE DURHAM, NC 27713

(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 5 2. Client #2 did not utilize his electric toothbrush. During morning observations in the home on 7/17/19 at 7:22 am, client #2 showed the surveyor his toothbrush. Further observations revealed the toothbrush was a manual one. Further observations revealed client #2 only had the manual toothbrush. Review on 7/16/19 of client #2's IPP dated 6/28/19 revealed he has an electric toothbrush. Review on 7/17/19 of client #2's health service summary dated 3/17/19 stated he should be using an electric toothbrush. During an interview on 7/17/19, the HM was able to locate client #2's electric toothbrush. Client #2's electric toothbrush was still in the unopened box inside of his dresser drawer. During an interview on 7/17/19, the QIDP was unaware client #2's electric toothbrush was not being used. 3. Clients #1 and #3 were not prompted on a consistent basis to wear their eyeglasses. a. During afternoon observations at the day program on 7/16/19 from 12:39 pm until 12:59 pm, client #1 was not wearing eyeglasses, while eating lunch. At no time was client #1 prompted to wear his eyeglasses. During evening observations in the home on 7/16/19 at 4:30 pm , client #1 was not wearing his eyeglasses but was later observed wearing them at 5:00 pm.	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G218	A. BUILDING _____ B. WING _____	07/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-OBIE	322 OBIE DRIVE DURHAM, NC 27713

(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 6 Review on 7/17/19 of client #1's vision assessment dated 7/10/17 revealed that he was diagnosed with optic nerve hypoplasia and the facility had been given a prescription for glasses. On an undated Community Home Life Assessment, client #1 required to wear eyeglasses for his adaptive equipment and was independent with wearing them but was dependent on staff to safely store them. During an interview with the QIDP on 7/17/19 revealed that client #1 should wear his glasses daily. b. During afternoon observations at the day program on 7/16/19 from 12:39pm until 12:59 pm, client #3 observed not to be wearing his eyeglasses. At no time was client #3 prompted to wear his eyeglasses. During evening observations in the home on 7/16/19 from 4:33 pm until 4:46pm, client #3 was not observed to be wearing his eyeglasses. Further observations during dinner from 5:30pm until 46pm, client #3 was observed not to be wearing his eyeglasses. At no time was client #3 prompted to wear his eyeglasses. During morning observations in the home on 7/17/19 from 6:17 am until 6:57 am, client #3 was not observed to be wearing his eyeglasses. At no time was client #3 prompted to wear his eyeglasses. Review on 7/17/19 of client #3's community/home life assessment dated 10/27/17 revealed he needs verbal cues to wear his eyeglasses. Review on 7/17/19 of client #3's visual	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G218	A. BUILDING _____ B. WING _____	07/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-OBIE	322 OBIE DRIVE DURHAM, NC 27713

(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 7 examination dated 7/20/18 stated his diagnosis are Myopia and Astigmatism. Further review revealed the recommendation of eyeglasses. During an interview on 7/17/19, the HM revealed client #3 is suppose to wear his eyeglasses all the time. During an interview on 7/17/19, the QIDP revealed client #3 should wear his eyeglasses all the time. 4. Client #4 was not given the opportunity to cut his food with a knife. During breakfast observations in the home on 7/17/19, client #4 was not given the opportunity to cut his own food. Further observations revealed Staff A cutting client #4's food without giving him any prompts. During an interview on 7/17/19, Staff A revealed client #4 should have been given the opportunity to cut his own food. Review on 7/17/19 of client #4's community/home life assessment dated 8/1/17 revealed he needs verbal cues to cut his own food. During an interview on 7/17/19, the HM confirmed client #4 should have been given the opportunity to cut his own food. During an interview on 7/17/19, the QIDP revealed client #4 should have been given hand over hand assistance to cut his own food. 5. Clients #2, #3 and #5 were not prompted to use a knife during meals.	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G218	A. BUILDING _____ B. WING _____	07/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-OBIE	322 OBIE DRIVE DURHAM, NC 27713

(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 8 a. During dinner observations in the home on 7/16/19 at 5:51 pm, client #2 was observed picking up a whole circular sized piece of ham with his fingers and began biting it. Further observations revealed there was not a knife at client #2's place setting. At no time was client #2 prompted to use a knife to cut his ham. During breakfast observations in the home on 7/17/19 at 7:15am, client #2 picked up a whole square sized waffle with his fingers and began biting it. Further observations revealed there was a knife at client #2's place setting. Additional observations revealed at no time was client #2 prompted to use the knife to cut his waffles. Review on 7/16/19 of client #2's community/home life assessment dated 6/9/18 revealed he is independent with using a knife to cut his own food. During an interview on 7/17/19, the QIDP revealed he was not aware of client #2 having an issue with not using a knife while eating. b. During dinner observations in the home on 7/16/19 at 5:47 pm, client #3 was observed picking up a whole circular sized piece of ham with his fingers and began biting it. Further observations revealed there was not a knife at client #3's place setting. At no time was client #3 prompted to use a knife to cut his ham. During breakfast observations in the home on 7/17/19 at 7:07am, client #3 picked up a whole square sized waffle with his fingers and began biting it. Further observations revealed there was a knife at client #3's place setting. Additional	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G218	A. BUILDING _____ B. WING _____	07/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-OBIE	322 OBIE DRIVE DURHAM, NC 27713

(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 9 observations revealed at no time was client #3 prompted to use the knife to cut his waffles. Review on 7/17/19 of client #3's community/home life assessment dated 10/27/17 revealed he is independent with using a knife to cut his own food. During an interview on 7/17/19, the QIDP revealed client #3 should have access to a knife while eating his food. c. During dinner observations in the home on 7/16/19 at 5:47 pm, client #5 was observed with only a spoon next to his dinner plate. He was served a slice of ham, mashed potatoes and whole brussel sprouts. Client #5 picked up the slice of ham and stuck it partially in his mouth and began to bite off pieces of ham. The HM was in the dining room and instructed staff to get butter knives and forks for the clients, which were placed on the table. At no time, was staff observed prompting client #5 to cut up the ham and he continue to stick large pieces in his mouth and chew. During morning observations in the home on 7/17/19 at 7:07 am, client #5 was served two intact waffles and scrambled eggs. Client #5 used his fork to break off pieces of waffles to eat. Staff did not prompt client #5 to use his fork during the meal. Review on 7/17/19 of client #5's community/home life assessment dated February 2018 revealed that he used all utensils as needed, with verbal cues. During an interview with the QIDP on 7/17/19	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G218	A. BUILDING _____ B. WING _____	07/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-OBIE	322 OBIE DRIVE DURHAM, NC 27713

(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 10 revealed that clients should have access to a knife while eating food.	W 249		
W 356	COMPREHENSIVE DENTAL TREATMENT CFR(s): 483.460(g)(2) The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure client #2 received dental treatment in a timely manner for relief of pain and infections. This affected 1 of 5 audit clients. The finding is: Client #2 did not receive dental treatment in a timely manner. Review on 7/16/19 of client #2's dental examination dated 1/29/19 stated, "Please extract returned root #13. [Client #2] broke tooth #13 @gumline. Please call oral surgeon to set up consult for extraction." Further review of client #2's record did not indicate the follow up with the oral surgeon had been completed. During an interview on 7/17/19, the home manager (HM) indicated the follow up with the oral surgeon for client #2 should had been completed. During an interview on 7/17/19, the qualified intellectual disabilities professional (QIDP)	W 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G218	A. BUILDING _____ B. WING _____	07/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-OBIE	322 OBIE DRIVE DURHAM, NC 27713

(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 356	Continued From page 11 revealed he was unaware of the recommendation for client #2 to have a follow up visit with the oral surgeon.	W 356		
W 369	DRUG ADMINISTRATION 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 observation, record review and staff interviews, the facility failed to ensure that 1 of 5 audit clients (#1) received the full dose of medication. The finding is: The facility did not replace the Exelon patch once it fell off of client #1's skin, until the next dosing. During an observation of medication administration in the home on 7/17/19 at 7:00 am, staff A had client #1 stand and face the wall, as staff A placed disposable gloves on his hands. Staff A removed an Exelon patch, extended release, from the box of medication and lifted the shirt of client #1. The patch was applied to the left shoulder blade; staff A rubbed the patch, for less than 30 seconds. Staff A was not observed removing any other patches from client #1's body. Review of June 2019 physician orders for client #1 on 7/17/19 revealed that client #1 should have an Exelon patch applied daily. The manufacturer's instructions, enclosed in the box of medication instructed the user to "every 24 hours remove the old patch and apply a new patch. Press down firmly for 30 seconds until the	W 369		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G218	A. BUILDING _____ B. WING _____	07/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-OBIE	322 OBIE DRIVE DURHAM, NC 27713

(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 369	Continued From page 12	W 369		

edges stick well when applying to clean, dry, hairless, intact skin in a place that will not be rubbed up against by tight clothing. If a patch falls off or if a dose is missed, apply a new patch immediately and then replace this patch at the usual application time." In an addition, the Exelon Patch Administration Record for July 2019 was reviewed. In the column that indicated the old patch was removed, by staff's initials, there were four blanks (7/1/19, 7/2/19, 7/3/19 and 7/17/19) and on 7/9/19 and 7/13/19 N/A was recorded. There was a diagram to instruct user where to apply the patch each date. The patch applied on 7/16/19 by staff A should have been intact on client #1's lower back, right side, the morning of 7/17/19.

During an interview with staff A on 7/17/19 revealed that he had discovered client #1's patch on the floor in his room, in his bed or seen it off in the shower, on numerous occasions while working third shift (10 pm-10 am). He had not reported to the nurse that the patch had a pattern of falling off.

During an interview with staff B on 7/17/19 revealed that when he assisted client #1 with showering this morning, before medication administration, there was no Exelon patch on client #1. Staff B commented that sometimes client #1 became incontinent during the night and it was possible the patch could come off then. Staff B had not witnessed client #1 tamper with the patch, since it was always placed in places out of reach on his back.

During an interview with the home manager (HM) on 7/17/19 acknowledged that he was aware that the Exelon patch was coming off and shared that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G218	A. BUILDING _____ B. WING _____	07/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-OBIE	322 OBIE DRIVE DURHAM, NC 27713

(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 369	Continued From page 13 ultimately, it was a medication error. HM stated that they should be contacting the nurse because it was the same as dropping a pill. During an interview with the registered nurse on 7/17/19 revealed that she must be contacted by group home staff whenever the Exelon patch for client #1 was found off so that she could instruct staff on re-application. The nurse shared that she was unaware that it was coming off and that staff could have used tape to keep it adhered to the skin. During an interview with the qualified individual professional (QIDP) on 7/17/19 revealed that staff needed to make sure the Exelon patch stayed on client #1 and that he was not aware of incidents of it falling off.	W 369		
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on record reviews and staff interview, the facility failed to ensure that each shift conducted a fire drill with clients, each quarter. The findings is: Facility did not execute fire drills consistently. Review of fire drill records on 7/16/19 revealed that data did not exist for 1st shift drills during October-December 2018; none for 2nd shift drills during July-September, 2018 or 3rd shifts during October-December 2018.	W 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G218	A. BUILDING _____ B. WING _____	07/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-OBIE	322 OBIE DRIVE DURHAM, NC 27713

(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 441	Continued From page 14 During an interview with the home manager (HM) on 7/18/19 revealed that after he reviewed the data logs for fire drills that he did not have any copies for the missing quarters.	W 441		
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 and interviews, the facility failed to ensure that the infections control prevention procedures were carried out. This potentially affected 2 of 5 audit clients (#4, #5) residing in the home. The findings are: Precautions were not taken to promote client health and prevent possible cross-contamination. a. During evening medication administration in the home on 7/16/19 at 5:04pm, client #4's Pulmicort capsule fell on the floor. Further observations revealed the capsules seal was unbroken and some of the contents had been poured into the inhaler. Additional observations revealed Staff C picking the capsule from off the floor and pouring the remainder of its' contents into the inhaler. Client #4 then proceeded with his breathing treatment. During an interview on 7/16/19, Staff C revealed the contents of the Pulmicort did not spill out so she just proceeded to pour the remainder into the inhaler.	W 455		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G218	A. BUILDING _____ B. WING _____	07/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-OBIE	322 OBIE DRIVE DURHAM, NC 27713

(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 15 During an interview on 7/16/19, the home manager (HM) stated "technically" the Pulmicort capsule should have been replaced, due to the fact it had fallen on the floor. During an interview on 7/17/19, the facility's nurse stated the Pulmicort capsule should have been disposed of "once the seal had been opened." During an interview on 7/17/19, the qualified intellectual disabilities professional (QIDP) revealed the Pulmicort capsule should have been replaced. b. During breakfast observations in the home on 7/17/19 client #5 touched two waffles with his fingers which were in a serving dish on the table. Further observations revealed another client at the table served himself the two waffles and proceeded to consume them. During an interview on 7/17/19, Staff B revealed the two waffles which client #5 touched should have been replaced prior to the other client consuming them. During an interview on 7/17/19, the QIDP revealed the two waffles which client #5 touched with his fingers should have been replaced, before the other client consumed them.	W 455		