

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

PRINTED: 07/18/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G218</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R-C <b>07/17/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>VOCA-OBIE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>322 OBIE DRIVE DURHAM, NC 27713</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 000}	<b>INITIAL COMMENTS</b>  A revisit was conducted on 7/16-17/19 for the previous deficiency cited on 5/15/19. The deficiency has not been corrected. The facility is not in compliance with all regulations surveyed.	{W 000}	<p style="text-align: center;"><b>RECEIVED</b></p> <p style="text-align: center;"><b>AUG 02 2019</b></p> <p style="text-align: center;"><b>DHSR-MH Licensure Sect</b></p>	
{W 192}	<p><b>STAFF TRAINING PROGRAM</b> CFR(s): 483.430(e)(2)</p> <p>For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure staff were adequately trained to demonstrate skills and competencies directed toward client #1's health needs. This affected 1 of 2 audit clients (#1). The finding is:</p> <p>Direct care staff did not consistently implement instructions from the facility nurse in identifying signs and symptoms of illness for client #1.</p> <p>Interview on 5/15/19 with staff A from the vocational setting where client #1 attends revealed on 3/8/19 client #1 came into work with a very harsh cough. Vocational staff A stated client #1 sneezed, coughed and stated he generally did not feel well. Upon picking client #1 up from the vocational setting, vocational staff A told facility staff client #1 was not feeling well. Vocational staff A stated he does not specifically remember which facility staff picked client #1 up on that Friday afternoon. Vocational staff A stated on Monday 3/11/19 client #1 was again dropped off to the vocational setting and client #1 stated he was very sick. Vocational staff A stated client</p>	{W 192}		<p>W.192 (recite) This deficiency will be corrected by the following actions:</p> <ul style="list-style-type: none"> <li>A. All physician orders will be reviewed for accuracy.</li> <li>B. All staff will be in service on medication procedure and following the guidelines for recognizing and reporting signs and symptoms.</li> <li>C. All staff will be trained on the competencies and directives to meet the needs of the people served.</li> <li>D. All staff will be in service on the reporting procedures when there is a question regarding health care needs.</li> <li>E. RN will in service on identifying sign and symptoms of illness</li> <li>F. RN will monitor 2 times monthly</li> <li>G. Residential Manager will monitor one time a week.</li> <li>H. Qualified Professional will monitor one time a week</li> </ul>

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

TITLE

(X6) DATE

*Munika Whack* Executive Director 8/2/19

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{W 192}	<p>Continued From page 1</p> <p>#1 was coughing, sneezing and moving slowly. Vocational staff A stated several times client #1 laid his head on the desk at work. Vocational staff A stated he contacted the Residential Manager by phone. Vocational staff A stated direct care staff were sent to pick client #1 up at work and take him home.</p> <p>Interview on 5/15/19 with client #1 regarding his illness on 3/8/19-3/11/19 revealed he was " Sick, really sick."</p> <p>Review on 5/15/19 of client #1's record revealed he was seen at a local physician office on 3/12/19 for coughing and that he was diagnosed with "Acute bronchitis" and prescribed antibiotics.</p> <p>Review on 5/15/19 of the electronic medication administration record (MAR) for March 8, 2019 and March 11, 2019 revealed no record of any vital signs, including a temperature, taken by direct care staff that were working on 3/8/19 or on 3/11/19.</p> <p>Interview on 5/15/19 with the facility Nurse revealed direct care staff are trained anytime a client presents with symptoms of illness they are to record vital signs such as temperature, blood pressure and pulse so this information is available to the facility nurse when they contact her. Further interview confirmed direct care staff working on 3/11/19 should have taken vital signs in the morning before sending client #1 to the vocational setting. The Nurse stated she should have been contacted to make the decision about sending him to the vocational setting . She confirmed direct care staff contacted after client #1 returned to facility from the vocational setting and an appointment was made for the physician</p>	{W 192}			

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{W 192}	Continued From page 2 the following day on 3/12/19.  Interview on 5/15/19 with the Operations Manager confirmed staff are trained by the nurse to recognize signs and symptoms of illness and should follow guidelines outlined by the nurse to obtain vital signs and contact her for further instructions before sending clients out to vocational programs if they demonstrate symptoms of illness.	{W 192}			

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W 130	<p><b>PROTECTION OF CLIENTS RIGHTS</b> CFR(s): 483.420(a)(7)</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>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:</p> <p>Clients #2 and #5 were not afforded privacy while using the bathroom.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>During an interview on 7/17/19, the qualified intellectual disabilities professional (QIDP) revealed client #2 can independently knock on the bathroom door.</p>	W 130	<p>W.130 This deficiency will be corrected by the following actions:</p> <ul style="list-style-type: none"> <li>A. All community / home life assessment will be reviewed/update and revised as needed.</li> <li>B. Consumers will be provided/afforded privacy.</li> <li>C. Consumer will be in-service on privacy</li> <li>D. Staff will be in serviced on providing encouraging and affording privacy to all consumers.</li> <li>E. Residential Manager will monitor one time a week.</li> <li>F. Qualified Professional will monitor one time a week</li> </ul>	09.14.2019

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*Maria Whuck* Executive Director 8/2/19

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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 102	<b>STAFF TRAINING PROGRAM</b> 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 102			

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W 192	<p>Continued From page 2</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>During an interview with staff B on 7/17/19</p>	W 192	<p>W.192 This deficiency will be corrected by the following actions:</p> <ul style="list-style-type: none"> <li>A. All physician orders will be reviewed for accuracy.</li> <li>B. All staff will be in service on medication procedure and following the guidelines for recognizing and reporting signs and symptoms.</li> <li>C. All staff will be trained on the competencies and directives to meet the needs of the people served.</li> <li>D. All staff will be in service on the reporting procedures when there is a question regarding health care needs.</li> <li>E. All staff will be in serviced on recognize medication errors , how to initiate med replacement and the correct way to document med errors</li> <li>F. RN will in service on identifying sign and symptoms of illness</li> <li>G. RN will monitor 2 times monthly</li> <li>H. Residential Manager will monitor one time a week.</li> <li>I. Qualified Professional will monitor one time a week</li> </ul>	09.14.2019	

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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			

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W 249	<p>Continued From page 4</p> <p>interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>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:</p> <p>1. Client #2 was not prompted to wash his hands after toileting.</p> <p>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 5:10 pm and did not wash his hands. At no time was client #2 prompted to wash his hands.</p> <p>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.</p> <p>During an interview on 7/17/19, the home manager (HM) revealed client #2 needs to be encouraged to wash his hands after toileting.</p> <p>During an interview on 7/17/19, the qualified intellectual disabilities professional (QIDP) needs a verbal cue to wash his hands after toileting.</p>	W 249	<p>W.249</p> <p>This deficiency will be corrected by the following actions:</p> <ul style="list-style-type: none"> <li>A. ISP will be update modified to meet the current needs of each consumer</li> <li>B. ISP will be updated, modified to meet the current ADL around hygiene and grooming</li> <li>C. All community / home life assessment will be reviewed/updated and revised as needed to address self help and potential cross contamination.</li> <li>D. All community / home life assessment will be reviewed/updated and revised as needed to address adaptive equipment</li> <li>E. All community / home life assessment will be reviewed/updated and revised as needed to address family style dining</li> <li>F. All consumers will be in service on the used of adaptive equipment – electric tooth brush and eyeglasses</li> <li>G. All consumer will be in serviced on universal precaution relating to washing hands.</li> <li>H. All consumer will be in serviced on family style dining and the use of utensils</li> <li>I. All staff will be in service on the use of adaptive equipment – electric tooth brushes and eyeglasses</li> <li>J. All staff will be in serviced on universal precautions relating to washing hands.</li> <li>K. All staff will be in serviced on family style dining and the use of utensils</li> <li>L. Residential Manager will monitor one time a week.</li> <li>M. Qualified Professional will monitor one time a week</li> </ul>	09.14.2019	



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W 249	<p>Continued From page 5</p> <p>2. Client #2 did not utilize his electric toothbrush.</p> <p>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.</p> <p>Review on 7/16/19 of client #2's IPP dated 6/28/19 revealed he has an electric toothbrush.</p> <p>Review on 7/17/19 of client #2's health service summary dated 3/17/19 stated he should be using an electric toothbrush.</p> <p>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.</p> <p>During an interview on 7/17/19, the QIDP was unaware client #2's electric toothbrush was not being used.</p> <p>3. Clients #1 and #3 were not prompted on a consistent basis to wear their eyeglasses.</p> <p>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.</p> <p>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.</p>	W 249			

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W 249	<p>Continued From page 6</p> <p>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.</p> <p>During an interview with the QIDP on 7/17/19 revealed that client #1 should wear his glasses daily.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Review on 7/17/19 of client #3's visual</p>	W 249			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G218</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/17/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>VOCA-OBIE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE: <b>322 OBIE DRIVE DURHAM, NC 27713</b>		
(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	<p>Continued From page 7</p> <p>examination dated 7/20/18 stated his diagnosis are Myopia and Astigmatism. Further review revealed the recommendation of eyeglasses.</p> <p>During an interview on 7/17/19, the HM revealed client #3 is suppose to wear his eyeglasses all the time.</p> <p>During an interview on 7/17/19, the QIDP revealed client #3 should wear his eyeglasses all the time.</p> <p>4. Client #4 was not given the opportunity to cut his food with a knife.</p> <p>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.</p> <p>During an interview on 7/17/19, Staff A revealed client #4 should have been given the opportunity to cut his own food.</p> <p>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.</p> <p>During an interview on 7/17/19, the HM confirmed client #4 should have been given the opportunity to cut his own food.</p> <p>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.</p> <p>5. Clients #2, #3 and #5 were not prompted to use a knife during meals.</p>	W 249			

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W 249	<p>Continued From page 8</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>	W 249			

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W 249	<p>Continued From page 9</p> <p>observations revealed at no time was client #3 prompted to use the knife to cut his waffles.</p> <p>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.</p> <p>During an interview on 7/17/19, the QIDP revealed client #3 should have access to a knife while eating his food.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>During an interview with the QIDP on 7/17/19</p>	W 249			

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W 249	Continued From page 10 revealed that clients should have access to a knife while eating food.	W 249			
W 356	<p><b>COMPREHENSIVE DENTAL TREATMENT CFR(s): 483.460(g)(2)</b></p> <p>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.</p> <p>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:</p> <p>Client #2 did not receive dental treatment in a timely manner.</p> <p>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.</p> <p>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.</p> <p>During an interview on 7/17/19, the qualified intellectual disabilities professional (QIDP)</p>	W 356	<p>W.356 This deficiency will be corrected by the following actions:</p> <ul style="list-style-type: none"> <li>A. All physician orders and medical consults will be reviewed for accuracy.</li> <li>B. All dental treatment will be received in a timely manner.</li> <li>C. RN will monitor monthly</li> <li>D. Qualified Professional will monitor monthly via core team meetings</li> </ul>	09.14.2019	

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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	<p><b>DRUG ADMINISTRATION</b> CFR(s): 483.460(k)(2)</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>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:</p> <p>The facility did not replace the Exelon patch once it fell off of client #1's skin, until the next dosing.</p> <p>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.</p> <p>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</p>	W 369	<p>W.369 This deficiency will be corrected by the following actions:</p> <ul style="list-style-type: none"> <li>A. RN will assess all orders.</li> <li>B. All physician orders will be reviewed for accuracy.</li> <li>C. All staff will be in service on medication procedure and following the guidelines for measuring and dispensing all medications</li> <li>D. All assessment will be reviewed, and recommendations discussed in core team, quarterly, or ISP.</li> <li>E. Staff will be in service on Medication Administration procedures</li> <li>F. RN will monitor monthly</li> <li>G. Residential Manager will monitor one time a week.</li> <li>H. Qualified Professional will monitor monthly</li> </ul>	09.14.2019

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W 369	<p>Continued From page 12</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>	W 369			



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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	W.441 This deficiency will be corrected by the following actions:  A. Fire drill will be conducted in the home B. Fire drills will be conducted with appropriate documentation, at varied times 1 <sup>st</sup> , 2 <sup>nd</sup> , and 3 <sup>rd</sup> shifts including weekends C. Fire drill will be conducted monthly D. Residential Manager will monitor one time a week. E. Qualified Professional will monitor one time a week	09.14.2019

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W 441	Continued From page 14	W 441			
W 455	<p>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.</p> <p><b>INFECTION CONTROL</b> CFR(s): 483.470(l)(1)</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable disease.</p> <p>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:</p> <p>Precautions were not taken to promote client health and prevent possible cross-contamination.</p> <p>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.</p> <p>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.</p>	W 455	<p>W.455 This deficiency will be corrected by the following actions:</p> <ul style="list-style-type: none"> <li>A. All precautions will be taken to ensure health and safety of all people served.</li> <li>B. Protective intervention equipment will be provided and accessible to prevent cross contamination.</li> <li>C. All people served will be in service on equipment</li> <li>D. All staff will be in-service on their equipment working conditions, an teaching people served on the use of said equipment, As well as cross containment/universal precautions</li> <li>E. Residential Manager will monitor one time a week.</li> <li>F. Qualified Professional will monitor one time a week</li> </ul>	09.14.2019	

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W 455	<p>Continued From page 15</p> <p>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.</p> <p>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."</p> <p>During an interview on 7/17/19, the qualified intellectual disabilities professional (QIDP) revealed the Pulmicort capsule should have been replaced.</p> <p>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.</p> <p>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.</p> <p>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.</p>	W 455			