STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G279	A. BUILDING _____ B. WING _____	10/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-OLIVE HOME	**707 EAST OLIVE STREET APEX, NC 27502**

(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 assure the right to privacy during the care of personal needs. This affected 2 of 4 audit clients (#4, #6). The findings are: Client #4 and client #6 were not afforded privacy during the care of personal needs. a. During observations in the home on 10/23/19 at 6:11am, client #4 was observed in the hallway right outside of the living room with Staff B. Staff B was looping a belt through client #4's pants, holding her shirt up. Her undergarments, stomach and back were exposed. Other clients in the home were walking down the hall and in the living room. Interview on 10/23/19 with Staff B indicated that clients should never get dressed or assisted with dressing in the hallway. This should always be done in the bedroom or bathroom with the door closed for privacy. Interview on 10/23/19 with the home manager revealed that staff should always assist clients with personal care in the privacy of their bedroom or bathroom with the door shut. b. Observations in the home on 10/23/19 at 6:19am revealed client #4 stating that she	W 130		

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

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W 130	Continued From page 1 needed to use the bathroom, as she was standing with her legs together and her hands crossed in front of her groin. She also stated she needed to brush her teeth (gums). Client #4 was observed to go into the bathroom with her toothbrush and toothpaste. At 6:21am, Staff B was observed to walk into the bathroom and ask client #4 if she needed assistance. Staff B did not knock on the door prior to entering the bathroom. Further observations in the home on 10/23/19 at 6:24am revealed Staff B walked into another bathroom without knocking. Client #6 was in this bathroom showering. Interview on 10/23/19 with Staff B revealed that staff should never walk into a bedroom or bathroom, door closed or not, without knocking first. Interview on 10/23/19 with the home manager revealed that it is the expectation that staff knock on bedroom and bathroom doors where clients are before entering. c. Observations in the home on 10/23/19 at 6:30am revealed client #5 emptying trash cans in the home so he could take the trash outside. He was being assisted by Staff B. Staff B prompted client #5 to follow her into the bathrooms to empty the trash cans. Staff B escorted client #5 into the bathroom where client #6 was doing personal care. Staff B did not knock on the bathroom door prior to entering. Staff B was observed to ask client #6 if he was putting his pull-up on. Client #5 was observed to empty the trash while client #6 was putting on his pull-up. Staff B held the bathroom door open during this observation.	W 130		

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W 130	Continued From page 2 Interview on 10/23/19 with Staff B revealed that staff should never walk into a bedroom or bathroom, door closed or not, without knocking first. Further interview revealed that staff should never take a client in a bedroom or bathroom where another client is toileting, dressing or doing any task related to personal care. Interview on 10/23/19 with the home manager revealed that it is the expectation that staff should provide every client with privacy during personal care and that clients should never be in a room with another client who is dressing, toileting, etc.	W 130		
W 137	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(12) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observations, record review and interviews,the facility failed to assure the use of personal possessions during personal care. This affected 1 of 4 audit clients (#6). The finding is: Client #6 was shaved with another client's electric razor. During observations in the home on 10/23/19 at 6:41am, Staff C was observed to come to the doorway of the office with an electric razor in her hand. She stated "[Client #6's] razor is not working." She then asked client #5 if she could use his razor and he said yes. Client #5 was	W 137		

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W 137	Continued From page 3 observed to go to his bedroom and get an electric razor and bring it back to Staff C. Staff C shut the office door. At 6:43am, Staff C opened the office door and gave client #5 his razor back and he was observed to take it back to his room. Review on 10/23/19 of client #6's IPP, dated 11/19/18, reveals an electric razor listed as a device for use while shaving. Interview on 10/23/19 with client #5 revealed that he gave Staff C his electric razor. Client #5 stated that sometimes his razor is used to shave his friend because his (client #6) razor does work sometimes. Interview on 10/23/19 with Staff C revealed that client #6's electric razor does not always work. Staff C stated "When it doesn't work, we ask [client #5] to use his cause he let's us." Interview on 10/23/19 with the home manager revealed that client's electric razors and other personal possessions should never be used for another client.	W 137		
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, record review and interviews, the facility failed to ensure client #4's Individual Program Plan (IPP) included information to support his independence. This	W 240		

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W 240	Continued From page 4 affected 1 of 4 audit clients. The finding is: Client #4's IPP did not include information regarding the use of her dentures. During observations at the day program and home on10/22-23/19, client #4 was not observed wearing dentures. Further observations during meals, the client did not consume 100% of her meal. Review on 10/23/19 of client #4's IPP dated 11/19/18 revealed, "No adaptive equipment at this time." Additional review of the record revealed she had a dental exam on 9/19/18. The exam report noted, "edentolous. Recommend pt wear dentures." Another document from the dental office dated 10/9/19 revealed, " I have today examined [Client #4]. She tells me that she doesn't have to wear them as long as she is able to maintain adequate nutrition. Further review of nutritional assessment evaluation dated 5/8/19 revealed, "No chewing or swallowing problem noted as long as she wears dentures.... weight 105#...DBW 105-120, BMI 19.2" Interview on 10/23/19 with the home manager revealed client #4 does not wear dentures since she refused and the dentist is ok with that. Interview on 10/23/19 with the Qualified Intellectual Disabilities Professional (QIDP) via phone confirmed there was no information regarding client #4's dentures in her IPP.	W 240		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair,	W 436		

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W 436	Continued From page 5 and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to assure a client was taught to use assistive devices appropriately and make informed choices about their use. This affected 1 of 4 audit clients (#1). The finding is: Client #1 was not prompted to wear his hearing aids. During observations in the home and community on 10/22/2019 from 3:45pm until 6:30pm, client #1 was observed to not have his hearing aids in his ears. Review on 10/23/19 of client #1's IPP, dated 3/1/19, revealed client #1 wears bilateral hearing aids. Further review of the IPP revealed the hearing aids should be worn "during all awake hours." Interview on 10/23/19 with the home manager revealed that client #1 should wear his hearing aids during all awake hours. However, the home manager revealed that sometimes when client #1 gets home from the day program he will take his hearing aids out. The home managemer also stated that if client #1 is going out into the community, he should be prompted by staff to wear his hearing aids.	W 436		

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W 460	Continued From page 6	W 460		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #2's diet was provided as indicated. This affected 1 of 4 audit clients. The finding is: Client #2's food consistency was not provided as indicated. During observations at the day program on 10/22/19 at 11:00am, client #2 was observed to be eating his lunch. He was eating a sandwich that was served whole, a baggie of veggie straws, and a half of a bag of cotton candy. Client #2 ate the sandwich in large pieces, and ate all of the veggie straws. He was observed putting large pieces of cotton candy in his mouth. Throughout the observation of lunch, client #2 had four coughing episodes while he was eating. During observations in the community on 10/22/19 at 5:00pm revealed client #2 eating fried chicken, mashed potatoes and cole slaw. At 5:07pm, Staff A used a rocker knife to cut client #2's fried chicken up. At 5:08pm, home management staff used hand-over-hand assistance with client #2 to use the rocker knife to cut the chicken up some more. Client #2 was observed to eat large pieces of fried chicken throughout the dinner observation.	W 460		

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W 460	Continued From page 7 Review on 10/22/19 of client #2's IPP, dated 8/25/19, revealed that client #2's diet is regular, finely chopped. Review on 10/22/19 of diet consistency information posted in the dining room of client #2's home revealed that finely chopped food is cut into 1/8 to 1/4" pieces. Interview on 10/22/19 with Staff D at the day program revealed that client #2 does well with eating and does not need any modifications to his food. Interview on 10/22/19 with Staff A revealed that she cut the chicken up. When asked if the chicken was finely chopped, she repeated "I cut it up." Staff E interjected and stated that the chicken was not the appropriate diet texture for being finely chopped and should have been cut into "dime size pieces." Interview on 10/23/19 with home manager revealed that client #2's food should be cut into finely chopped pieces. Further interview with the home manager revealed that when client #2's food is taken to the day program, it should be finely chopped prior to leaving his home in the morning. If not, the day program has a rocker knife that client #2 can use or if he refuses, with staff assistance, to finely chop his food. It is also the expectation that when dining out in the community, the same diet should be followed and client #2's food should be finely chopped.	W 460		
W 484	DINING AREAS AND SERVICE CFR(s): 483.480(d)(3) The facility must equip areas with tables, chairs,	W 484		

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W 484	Continued From page 8 eating utensils, and dishes designed to meet the developmental needs of each client. This STANDARD is not met as evidenced by: Based on observation, interviews and record review, the facility failed to provide recommended adaptive dining equipment. This affected 1 of 4 audit clients (#2). The finding is: Client #2 was not provided his adaptive dining equipment during meals. Observations at the day program on 10/22/19 at 11:00am revealed client #2 eating his lunch. The adaptive dining equipment for client #2 consisted of a small maroon spoon with foam handle. Observations in the community on 10/22/19 at 5:00pm revealed client #2 eating his dinner of fried chicken, mashed potatoes and coleslaw. The food was served on a serving tray with the fried chicken on a plate, mashed potatoes in a small bowl, and cole slaw in a small bowl. The adaptive dining equipment for client #2 consisted of a small maroon spoon with foam handle, high sided plate and rocker knife. Staff A was observed to put the fried chicken on the high sided plate. Client #2 was observed to eat the entire portion of his mashed potatoes from the bowl they were served in. After eating a small portion of the cole slaw, Staff E was observed to pour the coleslaw onto the high sided plate. During the observation, client #2 ate with his head down in his plate with staff prompting him several times to pick his head up when eating. Review on 10/22/19 of client #2's IPP, dated	W 484		

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W 484	Continued From page 9 8/25/19, revealed that client #2 utilizes adaptive dining equipment. He has a small maroon spoon with foam handle that is used daily during all meals; high sided plate used daily during all meals; plate raiser used daily in his home setting; dycem/non skid mat used daily during all meals; rocker knife used daily during meals to cut up food; and a foot stool. Interview on 10/23/19 with the home manager revealed that client #2 does utilize adaptive dining equipment. The home manager reported that client #2 has an adaptive spoon, high sided plate and dycem/non skid mat that should be used during all meals, whether he is dining at home, the day program or in the community. The home manager reported that the foot stool and plate raiser is only used at home as the table client #2 eats at when he is at the day program is high enough he does not need a plate raiser and his feet touch the floor. Further interview with the home manager revealed that client #2 should have his food finely chopped at his home prior to leaving for the day program each day. However, if it is not finely chopped before he leaves home, the day program should have a rocker knife available for client #2 to use cut his food.	W 484		