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

PRINTED: 10/14/2019
FORM APPROVED
OMB NO. 0938-0391

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 _____	R 10/11/2019

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 000	INITIAL COMMENTS A revisit was conducted on 10/11/19 for all previous deficiencies cited on 7/16 - 17/19. All deficiencies have not been corrected, and new noncompliance was found. The facility is not compliance with all regulations surveyed.	W 000	RECEIVED OCT 17 2019 DHSR-MH Licensure Sect	
{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, record reviews and staff interviews, the facility failed to ensure that all staff were sufficiently trained to initiate communication with the nurse for any medication consultations for 4 of 5 audited clients (#1, #2, #4 and #6). The finding are: 1. Staff were not sufficiently trained to consistently follow medication administration policies regarding dropped pills. a. During morning observations of medication administration on 10/11/19 at 7:08 am, Staff B physically assisted client #6 to push a dose of Therems from the pharmacy blister pack into a pill cup. The first pill of Therems, landed off of the napkin onto the desk and was removed by Staff B and placed in a disposable medication container. Client #6 attempted to push another pill out of the blister pack into the pill cup, but it landed on the floor. On the third try, Staff B explained to client #6 that she would push the pill from the blister pack, to ensure it landed in the pill cup. Staff B	{W 192}	W.192 (recite) This deficiency will be corrected by the following actions: A. All physician orders will be reviewed for accuracy. B. All staff will be in service on medication procedure and following the guidelines for recognizing and reporting signs and symptoms. C. All staff will be trained on the competencies and directives to meet the needs of the people served. D. All staff will be in service on the reporting procedures when there a pill has been dropped. E. RN will in service on reporting procedures for the disposal of medication. F. RN will monitor 2 times monthly G. Residential Manager will monitor one time a week. H. Qualified Professional will monitor one time a week	11.10.2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marika Whack MC — TITLE: Executive Director — (X6) DATE: 10/16/19

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}	Continued From page 1 did not contact the nurse to inform her that two doses spilled and were disposed into the container for client #6. Record review on 10/11/19 of client #6's October, 2019 physician's orders revealed that Therems was given once daily to treat vitamin D deficiency. b. During morning observations of medication administration on 10/11/19 at 7:54 am, Staff B verbally prompted client #2 to push a dose of Atorvastatin 40 mg out of the pharmacy blister pack into a pill cup. When client #2 pushed the dose out of the pack, it fell onto the desk. Staff B directed client #2 to push another pill from the pack into the cup. Staff B did not contact the nurse to inform her that client #2 had to dispose of a pill. Record review on 10/11/19 of client #2's October, 2019 physician's orders revealed that Atorvastatin 40 mg was given at 7:00 am. c. During morning observations of medication administration on 10/11/19 at 8:15 am, Staff B physically assisted client #4 to push a dose of Vitamin D3 1,000 units from the pharmacy blister pack into a pill cup. When client #4 pushed the dose out of the pack, it landed off of the napkin and was disposed of by Staff B. A second pill was popped and given to client #4. Staff B did not contact the nurse to inform her that client #4 had to dispose of a pill. Record review on 10/11/19 of client #4's October, 2019 physician's orders revealed that Vitamin D3 1,000 units was prescribed for 7 am. Interview with Staff B on 10/11/19 revealed that	{W 192}		

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{W 192}	Continued From page 2 she had to notify the nurse whenever a pill dropped. Staff B stated that when she was unable to get a hold of the nurse earlier in the med pass for client #5 after his pill dropped, the house manager (HM) was consulted and told Staff B to dispose of the pill and use the next dose. Interview with the HM on 10/11/19 revealed that after each incident that a pill has to be disposed, the nurse must be called. 2. Staff were not sufficiently trained to inform the nurse whenever medications were given outside of the 1 hour window. a. During morning observations of medication administration on 10/11/19 at 8:05 am, Staff B began to administer medications, prescribed at 7:00 am for client #1. Staff B did not contact the nurse to alert her that the medications would be given outside the 1 hour window. b. During morning observations of medication administration on 10/11/19 at 8:15 am, Staff B began to administer medications, prescribed at 7:00 am for client #4. Staff B did not contact the nurse to alert her that the medications would be given outside the 1 hour window. Records review of client #1 and #4's physician's orders dated October 2019 revealed that medications should be given at 7:00 am. An additional review on 10/11/19 of the facility's medication policy and agreement, dated April, 2013 revealed "medication must be administered no earlier or later than one hour before or after the designated time. No exceptions are acceptable unless approved by the nurse or the prescribing physician. This approval should be in	{W 192}		

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{W 192}	Continued From page 3 writing." Interview with the HM on 10/11/19 revealed that when medications needed to be given late, the nurse must be called to inform her that the medications were given outside of the 2 hour window and the reason for given late.	{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 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 eyeglasses and dining skills. This affected 2 of 5 audit clients (#2, #6). The findings are: 1. Client #2 was not prompted to wear his eyeglasses. During morning observations in the home on 10/11/19 from 6:36am though 8:43am, client #2 was not prompted by staff to wear his eyeglasses. Further observations revealed client #2 leaving	{W 249}	W249(recite) This deficiency will be corrected by the following actions: A. ISP will be update modified to meet the current needs of each consumer B. ISP will be updated, modified to meet the current ADL around adaptive equipment (glasses) C. All community / home life assessment will be reviewed/update and revised as needed to address the use adaptive equipment D. All community / home life assessment will be reviewed/update and revised as needed to address family style dining- and the use of eating utensils E. Written Training Plans will be implemented as needed to address assessments F. All staff will be in service on the use of adaptive equipment. G. All staff will be in service on the family style dining H. All staff will be in service on the use of adaptive equipment. I. Residential Manager will monitor one time a week. J. Qualified Professional will monitor one time a week	11.10.2019

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{W 249}	Continued From page 4 for the day program at 8:45am without wearing his eyeglasses. Review on 10/11/19 of client #2's community/home life assessment dated 9/1/10 revealed he requires verbal cues from staff to wear his eyeglasses. During an interview on 10/11/19, the qualified intellectual disabilities professional (QIDP) stated client #2 "should be prompted first thing in the morning" to put on his eyeglasses. Further interview revealed client #2's eyeglasses were in a dresser drawer in his bedroom. 2. Client #6 was not prompted to use a knife while eating. During breakfast observations in the home on 10/11/19 from 7:58am though 8:08am, client #6 picked up his two separate pancakes with his fingers, pulling them apart and consuming them. Further observations revealed client #6 had a fork and knife at his place setting. At no time was client #6 prompted to use his knife and fork to cut up and consume his pancakes. During an interview on 10/11/19, Staff A stated client #6 does know how to use a knife to cut up his food. Review on 10/11/19 of client #6's community/home life assessment dated 9/1/19 revealed he needs verbal cues from staff to use all his utensils. During an interview on 10/11/19, the QIDP revealed client #6 should have been verbally cued to use a knife while eating.	{W 249}		

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{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 observations, record review and staff interviews, the facility failed to ensure all medications were administered without error. This affected 2 of 5 clients (#1 and #4). The findings are: 1. Staff did not ensure that client #1 did not receive his full dose of mouthwash. During morning observation of medication administration on 10/11/19 at 8:05 am, Staff B physically assisted client #1 to pour a mouthwash product, Chlorhexidine Gluconate into a medication cup. The cup was clear and marked with lines, to measure the exact dose. Client #1 had a noticeable tremor to his hands but was able to pour the liquid without spillage. He filled the container 3/4th of the way to the rim. Record review of client #1's physician's orders dated October 2019 revealed that he was prescribed Chlorhexidine Gluconate 0.12% - 30 ml-1 oz. Interview with Staff B on 10/11/19 revealed that because of client #1's tremors, he was only able to pour 20 ml, but when she had to pour the mouthwash, she ensured that he received the full dose of 30 ml. 2. Staff did not administer medications within the	{W 369}	W.369 (recite) This deficiency will be corrected by the following actions: A. RN will assess all orders. B. All physician orders will be reviewed for accuracy. C. All staff will be in-serviced on medication procedure and following the guidelines for measuring and dispensing all medications. D. All medication will be dispensed within the designated time frame E. All assessment will be reviewed, and recommendations discussed in core team, quarterly, or ISP. F. Staff will be in service on Medication Administration procedures G. RN will monitor monthly H. Residential Manager will monitor one time a week. I. Qualified Professional will monitor monthly	11.10.2019

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{W 369}	Continued From page 6 1 hour window of the designated time. During morning observations of medication administration on 10/11/19, Staff B did not start to administer medications to client #1 until 8:05 am and client #4 until 8:15 am. Staff B elected not to contact the nurse to inform her that the 7:00 am medications, were given outside of the 1 hour window. Record review of the physician's orders dated October 2019 for clients #1 and #4 indicated that their morning dosage of medications should be given at 7:00 am. An additional review on 10/11/19 of the facility's medication policy and agreement, dated April, 2013 revealed "medication must be administered no earlier or later than one hour before or after the designated time. No exceptions are acceptable unless approved by the nurse or the prescribing physician. This approval should be in writing." Interview with the house manager (HM) on 10/11/19 revealed that when medications needed to be given late the nurse must be called to inform her that the medications were given outside of the 2 hour window and the reason for given late.	{W 369}		
{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	{W 455}		

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{W 455}	Continued From page 7 failed to ensure that the infections control prevention procedures were carried out. This potentially affected 2 of 5 audit clients (#2, #5) residing in the home. The findings are: Precautions were not taken to promote client health and prevent possible cross-contamination. a. During breakfast observations in the home on 10/11/19 at 7:37am, client #5 reached into the serving bowl containing the muffins and ate a piece of a muffin. Further observations revealed client #5 again reached into the serving bowl with the muffins a second time and touched one of the muffins. Further observations another client at the table served himself the muffin and proceeded to consume it. During an interview on 10/11/19, Staff A revealed the serving bowl with the muffins should have been removed from the table. During an interview on 10/11/19, the qualified intellectual disabilities professional (QIDP) revealed the serving bowl with the muffins should have been removed from the table. b. During breakfast observations in the home on 10/11/19 client #2 reached into a serving bowl containing bacon and removed a slice of bacon with his fingers. Staff B prompted client #2 to use his utensil, and then client #2 took a fork to get another slice of bacon. The bowl of bacon remained on the table and was used for clients #3 and #5 to get slices of bacon. During an interview on 10/11/19, with the QIDP revealed that the bacon should have been	{W 455}	W.455 (recite) This deficiency will be corrected by the following actions: A. All precautions will be taken to ensure health and safety of all people served. B. Protective intervention equipment will be provided and accessible to prevent cross contamination. C. All people served will be in service on possible cross-contaminations. D. The environment will be engineered during Family style dining to allow for active treatment but prevent cross contamination. E. All staff will be in-service on their equipment working conditions, a teaching people served on the use of said equipment, As well as cross containment/universal precautions F. Residential Manager will monitor one time a week. G. Qualified Professional will monitor one time a week	11.10.2019

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{W 455}	Continued From page 8 removed from the table once client #2 touched it with fingers.	{W 455}		
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, document/record reviews and interviews, 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 area of diet. This effected 2 of 5 audit clients (#1, #4). The findings are: Clients #1 and #4 diets were not followed. a. During breakfast observations in the home on 10/11/19 at 7:27am, client #1 began eating a bowl of Corn Flakes. Further observations revealed client #1's bowl of Corn Flakes was served regular and not altered. Review on 10/11/19 of the Obie Diet Order dated 6/12/19 revealed client #1's food should be served mechanical soft. During an interview on 10/11/19, the home manager revealed the diet orders are current. Further interview revealed client #1 should have been served oatmeal instead of the Corn Flakes. During an interview on 10/11/19, the qualified intellectual disabilities professional (QIDP)	W 460	W.460 This deficiency will be corrected by the following actions: A. Nutritional assessment will be conducted to ensure proper food consistency B. All people served will receive a nourishing, well-balanced diet including modified and specially prescribed diets. C. All staff will be in service on Food consistency orders D. Residential Manager will monitor one time a week. E. Qualified Professional will monitor one time a week	11.10.2019

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W 460	Continued From page 9 revealed client #1's food is served mechanical soft, due to the fact he is edentulous. b. During breakfast observations in the home on 10/11/19 at 7:27am, client #4 began consuming two whole muffins. Further observations revealed the two muffins client #4 consumed were served regular and not altered. During an interview on 10/11/19, Staff B revealed client #4's muffins should have been served in pieces. Review on 10/11/19 of the Obie Diet Order dated 6/12/19 revealed client #4's food should be served "...Bite Size Pieces, 3/4 inch - 1 inch Pieces." During an interview on 10/11/19, the QIDP revealed client #4's food is served in bite size pieces, due to the fact he is missing some teeth.	W 460		

Community Alternatives – NC
Southeast Region
1001 Navaho Drive Suite 101
Raleigh, NC 27609
Phone: 984-205-2630
FAX: 984-205-2643

FAX

To: Evgina Barnes
From: J. Kearney
Fax: 919 715 8078
Pages: 10
Phone: 919-855-3795
Date: 10/16/19
Re: Durig
CC:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Comments: OBRE 2019

ResCare
Residential Services

October 16, 2019

Eugina Barnes, BSW QIDP
Facility Survey Consultant I
Mental Health Licensure and Certification section
NC Division of Health Services Regulations
2718 Mail Service Center
Raleigh NC 27699-27118
919.855.3795 office
919.715.8078 fax

RE: **Plan of Correction for Survey conducted: October 11, 2019**
VOCA-Obie Drive
322 Obie Drive Durham NC 27713
Provider Number 34G218
MHL# 032-069
NC00150451 (resite)

Ms. Eugina Barnes,

We appreciate the courtesy extended by you while surveying the **VOCA-Obie Drive Home**, North Carolina.

As indicated on the Plan of Correction, we will have the Standard Level Deficiencies corrected for, the Complaint Survey conducted on **October 11, 2019** recite will be completed on **November 10, 2019.**

We are committed to providing the highest possible care for the people we serve at **VOCA-Obie Drive Home.**

If you have questions, please contact JerMaine Kearney, Program Manager 984.205.2633.

Sincerely,
Marika Whack MC

Marika Whack, Executive Director
Community Alternatives North Carolina- Southeast Region
1001 Navaho Drive, Suite 101
Raleigh, North Carolina, 27609
919.827.2790 cell
984.205.2634 office
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mawhack@rescare.com