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VOCA-CREEKWAY	424 CREEKWAY DRIVE FUQUAY VARINA, NC 27526

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E 004	Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.	E 004		

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

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E 004	Continued From page 1 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Emergency Preparedness (EP) plan was reviewed and updated every two years annually. The finding is: The facility's EP plan was not reviewed or updated every two years. Review on 11/16/2020 of the facility's EP plan revealed the date of their plan was 8/14/2017. Further review revealed there was not an updated plan located in the home. During an interview on 11/16/2020, the executive director revealed she was not aware if the EP plan had been reviewed or updated every two years.	E 004		
E 020	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.475(b)(3) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC). At a minimum, the policies and procedures must address the following:] [(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.	E 020		

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E 020	Continued From page 2 *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop specific policies and procedures to address emergency preparedness (EP) including evacuation locations based on a community and facility risk assessment. The finding is: The facility did not have an accurate emergency plan which included evacuation locations.	E 020		

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E 020	Continued From page 3 Review on 11/16/2020 of the facility's EP plan revealed the plan did not include accurate information in regards to the facility's evacuation locations in the event of flood, fire, tornadoes, hurricanes, winter storms, bio terrorism, missing residents or other emergencies. Further review revealed there were instructions to relocate to one local high school, but directions to a totally different local high school. During an interview on 11/16/2020, staff reported they were not sure where the home would evacuate if they needed to during an emergency. During an interview on 11/16/2020, the home manager (HM) confirmed the EP plan did not include accurate information pertaining to alternate evacuate locations. Further interview revealed the current information could confuse staff if they needed to evacuate. During an interview on 1/16/2020, the executive director revealed she was unaware the EP plan did not include accurate information pertaining to alternate evacuate locations.	E 020		
E 030	Names and Contact Information CFR(s): 483.475(c)(1) [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under	E 030		

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E 030	Continued From page 4 arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers.	E 030		

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E 030	Continued From page 5 *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure an emergency preparedness (EP) communication plan was developed and maintained in compliance with Federal, State and local laws. The finding is:	E 030		

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E 030	Continued From page 6 The facility's EP plan did not include an updated face sheet. Review on 11/16/2020 of the facility's EP plan had the wrong contact information. Further review revealed the face sheet had the contact information for a client who was decreased. Additional review revealed a client who was admitted on 8/27/2019 information was not included. Also, the EP plan included former staff and not the new staff. During an interview on 11/16/2020, the executive director confirmed the face sheet for the facility contained the incorrect information.	E 030		
E 037	EP Training Program CFR(s): 483.475(d)(1) *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the	E 037		

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E 037	Continued From page 7 [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures.	E 037		

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E 037	Continued From page 8 (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include	E 037		

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instruction in the location and use of alarm systems and signals and firefighting equipment.

(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:

(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

(ii) Provide emergency preparedness training at least every 2 years.

(iii) Maintain documentation of the training.

(iv) Demonstrate staff knowledge of emergency procedures.

(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.

*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide

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E 037	Continued From page 10 emergency preparedness training at least every 2 years. This STANDARD is not met as evidenced by: Based on interviews and record review the facility failed to ensure direct care staff in the home were adequately trained on the facility's emergency plan (EP). This potentially affected all the clients residing in the facility. The finding is: Management did not provide training for all the direct care staff who work in the facility. Review on 11/16/2020 of the facility's EP plan revealed there was a training held on 6/24/2020. Additional review revealed only four or seven staff had been trained. Further review revealed there were no other trainings held. During an interview on 1/16/2020, the home manager (HM) confirmed only four of seven staff have been trained in the EP plan. Further interview revealed the three staff just were not trained. During an interview on 11/16/2020, the executive director was not aware only four of seven staff have completed the EP plan training.	E 037		
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on record review and interview, the facility	W 125		

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W 125	Continued From page 11 failed to ensure regarding client (#6) with a need for legal guardianship appointed by the court. This affected 1 of 4 audit clients. The findings are: Client #6 does not have documentation of a legal guardian. Review on 11/16/2020 of client #6's record revealed there is no documentation of guardianship. Further review of client #6's individual program plan (IPP) dated 7/28/2020 revealed his uncle has been signing his consents; including a behavior support plan (BSP). During an interview on 11/16/2020, the executive director stated on 7/17/2019 the former home manager went to court to declare client #6 was not incompetent and would not need a legal guardian. Further interview revealed the company was not aware of the former home mangers actions. Additional interview revealed client #6 does require a legal guardian, due to him being legally declared incompetent.	W 125		
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, interviews and record reviews, the facility failed to ensure 1 of 4 audit clients (#1) individual program plan (IPP) included specific information to address the usage of washable incontinence pads. The finding is:	W 240		

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W 240	Continued From page 12 Client #1's IPP did not include guidelines to address the usage of washable incontinence pads. During observations in the home on 9:26am, when the surveyor entered the home there where two washable incontinence pads on a couch. Further observations revealed client #1 sitting on the washable incontinence pads. Review on 11/16/2020 of client #1's IPP dated 3/13/2020 revealed there was no information in regards to the usage of washable incontinence pads. Further review revealed there was no information regarding the use of a washable incontinence pad mentioned in client #1's behavior support plan (BSP). During an interview on 11/16/2020, Staff B revealed the use of the washable incontinence pads is part of client #1's BSP. Further interview revealed client #1 wears disposable briefs. During an interview on 11/25/2020, the home manager (HM) revealed client #1 does have a behavior of urinating on herself.	W 240		
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.	W 249		

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W 249	Continued From page 13 This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure each client received a continuous active treatment program consisting of needed interventions and services identified in the individual program plan (IPP) in the area of self help skills for 1 of 4 audit clients (#2). The finding is: Client #2 was not prompted to wash his clothes. During observations in the home on 11/16/2020 at 4:53pm, the executive director (ED) was observed sorting and placing client #2's clothes into the washing machine. Further observations revealed the ED putting the detergent into the machine and turning it on. At no time was client #2 prompted to wash his own clothes. Review on 11/16/2020 of client #2's community/home life assessment dated 9/1/2020 revealed he needs verbal cues to sort his laundry, measure correct amount of soap, set dials and turn on washing machine. During an interview on 11/25/2020, the ED revealed she was just "trying to help' client #2 with his laundry.	W 249		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces,	W 436		

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W 436	Continued From page 14 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 ensure recommended equipment specifically eyeglasses were furnished for 2 of 4 audit clients (#2, #6). The findings are: A. Clients #2 and #6 were not prompted to wear their eyeglasses. 1. During observations at the home on 11/16/2020, from 9:26am until 1:03pm and 3:30pm until 7:30pm, client #2 was not prompted to wear his eyeglasses. Review on 11/16/2020 of client #2's individual program plan (IPP) dated 9/17/2020 revealed, "Adaptive Equipment: Eyeglasses; assist with vision and wear during awake hours." During an interview on 11/24/2020, the home manager (HM) stated she was not sure if client #2 wore eyeglasses. During an interview on 11/25/2020, the executive director (ED) stated she was not aware if client #2 wore eyeglasses. 2. During observations at the home on 11/16/2020, from 9:26am until 1:03pm and 3:30pm until 7:30pm, client #6 was not prompted to wear his eyeglasses. Review on 11/16/2020 of client #6's IPP dated	W 436		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G228	A. BUILDING _____ B. WING _____	11/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 436	Continued From page 15 7/28/2020 revealed, "Adaptive Equipment: Eyeglasses." Additional review of client #6's community/Home Life Assessment dated 7/28/2020 revealed he has eyeglasses which he wears independently. During an interview on 11/16/2020, the HM stated client #6 chooses not to wear his eyeglasses. Further interview revealed client #6 needs verbal prompts to wear his eyeglasses. During an interview on 11/25/2020, the ED stated she was not aware if client #6 wore eyeglasses.	W 436		
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 review of fire drill reports and interview, the facility failed to ensure fire evacuation drills were conducted at varied times. This affected all clients residing in the home. The finding is: Fire drills third shift were not conducted at varied times. Review of fire drill reports on 11/16/2020 revealed the following: Eleven fire drills were conducted on third shift: 3:43am, 4:10am, 4:06am, 3:47am, 4:10am, 4am, 3:30am, 1:30am, 4am, 1am, and 4am. During an interview on 11/16/2020, the executive director confirmed the fire drills conducted on	W 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G228	A. BUILDING _____ B. WING _____	11/25/2020

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W 441	Continued From page 16 third shift were not varied. Further interview revealed third shift hours are 11pm until 8am.	W 441		