		AND HUMAN SERVICES				-	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		34G228	B. WING			11/	25/2020
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
VOCA-C	REEKWAY				24 CREEKWAY DRIVE UQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
E 004	Develop EP Plan, F CFR(s): 483.475(a)	Review and Update Annually )	EO	04			
	Federal, State and preparedness requidevelop establish a	irements. The [facility] must and maintain a comprehensive edness program that meets the					
		eparedness program must limited to, the following					
	and maintain an en that must be [reviev	n. The [facility] must develop nergency preparedness plan wed], and updated at least e plan must do all of the					
	§485.625(a):] Emer CAH] must comply State, and local em requirements. The develop and mainta emergency prepare	482.15 and CAHs at rgency Plan. The [hospital or with all applicable Federal, nergency preparedness [hospital or CAH] must ain a comprehensive edness program that meets the s section, utilizing an ch.					
	Plan. The LTC facil an emergency prep	s at §483.73(a):] Emergency ity must develop and maintain paredness plan that must be ted at least annually.					
	Plan. The ESRD fa maintain an emerge	ies at §494.62(a):] Emergency cility must develop and ency preparedness plan that ], and updated at least every 2					

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

TITLE

(X6) DATE

PRINTED: 11/30/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURV COMPLETE         NAME OF PROVIDER OR SUPPLIER       34G228       B. WING       11/25/20         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       424 CREEKWAY DRIVE			AND HUMAN SERVICES			FORM	11/30/2020 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       VOCA-CREFKWAY     424 CREEKWAY DRIVE	STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DATE	E SURVEY
VOCA-CREEKWAY DRIVE			34G228	B. WING		11/2	25/2020
VOCA-CREEKWAY	NAME OF PI	PROVIDER OR SUPPLIER					
	VOCA-CR	REEKWAY			424 CREEKWAY DRIVE FUQUAY VARINA, NC 27526		
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETION DATE
E 004       Continued From page 1       E 004         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 020         Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.475(b)(3)       E 020         (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) (1) of this section, risk assessment at paragraph (a) (1) of section, and the communication plan at pragargaph (c) of this section, risk assessment at paragraph (a) from the fracility, which includes consideration of care and treatment needs of evacues; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.	E 020	This STANDARD is Based on record re failed to ensure the (EP) plan was revie years annually. The The facility's EP pla updated every two Review on 11/16/20 revealed the date of Further review reve plan located in the During an interview director revealed sh plan had been revie years. Policies for Evac. a CFR(s): 483.475(b) [(b) Policies and pro- develop and implen policies and proced plan set forth in par assessment at para and the communica this section. The po- reviewed and upda (annually for LTC). and procedures mu [(3) or (1), (2), (6)] \$ [facility], which inclu- treatment needs of responsibilities; trar evacuation location means of communication the communication	s not met as evidenced by: eview and interview, the facility Emergency Preparedness ewed and updated every two e finding is: an was not reviewed or years. 200 of the facility's EP plan f their plan was 8/14/2017. ealed there was not an updated home. on 11/16/2020, the executive ne was not aware if the EP ewed or updated every two nd Primary/Alt. Comm. 0(3) ocedures. The [facilities] must nent emergency preparedness lures, based on the emergency ragraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of olicies and procedures must be ted at least every 2 years At a minimum, the policies ust address the following:] Safe evacuation from the udes consideration of care and evacuees; staff nsportation; identification of (s); and primary and alternate		4		

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		AND HUMAN SERVICES				FORM	11/30/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G228	B. WING	;		11/25/2020	
NAME OF I	PROVIDER OR SUPPLIER		-		STREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-C	REEKWAY				424 CREEKWAY DRIVE FUQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
E 020	20 Continued From page 2			020			
	§416.54(b)(2):] Safe evacuation froi includes the followin (i) Consideration of (ii) Staff responsibil (iii) Transportation. (iv) Identification of (v) Primary and alter communication with assistance. * [For CORFs at §4 Rehabilitation Agen §485.727(b)(1), and §494.62(b)(2):] Safe evacuation from Rehabilitation Agen Agencies as Provid Therapy and Speed Services; and ESRI staff responsibilities * [For RHCs/FQHC evacuation from the appropriate placem responsibilities and This STANDARD is Based on record re facility failed to deve procedures to addre (EP) including evac community and faci finding is: The facility did not f	care needs of evacuees. ities. evacuation location(s).					

		AND HUMAN SERVICES				FORM	11/30/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED	
		34G228	B. WING	i		11/2	25/2020
NAME OF	PROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-C	REEKWAY				124 CREEKWAY DRIVE FUQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
E 020	Review on 11/16/20 revealed the plan d information in regar locations in the even hurricanes, winter s residents or other er revealed there were one local high schood different local high schood buring an interview director accurate interview director revealed the current staff if they needed During an interview director revealed schood did not include accurate Names and Contact CFR(s): 483.475(c) [(c) The [facility mu emergency prepared that complies with F and must be review 2 years (annually for plan must include a (1) Names and contact following: (i) Staff.	20 of the facility's EP plan id not include accurate rds to the facility's evacuation ant of flood, fire, tornadoes, storms, bio terrorism, missing emergencies. Further review e instructions to relocate to ool, but directions to a totally school. o on 11/16/2020, staff reported where the home would eded to during an emergency. o on 11/16/2020, the home firmed the EP plan did not formation pertaining to locations. Further interview at information could confuse to evacuate. o on 1/16/2020, the executive ne was unaware the EP plan urate information pertaining to locations. et Information (1) st develop and maintain an edness communication plan Federal, State and local laws yed and updated at least every or LTC).] The communication		020			

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		AND HUMAN SERVICES				FORM	11/30/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G228	B. WING			11/:	25/2020
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-C	REEKWAY				124 CREEKWAY DRIVE FUQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
E 030	§485.625(c)] The cr include all of the fol (1) Names and con following: (i) Staff. (ii) Entities prov arrangement. (iii) Patients' ph (iv) Other [hosp (v) Volunteers. *[For RNHCIs at §4 communication plan following: (1) Names and con following: (i) Staff. (ii) Entities prov arrangement. (iii) Next of kin, (iv) Other RNHC (v) Volunteers. *[For ASCs at §416 plan must include a (1) Names and con following: (i) Staff.	482.15(c) and CAHs at ommunication plan must lowing: tact information for the viding services under sysicians bitals and CAHs]. 03.748(c):] The n must include all of the tact information for the viding services under guardian, or custodian. Cls. .45(c):] The communication II of the following: tact information for the	E	030			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPR CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938									
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED			
		34G228	B. WING			11/:	25/2020		
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE				
VOCA-C	REEKWAY				24 CREEKWAY DRIVE FUQUAY VARINA, NC 27526				
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG				(X5) COMPLETION DATE		
E 030	Continued From pa	ge 5	EC	)30					
	*[For Hospices at § communication plan following: (1) Names and con following: (i) Hospice emp (ii) Entities prov arrangement. (iii) Patients' ph (iv) Other hospi *[For HHAs at §484 plan must include a (1) Names and con following: (i) Staff. (ii) Entities prov arrangement. (iii) Patients' ph (iv) Volunteers. *[For OPOs at §486 plan must include a (2) Names and con following: (i) Staff. (ii) Entities prov arrangement. (iii) Entities prov arrangement. (iii) Staff. (ii) Entities prov arrangement. (iii) Volunteers. (iv) Other OPO (v) Transplant a OPO's Donation Se This STANDARD is Based on document facility failed to ensi- preparedness (EP) developed and mai	418.113(c):] The n must include all of the tact information for the bloyees. viding services under sysicians. ices. 1.102(c):] The communication ill of the following: tact information for the viding services under sysicians. 3.360(c):] The communication ill of the following: tact information for the viding services under s. and donor hospitals in the ervice Area (DSA). s not met as evidenced by: nt review and interview, the							

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: WVWN11

Facility ID: 921719

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PRINTED: 11/30/2020

DEPARTMENT OF HEALTH AND HUMAN SERVICES FC CENTERS FOR MEDICARE & MEDICAID SERVICES OMB									
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED			
		34G228	B. WING			11/:	25/2020		
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-			
VOCA-CI	REEKWAY				124 CREEKWAY DRIVE FUQUAY VARINA, NC 27526				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE		
E 030	Continued From pa	ge 6	EC	)30					
	The facility's EP pla face sheet.	n did not include an updated							
E 037	the wrong contact in revealed the face s information for a cli Additional review re admitted on 8/27/20 included. Also, the and not the new sta	on 11/16/2020, the executive the face sheet for the facility rect information. m	E	)37					
	Hospitals at §482.1 at §484.102, "Organ OPOs at §486.360, Training program. T following: (i) Initial training policies and proced staff, individuals pro arrangement, and v expected roles. (ii) Provide eme at least every 2 yea (iii) Maintain do preparedness traini (iv) Demonstrate emergency procedu (v) If the emerg	cumentation of all emergency ng. te staff knowledge of							

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PRINTED: 11/30/2020

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/30/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G228	B. WING			11/2	25/2020
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-CI	REEKWAY				24 CREEKWAY DRIVE UQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
E 037	hospice must do all (i) Initial training policies and proced hospice employees services under arra expected roles. (ii) Demonstrate emergency procedu (iii) Provide email at least every 2 yea (iv) Periodically emergency prepare employees (includin special emphasis p procedures necession others. (v) Maintain door preparedness traini (vi) If the emergent and procedures are hospice must conduct policies and proced *[For PRTFs at §44 program. The PRTF (i) Initial training policies and proced staff, individuals pro- arrangement, and v expected roles. (ii) After initial trainity preparedness traini	act training on the updated lures. 418.113(d):] (1) Training. The of the following: g in emergency preparedness lures to all new and existing , and individuals providing ngement, consistent with their e staff knowledge of ures. ergency preparedness training rs. review and rehearse its edness plan with hospice ing nonemployee staff), with laced on carrying out the ary to protect patients and cumentation of all emergency ng. gency preparedness policies e significantly updated, the uct training on the updated ures. 1.184(d):] (1) Training must do all of the following: g in emergency preparedness lures to all new and existing oviding services under rolunteers, consistent with their raining, provide emergency ng every 2 years. te staff knowledge of	EC	137			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/30/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G228	B. WING			11/2	25/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-CI	REEKWAY				424 CREEKWAY DRIVE FUQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
E 037	preparedness traini (v) If the emerg and procedures are PRTF must conduct policies and proced *[For LTC Facilities Program. The LTC following: (i) Initial training policies and proced staff, individuals pro- arrangement, and v expected role. (ii) Provide emer at least annually. (iii) Maintain do preparedness traini (iv) Demonstrate emergency procedu *[For CORFs at §48 CORF must do all of (i) Provide initial preparedness polici and existing staff, ir services under arra consistent with their (ii) Provide emerg at least every 2 yea (iii) Maintain do (iv) Demonstrate emergency procedu be oriented and ass responsibilities	cumentation of all emergency ng. ency preparedness policies significantly updated, the t training on the updated ures. at §483.73(d):] (1) Training facility must do all of the g in emergency preparedness ures to all new and existing oviding services under rolunteers, consistent with their ergency preparedness training cumentation of all emergency ng. e staff knowledge of ures. 85.68(d):](1) Training. The of the following: I training in emergency es and procedures to all new ndividuals providing ngement, and volunteers, expected roles. ergency preparedness training rs. cumentation of the training. te staff knowledge of ures. All new personnel must signed specific regarding the CORF's hin 2 weeks of their first	E	037			

		AND HUMAN SERVICES				FORM	: 11/30/2020 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY IPLETED
		34G228	B. WING	·		11/:	25/2020
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-C	REEKWAY				24 CREEKWAY DRIVE UQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 037	instruction in the loc systems and signal (v) If the emer and procedures are CORF must conduct policies and proced *[For CAHs at §485 The CAH must do a (i) Initial training policies and proced reporting and exting and where necessa personnel, and gue cooperation with authorities, to all ne individuals providing and volunteers, roles. (ii) Provide emer at least every 2 yea (iii) Maintain do (iv) Demonstrat emergency procedu (v) If the emer and procedures are CAH must conduct policies and proced *[For CMHCs at §4 CMHC must provid preparedness polic and existing staff, ir under arrangement with their expected documentation of th demonstrate staff k	cation and use of alarm s and firefighting equipment. rgency preparedness policies e significantly updated, the ct training on the updated lures. 5.625(d):] (1) Training program. all of the following: g in emergency preparedness lures, including prompt guishing of fires, protection, ary, evacuation of patients, stst, fire prevention, and firefighting and disaster ew and existing staff, g services under arrangement, consistent with their expected ergency preparedness training trs. coumentation of the training. te staff knowledge of ures. rgency preparedness policies e significantly updated, the training on the updated lures. 85.920(d):] (1) Training. The e initial training in emergency ies and procedures to all new ndividuals providing services c, and volunteers, consistent	E	037			

CENTERS FOR MEDICARE & MEDICAID SERVICES	OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
34G228 B. WING	11/25/2020
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY	
VOCA-CREEKWAY 424 CREEKWAY DRIV FUQUAY VARINA, N	
PREFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGPREFIX TAG(EACH CORRE CROSS-REFERETAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERE	S PLAN OF CORRECTION (X5) ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DATE DEFICIENCY)
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 11/16/2020, 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.       W 125         W 125       PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3)       W 125         W 125       PROTECTION OF CLIENTS RIGHTS of 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	

		AND HUMAN SERVICES				FORM	11/30/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G228	B. WING			11/2	25/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-CI	REEKWAY				24 CREEKWAY DRIVE FUQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 125	failed to ensure reg for legal guardiansh This affected 1 of 4 are: Client #6 does not h	arding client (#6) with a need hip appointed by the court. audit clients. The findings	W 1	125			
W 240	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. INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence.		W 2	240			
	relevant intervention toward independen This STANDARD is Based on observat reviews, the facility clients (#1) individu specific information	ns to support the individual nce. s not met as evidenced by:					

		AND HUMAN SERVICES				FORM	11/30/2020 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G228	B. WING			11/25/2020	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-CI	REEKWAY				24 CREEKWAY DRIVE UQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 240	Continued From pa	ige 12	W 2	W 240			
	Client #1's IPP did not include guidelines to address the usage of washable incontinence pads.						
	when the surveyor e two washable incon	s in the home on 9:26am, entered the home there where ntinence pads on a couch. ns revealed client #1 sitting on tinence pads.					
	3/13/2020 revealed regards to the usag pads. Further revie information regardir	020 of client #1's IPP dated I there was no information in ge of washable incontinence w revealed there was no ng the use of a washable nentioned in client #1's an (BSP).					
	revealed the use of pads is part of clien	on 11/16/2020, Staff B the washable incontinence at #1's BSP. Further interview vears disposable briefs.					
W 249	manager (HM) reve behavior of urinating	MENTATION	W 2	249			
	formulated a client's each client must red treatment program interventions and se and frequency to su	rdisciplinary team has s individual program plan, ceive a continuous active consisting of needed ervices in sufficient number upport the achievement of the d in the individual program					

Facility ID: 921719

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		AND HUMAN SERVICES				FORM	11/30/2020 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G228	B. WING			11/25/2020	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-CI	REEKWAY				24 CREEKWAY DRIVE UQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 249	Continued From pa	ge 13	W 2	249			
	Based on observat reviews, the facility received a continuo consisting of neede identified in the indi	s not met as evidenced by: tions, interviews and record failed to ensure each client bus active treatment program ed interventions and services ividual program plan (IPP) in to skills for 1 of 4 audit clients					
	Client #2 was not p	rompted to wash his clothes.					
	at 4:53pm, the exec observed sorting ar into the washing ma revealed the ED pu	s in the home on 11/16/2020 cutive director (ED) was nd placing client #2's clothes achine. Further observations tting the detergent into the g it on. At no time was client sh his own clothes.					
	revealed he needs	fe assessment dated 9/1/2020 verbal cues to sort his laundry, nount of soap, set dials and					
W 436	revealed she was ju with his laundry.		W 4	136			
	and teach clients to choices about the u	rnish, maintain in good repair, o use and to make informed use of dentures, eyeglasses, communications aids, braces,					

Facility ID: 921719

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		AND HUMAN SERVICES				FORM	: 11/30/2020 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY
		34G228	B. WING	·		11/	25/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
VOCA-C	REEKWAY				24 CREEKWAY DRIVE UQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 436	and other devices i	-	W 4	436			
	Based on observat interviews, the facili recommended equi	s not met as evidenced by: tions, record review and lity failed to ensure ipment specifically eyeglasses 2 of 4 audit clients (#2, #6).					
	A. Clients #2 and # their eyeglasses.	#6 were not prompted to wear					
	11/16/2020, from 9:	tions at the home on :26am until 1:03pm and m, client #2 was not prompted sses.					
	program plan (IPP)	020 of client #2's individual dated 9/17/2020 revealed, ent: Eyeglasses; assist with ring awake hours."					
		/ on 11/24/2020, the home ed she was not sure if client s.					
		on 11/25/2020, the executive d she was not aware if client #2					
	11/16/2020, from 9:	tions at the home on :26am until 1:03pm and m, client #6 was not prompted sses.					
	Review on 11/16/20	020 of client #6's IPP dated					

STATE MENUTOR DEPICIENCIES AND PLAN JUBBANT STATEMENT ON DEPOLER AND PLAN JUBBANT STATEMENT OF DEPOLENCES VOCA-CVECKWAY       02) WALTIME CONSTRUCTION A BULINOM			AND HUMAN SERVICES				FORM	11/30/2020 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITV, STATE, ZP CODE       VOCA-CREEKWAY     STREET ADDRESS, CITV, STATE, ZP CODE       VAIL     SUMMARY STATEMENT OF DEFICIENCIES, IEACH DEFICIENCY ON IST BE PRECEDED BY PLLI, RESULATORY ON IT/16/2020, the HM stated client free on It/16/2020, the ED stated she was not aware if client #6 wore eyeglasses. EVACUATION DRILLS VW 441     VV 441       This STANDARD is not met as evidenced by: Based on review of fire drill reports on 11/16/2020 revealed the following: Eleven fire drill swere conducted on third shift: 343am, 410am, 4am, 1am, and 4am. During an interview on 11/16/2020, the executive			(X1) PROVIDER/SUPPLIER/CLIA	· ·		E CONSTRUCTION		
VOCA-CREEKWAY         242 GREY WAN, NC. 27526           PRETRX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY VILL REGULATORY OR LSC DENTIFYING INFORMATION)         D         PREFIX TAG         PREFIX (EACH CORRECTIVA OR TAGEN OR DATE) (EACH CORRECTIVA OR LSC DENTIFYING INFORMATION)         D         PREFIX TAG         PREFIX (EACH CORRECTIVA CRUCK)         D           W 436         Continued From page 15 7/28/2020 revealed, "Additional review of client #6's communit/Whome Life Assessment dated 7/28/2020 revealed has eyeglasses. Further interview on 11/16/2020, the HM stated client #6 chooses not to wear his eyeglasses. Further interview on 011/16/2020, the ED stated she was not aware if client #6 onces on to wear his eyeglasses. Further interview revealed client #6 needs verbal prompts to wear not aware if client #0 once eyeglasses. FURTHER interview of fire drill sunder varied conditions.         W 441           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 under varied conditions.         W 441           Fire drills hind shift were not conducted at varied times.         Fire drills hind shift were not conducted at varied times.           Review of fire drill reports on 11/16/2020 revealed the following:         Eleven fire drill reports on 11/16/2020 revealed the following:           Eleven fire drills were conducted on third shift: 3.43am, 4.10am, 4.05am, 3.47am, 4.10am, 4am, 3.03am, 13.20am, 4.41         Life Additional evacuation			34G228	B. WING			11/2	25/2020
VOCACREEKWAY         FUQUAY VARINA, NC 27526           (X4) ID PREEX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE REFICEDED & FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREEX TAG         PROVIDER'S ALCORRECTIVE ATION BOULD & CROSS-REFERENCE NO SHOULD & CROSS-REFERENCE NO SHOULD & CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY         COMPLETION DEFICIENCY           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.         W 436         W 436           During an interview on 111/16/2020, the HM stated client #6 chooses not to wear his eyeglasses. Further interview revealed client #6 wore eyeglasses. Further interview revealed client #6 wore eyeglasses.         W 441           VA40L W 441         EVACUATION DRILLS CFR(s): 483.470(i)(1)         W 441           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 were not conducted at varied times.           Fire drills were conducted on third shift: 3:43am, 4:10am, 4:06am, 3:47am, 4:10am, 4am, 3:30am, 1:30am, 4:47am, 4:10am, 4:47am,	NAME OF F	PROVIDER OR SUPPLIER						
Price with the procession of the second o	VOCA-CI	REEKWAY						
7/28/2020 revealed, "Adaptive Equipment:         Eyeglasses."         Life         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.         CFR(s): 483.470(i)(1)         The facility must hold evacuation drills under         varied conditions.         W 441         EVACUATION DRILLS         V 441         EVACUATION To the as evidenced by:         Based on review of fire drill reports and interview,         vt aried conditions.         W 441         Cients 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, 4:0am, 3:47am, 4:10am, 4am,         3:30am, 1:30am, 4am, 1am, and 4am.         During an interview on 11/16/2020, the executive	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
		7/28/2020 revealed Eyeglasses." Addit community/Home L 7/28/2020 revealed wears independent During an interview client #6 chooses n Further interview re prompts to wear his During an interview she was not aware EVACUATION DRII CFR(s): 483.470(i)( The facility must ho varied conditions. This STANDARD is Based on review of the facility failed to were conducted at clients residing in th Fire drills third shift times. Review of fire drill r the following: Eleven fire drills we 3:43am, 4:10am, 4: 3:30am, 1:30am, 4: During an interview	<ul> <li>adaptive Equipment:</li> <li>ional review of client #6's</li> <li>ife Assessment dated</li> <li>he has eyeglasses which he</li> <li>and 11/16/2020, the HM stated</li> <li>and 11/16/2020, the HM stated</li> <li>and 11/25/2020, the ED stated</li> <li>and 11/25/2020, the ED stated</li> <li>and evacuation drills under</li> <li>and evacuation drills under</li> <li>and met as evidenced by:</li> <li>f fire drill reports and interview,</li> <li>ensure fire evacuation drills</li> <li>varied times. This affected all</li> <li>he home. The finding is:</li> <li>were not conducted at varied</li> <li>eports on 11/16/2020 revealed</li> <li>eports on 11/16/2020, the executive</li> </ul>					

		AND HUMAN SERVICES					FORM	11/30/2020 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X <sup>-</sup> AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G228	B. WING	B		11/25/2020		
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP COD	E		
VOCA-C	REEKWAY				4 CREEKWAY DRIVE JQUAY VARINA, NC 27526			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD	BE	(X5) COMPLETION DATE
W 441	third shift were not	nge 16 varied. Further interview hours are 11pm until 8am.	W	441				

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