STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G282	A. BUILDING _____ B. WING _____	12/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-LAURELWOOD	200 LAURELWOOD DR SMITHFIELD, NC 27577

(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
E 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) [(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 the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. *[For LTC facilities at §483.73(a)(1):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a)(1):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] Emergency	E 006		

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

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	(X3) DATE SURVEY COMPLETED
	34G282	A. BUILDING _____ B. WING _____	12/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-LAURELWOOD	200 LAURELWOOD DR SMITHFIELD, NC 27577

(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
E 006	Continued From page 1	E 006		

Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:
(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.
(2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.
This STANDARD is not met as evidenced by:
Based on policy review and staff interview, the facility failed to develop an emergency preparedness (EP) plan including and based upon a community and facility-based risk assessment utilizing an all-hazards approach. This had the potential to affect all clients (#2, #3, #4, #5 and #6). The finding is:

Review on 12/15/20 of the facility's EP plan, last revised on May 2020, revealed the plan did not provide specific information in regards to a facility-based risk assessment utilizing an all-hazards approach.

Interview on 12/16/20 with the resident manager (RM) revealed when she looked through the EP she could not locate a risk assessment and had not participated in developing one.

Interview on 12/16/20 with the qualified intellectual disabilities professional (QIDP) revealed that the RM coordinated EP activities for the home and that the program manager (PM) reviewed the content.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G282	A. BUILDING _____ B. WING _____	12/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-LAURELWOOD	200 LAURELWOOD DR SMITHFIELD, NC 27577

(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 104	Continued From page 2	W 104		
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the governing body and management failed to exercise general policy and operating direction over the facility by failing to ensure maintenance of the home's sidewalk and driveway, so that it remained in good repair. This had the ability to affect 4 of 5 audit clients (#2, #3, #5 and #6). The finding is: During observations of the home on 12/15/20 at 2:00 pm, the driveway and sidewalk leading to the front door entrance, had large cracks and a raised surface where the sidewalk and driveway were joined. There was an attempt to bridge the gap of the surface, by adding a cement filler at the end of the sidewalk. Review on 12/15/20 of the facility's fire drill/evacuation reports listed 15 instances since February '20 that staff were challenged rolling the wheelchairs over the cracked surface. The dates included: On 2/20/20, 3/31/20, 4/28/20, 5/25/20, 5/30/20, 6/15/20, 7/9/20, 8/10/20, 9/8/20, 10/10/20, 10/27/20, 11/6/20, 11/16/20, 11/17/20 and 12/1/20. An additonal review of the reports acknowledged a work order or intention to make repairs on the following dates: 5/26/20, 7/28/20, 8/10/20, 9/1/20 and 10/30/20.	W 104		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G282	A. BUILDING _____ B. WING _____	12/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-LAURELWOOD	200 LAURELWOOD DR SMITHFIELD, NC 27577

(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 104	Continued From page 3 Review on 12/16/20 of service orders revealed on 9/14/20 a management employee submitted an urgent written request noting "driveway is uneven and cracked in the middle portion of the driveway (concrete). This needs to be escalated." On 9/24/20 contact was made with a vendor with a proposal forwarded to management on 10/25/20. On 11/19/20 management learned that a 2nd vendor only served industrial clients. On 12/3/20, the 3rd vendor was contacted and would make a visit to the home the following week. Interview on 12/15/20 with staff A and D revealed that the cement filler had not helped navigate the clients wheelchairs over the raised surface, when conducting fire drills. Both staff mentioned that someone came to the home last week to look at the driveway but they did not know if repairs were ordered. Interview on 12/16/20 with the resident manager (RM) revealed that she has been aware of staff's concern with the cracked sidewalk since transferring to the home in July. She submitted a work order, spoke with a vendor who recommended that the entire driveway be resurfaced. Staff recently informed the RM that another vendor came to the home last week to look at the sidewalk. Interview on 12/16/20 with the qualified intellectual disabilities professional (QIDP) revealed that the driveway had cracks in it for the past year however around May 2020, the cracked became raised, creating hazards for stumbling. The QIDP recalled asking the previous RM to submit a work order, late Spring. The QIDP did not recall a response from management	W 104		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G282	A. BUILDING _____ B. WING _____	12/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-LAURELWOOD	200 LAURELWOOD DR SMITHFIELD, NC 27577

(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 104	Continued From page 4 regarding the repair. Interview on 12/16/20 with the assistant executive director (AED) revealed that she became aware of a work order to repair the sidewalk/driveway at the home in September 2020. The order was written as urgent on 9/14/20 and that status required 3 proposals from vendors before presenting to capital expenditure. One vendor was sent to the home in October and sent a proposal; and then another vendor went to the home last week and they have not received their proposal. Ordinarily the program manager was handling the work order but he was on leave.	W 104		
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure 1 of 5 audit clients (#5) individual program plan (IPP) included training to meet the client's needs with complying with evacuating during fire drills. The finding is: Review on 12/15/20 of the IPP for client #5 dated 5/8/20 revealed that there was no identified program that addressed non-compliance specifically with fire drills. An updated behavior support plan, dated 5/8/20 had a goal of 1 or less non-compliance episodes within a 12 month consecutive period. In the event that client #5	W 227		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G282	A. BUILDING _____ B. WING _____	12/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-LAURELWOOD	200 LAURELWOOD DR SMITHFIELD, NC 27577

(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 227	Continued From page 5	W 227		

refused to honor staff's requests, refused to leave an area or remained standing in the hall, staff were directed to offer redirection, no more than 30 seconds intervals, up to 5 minutes.

Review on 12/15/20 of the facility's monthly fire drill reports revealed multiple incidents of client #5 non-complying with evacuating from the home. Staff conducting the drills had to physically assist client #5 from the home instead of issuing verbal cues. Client #5 was noted to need physical assistance during these fire drills:

On 3/22/20 at 6:34 PM, client #5 refused to evacuate from her room, until staff redirected her. The former RM met with client #5 and counseled her on why it was important to go outside during the drill.
On 3/29/20 at 7:08 AM, client #5 began screaming during the drill and did not want to comply.
On 10/18/20 from 2:29 PM - 2:41 PM, client #5 was in her room resting when the fire alarm sounded. Client #5 refused to move and began screaming. Staff had to physically prompt her to evacuate the home. Staff noted to follow up with the qualified intellectual disabilities professional (QIDP). A response from the QIDP was not recorded.
On 12/14/20 at 4:14 PM, client #5 refused to evacuate the home from the living room. Staff had to physically prompt client #5 to leave and counseled her on the importance of fire drills.

Interview on 12/16/20 with the resident manager (RM) revealed that she was assigned to the home on 7/1/20. On 12/14/20, she was working in the home and witnessed client #5's noncompliance during a fire drill that they conducted at 4:14 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G282	A. BUILDING _____ B. WING _____	12/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-LAURELWOOD	200 LAURELWOOD DR SMITHFIELD, NC 27577

(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 227	Continued From page 6 She stated that client #5 began to scream, pull on her hair and would not move. Staff had to assist client #5 from the home. Afterward the RM emailed the QIDP and made her aware of the incident and requested behavioral supports. The QIDP responded that the psychologist would be contacted. Interview on 12/16/20 with the QIDP revealed that she did not review the fire drill reports or know until 12/14/20 that client #5 sometimes required physical prompts from staff. She further stated that client #5 already had a BSP to address her behavior of noncompliance. The QIDP acknowledged that during a fire drill, staff should not wait 5 minutes for client #5 to comply with their request to evacuate the home.	W 227		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure the system of administrating medications as ordered was implemented. This affected 2 of 5 audit clients (#3 and #4). The finding is: A. During morning medication administration in the home on 12/16/20 at 7:10 am, staff A assisted client #3 to pop 5 whole pills out of blister packs into a container of yogurt. The pills were stirred into the food, and then ingested by client #3. Client #3 also received an antacid tablet, which	W 368		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G282	A. BUILDING _____ B. WING _____	12/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-LAURELWOOD	200 LAURELWOOD DR SMITHFIELD, NC 27577

(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 368	Continued From page 7 she chewed. Review on 12/16/20 of client #3's physician orders dated 11/20/20 revealed instructions, "medications crushed in applesauce or nectar thickened liquids." It was noted that client #3 was diagnosed with dysphagia. B. During morning medication administration in the home on 12/16/20 at 7:39 am, staff A assisted client #4 to pop 10 pills into a container of yogurt. The pills were stirred into the food, and then ingested by client #4. Client #4 received a nutritional shake afterwards. Review on 12/16/20 of client #4's physician orders dated 11/20/20 revealed instructions, "medications crushed in applesauce or pudding." During an interview with staff A on 12/16/20, she revealed that she has never crushed pills before giving to clients #3 and #4 during medication administration. Staff A stated that she was train to only review the blister pack container of the medication and the electronic physician order. She never noticed any language before today that instructed her to crush medications before giving, until she made a thorough review of the electronic physician order again and saw those instructions. During an interview with the qualified intellectual disabilities professional (QIDP) on 12/16/20 revealed that earlier this year, client #3's physician orders changed to crush medications. The previous resident manager (RM) gave an in-service to all staff to start crushing her medications.	W 368		
W 447	EVACUATION DRILLS	W 447		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G282	A. BUILDING _____ B. WING _____	12/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-LAURELWOOD	200 LAURELWOOD DR SMITHFIELD, NC 27577

(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 447	Continued From page 8 CFR(s): 483.470(i)(2)(iii) The facility must file a report and evaluation on each evacuation drill. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to implement corrective measures after problems with fire drills were repeatedly identified. This had the potential to affect all clients (#2, #3, #4, #5 and #6). The findings are: Review on 12/15/20 of the facility's fire drill/evacuation report revealed the following irregularities: On 2/29/20 at 7:08 am client #5 was noncompliant with staff's request to evacuate the home independently during a fire drill. There was no response from management with recommendations. On 3/22/20 at 6:34 pm client #5 was noncompliant with staff's request to evacuate the home independently during a fire drill. There was no response from management with recommendations. On 3/31/20 at 10:00 pm staff reported that it took 10 minutes, 3 seconds to evacuate 4 clients using wheelchairs from the home. There were no recommendations for improvement from management. On 4/29/20 at 5:32 am staff reported that it took 5 minutes, 18 seconds to physically assist 4 out of 6 clients from evacuating the home. There were no recommendations for improvement from	W 447		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G282	A. BUILDING _____ B. WING _____	12/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-LAURELWOOD	200 LAURELWOOD DR SMITHFIELD, NC 27577

(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 447	Continued From page 9	W 447		

management.

On 7/9/20 at 10:55 am staff reported that the broken and uneven pavement made it hard for wheelchairs to roll. Staff and clients had stumbled over uneven pavement. There was a recommendation to submit a work order and notify upper management. The pavement remained broken at the time of survey.

On 8/13/20 at 4:03 pm staff reported that they exited the back door because of the numerous trip hazards at the front of the house. Recommendations for improvement suggested that repairs need to be made to the driveway and sidewalk of the home. The pavement remained broken at the time of the survey.

On 8/28/20 at 10:20 pm staff reported that it took 15 minutes to physically assist 4 out of 6 clients from evacuating the home. There were no recommendations for improvement from management.

On 10/6/20 at 8:45 am staff reported that it took 10 minutes to conduct fire drill. Staff stated "difficulty evacuating 4 clients requiring physical assistance for 2 staff persons."

On 10/10/20 at 3:26 pm staff reported that it took 12 minutes to physically assist 4 out of 6 clients from the home. The sidewalk was noted to be uneven. A recommendation to follow up with work order was the response from the resident manager (RM).

On 10/12/20 at 10:25 pm staff reported that it took 12 minutes to physically assist 4 out of 6 clients from the home. The RM responded to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G282	A. BUILDING _____ B. WING _____	12/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-LAURELWOOD	200 LAURELWOOD DR SMITHFIELD, NC 27577

(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 447	Continued From page 10 follow up with the work order. On 10/18/20 at 2:29 pm client #5 was noncompliant with staff's request to evacuate the home and was physically assisted by staff. A recommendation to follow up with the qualified intellectual disabilities professional (QIDP) was noted. On 10/27/20 at 10:25 pm staff reported that it took 12 minutes to physically assist 4 out of 6 clients from the home. The RM responded to follow up with the work order. On 11/6/20 at 4:00 pm staff reported that it took 17 minutes to evacuate clients from the home, due to uneven surface of the driveway and sidewalk that made it hard to operate the wheelchairs. The pavement remained broken at the time of the survey. Interview on 12/16/20 with the RM revealed that she was unaware of an ideal timeframe to evacuate clients while conducting fire drills. Also the RM stated that management had not made her aware of progress on the sidewalk repair. Interview on 12/16/20 with the QIDP revealed that she did not know the status of any repairs to the sidewalk. She further stated that she only became aware of issues with client #5 becoming noncompliant during fire drills this week. The QIDP stated that the RM handled all training with the group home staff.	W 447		
W 481	MENUS CFR(s): 483.480(c)(2) Menus for food actually served must be kept on	W 481		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G282	A. BUILDING _____ B. WING _____	12/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-LAURELWOOD	200 LAURELWOOD DR SMITHFIELD, NC 27577

(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 481	Continued From page 11	W 481		

file for 30 days.
This STANDARD is not met as evidenced by:
Based on observations, record review and interviews, the facility failed to keep a record of food substitutions for the home. This had the potential to affect all clients (#2, #3, #4, #5 and #6). The finding is:

During lunch observations in the home on 12/15/20 at 12:40 pm, all of the clients were served scrambled eggs, spinach, wheat bread and jello.

During dinner observations in the home on 12/15/20 at 5:40 pm, all of the clients were offered baked pork loin, cream potatoes, peas or spinach.

During breakfast observations in the home on 12/16/20 at 6:45 am, all of the clients were offered leftover scrambled eggs, fried egg and oatmeal.

Review of the December 2020 menu revealed the following meals:

12/15/20 for lunch
egg muffin bake
California blend
seasonal fruit of choice
pudding cups

12/15/20 for dinner
glazed baked pork loin
white rice
carrots
canned fruit of choice

12/16/20 for breakfast

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G282	A. BUILDING _____ B. WING _____	12/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-LAURELWOOD	200 LAURELWOOD DR SMITHFIELD, NC 27577

(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 481	Continued From page 12 egg whole wheat bread whole milk Interview with the resident manager (RM) on 12/16/20 revealed that she substituted lunch on 12/15/20 because she did not know how to make an egg muffin and to print the recipes took too many pages. The RM also commented that the menu items were substituted because she did not have a chance to return to the grocery store to purchase the items. Initially, the RM suggested that any menu substitution was supposed to be recorded in the communication log, but when presented there were no recent entries. The RM also acknowledged that she did not make her Area Supervisor aware that the menu was substituted. Interview with the qualified intellectual disabilities professional (QIDP) on 12/16/20 revealed that the RM received an electronic copy of the menu and recipes every Wednesday. The expectation was for the RM to purchase food for the home based on the weekly menu. The QIDP stated that menu substitutions should be communicated to the area supervisor.	W 481		