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 _____	04/06/2021

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
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039		

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

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	34G218	A. BUILDING _____ B. WING _____	04/06/2021

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E 039	Continued From page 1 (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility- based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d) (2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039		

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E 039	Continued From page 2 (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]	E 039		

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	34G218	A. BUILDING _____ B. WING _____	04/06/2021

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E 039	Continued From page 3 (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to	E 039		

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	34G218	A. BUILDING _____ B. WING _____	04/06/2021

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E 039	Continued From page 4 test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises	E 039		

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	34G218	A. BUILDING _____ B. WING _____	04/06/2021

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E 039	Continued From page 5 to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise	E 039		

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E 039	Continued From page 6 is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on document review and interviews, the facility failed to ensure facility/community-based or tabletop exercises to test their Emergency Preparedness (EP) plan were conducted. This potentially affected clients #1, #2, #3, #4, #5 and #6. The finding is: Review on 4/5/21 of the facility's EP plan reviewed on 2/5/21, did not include a full-scale community-based or tabletop exercise for 2020, which included all staff working in the home. During an interview on 4/6/21, the qualified intellectual disabilities professional (QIDP) confirmed the table top exercise did not include all the staff working in the home.	E 039		
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.	W 130		

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W 130	Continued From page 7 This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure privacy for 2 of 5 audit clients (#1 and #5) residing in the home. The findings are: A. During observations in the home on 4/5/21 at 4:50pm, client #5 was observed exiting the bathroom without any clothes on. Further observations revealed Staff B walking directly behind client #5 when he exited the bathroom and went into his bedroom. Additional observations revealed client #5's bedroom door remained wide open while client #5 was getting dressed. At 4:51pm another client walked down the hall and looked into client #5's bedroom while he had no clothes on. Staff B remained in client #5's bedroom while he was getting dressed. At no time was client #5 prompted to close his bedroom door nor did staff close the door. During an immediate interview, Staff B revealed client #5 will shut the door on his own for privacy. Further interview revealed she did not realize client #5 did not have his bathrobe when she looked in on him while he was in the bathroom. During an interview on 4/6/21, the qualified intellectual disabilities professional (QIDP) stated client #5 should have been prompted to have his bathrobe with him when he went into the bathroom and prompted to shut the door of his bedroom while he was getting dressed. B. During observations in the home on 4/6/21 at 5:54am, client #1 was observed exiting his bedroom and entering the bathroom. Further observations revealed client #1's bathrobe was wide open and he did not have any clothes on	W 130		

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W 130	Continued From page 8 underneath his bathrobe. At 6:04am, client #1 was observed walking out of the bathroom with his bathrobe wide open and not wearing any clothes underneath the bathrobe and walking past the surveyor towards the laundry room. Staff C was walking with client #1 and reached out and tried to close the front of his bathrobe. During an immediate interview, Staff C stated client #1 does have a belt for the bathrobe, but he was not sure where it was. During an interview on 4/6/21, the QIDP revealed client #1 should have been prompted to ensure his bathrobe was secured with a belt before he exited both his bedroom and the bathroom.	W 130		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, policy review and interviews, the facility failed to ensure staff were sufficiently trained regarding the disposer of medications. The finding is: During medication observations in the home on 4/5/21 at 4:00pm, a pill landed on the floor while the client was punching his bubble pack. The Staff B picked up the pill and put it in the trash can. Further observations revealed Staff B called the pharmacy and the facility nurse.	W 189		

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	34G218	A. BUILDING _____ B. WING _____	04/06/2021

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W 189	Continued From page 9 During an interview on 4/6/21 Staff D stated if a pill is dropped on the floor it should never be put into the trash can. Further interview revealed the pill is put into a bottle of Pill Buster, which is kept in the medication closet, the nurse and the pharmacy should be called. During an interview on 4/6/21, the qualified intellectual disabilities professional (QIDP) was informed by the surveyor about the interview were Staff D told them about the Pill Buster.	W 189		
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 review and interviews, the facility failed to ensure staff were sufficiently trained in reporting medical concerns. This affected 1 of 5 audit clients (#4). The finding is: During dinner observations in the home on 4/5/21 at 5:05pm, client #4 served himself his food at the table. Additional observations revealed Staff B did not cue client #4 to take sips of liquids between bites of food. Client #4 put a folded whole soft taco, which ground meat, cut tomatoes, cheese and pieces of lettuce, into his mouth and took a bite longer than one inches. Further observations revealed client #4 consumed the soft taco in four bites. Further observations at 5:09pm, revealed client #4 consuming three pieces of melon in the shape of	W 192		

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W 192	Continued From page 10 squares into his mouth and immediately coughing. Between 5:10pm and 5:11pm, client #4 coughed four times and then got up from the table. At 5:12pm, Staff B escorted client #4 into the bathroom; while walking into the bathroom client #4 had spit coming from out of his mouth, while he was going into the bathroom. Additional observations revealed client #4 and Staff B entering and exiting the bathroom a total of four times between 5:13pm and 5:17pm; during that time client #4 was coughing and spit was coming out of his mouth. During an immediate interview, Staff B stated client #4's diet is "bite size." Review on 4/5/21 of the homes diet list dated 12/28/20 stated client #4's food is "finely chopped-1/4 inch pieces maximum. Follow meal time guidelines provided for safe eating." Review on 4/5/21 of client #4's Safe/Eating/Drinking Guideline dated 11/16/19 stated, "7. Report any coughing...episode to the supervisor...." During an interview on 4/6/21, the facility nurse revealed she was not informed of client #4's coughing episodes.	W 192		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.	W 263		

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W 263	Continued From page 11 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure restrictive programs were conducted with the written informed consent of a legal guardian. This affected 3 of 5 audit clients (#1, #3 and #6). The findings are: A. Review on 4/5/21 of client #1's behavior support plan (BSP) consents were last signed by the guardian on 7/10/19. Further review revealed client #1's behavior medications are Citalopram, Aripiprazole, Exelon Patch and Namenda. B. Review on 4/5/21 of client #3's BSP consents were last signed by the guardian on 6/25/19. Further review revealed client #3's behavior medications are Invega Sustenna Injection. C. Review on 4/5/21 of client #6's consents were last signed by the guardian on 6/25/19. Further review revealed client #6's behavior medications are Depakote, Abilify and Hydroxyzine. During an interview on 4/6/21, the qualified intellectual disabilities professional (QIDP) confirmed clients #1, #3 and #6 records did not include updated BSP consents, which were signed and dated by their guardians. During an interview on 4/5/21, management staff are aware BSP consents have not been done in a timely manner.	W 263		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health	W 340		

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W 340	Continued From page 12 measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the nursing services failed to ensure that staff were sufficiently trained in the wearing of face masks in regards to COVID-19 protocol. This potentially effected all clients (#1, #2, #3, #4, #5 and #6) residing in the home. The finding is: During observations in the home on 4/6/21 between 5:52am - 6:39am, Staff A's face mask was below his nose while he was in the home. Staff A was observed not wearing a face mask from 6:39am until 7:48am. During an immediate interview at 7:48am, Staff A revealed staff are suppose to wear a face mask at all times while they are in the home. When the surveyor attempted to ask another question, Staff A mu,bled under his breath and walked away to put on a face mask. Review on 4/6/21 of the facility's policy about face masks states, "Instruct staff to follow the North Carolina holiday guidance to prevent the introduction of COVID-19 into the facility. Follow masking...." During an interview on 4/6/21, the qualified intellectual disabilities professional (QIDP) revealed staff are to wear face mask at all times while they are working in the home. Further interview revealed staff have been trained in the wearing of face masks.	W 340		

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	34G218	A. BUILDING _____ B. WING _____	04/06/2021

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W 368	Continued From page 13	W 368		
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 medications has been updated. This affected 3 of 5 clients (#1, #3 and #6). The findings are: Review on 4/5/21 of client #1's physician orders revealed the last one signed by the physician was on 7/2/20. Review on 4/5/21 of client #3's physician orders revealed the last one signed by the physician was on 10/11/19. Review on 4/5/21 of client #6's physician order revealed the last one signed by the physician was on 7/2/20. Further review revealed there were no updated physician orders for clients #1, #3 and #6. During an interview on 4/6/21, the qualified intellectual disabilities professional (QIDP) confirmed clients #1, #3 and #6 do not have updated physician orders.	W 368		
W 418	CLIENT BEDROOMS CFR(s): 483.470(b)(4)(ii) The facility must provide each client with a clean, comfortable mattress. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure client #6 had a comfortable	W 418		

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	34G218	A. BUILDING _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-OBIE	322 OBIE DRIVE DURHAM, NC 27713

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W 418	Continued From page 14 mattress. This affected 1 of 5 audit clients. The finding is: During observations in the group home on 4/5 - 6/21 at 9:27am, Staff D was assisting client #6 with turning over the mattress on his bed. Further observations revealed client #6's mattress had a rip which was the entire length on the mattress on both sides. During an interview on 4/6/21, the qualified intellectual disabilities professional (QIDP) confirmed client #6's mattress was ripped on both sides. The QIDP revealed client #6 has had a brand new bedroom set, which was two weeks ago.	W 418		
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, 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 1 of 5 audit clients (#6). The finding is: During observations in the home on 4/5/21, client #6 was not observed wearing his eyeglasses in the home. Further observations on 4/5/21, client	W 436		

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W 436	Continued From page 15 #6 was observed standing under the television (hanging on the wall) and looking up at it. At no time was client #6 prompted to put on his eyeglasses. During a review on 4/5/21 of client #6's individual program plan (IPP) dated 3/21/20 revealed, "Adaptive Equipment: Eyeglasses; visual aid...." During a review on 4/5/21 of client #6's vision examination dated 7/10/19 revealed, "Glaucoma both eyes." During an interview on 4/6/21, the qualified intellectual disabilities professional (QIDP) revealed staff should be prompting client #6 to wear his eyeglasses. Further interview revealed client #6 is to wear his eyeglasses all day.	W 436		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #4's diet was provided as prescribed. This affected 1 of 5 clients (#4). The finding is: During dinner observations in the home on 4/5/21 at 5:05pm, client #4 served himself his food at the table. Additional observations revealed Staff B did not cue client #4 to take sips of liquids between bites of food. Client #4 put a folded whole soft taco, which ground meat, cut	W 460		

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W 460	Continued From page 16	W 460		

tomatoes, cheese and pieces of lettuce, into his mouth and took a bite longer than one inches. Further observations revealed client #4 consumed the soft taco in four bites. Further observations at 5:09pm, revealed client #4 consuming three pieces of melon in the shape of squares into his mouth and immediately coughing. Between 5:10pm and 5:11pm, client #4 coughed four times and then got up from the table. At 5:12pm, Staff B escorted client #4 into the bathroom; while walking into the bathroom client #4 had spit coming from out of his mouth, while he was going into the bathroom. Additional observations revealed client #4 and Staff B entering and exiting the bathroom a total of four times between 5:13pm and 5:17pm; during that time client #4 was coughing and spit was coming out of his mouth.

During an immediate interview, Staff B stated client #4's diet is "bite size."

Review on 4/5/21 of the homes diet list dated 12/28/20 stated client #4's food is "finely chopped-1/4 inch pieces maximum. Follow meal time guidelines provided for safe eating."

Review on 4/5/21 of client #4's Safe/Eating/Drinking Guideline dated 11/16/19 stated, "1. Prepare all food to Finely Chopped Consistency-1/4 inch pieces maximum per guidelines unless already that size or smaller. All food must be chopped in the kitchen prior to bringing to the table for him...4. Encourage/assist him to take safe size bites with sips of liquid between bites with prompts as necessary...5. Provide cuing/verbal prompting as needed to ensure safe rate of eating and small sips and small bites, remember he is to alternate bites of

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W 460	Continued From page 17 solids and liquids...6. Make sure his mouth is empty before his next bite is taken. 7. Report any coughing...episode to the supervisor...." During an interview on 4/6/21, the facility nurse revealed she was not informed of client #4's coughing episodes. During an interview on 4/6/21, the qualified intellectual disabilites professional (QIDP) revealed staff should have followed client #4's eating and drinking guidelines. Further interview revealed client #4's food should always be finely chopped.	W 460		