DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE 8					FORM	APPROVED 0938-0391
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	``'		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	34G218	B. WING			04/0	06/2021
NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 22 OBIE DRIVE		
VOCA-OBIE				DURHAM, NC 27713		
PREFIX (EACH DEFICIENCY M	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
HHAs at §484.102, C "Organizations" unde §485.920, RHC/FQH Facilities at §494.62]: (2) Testing. The [facil to test the emergency must do all of the follo (i) Participate in a community-based eve (A) When a c not accessible, condu exercise every 2 (B) If the [fac natural or man-made activation of the emer is exempt from engag community-based or functional exercise un the actual event. (ii) Conduct an ac every 2 years, opposi functional exercise un this section is conduc not limited to the follo (A) A second community-based or functional exercise; o (B) A mock d (C) A tabletop is led by a facilitator a discussion using a na clinically-relevant	2) .748, ASCs at §416.54, CORFs at §485.68, OPO, er §485.727, CMHC at IC at §491.12, ESRD : lity] must conduct exercises y plan annually. The [facility] owing: a full-scale exercise that is rery 2 years; or community-based exercise is uct a facility-based functional years; or cility] experiences an actual e emergency that requires rgency plan, the [facility] ging in its next required individual, facility-based ercise following the onset of dditional exercise at least ite the year the full-scale or nder paragraph (d)(2)(i) of cted, that may include, but is owing: I full-scale exercise that is individual, facility-based or lisaster drill; or p exercise or workshop that and includes a group	EO	039			

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

TITLE

(X6) DATE

PRINTED: 04/08/2021

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.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/08/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G218	B. WING			04/(	06/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-O	BIE				22 OBIE DRIVE DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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
E 039	maintain documenta exercises, and emer revise the [facility's] *[For Hospices at 4 (2) Testing for hosp patient's home. The exercises to test the annually. The hosp (i) Participate in community based ener (A) When an not accessible, com- based functional ex (B) If the hose or man-made emer of the emergency p exempt from engag scale community-based of the onset of the em (ii) Conduct an years, opposite the functional exercise this section is condu- not limited to the fol (A) A seco community-based of exercise; or (B) A mock (C) A table is led by a facilitator discussion using a clinically-releva	the [facility's] response to and ation of all drills, tabletop regency events, and emergency plan, as needed. 18.113(d):] bices that provide care in the e hospice must conduct e emergency plan at least ice must do the following: n a full-scale exercise that is very 2 years; or community based exercise is duct an individual facility ercise every 2 years; or ospice experiences a natural gency that requires activation lan, the hospital is ing in its next required full ased exercise or individual functional exercise following ergency event. additional exercise every 2 year the full-scale or under paragraph (d) (2)(i) of ucted, that may include, but is lowing: nd full-scale exercise that is r a facility based functional a disaster drill; or top exercise or workshop that and includes a group narrated, nt emergency scenario, and a ements, directed messages, or	ΕC	039			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/08/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G218	B. WING			04/0	06/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-O	BIE				322 OBIE DRIVE DURHAM, NC 27713		
(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 039	Continued From pa	ge 2	E	)39			
	care directly. The h exercises to test the year. The hospice (i) Participate in that is community-b (A) When a not accessible, com- facility-based function (B) If the hospice or man-made emer of the emergency p exempt from engage full-scale communit functional of the emergency e (ii) Conduct an that may include, but following: (A) A second community-based of exercise; or (B) A moch (C) A table by a facilitator that if using a narrated, emergency scenario statements, directed questions dese emergency plan. (iii) Analyze the maintain document exercises, and emergency the hospice's emergency	a community-based exercise is duct an annual individual onal exercise; or ospice experiences a natural gency that requires activation lan, the hospice is ing in its next required y based or facility-based exercise following the onset vent. additional annual exercise ut is not limited to the additional annual exercise to the full-scale exercise that is or a facility based functional c disaster drill; or top exercise or workshop led ncludes a group discussion clinically-relevant o, and a set of problem d messages, or prepared signed to challenge an e hospice's response to and ation of all drills, tabletop ergency events and revise gency plan, as needed. 1.184(d), Hospitals at					

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/08/2021 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION		E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-O	BIE				22 OBIE DRIVE DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	conduct exercises t twice per year. The do the following: (i) Participate in that is community-b (A) When a not accessible, com- facility-based function (B) If the [P experiences an acture emergency that req emergency plan, the engaging in its next based or functional exercises emergency event. (ii) Conduct an and that may includ following: (A) A second community-based of functional exercise; (B) A mockd (C) A tablet is led by a facilitator discussion, using a clinically-releva set of problem state prepared questions emergency plan. (iii) Analyze the maintain documenta exercises, and eme the [facility's] emergency *[For LTC Facilities	ATF, Hospital, CAH] must o test the emergency plan e [PRTF, Hospital, CAH] must in an annual full-scale exercise ased; or in community-based exercise is duct an annual individual, onal exercise; or RTF, Hospital, CAH] ual natural or man-made uires activation of the e [facility] is exempt from required full-scale community individual, facility-based following the onset of the [additional] annual exercise or e, but is not limited to the ad full-scale exercise that is or individual, a facility-based or disaster drill; or op exercise or workshop that and includes a group narrated, in emergency scenario, and a ements, directed messages, or designed to challenge an [facility's] response to and ation of all drills, tabletop rgency events and revise jency plan, as needed.	E	039			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/08/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G218	B. WING			04/	06/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-O	BIE				22 OBIE DRIVE DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	test the emergency including unannoun emergency procedu ICF/IID] must do the (i) Participate in that is community-b (A) When a not accessible, com- facility-based function (B) If the [L] an actual natural or requires activation of the LTC facility is ex- required a full-scale individual, facilit following the onset (ii) Conduct an that may include, but following: (A) A secon community-based of functional exercise; (B) A mock (C) A table is led by a facilitator using a narrated, emergency scenario statements, directed questions dese emergency plan. (iii) Analyze the response to and ma drills, tabletop exercise emergency plan, as *[For ICF/IIDs at §4]	plan at least twice per year, ced staff drills using the ures. The [LTC facility, e following: n an annual full-scale exercise based; or a community-based exercise is duct an annual individual, onal exercise. TC facility] facility experiences man-made emergency that of the emergency plan, kempt from engaging its next e community-based or ty-based functional exercise of the emergency event. additional annual exercise ut is not limited to the nd full-scale exercise that is or an individual, facility based or c disaster drill; or top exercise or workshop that r includes a group discussion, clinically-relevant o, and a set of problem d messages, or prepared signed to challenge an e [LTC facility] facility's aintain documentation of all cises, and emergency the [LTC facility] facility's a needed.	EO	39			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/08/2021 APPROVED 0938-0391
STATEMENT OF DE AND PLAN OF COR	FICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>·</i>		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G218	B. WING	i		04/	06/2021
NAME OF PROVID	DER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-OBIE					22 OBIE DRIVE DURHAM, NC 27713		
	(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
to te The that not a facili natu activ is ex full-s of th () may com func is lea discu set o prep eme () mair exer the I * [Foi (d)(2) to te follow	ICF/IID must de (i) Participate in is community-b (A) When a accessible, con- ity-based function (B) If the IC accessible, con- ity-based function (B) If the IC accessible, con- ity-based function (B) If the IC accession of the em- cempt from eng scale community- based function accessed function accessed function (ii) Conduct an rinclude, but is (A) A secon- munity-based of tional exercise; (B) A mock (C) A tablet d by a facilitator ussion, using a clinically-releva- of problem state bared questions ergency plan. (iii) Analyze the natin documenta- rcises, and eme ICF/IID's emerg r OPOs at §486 (2) Testing. The of the emergen wing: (i) Conduct a participate (i) Conduct a participate (ii) Conduct a participate (iii) Conduct (iii) Conduct (	icy plan at least twice per year. o the following: a an annual full-scale exercise based; or a community-based exercise is duct an annual individual, onal exercise; or. CF/IID experiences an actual de emergency that requires hergency plan, the ICF/IID aging in its next required cy-based or individual, facility- al exercise following the onset vent. additional annual exercise that not limited to the following: and full-scale exercise that is or an individual, facility-based or disaster drill; or cop exercise or workshop that r and includes a group narrated, nt emergency scenario, and a ements, directed messages, or designed to challenge an ICF/IID's response to and ation of all drills, tabletop ergency events, and revise jency plan, as needed.		039			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/08/2021 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G218	B. WING			04/0	06/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-O	BIE				22 OBIE DRIVE URHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 039 W 130	emergency scenari statements, dira questions designed plan. If the OPO ex or man-made emer of the emergency p engaging in its next following the onset (ii) Analyze the maintain document and emergency eve and OPO's] emerge This STANDARD is Based on document facility failed to ens or tabletop exercise Preparedness (EP) potentially affected #6. The finding is: Review on 4/5/21 o reviewed on 2/5/21 community-based of which included all s During an interview intellectual disabiliti confirmed the table all the staff working PROTECTION OF CFR(s): 483.420(a)	r and includes a group narrated, clinically relevant o, and a set of problem ected messages, or prepared to challenge an emergency periences an actual natural gency that requires activation lan, the OPO is exempt from a required testing exercise of the emergency event. OPO's response to and ation of all tabletop exercises, ents, and revise the [RNHCI's ency plan, as needed. s not met as evidenced by: nt review and interviews, the ure facility/community-based es to test their Emergency plan were conducted. This clients #1, #2, #3, #4, #5 and f the facility's EP plan , did not include a full-scale or tabletop exercise for 2020, taff working in the home. on 4/6/21, the qualified es professional (QIDP) top exercise did not include in the home. CLIENTS RIGHTS (7)	E 0				

Facility ID: 922326

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		AND HUMAN SERVICES			FORM	04/08/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE	E SURVEY PLETED
		34G218	B. WING		04/(	06/2021
NAME OF I	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
VOCA-O	BIE		-	22 OBIE DRIVE DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 130	Continued From pa	ige 7	W 130			
	Based on observat failed to ensure priv and #5) residing in A. During observat 4:50pm, client #5 w bathroom without a observations revea behind client #5 wh and went into his be observations revea remained wide ope dressed. At 4:51pr the hall and looked he had no clothes of #5's bedroom while no time was client # bedroom door nor of During an immedia client #5 will shut th Further interview re client #5 did not hav looked in on him wh During an interview intellectual disabiliti client #5 should hav bathrobe with him w bathroom and prom bedroom while he w B. During observat 5:54am, client #1 w bedroom and enter observations revea	s not met as evidenced by: tions and interviews, the facility vacy for 2 of 5 audit clients (#1 the home. The findings are: tions in the home on 4/5/21 at vas observed exiting the ny clothes on. Further led Staff B walking directly en he exited the bathroom edroom. Additional led client #5's bedroom door n while client #5 was getting n another client walked down into client #5's bedroom while on. Staff B remained in client e he was getting dressed. At #5 prompted to close his did staff close the door. te interview, Staff B revealed he door on his own for privacy. evealed she did not realize ve his bathrobe when she hile he was in the bathroom. on 4/6/21, the qualified tes professional (QIDP) stated ve been prompted to have his when he went into the npted to shut the door of his was getting dressed. tions in the home on 4/6/21 at vas observed exiting his ing the bathroom. Further led client #1's bathrobe was did not have any clothes on				

Facility ID: 922326

If continuation sheet Page 8 of 18

STATE MENT OF DEFICIENCIES AND PLAN OF CORRECTION     (M1) PROVIDERS UPPLIER IDENTIFICATION NUMBER: 346218     (P2) MLTITLE CONSTRUCTION A BULINIO 2008/2021     (P3) OUT ESUMPY COMPLIED 322 OBE DRIVE 322 OBE DRIVE 334 OBE 344 OBE 34			AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/08/2021 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       YOCA-OBIE     322 OBIE DRIVE       DIVERMAN, NC 27713     PROVIDERS OF AVE CORRECTIVE ACTION SYNCE DEPARTMENT OF DEFICIENCIES       PREFIX TAG     REGULATORY OR LSC DENTIFYING INFORMATION)     PREFIX REGULATORY OR LSC DENTIFYING INFORMATION)     PREFIX TAG       W 130     Continued From page 8 underneath his bathrobe. At 6:04am, client #1 was observed walking out of the bathroom with his bathrobe walked open and not wearing any clothes underneath the bathrobe. At 6:04am, client #1 was not sure where it was.     W 130       During an immediate interview, Staff C stated client #1 should have been prompted to ensure his bathrobe was secured with a belt before he exited both his bedfroom and the bathroom.     W 189       W 189     STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1)     W 189       This STANDARD is not met as evidenced by: Based on observations, policy review and interviews, the facility failed to ensure staff were sufficiently and competently.     W 189       During medication observations in the home on 4/5/21 at 4.00pm, a pill landed on the floor while the client regarding the disposer of medications. The finding is:     During medication observations in the home on 4/5/21 at 4.00pm, a pill and put it in the trash can. Further observations proveaded Staff B called	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· ·		E CONSTRUCTION	(X3) DATE	E SURVEY
VOCA-OBJE         322 OBJE DRIVE DURHAM, NC 27713           PREFIX TAG         SUMMARY STATEMENT OF DEFICIENCIES RECOLTORY OR LSC IDENTIFYING INFORMATION)         D         D         PREFIX TAG         PROVIDENTS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE         0009           W 130         Continued From page 8 undemeath his bathrobe. At 6:04am, client #1 was observed usking 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.         W 130           During an immediate interview, Staff C stated 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 189           W 188         STAFF TRAINING PROCRAM CFR(s): 433.430(e)(11         W 189           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.         W 189           This STANDARD is not met as evidenced by: Based on observations, note; staff were sufficiently rained 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 flor while the client was punching his blubble pack. The Staff B picked up the pill and put it in the trash can. Further Observations Staff C called			34G218	B. WING			04/0	06/2021
VOCA-OBIE         DURHAM, NC 27713           (M) ID TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE RECEDED BY FULL REGULATORY OR LSC IDENTFYING INFORMATION)         ID PREFIX TAG         POVIDER'S ALL OF CORRECTION (EACH DEFICIENCY)         O(9) (EACH DEFICIENCY)           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. At 6:04am, client #1 was observed walking with client #1 and reached out and tried to close the front of his bathrobe.         W 130           During an interview on 4/6/21, the QIDP revealed client #1 about have a bell for the bathroom. Not sure where it was.         W 189         W 189           W 180         STAFT FTANING PROGRAM CFR(s): 483.430(e)(1)         W 189         W 189           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.         W 189           This STANDARD is not met as evidenced by: Based on observations, policy review and interviews, the facility failed to ensure staff were sufficiently rained 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 Staff Called	NAME OF F	PROVIDER OR SUPPLIER						
Preferx TAG       RECULATORY OR LSC DENTIFYING INFORMATION)       PREFIX TAG       CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE OD THE APPROPRIATE       COMMENTION DATE         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.       W 130       W 130         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 189       W 189         W 188       STAFT TRAINING PROGRAM CFR(s): 483.430(e)(1)       W 189       W 189         This STANDARD is not met as evidenced by: Based on observations, policy review and interviews, the facility field to ensure staff were sufficiently trained regarding the disposer of medications. The finding is:       W 189         During medication observations in the home on 4/5/21 at 4:00pm, a pill landed on the flox 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       W 189	VOCA-OI	BIE						
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 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         medication. Shervations in the home on         4/5/21 at 4::000m, a pill landed on the floor while <td>PRÉFIX</td> <td>(EACH DEFICIENCY</td> <td>MUST BE PRECEDED BY FULL</td> <td>PREFI</td> <td>x</td> <td>(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE</td> <td>BE</td> <td>COMPLETION</td>	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETION
		underneath his bath was observed walk his bathrobe wide of clothes underneath past the surveyor to C was walking with tried to close the from During an immediat client #1 does have was not sure where During an interview client #1 should have his bathrobe was se exited both his bed STAFF TRAINING CFR(s): 483.430(e) The facility must pro- initial and continuin employee to perfor efficiently, and com This STANDARD is Based on observat interviews, the facili sufficiently trained r medications. The f During medication of 4/5/21 at 4:00pm, at the client was punc Staff B picked up th can. Further observation	At 6:04am, client #1 ing out of the bathroom with pen and not wearing any the bathrobe and walking owards the laundry room. Staff client #1 and reached out and ont of his bathrobe. At it was. on 4/6/21, the QIDP revealed we been prompted to ensure ecured with a belt before he room and the bathroom. PROGRAM (1) ovide each employee with g training that enables the m his or her duties effectively, petently. s not met as evidenced by: ions, policy review and ty failed to ensure staff were egarding the disposer of inding is: observations in the home on pill landed on the floor while hing his bubble pack. The is pill and put it in the trash vations revealed Staff B called					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	04/08/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G218	B. WING	 	04/(	06/2021
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-OI	BIE			22 OBIE DRIVE PURHAM, NC 27713		
(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
W 189	<ul> <li>pill is dropped on the into the trash can.</li> <li>pill is put into a bott in the medication of pharmacy should be During an interview intellectual disabilitie informed by the sur Staff D told them als STAFF TRAINING CFR(s): 483.430(e)</li> <li>For employees who must focus on skills toward clients' healther the sufficiently trained in This STANDARD is Based on observation interviews, the facilities ufficiently trained in This affected 1 of 5 is:</li> <li>During dinner observation consumed the soft consumed the soft consumed the soft observations at 5:05 pm</li> </ul>	on 4/6/21 Staff D stated if a e floor it should never be put Further interview revealed the le of Pill Buster, which is kept oset, the nurse and the e called. on 4/6/21, the qualified es professional (QIDP) was veyor about the interview were bout the Pill Buster. PROGRAM (2) work with clients, training and competencies directed th needs. s not met as evidenced by: ions, record review and ty failed to ensure staff were n reporting medical concerns. audit clients (#4). The finding rvations in the home on 4/5/21 served himself his food at the pservations revealed Staff B 4 to take sips of liquids bd. Client #4 put a folded ich ground meat, cut and pieces of lettuce, into his ite longer than one inches. is revealed client #4 taco in four bites. Further 9pm, revealed client #4	W			
	observations at 5:09					

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DEPARTMENT OF HEALTH AND F CENTERS FOR MEDICARE & MEI					FORM	04/08/2021 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PR	ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	34G218	B. WING	i		04/0	06/2021
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-OBIE			_	322 OBIE DRIVE DURHAM, NC 27713		
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST E TAG REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
<ul> <li>W 192 Continued From page 10 squares into his mouth an coughing. Between 5:10p #4 coughed four times and table. At 5:12pm, Staff B of the bathroom; while walkin client #4 had spit coming f while he was going into the observations revealed clie entering and exiting the bat times between 5:13pm an time client #4 was coughin out of his mouth.</li> <li>During an immediate inter client #4's diet is "bite size</li> <li>Review on 4/5/21 of the ho 12/28/20 stated client #4's chopped-1/4 inch pieces n time guidelines provided for</li> <li>Review on 4/5/21 of client Safe/Eating/Drinking Guid stated, "7. Report any cou- supervisor"</li> <li>During an interview on 4/6 revealed she was not infor coughing episodes.</li> <li>W 263 PROGRAM MONITORING CFR(s): 483.440(f)(3)(ii)</li> <li>The committee should ins are conducted only with th consent of the client, pare minor) or legal guardian.</li> </ul>	om and 5:11pm, client d then got up from the escorted client #4 into ng into the bathroom from out of his mouth, e bathroom. Additional ent #4 and Staff B athroom a total of four d 5:17pm; during that ng and spit was coming view, Staff B stated s." omes diet list dated s food is "finely maximum. Follow meal or safe eating." #4's leline dated 11/16/19 ughingepisode to the 5/21, the facility nurse rmed of client #4's G & CHANGE ure that these programs ie written informed	W 1				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE COMP         MAME OF PROVIDER OR SUPPLIER       34G218       B. WING       04/0         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE 322 OBIE DRIVE       322 OBIE DRIVE	0938-0391 E SURVEY PLETED 06/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 322 OBIE DRIVE	(X5) COMPLETION
322 OBIE DRIVE	COMPLETION
322 OBIE DRIVE	COMPLETION
VOCA-OBIE DURHAM, NC 27713	COMPLETION
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGPREFIX TAG(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
W 263       Continued From page 11       W 263         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 Sustema 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.       W 340         W 340       NURSING SERVICES       W 340         W 340       NURSING SERVICES       W 340	

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & MI	FORM	RINTED: 04/08/2021 FORM APPROVED MB NO. 0938-0391						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DAT	(X3) DATE SURVEY COMPLETED		
	34G218	B. WING _			04/	04/06/2021		
NAME OF PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE				
VOCA-OBIE		322 OBIE DRIVE DURHAM, NC 27713						
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	BE PRECEDED BY FULL	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
health and hygiene meth This STANDARD is not Based on observations, interview, the nursing set that staff were sufficiently of face masks in regards This potentially effected #5 and #6) residing in the During observations in th between 5:52am - 6:39ai was below his nose while Staff A was observed not from 6:39am until 7:48ar During an immediate interevealed staff are suppor at all times while they are surveyor attempted to as A mu,bled under his brea put on a face mask.	but are not limited to as needed in appropriate nods. met as evidenced by: record review and rvices failed to ensure y trained in the wearing to COVID-19 protocol. all clients (#1, #2, #3, #4, e home. The finding is: the home on 4/6/21 m, Staff A's face mask e he was in the home. t wearing a face mask the home at 7:48am, Staff A se to wear a face mask e in the home. When the sk another question, Staff ath and walked away to facility's policy about face taff to follow the North the to prevent the 9 into the facility. Follow /6/21, the qualified ofessional (QIDP) ar face mask at all times the home. Further	W 34	40					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 34G218 B. WING 04/06/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 322 OBIE DRIVE **VOCA-OBIE DURHAM, NC 27713** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) W 368 Continued From page 13 W 368 W 368 DRUG ADMINISTRATION W 368 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 gualified intellectual disabilities professional (QIDP) confirmed clients #1, #3 and #6 do not have updated physician orders. W 418 CLIENT BEDROOMS W 418 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

FORM CMS-2567(02-99) Previous Versions Obsolete

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PRINTED: 04/08/2021

		AND HUMAN SERVICES			FORM	04/08/2021 APPROVED
		. ,	LE CONSTRUCTION	MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		34G218	B. WING		04/06/2021	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
VOCA-OI	BIE			322 OBIE DRIVE DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
W 418 W 436	mattress. This affe finding is: During observations 6/21 at 9:27am, Sta with turning over the observations reveal rip which was the en- both sides. During an interview intellectual disabilitie confirmed client #6' sides. The QIDP re- brand new bedroom ago. SPACE AND EQUIF CFR(s): 483.470(g) The facility must fur and teach clients to choices about the u hearing and other c and other devices ic interdisciplinary teal This STANDARD is Based on observat interviews, the facilit recommended equi eyeglasses, were fu (#6). The finding is	ected 1 of 5 audit clients. The s in the group home on 4/5 - aff D was assisting client #6 e mattress on his bed. Further led client #6's mattress had a ntire length on the mattress on on 4/6/21, the qualified ies professional (QIDP) 's mattress was ripped on both evealed client #6 has had a n set, which was two weeks PMENT )(2) mish, maintain in good repair, o use and to make informed use of dentures, eyeglasses, communications aids, braces, dentified by the im as needed by the client. s not met as evidenced by: tions, record review and ity failed to ensure ipment, specifically urnished for 1 of 5 audit clients	W 418			
	#6 was not observe	ed wearing his eyeglasses in observations on 4/5/21, client				

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		AND HUMAN SERVICES			FORM	04/08/2021 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G218	B. WING		04/06/2021	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
VOCA-O	BIE			322 OBIE DRIVE DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
W 436	<ul> <li>#6 was observed st (hanging on the wa time was client #6 p eyeglasses.</li> <li>During a review on program plan (IPP) "Adaptive Equipme</li> <li>During a review on examination dated both eyes."</li> <li>During an interview intellectual disabiliti revealed staff shou wear his eyeglasse client #6 is to wear FOOD AND NUTRI CFR(s): 483.480(a)</li> <li>Each client must re well-balanced diet i specially-prescribed</li> <li>This STANDARD is Based on observat interviews, the facili diet was provided a of 5 clients (#4). Th</li> <li>During dinner obse at 5:05pm, client #4 table. Additional ob did not cue client #4 between bites of for</li> </ul>	tanding under the television II) and looking up at it. At no prompted to put on his 4/5/21 of client #6's individual dated 3/21/20 revealed, nt: Eyeglasses; visual aid" 4/5/21 of client #6's vision 7/10/19 revealed, "Glaucoma on 4/6/21, the qualified tes professional (QIDP) Id be prompting client #6 to s. Further interview revealed his eyeglasses all day. ITION SERVICES 0(1) beceive a nourishing, ncluding modified and d diets. s not met as evidenced by: tions, record review and ity failed to ensure client #4's as prescribed. This affected 1	W 436	5		

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		AND HUMAN SERVICES				FORM	04/08/2021 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SU		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G218	B. WING	i		04/(	06/2021
NAME OF F	PROVIDER OR SUPPLIER		-		STREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-O	BIE			-	22 OBIE DRIVE DURHAM, NC 27713		
(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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 460	mouth and took a b Further observation consumed the soft observations at 5:0 consuming three pi squares into his mo coughing. Between #4 coughed four tim table. At 5:12pm, S the bathroom; while client #4 had spit co while he was going observations reveal entering and exiting times between 5:13 time client #4 was co out of his mouth. During an immediat client #4's diet is "b Review on 4/5/21 o 12/28/20 stated clie chopped-1/4 inch p time guidelines prov Review on 4/5/21 o Safe/Eating/Drinkin stated, "1. Prepare Consistency-1/4 inc guidelines unless a food must be chopp bringing to the table him to take safe siz between bites with Provide cuing/verba ensure safe rate of	and pieces of lettuce, into his ite longer than one inches. its revealed client #4 taco in four bites. Further 9pm, revealed client #4 ecces of melon in the shape of outh and immediately n 5:10pm and 5:11pm, client nes and then got up from the Staff B escorted client #4 into e walking into the bathroom oming from out of his mouth, into the bathroom. Additional led client #4 and Staff B g the bathroom a total of four 8pm and 5:17pm; during that coughing and spit was coming te interview, Staff B stated ite size." f the homes diet list dated ent #4's food is "finely ieces maximum. Follow meal vided for safe eating."	W 4	460			

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		AND HUMAN SERVICES				FORM	04/08/2021 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G218	B. WING	i		04/06/2021	
NAME OF F	PROVIDER OR SUPPLIER		-		STREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-O	BIE				22 OBIE DRIVE DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT 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
W 460	empty before his ne any coughingepis During an interview revealed she was n coughing episodes. During an interview intellectual disabilite revealed staff shou eating and drinking	6. Make sure his mouth is ext bite is taken. 7. Report ode to the supervisor" on 4/6/21, the facility nurse not informed of client #4's		460			

Facility ID: 922326

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