DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/19/2021 FORM APPROVED OMB NO. 0938-0391

E 000 Initial Comments  A revisit was conducted on 5/11/21 for all previous deficiencies cited on 12/16/20. The following deficiencies have been corrected: W104, W227, W368, W447, and W481. The facility remained out of compliance in E006 and had new areas of non-compliance in W382 and W383.  (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 and the plan will implement strategies the event of an emergency—to including missing residents.  (2) Include strategies for addressing emergency events identified by the risk assessment and the plan will implement strategies the event of an emergency—to including missing residents.  (2) Include strategies for addressing emergency events identified by the risk assessment, utilizing an all-hazards approach, including missing residents.  (2) Include strategies for addressing emergency events identified by the risk assessment.  (1) Be based on and include a documented, facility-based and community-based risk assessment.  (1) Be based on and include a documented, facility-based and community-based risk assessment.  (1) Be based on and include a documented, facility phase and community-based risk assessment.  (2) Include strategies for addressing emergency events identified by the risk assessment.  (3) Be based on and include a documented, facility phase and community-based risk assessment.  (4) For ICF/flDs at §483.475(a)(1):] Emergency Plan. The ICF/flD must develop and maintain an emergency preparedness plan that must be	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED
STREET ADDRESS CITY, STATE, ZIP CODE 200 LAURELWOOD DR SUMMAY STATEMENT OF DEFICIENCIES: (EACH OPERIOD NUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   DEFICE ADDRESS CASS-REFERENCED TO THE APPROPRIATE DEFICIENCY (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMMETTION OF THE APPROPRIATE DEFICIENCY (CASS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   DEFICIENCY (CASS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMMETTION OF THE APPROPRIATE DEFICIENCY (CASS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMMETTION OF THE APPROPRIATE DEFICIENCY (CASS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMMETTION OF THE APPROPRIATE DEFICIENCY (CASS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMMETTION OF THE APPROPRIATE DEFICIENCY (CASS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMMETTION OF THE APPROPRIATE DEFICIENCY (CASS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMMETTION OF THE APPROPRIATE DEFICIENCY (CASS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMMETTION OF THE APPROPRIATE DEFICIENCY (CASS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMMETTION OF THE APPROPRIATE DEFICIENCY (CASS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMMETTION OF THE APPROPRIATE DEFICIENCY (CASS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMMETTION OF THE APPROPRIATE DEFICIENCY (CASS-REFERENCED TO TH			34G282	B. WING_		
VOCA-LAURELWOOD   Z00 LAURELWOOD DR SMTHFIELD, NC 27577.     VAN ID PREFIX   SUMMARY STATEMENT OF DEFICIENCIES   PROVIDENT FLAN OF CORRECTION SHOULD BE CREATED AND PROVIDENCY MUST BE PRECEDED BY FULL   PROVIDENT FLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERNEED TO THE APPROPRIATE PERIOD OF COMPANIES OF CROSS-REFERNEED TO THE APPROPRIATE PERIOD OF CROSS-REFERNEED TO THE APPROPRIATE COMMENT OF CROSS-REFERN	NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	
PRÉEIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  E 000  Initial Comments  A revisit was conducted on 5/11/21 for all previous deficiencies cited on 12/16/20. The following deficiencies cited on 12/16/20. The following deficiencies have been corrected: W1704, W.227, W368, W447, and W481. The facility remained out of compliance in E005 and had new areas of non-compliance in W362 and W383.  (E 006)  [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 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 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 will implement strategies the event of an emergency—to include but not include but not infinited to all potential risk that would directly impact a person the lives of the people served on site will be addressed E. Management will in services staff on the plan annually.  **For LCF/flDs at §483.475(a)(1):] Emergency Plan. The [CF/flD must tevelop and maintain an emergency preparedness plan that must be reviewed; and updated at least annually.  **Torrection of the propie served on site will be addressed E. Management will in avertices staff on the plan annual				j	200 LAURELWOOD DR	A STATE OF THE STA
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emergency preparedness plan that must be	(E 006)	Plan Based on All H CFR(s): 483.475(a)  [(a) Emergency Plan and maintain an emithat must be review 2 years. The plan in (1) Be based on and facility-based and coassessment, utilizing (2) Include strategie events identified by "[For LTC facilities a Plan. The LTC facilities an emergency prepareviewed, and updated must do the following (1) Be based on and facility-based and coassessment, utilizing including missing re (2) Include strategie events identified by "[For ICF/IIDs at §48]	n. The [facility] must develop ergency preparedness plan ed, and updated at least every nust do the following:]  I include a documented, ommunity-based risk g an all-hazards approach.*  It §483.73(a)(1):] Emergency the risk assessment.  It §483.73(a)(1):] Emergency the dat least annually. The plan is include a documented, ommunity-based risk g an all-hazards approach, sidents.  Is for addressing emergency the risk assessment.	{E 006	This deficiency will be corrected by following actions  A. The facility will develop an maintain a emergency preparedness plan and it viewed and updated and strategies will be identified the risk assessment and the will implement strategies the risk assessment and the will implement strategies the risk assessment and the will implement strategies the event of an emergency—to include but not limited to a potential risk that would dimpact a person the lives people living in the group D. A method of communication specific needs of the people served on site will be addressed in the plan annually G. Management will in service staff on the plan annually G. Management will have the	d  vill be hually. I via e plan the  I via e plan the o all irectly of the home ing le essed ent es
	ABORATORY	emergency prepared	iness plan that must be	471DF	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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/19/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G282	8. WINC	à			R
NAME OF PROVIDER OR SUPPLIER  VOCA-LAURELWOOD				2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 LAURELWOOD DR MITHFIELD, NC 27577	1 00	/11/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
{E 006}	reviewed, and updar plan must do the for (1) Be based on and facility-based and coassessment, utilizing including missing of (2) Include strategies events identified by  * [For Hospices at § Plan. The Hospice remergency prepare reviewed, and updar plan must do the fol (1) Be based on and facility-based and coassessment, utilizing (2) Include strategies events identified by including the managor power failures, not emergencies that we ability to provide car This STANDARD is Based on policy revisability failed to dever preparedness (EP) upon a community assessment utilizing This had the potentic #3, #4, #5 and #6).  A review on 5/11/21 "Summary of Hazard revealed the plan we facility, at a different vague using a bar gire.	ated at least every 2 years. The llowing: d include a documented, community-based risk g an all-hazards approach, ients. Is for addressing emergency the risk assessment.  A18.113(a)(2):] Emergency must develop and maintain an dness plan that must be ted at least every 2 years. The lowing: d include a documented, community-based risk g an all-hazards approach. Is for addressing emergency the risk assessment, itement of the consequences atural disasters, and other bould affect the hospice's e. Inot met as evidenced by: All the process of the facility-based risk an all-hazards approach, all to affect all clients (#1, #2, The finding is:  of the facility's submitted dis Analysis, dated 2017, as created for their sister location. The summary was raph and identified the largest	{E 0	06}			
	threat to the facility be of Correction binder	eing technology. In the Plan contained an email from the		-	•		,

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 05/19/2021 FORM APPROVED OMB NO. 0938-0391

		& MEDICAID SERVICES				OMB	NO. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLL (DENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
	34G282		B. WING				R 05/11/2021	
NAME OF	PROVIDER OR SUPPLIER	••	<del></del>	STR	EET ADDRESS, CITY, STATE, ZIP C	DDE	·	
VOCA-L	AURELWOOD	,	- 1	200	LAURELWOOD DR			
	V 13.		:	SM	ITHFIELD, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(XS) COMPLETION : DATE	
{E 006}	Program Director (F acknowledged that did not contain the r how and why the inf PD also commented initially, 2-3 years as contact RISK to req An interview on 5/11 would fax over to the	PD) dated 1/07/21 which the performance analysis (PA) isk assessment to determine formation was collected. The distance that the PA was done go and that they needed to uest a new assessment.  1/21 with the PD revealed he a Home Manager (HM) the	{E 00	06}				
	An interview on 5/11 Intellectual Disabiliting revealed they were a community-based rispecific to this home DRUG STORAGE A CFR(s): 483.460(l)(2). The facility must keel locked except when administration.  This STANDARD is Based on observation staff interviews, the fitter medication room unauthorized access.	community-based risk ew.  /21 with the HM and Qualified es Professional (QIDP) unaware that the new esk assessment was not e.  ND RECORDKEEPING  P all drugs and biologicals being prepared for  not met as evidenced by: ens, training records and acility failed to ensure that remained locked to prevent This had the potential to	W 38	82 Th	.382 (	e locked eing be left ed on lication ot during	07.11.2021	
	and #6). The findings During noon observa administration on 5/1 walked out of the me	tions of the medication 1/21 at 12:22 PM, Staff A dication room, in order to get a wheelchair. Staff B was	,		<ul> <li>D. Medication Monitor C sheets will be comple weekly.</li> <li>E. Site Supervisor will m time a week</li> <li>F. Qualified Professiona monitor one time a w</li> </ul>	eted onitor one I will		

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/19/2021 **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: A. BUILDING \_ COMPLETED 34G282 8. WING 05/11/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 LAURELWOOD DR VOCA-LAURELWOOD SMITHFIELD, NC 27577 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID A PROVIDER'S PLAN OF CORRECTION ( XS) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TEACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) W 382 Continued From page 3 W 382 making lunch and the Qualified Intellectual Disabilities Professional (QIDP) was assisting clients wash their hands before eating lunch. The medication closet was left open and the cabinet with medications was unlocked. The medications were inside of the cabinet. The door to the medication room was left open with the surveyor remaining inside alone for until 12:23 PM An additional observation on 5/11/21 at 12:31 pm, Staff A walked out of the medication room, in order to get Client #5, who uses a wheelchair. Staff B and the QIDP remained occupied with the other clients. The medication cabinet, the door to the medication closet and the door to the medication room remained open for two minutes. Review on 5/11/21 of a training on Medication Administration, held on 12/30/20 showed that staff were instructed to do the following: Ensure medication closet is locked appropriately. Never leave open even if someone else is in the office. An interview on 5/11/21 with Staff A revealed normally the other staff bring the clients to the medication room, so that Staff C does not have to exit. An interview on 5/11/21 with the Home Manager

W 383

locked up during med pass.

keys to the drug storage area.

CFR(s): 483.460(l)(2)

(HM) indicated that everything is supposed to be

Only authorized persons may have access to the

DRUG STORAGE AND RECORDKEEPING

W 383

DEPAR CENTE	TMENT OF HEALTH	AND HUMAN SERVICES		•	PRINTED: 05/19/2021 FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
	PROVIDER OR SUPPLIER	34G282		STREET ADDRESS, CITY, STATE, ZIP CODE 200 LAURELWOOD DR	R 05/11/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOLL  CROSS-REFERENCED TO THE APPRI  DEFICIENCY)	JLD BE COMPLETION
	This STANDARD is Based on observati interviews, the facilit the medication room not present. This has clients (#1, #2, #3, # are:  During observations administration in the 12:18-12:40 PM, Stamedication closet op A walked out of the releaving the surveyor Clients #2 and #4.  A review on 5/11/21 of training on medication staff were instructed on person.  An interview on 5/11/ normally she does not during med pass.  An interview on 5/11/ (HM) revealed that st	on of met as evidenced by: ions, training records and by failed to secure the key to h, when authorized staff were d the potential to affect 6 of 6 4, #5 and #6 ). The findings  of the afternoon medication home on 5/11/21 from aff A left the lock box to the even with the keys inside. Staff medication room twice, alone in the room, to get  of the facility's 12/30/20 on administration showed that to maintain medication key  21 with Staff A revealed that of leave box unsecured  21 with the Home Manager taff have been trained that bocked up during med pass.	W 383	W.383 This deficiency will be corrected following actions:  A. All medications will be locand keys will be secured being administered.  B. No medications will be location of medication.  C. All mediation will be location of medication.  D. Staff will be in serviced of ensuring that all medicate remains locked except diadministration.  E. Staff will be in serviced professional will be completed weekly.  G. Site Supervisor will montaine a week.  H. Qualified Professional will montaine a week.	ocked unless  eft  ked n staff location on tion luring protocol dication set d