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

PRINTED: 07/23/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G225	A. BUILDING _____ B. WING _____	R 07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-GENTRY	2219 GENTRY DRIVE DURHAM, NC 27705

(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 000	INITIAL COMMENTS A revisit was conducted on 7/22/21 for deficiencies previously cited on 3/22 - 3/23/21. Four deficiencies were recited and one new area of non-compliance was identified. The facility remains out of compliance.	W 000		
{W 249}	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 3 of 3 audit clients (#2, #3 and #4) received a continuous active treatment program consisting of needed interventions and services to support the accomplishment of objectives as identified in the Individual Program Plan (IPP) in the area of family style dining. The findings are: During breakfast observations in the home on 7/22/21 at 7:20am, Staff A prepared plates/bowls of food (instant cream of wheat and biscuits) in the kitchen for each client without their participation. The staff brought the food into the dining room and placed it at individual place settings. Additional observations revealed Staff A opening individual fruit cups, placing them at	{W 249}	W.249 (recite) This deficiency will be corrected by the following actions: A. ISP will be update/modified to meet the current dietary needs or need for restrictions if applicable. B. Consumers will be actively involved in food preparation C. Community / home life assessment will be completed on all consumers D. The people served will be in serviced on family style dining and understanding the role of encouraging choice and providing food choice based upon dietary orders. E. Staff will be in serviced on family style dining and understanding the role of encouraging choice and providing safety while dining. F. Staff will be in serviced on all rights—focus on "choice" "interaction" increasing independence G. Staff will be in serviced on all family dining. H. Residential Manager will monitor one time a week. I. Qualified Professional will monitor one time a week.	08.21.2021

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

Marika Whack-Lyn | Executive Director | 7/30/2021

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.

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{W 249}	Continued From page 1 each client's plate and pouring cups of water and juice for all of the clients. The clients were not prompted or assisted to participate in family style dining tasks (i.e. Pouring drinks, passing food, serving themselves, etc). Interview on 7/22/21 with Staff A revealed clients can serve themselves at meals and do participate with family style dining "sometimes". Review on 7/22/21 of client #2's Community Home Life Assessment (CHLA) dated 4/1/21 revealed he requires verbal cues to participate in family style dining and can independently pour liquids from a pitcher. Review on 7/22/21 of client #3's CHLA dated 8/18/20 revealed she requires physical assistance to participate in family style dining and pass food items to others. Review on 7/22/21 of client #4's CHLA dated 6/30/20 revealed no information regarding his family style dining skills; however, the assessment noted he could use a toaster, microwave and stove and complete other cooking and mixing tasks all with verbal prompts. Interview on 7/22/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed clients should be participating with family style dining given assistance from staff.	{W 249}		
{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	{W 263}		

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{W 263}	Continued From page 2 minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 1 of 3 audit clients (#3). The findings is: Review on 7/22/21 of client #3's Behavior Support Plan (BSP) dated 3/23/19 revealed an objective to exhibit 0 episodes of agitation per month for 12 consecutive months. The BSP incorporated the use of Clonazepam, Divvalproex, Latuda and Melatonin. Additional review of the record revealed a consent for the BSP dated 3/23/19. The consent noted, "I understand that this authorization will expire on 3/23/20." No current consent could be located. Interview on 7/22//21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed a current consent had not been obtained from client #3's guardian.	{W 263}	W.263 (recite) This deficiency will be corrected by the following actions A. An Addendum will be added to ISP to meet the current needs of the people being served. B. All consents will be signed and in place before the implementation of plan. C. All consents will be current and updated annual or as needed for changes in plan. D. Qualified Professional will monitor monthly E. Qualified Professional will update annual or as needed	08.21.2021
{W 312}	DRUG USAGE CFR(s): 483.450(e)(2) Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and interview, the facility	{W 312}		

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{W 312}	Continued From page 3 failed to ensure drugs used to manage client #4's inappropriate behaviors were used only as an integral part of his Individual Program Plan. This affected 1 of 3 audit clients. The finding is: Review on 7/22/21 of client #4's physician's orders signed 5/20/21 revealed orders for Seroquel 50mg, take 1 tablet by mouth at bedtime, Zoloft 100mg, take 1 and 1/2 tablets by mouth once daily, Loxapine 5mg, take 2 capsules by mouth at bedtime and Klonopin .5mg, take 1 tablet by mouth twice daily. Additional review of the record indicated the medications were used for depression (Zoloft), aggression (Seroquel), mood stabilization (Loxapine) and daytime sleeping (Klonopin). Further review of the record did not identify a formal behavior plan. The use of Seroquel, Zoloft, Loxapine and Klonopin were not included in a formal behavior plan for client #4. Interview on 7/22/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4 ingests the medications for behavior support; however, the medications were not included in a formal behavior plan.	{W 312}	W.312 (recite) This deficiency will be corrected by the following actions: A. All physicians orders will be reviewed. B. There will be current orders for all medication in the person serve records. C. The team will ensure that all orders are implemented D. All the orders will be reviewed and discussed at the monthly core team/quarterlies/annual ISP. E. All medication used to manage consumers inappropriate behavior will be added to formal behavior support plan F. There will be supporting documentation for all Orders G. RN will review monthly H. Site Supervisor will monitor one time a week. I. Clinical Manager will monitor one time a week	08.21.2021
W 383	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) Only authorized persons may have access to the keys to the drug storage area. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the keys to the drug storage area were only accessible to authorized persons. The finding is:	W 383		

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W 383	Continued From page 4 During observations in the home on 7/22/21 from 7:56am - 9:51am, the keys to the medication closet were inserted in the key hole located on the door knob of the door to the drug storage area. After being questioned by the surveyor regarding the keys, the medication technician (MT) removed them from the key hole and placed them on a hook located in an unlocked office of the home. Interview on 7/22/21 with the MT revealed the keys are not generally kept in the key hole of the medication closet door and should be kept on a hook in the office. Interview on 7/22/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the keys to the medication closet should not be in the key hole of the door to the medication closet; however, they are usually kept hanging from a hook in the office. Additional interview indicated the facility does not have a policy regarding the location of keys to the medication closet or their accessiblity. Interview om 7/22/21 via phone with the facility's nurse confirmed the keys to the drug storage area should not be left in the key hole and hanging from the door knob to the medication closet. Additional interview revealed a facility policy regarding accessiblity of the keys could not be located.	W 383	W.383 This deficiency will be corrected by the following actions: A. All medications will be locked and keys will be secured unless being administered. B. No medications will be left unattended. C. All mediation will be locked when not in use or when staff steps out of medication location D. Staff will be in serviced on ensuring that all medication remains locked except during administration. E. Staff will be in serviced protocol for securing keys to medication closet F. Medication Monitor Closet sheets will be completed weekly. G. Site Supervisor will monitor one time a week. H. Qualified Professional will monitor one time a week.	09.20.2021
{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.	{W 460}		

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{W 460}	Continued From page 5 This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure modified diets for 2 of 3 audit clients (#2 and #4) were followed as indicated. The findings are: A. During breakfast observations in the home on 7/22/21 at 7:25am, client #4 consumed a whole biscuit, sliced peaches and creme of wheat. Interview on 7/22/21 with Staff A revealed some of client #4's foods are pureed and some are mechanical soft. The staff stated none of the foods consumed by client #4 at breakfast needed to be pureed because they were soft. Interview with Staff B indicated client #4 consumes a pureed diet. Review on 7/22/21 of a note by the dietitian (dated 5/19/21) posted in the kitchen of the home indicated client #4 consumes a "pureed consistency". Interview on 7/22/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4's diet had changed to a pureed consistency and his food should be processed in the blender. B. During breakfast observations in the home on 7/22/21 at 7:25am, client #2 consumed a bowl of cream of wheat with a whole biscuit crumbled up in it and sliced peaches. Interview on 7/22/21 with Staff A revealed client #2 consumes a pureed diet and they usually just "mash" his biscuit up in his cereal or cream of	{W 460}	W.460 (recite) This deficiency will be corrected by the following actions: A. Nutritionist will complete and assessment on consumers B. Recommendations will be added based upon assessment C. Nutritional assessments will be conducted to ensure proper food consistency D. All people served will receive a nourishing, well-balanced diet including modified and specially prescribed diets. E. All staff will be in service on Food consistency orders F. Site Supervisor will monitor one time a week. G. Clinical Manager will monitor one time a week	08.21.2021

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{W 460}	Continued From page 6 wheat to soften it. The staff indicated client #2's biscuit and peaches were not processed in the blender to a pureed consistency. Review on 7/22/21 of client #2's Individual Program Plan (IPP) dated 4/7/21 revealed he consumes a "Regular, pureed diet..." Additional review of a list of client's diets posted in the kitchen of the home also noted client #4 receives a regular pureed diet. Interview on 7/22/21 with the QIDP confirmed all of client #2's food should be served pureed and should not have been mixed together prior to serving.	{W 460}		