February 16, 2022

Kimberly C. MCCaskill, MSW
Facility Compliance Consultant I
Mental Health Licensure and Certification section
NC Division of Health Services Regulations
2718 Mail Service Center
Raleigh NC 27699-2718
919.855.3795 office
919.715.8078 fax

RE: Plan of Correction for Annual recertification survey Completed February 4, 2022
VOCA -Sixth Street Group Homes
201 North Sixth, Sanford, NC 27330
Provider Number : 34G270
MHL# 053-023

Dear Ms. McCaskill

We appreciate the courtesy extended by you while surveying the VOCA Sixth Street Group Home, 201 North Sixth, Sanford, NC 27330

As indicated on the Plan of Correction, we will have the Deficiencies corrected for, the Annual survey completed on February 04, 2022 completed April 04, 2022

We are committed to providing the highest possible care for the people we serve at VOCA Sixth Street Group Home

If you have questions, please contact Cynthia Bradford, Assistant Executive Director 276.252.8193 cell 984.205.2630 ext. 238. Or JerMaine Kearney, Program Manager 984.205.2630 ext 403

Sincerely,

Cynthia Bradford, Assistant Executive Director
Community Alternatives North Carolina- Southeast Region
1001 Navaho Drive suite 101
Raleigh, North Carolina, 27609
276.252.8193 cell
984.205.2630 ext. 238
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/10/2022
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
	34G270	A. BUILDING _____ B. WING _____	C 02/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-SIXTH STREET GROUP HOME	201 NORTH SIXTH STREET SANFORD, NC 27330

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W 000	INITIAL COMMENTS A recertification and complaint survey were completed on 2/4/2022 for intake #NC 00184969. The complaint was substantiated and deficiencies were cited.	W 000		
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations and interviews, the governing body failed to ensure flooring, lighting and ceiling fans in the facility were maintained in good condition. The finding is: A. During observations on 2/3/22 in the facility at 9:30am, lighting in the den was in need of repair. There was track lighting in the den area and two of the three lights were not working. B. Flooring in client #3's bedroom was ripped up from the floor leaving exposed pieces of flooring and making this a trip hazard. C. Flooring in client #1's bedroom was indented and in need of repair. D. The ceiling fan in the kitchen rattled throughout observations in the facility. Client #3 stated, "That makes too much noise." Interview on 2/3/22 with staff A revealed he had reported all of the above needed repairs several weeks ago but had not received a response from his request. Interview on 2/3/22 with the qualified intellectual;	W 104	W.104 This deficiency will be corrected by the following actions: A. The home will be well maintained with necessities – for consumer. B. Management will do a Maintenance checklist. Identifying all items needing to be repaired/replaced C. The home will be free of potential hazards. D. maintenance request will be submitted for completion. E. Management will ensure home F. If a modification or change need to take place management will follow up until item is completed G. Site Supervisor will monitor one time a week. H. Qualified Professional will monitor one time a week	04.04.2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cynthia Blackford | TITLE: Asso Executive Director | (X6) DATE: 2/15/2022

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 104	Continued From page 1 disabilities professional (QIDP) revealed he was not aware of these needed repairs but he would complete work orders to get them completed.	W 104		
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. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #3's right to privacy during care of her personal needs. This affected 1 non audit client (#3). The finding is: During observations in the facility on 2/4/22 staff E assisted client #3 into the bathroom in her wheelchair for toileting. At 8:15am from the hallway, client #3 was in full view of anyone who passed the bathroom as the door was wide open. Staff E verbally cued client #3 to finish up and to wash her hands while she stood in the hallway. Interview on 2/3/22 with staff E revealed she left the bathroom door open so she could supervise client #3 from the hallway. Review on 2/3/22 of client #3's record revealed an individual program plan (IPP) dated 8/19/21 revealed she needs assistance to protect her privacy. Interview on 2/4/22 with the Program Director revealed direct care staff should assist client #3 with protecting her privacy during toileting and self care.	W 130	W130 This deficiency will be corrected by the following actions: A. All community/ home assessment will be reviewed to look at all current needs of persons served. B. Team will address all privacy issues via written training program. C. All person served will be afforded the opportunity for privacy. D. Adequate supervision will be provided for consumers to ensure privacy E. Consumer's will be in-service on requesting privacy. F. staff will be in-service on ensuring that all consumers are being monitored, assess and provided active treatment and privacy G. Residential Manager will monitor on time a week. H. Qualified Professional will monitor one time a week.	04.04.2022
W 186	DIRECT CARE STAFF	W 186		

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W 186	Continued From page 2 CFR(s): 483.430(d)(1-2) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on observations, record reviews and confirmed by interviews with staff, the facility failed to ensure there were sufficient staff to assist 2 of 3 audit clients (#1 and #2) as documented in their individual program plans (IPP) specifically relating to medication administration, repositioning and transfer guidelines. The findings are: Review of the staff schedules for 2/3/22 revealed staff E was scheduled to work from 10pm on 2/2/22 until 2pm on 2/3/22. Staff C was scheduled to arrive at work at 8:00am and work until 2pm. During observations on 2/3/22 staff A, staff E and staff B were working with the clients at the facility at 9:30am. At 10:00am staff C arrived and staff E and and staff A left the facility. Further review on 2/3/22 of the staff schedules revealed staff C was scheduled to arrive at work at 8:00am but arrived 2 hours late at 10:00am which left 2 direct care staff alone and no current medication certified staff on duty to administer client medications and more specifically, client #1's insulin that was scheduled to be administered between 9:00-11:00am. Staff E who was medication certified, left the facility at 10:00am but was scheduled to work until 2:00pm	W 186	W186 This deficiency will be corrected by the following actions: A. Management will schedule at least 2 direct staff (not including management staff) per shift, to ensure that the needs of the consumers are sufficiently met. B. All staff will be in serviced on Consumer Specific before working. C. Staff working will be trained to provide all services needed to the people in the home. D. RN will ensure that medication monitoring is completed. E. Consumers will be engaged and will be trained on all Written Training Programs F. RN will work to ensure that all staff working are medication certified. G. Site Supervisor will monitor scheduling and staffing weekly to ensure that consumers' needs in these areas are being met. H. Qualified Professional will monitor weekly.	04.04.2022

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W 186	Continued From page 3 on 2/3/22. Review on 2/3/22 of client #1's individual program plan (IPP) dated 12/30/21 revealed she has diagnoses of Muscular Dystrophy, Insulin Dependent Diabetes Type I and client #1 uses a wheelchair for mobility. Further review revealed direct care staff use a manual crank hoyer lift or 2 direct care staff are required to assist with any transfers. Review on 2/3/22 of client #2's IPP dated 12/9/21 revealed she has diagnoses of Athetoid and Spastic Cerebral Palsy and Quadraparesis and requires a manual crank hoyer left or 2 person transfer. Interview on 2/3/22 with staff B revealed staff E was medication certified and decided to leave her shift early, leaving the facility without a medication certified staff until 12:00 noon. Staff B stated she was medication certified but she had not worked at the facility in 8 months and had not been updated by the Nurse or the qualified intellectual disabilities professional (QIDP) and did not feel comfortable assuming medication administration duties. Interview on 2/3/22 with staff E, A and C revealed direct care staff arriving and leaving their shifts as scheduled had been an ongoing problem. Additional interview revealed the QIDP was not at the home more than twice a month and the facility was currently without a residence manager. Interview on 2/4/22 with the Program Director revealed facility staffing had been an ongoing challenge and that direct care staff are not authorized to modify their assigned shift without	W 186		

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W 186	Continued From page 4 authorization from management staff on call.	W 186	W.249 This deficiency will be corrected by the following actions: A. All ISP will be reviewed by the qualified personnel B. All current goals will be assessed, modified, update or discontinued to meet meal assessment needs. Team will meet and make that decision. C. Home and community assessments will be updated, D. All people served will be afford continuous active treatment E. Adequate supervision will be provided for consumers. F. All menus will be reviewed and assessed globally for all people served in home G. Meal assessments will be completed on all people served. H. All WTP will be implemented and monitored monthly if applicable and based upon assessments for continues success of goal I. PT will be assessing the need for the use of adaptive equipment. J. PT will give guideline for the use of equipment K. OT will be assessing the need for the use of adaptive equipment. L. OT will give guideline for the use of equipment M. Staff will be in serviced on the importance of giving privacy and teaching privacy. N. All people served will be afforded opportunity to participate in meal preparation.	04.02.2022
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 review and interviews, the facility failed to ensure 2 of 3 audit clients (#2 and # 5) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of food preparation, communication, toothbrushing, dining guidelines and leisure . The findings are: A. During mealtime preparation observations on 2/3/22 at lunch at 11:35am staff C prepared all of client #2's meal items which included a meat sandwich, chips, fruit cup in the food processor without her assistance. During mealtime observations on 2/3/22 at supper at 6:00pm, staff F prepared all of client #2's meal items which included hamburger and bread, french fries and fruit in the food processor without her assistance. During breakfast observations on 2/4/22 at	W 249		

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W 249	Continued From page 5 6:25am staff E prepared client #2's meal items which included a biscuit, cereal, scrambled eggs in the food processor without her assistance. Interview on 2/4/22 with staff E regarding client #2 assisting with meal preparation revealed, " No, she cannot use the food processor." Review on 2/3/22 of client #2's individual program plan (IPP) dated 12/9/21 revealed she has a written training objective to assist with meal preparation with 50% accuracy for 12 consecutive months by helping to grind her food. Interview on 2/4/22 with the Program Director revealed client #2's training programs are current and should be implemented at each opportunity. B. During observations on 2/4/22 at the facility client #5 was asleep in the living room after breakfast from 7:00am-8:45am. He was never observed to be taken to the bathroom for toothbrushing after his breakfast meal at 6:40am. Interview on 2/4/22 with staff E regarding toothbrushing for client #5 revealed, "We will brush them later today, we can't make them brush them their teeth if they don't want to." Review on 2/4/22 of client #5's IPP dated 12/16/21 revealed he has a formal goal for toothbrushing after each meal. Interview on 2/4/22 with the Program Director revealed client #5's formal objectives are current and should be implemented as written. C. During observations on 2/3/22 from 4:15pm-5:25pm client #2 sat in her wheelchair	W 249	W.249 (continued) This deficiency will be corrected by the following actions: O. Persons served will discuss privacy in weekly residential council meetings P. Staff to be in-service on diets Q. Staff to be in-service on leisure activities R. Staff to be in-service on WTP S. Staff to be in serviced on the eating/adaptive equipment T. Staff will be in-service on ensuring that all consumers are being monitored U. All staff will be in service on all Individual Support Plans V. All staff will be in service on the definition and scope of Active Treatment W. Site Supervisor will monitor two time a week. (rotating shifts) All ISP will be reviewed and discussed at the monthly core team/quarterlies/annual ISP meetings this will address the status of all goals. X. Qualified Professional will monitor two time a week (rotating shifts)	04.02.2022

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W 249	Continued From page 6 the living room watching a Netflix movie selected by staff D. No other leisure activities or options were provided to her. Client #2 appeared to be sleeping throughout these observations. Review on 2/3/22 of client #2's IPP dated 12/9/21 revealed she should be provided choices throughout her day and she should be encouraged to use her communication device. She has formal objectives to identify the value of money and to assist with meal preparation. Interview on 2/4/22 with the Program Director revealed client #2 likes to look at her IPAD in her bedroom, should be repositioned every 2 hours and be provided choices throughout her day about activities in the facility. D. During observations in the facility on 2/4/22 at 6:40am client #2 was slumped down in her wheelchair without her chest strap positioned and secured. Staff E propelled her wheelchair to the dining room table. the surveyor asked if this was the position client #2 needed to be in when she was dining. Staff E stated, "Fine! I will check her." Staff E rolled client #2 to the living room area, tilted her wheelchair and adjusted client #2's positioning and returned her to the dining room table sitting upright with the chest strap secured into place. Client #2 was fed her pureed texture meal by staff E at the table and was observed to not have any difficulties consuming her meal. Review on 2/4/22 of client #2's IPP dated 12/9/21 revealed she has diagnoses of Mild Intellectual disabilities, Depression, GERD, Athetoid and Spastic Cerebral Palsy with oral and verbal Apraxia and Oral Dysphagia with Quadriparisis.	W 249		

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W 249	Continued From page 7 Further review of client #2's IPP revealed guidelines for dining which indicated client #2 "Should be seated upright in her wheelchair to promote safe consumption of her food. She should also sit upright for 30 minutes after meals. Additional review revealed staff should take sufficient time when assisting client #2 with her meals and they should make certain she has swallowed the food in her mouth and that her tongue and mouth are clear before offering her additional food. Client #2 may swallow multiple times when clearing her mouth and throat. She should be offered something to drink during meals after taking a few bites to help clean her mouth and throat. Interview on 2/4/22 with the Program Director revealed these dining guidelines for client #2 are staff current and that positioning for client #2 is very important for meals specifically. E. During observations in the facility on 2/3/22 and 2/4/22 clients #1, #2, #3 #4, #5 and #6 sat for periods of time in front of the television during observations, often asleep. For example: On 2/4/22 from 7:45am-9:00am client #2 who was asleep in her wheelchair and clients #4, #5 and #6 sat in the living room area sleeping while a movie was playing on the television. During interviews on 2/4/22 when staff E was asked what sorts of leisure activities were available for clients in the facility she stated there were a few games available but the clients had not expressed an interest in these activities. She pointed to a cabinet where the following activities were on a shelf: A board game with lights, a sorting tray with paper clips, a ring toss, a football, several puzzles and 2 other board	W 249		

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W 249	Continued From page 8 games. She also indicated crayons and paper were available if the clients wanted to draw. Interview on 2/3/22 with the qualified intellectual disabilities professional (QIDP) indicated there were activities for the clients to be involved in. He stated at the present time the facility is without a residence manager and this had presented several challenges.	W 249		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record review and confirmed by interview with staff, the facility did not provide data as prescribed by 2 of 3 audit clients (#1 and #2) formal objective programs. The findings are: A. Review on 2/3/22 of client #1's individual program plan (IPP) dated 12/30/21 revealed written training programs to participate in disaster drills, brush her teeth after meals, serves herself at meals hand over hand, participate in showering and learn the value of money. This included 5 of 5 written training objectives for client #1. Review of the progress summaries for these training programs for the month of January 2021 revealed: 1) Participate in disaster drills: (to be trained weekly)	W 252	W.252 This deficiency will be corrected by the following actions: A. All Individual Support Plans-WTP will be reviewed and revise as needed to ensure objectives of are in place regarding need of consumer B. Qualified Professional will ensure that all data collected has been reviewed. C. ISP/WTP will be update modified to meet the data collected. D. All WTP will be revised, updated or discontinued if objectives have been met E. All people served will be in service on their WTP F. All staff will be in- service on their WTP objectives and desired outcomes. G. Site Supervisor will monitor two time a week. H. Qualified Professional will monitor two times a week I. Qualified Professional will collect data monthly on monthly notes	04.02.2022

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W 252	Continued From page 9 January 2022: 1 training day 2) Brush her teeth after meals: (to be trained daily) January 2022: 1 training day 3) Serves herself at meals hand over hand: (to be trained daily) January 2022: 1 training day 4) Participate in showering: (to be trained daily) January 2022: 1 training day 5) Learn the value of money : (to be trained daily) January 2022: 1 training day Interview on 2/3/22 with the Area Director and the qualified intellectual disabilities professional (QIDP) revealed they were unaware that direct care staff had only collected data for one day in January 2022 for all of client #1's programs. B) Review on 2/3/22 of client #2's IPP dated 12/9/21 revealed written training programs to participate in meal preparation, learn the value of money and brush her teeth after meals. This included 3 of 3 written training objectives for the month of January 2022. Review of the progress summaries revealed the following: 1) Participate in meal preparation: (to be trained daily) January 2022: 1 training day 2) Learn the value of money: (to be trained daily) January 2022: 1 training day 3) Brush her teeth after meals: (to be trained	W 252		

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W 252	Continued From page 10 daily) January 2022: 1 training day Interview on 2/3/22 with the Area Director and the QIDP revealed they were unaware that direct care staff had only collected data for one day in January 2022 for all of client #2's programs.	W 252	W.255 *This deficiency will be corrected by the following actions:* A. *ALL ISP will be reviewed and revised as necessary.* B. *All WTP will be reviewed and assessed for continually care. All goals will be modified and assessed for progress.* C. *Medication assessment will be completed on all person served.* D. *All objectives of goals will meet the needs of the person being served.* E. *All staff will be in service on all new and current WTP* F. *All formal objective programs will be based on ADL, safety (fire drills), meal preparations Money* G. *Qualified Professional will in service all people served on goals with supporting documentation of all WTP in service* H. *Site Supervisor will monthly weekly* I. *Qualified Professional will monitor weekly* J. *Qualified Professional will assess all WTP in core team monthly*	04.04.2022
W 255	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(i) The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and staff interview, the qualified intellectual disabilities professional (QIDP) failed to ensure client #5's training goals were changed in response to him meeting criteria for completion. This affected 1 of 3 audit clients (#5). The findings are: Review on 2/3/22 of client #5's individual program plan (IPP) dated 12/15/21 revealed three training programs which included: Will brush his teeth after each meal accordingly to task analysis with 70% accuracy, will wear eyeglasses independently with 35% completion and will assist with meal preparation with 35% completion. This included 3 of 6 written training objectives. Review on 2/3/22 of client #5's progress summaries summaries revealed the following: A) Brushing teeth: 8/2021: 100%	W 255		

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W 255	Continued From page 11 9/2021: 100% 10/2021: 100% 11/2021: 100% B) Wearing eyeglasses: 8/2021: 100% 9/2021: 100% 10/2021: 100% 11/2021: 100% C) Meal Preparation: 8/2021: 100% 9/2021: 100% 10/2021: 100% 11/2021: 100% Interview on 2/3/22 with the QIDP revealed these programs are ongoing and have not been updated or revised despite client #5 having met criteria for completion.	W 255		
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the restrictive behavior support plans (BSP's) for 2 of 3 audit clients (#2 and #5) were reviewed and monitored by the human rights committee (HRC). The findings are: A. Review on 2/3/22 of client #2's individual program plan (IPP) dated 12/9/21 revealed she has a diagnosis of Depression and has a history	W 262		

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W 262	Continued From page 12 of crying and physical aggression. Further review of the IPP also indicates that client #2 receives Alprazolam 0.25mg. and Melatonin 10mg. to help with sleep. Further review on 2/3/22 revealed a BSP dated 11/23/20 to have 1 or less physical aggression per month for 12 consecutive months which incorporates the use of Melatonin and Alprazolam. Additional review revealed no evidence of any consent from the HRC. Interview on 2/3/22 with the qualified intellectual disabilities professional (QIDP) revealed there was no documentation of approval from the HRC in client #2's record. B. Review on 2/3/22 of client #5's IPP dated 12/15/21 revealed he has diagnoses of Infantile Autism and Severe Intellectual Disability. He has a behavior support program dated 5/26/21 to address Physical aggression and non compliance. This program incorporates the use of Lorazepam 1 mg, .Ziprasidone 40mg., Ziprasidone 80 mg. and Chlorpromazine 100 mg. Further review on 2/3/22 did not reveal any documentation of HRC approval for client #5's behavior support program which included the use of Lorazepam 1 mg, .Ziprasidone 40mg., Ziprasidone 80 mg. and Chlorpromazine 100 mg. Interview on 2/3/22 with the QIDP revealed he could not locate HRC approval for this program for client #5.	W 262	W262 This deficiency will be corrected by the following actions: A. All behavioral support plans will be reviewed. B. All Behavioral Support Plans will be updated to address the current needs and technique to manager inappropriate behavior C. All proper techniques will be used to manage behaviors D. Psychologist will review all plans. E. Qualified Professional will review and obtain guardian consent. F. Qualified Professional will have consented BSP reviewed and signed by HRC representative G. All staff will be in-service on all Behavioral Support Plans and proper documentation. H. Site Supervisor will monitor one time a week I. Qualified Professional will monitor one time a week	04.04.2022
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii)	W 263		

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W 263	Continued From page 13 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. 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 2 of 3 audit clients (#2 and #5). The findings are: A. Review on 2/3/22 of client #2's individual program plan (IPP) dated 12/9/21 revealed she has a diagnosis of Depression and has a history of crying and physical aggression. Further review of the IPP also indicates that client #2 has been adjudicated incompetent and appointed a legal guardian. Additional review revealed that client #2 receives Alprazolam 0.25mg. and Melatonin 10mg. to help with sleep. Further review on 2/3/22 of client #2's record revealed a behavioral support program (BSP) dated 11/23/20 to have 1 or less physical aggression per month for 12 consecutive months which incorporates the use of Melatonin and Alprazolam. Additional review revealed no evidence of any written informed consent from the legal guardian. Interview on 2/3/22 with the qualified intellectual disabilities professional (QIDP) revealed there was no documentation of approval from the legal guardian. for client #2. B. Review on 2/3/22 of client #5's IPP dated 12/15/21 revealed he has diagnoses of Infantile Autism and Severe Intellectual Disability. He has a BSP dated 5/26/21 to address Physical	W 263	W.263 This deficiency will be corrected by the following actions: A. All behavioral support plans will be reviewed. B. All Behavioral Support Plans will be updated to address the current needs and technique to manager inappropriate behavior C. All proper techniques will be used to manage behaviors D. Psychologist will review all plans. E. Qualified Professional will review and obtain informed guardian consent for all plans before implementation F. All staff will be in-service on all Behavioral Support Plans and proper documentation. G. Site Supervisor will monitor one time a week H. Qualified Professional will monitor one time a week	04.04.2022

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W 263	Continued From page 14 aggression and non compliance. This program incorporates the use of Lorazepam 1 mg, .Ziprasidone 40mg., Ziprasidone 80 mg. and Chlorpromazine 100 mg. Further review on 2/3/22 did not reveal any documentation of guardian approval for client #5's behavior support program which included the use of Lorazepam 1 mg., Ziprasidone 40mg., Ziprasidone 80 mg. and Chlorpromazine 100 mg. Review on 2/3/22 of a psychiatry note dated 12/18/21 for client #5 revealed, "Update consent for Thorazine." Interview on 2/3/22 with the qualified intellectual disabilities professional (QIDP) revealed there was no documentation of approval from the legal guardian for client #5.	W 263		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to provide nursing services in accordance with the needs of 1 of 5 audit clients (#1) relative to her acute needs relative to skin breakdown and identified nursing needs. The findings are: A. Review on 2/3/22 of client #1's individual program plan (IPP) dated 12/30/21 revealed she has the following diagnoses: Muscular Dystrophy, cardiomyopathy, hypertension, History of Atrial Fibrillation and Insulin Dependent Type I Diabetes.	W 331		

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W 331	Continued From page 15 Further review on 2/3/22 of client #1's IPP revealed that she uses a wheelchair for mobility and depends on staff to assist her with turning, repositioning and all of her basic daily care needs. Review on 2/3/22 of her nursing notes revealed the following: 1) 6/12/21: Appointment with physician. Direct care staff F transported to appointment and reported client #1 has open wound on her coccyx area. Referral for Occupational therapy, Nursing and physical therapy. 2) 8/12/21: Received referrals and Nurse contacted DCS to send Dr. visit documentation to triage text line. Documents received. 3) 9/12/21 : "Training with direct care staff and site supervision completed on delivery of wound care, which including turning every 2 hours with pillow placement, Avellyx boarder dressing care and application. DSP's return demonstrated on this Nurse a lift sheet, turning and safety, skin integrity and moisture barrier use, bed pan placement and emptying as well as providing privacy for bed baths. Inservice sheet located in GH binder for compliance." 4) 10/12/21: DCS called to report client #1 had appointment with cardiology. Advised DCS to call with any changes in her condition. DCS voiced understanding. 5) 12/13/21: DCS reported client returned from her appointment for wound care. Client has a stage 2 sacral ulcer. Client was given a foam like	W 331	W.331 This deficiency will be corrected by the following actions: A. The facility will provide obtain and maintain preventive general medical care B. All medical appointment will be reviewed. C. The RN will complete Medical follow up, with supporting documentation. D. The team will ensure appointments are schedule and follow up . E. All the appointments will be reviewed and discussed at the monthly core team/ quarterlies/annual ISP. F. RN will provide direct on site assessment to the consumers for the immediate medical issues. There will be G. All physician orders will be reviewed, and all annual health screenings will be completed with supporting documentation if unable to complete/obtain/referred, the team will assess options with guardian. H. Qualified Professional will consult the guardian of all medical needs and to obtain consent for treatment. I. RN will review monthly J. Site Supervisor will monitor one time a week. K. Qualified Professional will monitor one time a week	04.04.2022

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W 331	Continued From page 16 cushion to help alleviate some of the pressure on client's sacral area. DCS stated client was given guard paste to apply to the wound. Client next appointment is on 12/20/21 at 9am. DCS instructed to continue to monitor client if any noted changes or the wound appears to be large contact triage and for any other problems and or concerns. DCS voiced understanding. 6) 12/20/21 Staff C called on behalf of client #1 and said client #1 had wound care appointment today. There are not any changes in medications or treatment orders. DCS reported physician feels wound has improved . Nursing asked staff to send paperwork to Nursing. 7) 1/5/22: DCS (staff C) reported that the client has returned from her appointment. her wound on the buttocks was assessed and the physician said her wound is clear and stable. 8) 2/3/22: Patient refusing to be transported to appointment. Reschedule appointment. Will begin referral to wound clinic. No treatment changes yet. Further review on 2/3/22 of the nursing notes revealed no further direct on site assessment by the facility Nurse to assess client #1's wound to her sacral area. There are no notes by the facility Nurse to describe the wound, no monitoring of staff's treatment or any on going assessment other than phone contacts from September 2021-February 2022. Interview on 2/4/22 with direct care staff A, staff C and staff E confirmed the facility Nurse has not been on site to assess client #1 in several weeks.	W 331		

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W 331	Continued From page 17 Interview on 2/4/22 with the Program Director revealed this is the only nursing documentation he could locate about client #1's sacral wound. Further interview confirmed that the facility nurse was not available on 2/4/22. B) Review on 2/4/22 of client #1's physician orders revealed that the last transcribed quarterly physician orders were dated 6/29/21. Interviews on 2/3/22 with the Area Director, qualified intellectual disabilities professional (QIDP) revealed the quarterly physician orders for client #1 that are dated 6/29/21 are the most recent physician orders that could be located for client #1.	W 331		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure all medications were administered without error. This affected 2 of 3 audit clients (#1 and #5) observed receiving medications. The findings are: A. During observations in the facility on 2/3/22 at 12:20pm, staff C took client #1's blood sugar and reported it was 191. She indicated she could not administer her insulin as she was not yet medication certified. Staff B stated she was medication certified but had been away from the facility for 8 months and that the nurse had not gone over client #1's medications to determine if	W 369	W369 This deficiency will be corrected by the following actions: A. RN will assess all orders. B. All physician orders will be reviewed for accuracy. C. All staff will be in service on medication procedure and following the guidelines (medication rights) for dispensing all medications D. Consumers will be assessed for the ability to self-medicate (if applicable) E. Staff will be in service on Medication Administration procedures F. RN will monitor monthly G. Site Supervisor will monitor two times a week. H. Qualified Professional will monitor monthly	04.04.2022

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W 369	Continued From page 18 there any changes. Both staff stated they were waiting for staff F to arrive to administer medications. During observations of medication administration on 2/3/22 at 12:30pm staff F arrived at work and gave client #1 (7) units of Novolog insulin into her forearm while she was sitting at the dining room table. She did not pull up her shirt sleeve but administered the Flexpen injection through her shirt. Review on 2/4/22 of her physician orders dated 6/29/21 revealed she is to receive Novolog injectable Flexpen, inject 7 units subcutaneously before brunch and 5 units before supper plus sliding scale as directed up to 10 units daily. Administer between 9am-11am and 17-00-1800 daily. Interview on 2/3/22 with the Area Director and the qualified intellectual disabilities professional (QIDP) revealed the facility policy is that clients can receive medications one hour before and one hour after they are prescribed by the physician. Additional interview with the Area Director confirmed client #1's Insulin was given outside the medication administration window and this was a medication error. B. During observations of medication administration on 2/3/22 at 5:10pm staff F gave client #5 the following medications : Chlorpromazine 100mg. (1), Diazepam 10mg. (1) Fish oil (2) 1,000 mg. and Metformin 1,000mg. (1). Review on 2/3/22 of client #5's physician orders dated 10/13/21 revealed the following:	W 369		

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W 369	Continued From page 19 Chlorpromazine 100mg. (1),) Fish oil (2) 1,000 mg. and Metformin 1,000mg. (1). Further review did not reveal signed physician order for Diazepam 10 mg. (1). Review on 2/4/22 of client #5's behavior support program (dated 5/26/21) revealed he receives Diazepam 10 mg. Take 1/2 tablet for crisis medication (maximum of 10mg. in 24 hours) and Diazepam 10mg. Take 1 tablet by mouth twice daily. Interview on 2/3/22 with staff F revealed client #5 has taken Diazepam 10 mg. for some time but a physician's order could not be located. Interview on 2/4/22 with the Program Director revealed the facility Nurse was unavailable but management staff would track down this physician order for client #5. As of the time of the exit on 2/4/22, this physician order for client #5 had not been located. C. During observation of medication administration on 2/4/22 at 6:55am staff A administered the following medications to client #1 in her bedroom: Xarelto 20mg. (1), Toviaz 8mg. (1), Potassium Chloride 100 meq (1), Omeprazole 20 mg. (1), Metoprolol 25 mg. (1), Levothyroxine 50 meq. (1), Duloxetine 60 mg. (1), Duloxetine 20 mg. (1), Baclofen 10 mg. (1), Amlodopine 200 mg. (1), Torsemide 20 mg. (3). Review on 2/4/22 of her physician orders dated 6/29/21 revealed the following are to administered at 7am: Xarelto 20mg. (1), Toviaz 8mg. (1), Potassium Chloride 100 meq (1), Omeprazole 20 mg. (1), Metoprolol 25 mg. (1), Levothyroxine 50 meq. (1), Duloxetine 20 mg.	W 369		

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W 369	Continued From page 20 (1), Baclofen 10 mg. (1), Amlodopine 200 mg. (1), Torsemide 20 mg. (3). Further review of the physician orders dated 6/29/21 revealed Duloxetine 60 mg. (1) is to be administered at 10am. This was further confirmed by review of the medication administration record. Interview on 2/4/22 with staff A confirmed client #1's Duloxetine 60 mg. (1) is to be administered at 10am. He further confirmed facility policy states that medications can be given an hour before they are ordered or an hour after. Interview on 2/4/22 with the Program Director confirmed facility policy states that medications can be given an hour before they are ordered or an hour after. Further interview with the Area Director revealed staff A gave client #1 Duloxetine 60 mg. outside of the medication administration window and this is a medication error.	W 369		
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 observation, record review and interview, the facility failed to provide client #2 with her adaptive communication device as documented in her individual program and to teach client #5 to wear and take care of his prescribed glasses. This affected 2 of 3 audit	W 436	W.436 This deficiency will be corrected by the following actions: A. All equipment will be maintained ,in good working conditions, and cleaned B. All people severed will have full access to all equipment C. All staff will be in-service on their equipment working conditions, and proper cleaning on said equipment D. Site Supervisor will monitor one time a week. E. Qualified Professional will monitor one time a week	04.04.2022

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(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 436	Continued From page 21 clients (#2 and #5) . The findings are: A. Throughout observations on 2/3/22 and on 2/4/22 direct care staff asked client #2 if she would like to watch a movie or if she wanted to go to her bedroom. During observations on 2/3/22 at 4:55pm client #2 vocalized several times in the living room and direct staff did not respond to her. No adaptive communication devices were observed to be used. She remained in her wheelchair without repositioning from 4:15pm until after 6:20pm after supper. Review on 2/3/22 of client #2's IPP dated 12/9/21 that client #2 was non verbal and that she had spastic quadriparesis. Further review of the IPP revealed client #2 has Oral and Verbal Apraxia. Additional review revealed she has a communication board that is used for her to communicate. The IPP states,"It is important for client #2 to be encouraged to use her augmentative communication device." Interview staff E on 2/3/22 regarding client #2's communication device revealed, "Oh there it is, (pointing to her IPAD)" Staff C stated, "No that is not her communication device. I have not seen that in quite some time." Interview on 2/3/22 with the qualified intellectual disabilities professional (QIDP) and Program Director revealed client #2 does not have an augmentative communication device at the current time. Further interview also confirmed client #2 does not have a communication board as described in her IPP. B. During observations on 2/3/22 and on 2/4/22 client #5 was not observed to wear glasses.	W 436		

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OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G270	A. BUILDING _____ B. WING _____	C 02/04/2022

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W 436	Continued From page 22 Review on 2/3/22 of client #5's IPP dated 12/16/21 revealed he wears glasses to improve his vision and that he should be provided routine maintenance and cleaning of his glasses. Interview on 2/4/22 with staff E revealed, " Yes, he has glasses they are up here in a bin the staff office." Staff E showed the surveyor client #5's glasses. Staff E stated he will not wear them and we have reported this to the QIDP." Interview on 2/4/21 with the Program Director revealed client #5 does not have a written training objective to tolerate wearing his eyeglasses.	W 436		