	-04-122 04:52 FR	OM- LA MIEDICAID SERVICES			T-079	P0003/		F-740 บองจ - บงอ เ
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		X3) DATE	SURVEY PLETED
		34G228	B. WING	*******	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~		01/2	25/2022
	PROVIDER OR SUPPLIER			424	REET ADDRESS, CITY, STATE, ZIP C CREEKWAY DRIVE QUAY VARINA, NC 27526	ODE		Alica de Alexandra
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
	S403.748(a), §416. §441.184(a), §460. §483.475(a), §484. §465.025(a), §485. §486.360(a), §491. The [facility] must of Federal, State and preparedness requirements of this preparedness programments of the preparedness programments. The comply State, and local enrequirements. The develop and maintain emergency prepared p	54(a), §418.113(a), 84(a), §482.15(a), §483.73(a), 102(a), §485.68(a), 727(a), §485.920(a), 12(a), §494.62(a). comply with all applicable local emergency direments. The [facility] must and maintain a comprehensive edness program that meets the is section. The emergency gram must include, but not be wing elements: In. The [facility] must develop mergency preparedness plan wed], and updated at least e plan must do all of the §482.15 and CAHs at ergency Plan. The [hospital or with all applicable Federal, mergency preparedness e [hospital or CAH] must tain a comprehensive redness program that meets the is section, utilizing an		004	E 004 This deficiency will be confollowing actions: A. The Site Supervisor the EPP prepared the home to include information for reladministrative state information. B. Site Supervisor will document on this week. C. The Lead Site Supervisor and documently. D. Qualified Profession monitor and documently. E. Management will document this monoducting site relatives.	or will up ness boo de curre sidents a ff contact Il monito one time ervisor v iment the onal will iment the monitor onthiy w	odate ok for ent and ct or and e a vill is and	3.25.2022 (X6) DATE
Acuadoficio	-/Llane	la fellouson	1	Ø(j	ran Managel	n providence	1/3/2	1000 that

Any deficiency statement ending with an acterisk (*) depose a delicency 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.

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

Event ID: 831X11

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	04-122 04:53 FR)M- & MEDICAID SEKVICES				4/0025 Jiviib inu	F-740 . <u>uaso-usa i</u>
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		ONSTRUCTION	(X3) DA1	TE SURVEY MPLETED
		34G228	B. WING	i		01	/25/2022
NAME OF F	PROVIDER OR SUPPLIER	<u></u>		i	SET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-CF	REEKWAY				Creekway drive Quay Varina, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC [DENTIFYING INFORMATION]	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
E 004	Continued From pa	age 1	E	004)			:
	Plan. The ESRD fa maintain an emerg	ocility must develop and ency preparedness plan that I], and updated at least every 2	,				
	Based on record refailed to ensure the	is not met as evidenced by: eview and interview, the facility a Emergency Preparedness wed and/or updated as ng is:	: :				
	reveated a manag- updated 11/1/20) a 11/6/20). Additional include any informal had recently transfigured. Qualified Intellecture	of the facility's EP plan ement staff directory (last and a client list (last updated al review of the plan did not ation regarding a client who ferred to the facility or the al Disabilities Professional tly began working at the home.		:			
E 037	EP plan did not incinformation. EP Training Progr		• Е	037			
	§441.184(d)(1), §4 §483.73(d)(1), §4 §485.68(d)(1), §4 §485.920(d)(1), §4 *[For RNCHIs at § Hospitals at §482 at §484.102, "Org OPOs at §486.36	11(1) 416.54(d)(1), §418.113(d)(1), 460.84(d)(1), §482.15(d)(1), 83.475(d)(1), §484.102(d)(1), 85.625(d)(1), §485.727(d)(1), 486.360(d)(1), §491.12(d)(1). 6403.748, ASCs at §416.54, .15, ICF/IIDs at §483.475, HHAs anizations" under §485.727, 0, RHC/FQHCs at §491.12:] ram. The [facility] must do all of					

02-	04-122 04:53 FR	OM-				T-079 P0005	/0025	F-740
CENTER	S FOR MEDICARE	& MEDICAID SERVICES				<u> </u>	MB NO	. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		CONSTRUC	STION		(E SURVEY MPLETED
		34G228	B. WING			W	01	/25/2022
NAME OF F	ROVIDER OR SUPPLIER	>		STR	EET ADDRI	ESS, CITY, STATE, ZIP CODE		
VOCA-C	REEKWAY				CREEKW. QUAY VA	AY DRIVE RINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EAC	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD -REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
€ 037	policies and proced staff, individuals pro arrangement, and vexpected roles. (ii) Provide emerge least every 2 years (iii) Maintain docum preparedness train (iv) Demonstrate st procedures. (v) If the emergency procedures are signed to an employees and procedures. *[For Hospices at § hospice must do al (i) Initial training in policies and procedures services under arraexpected roles. (ii) Demonstrate st	emergency preparedness fures to all new and existing cividing services under volunteers, consistent with their ney preparedness training at entation of all emergency ing, caff knowledge of emergency by preparedness policies and inficantly updated, the [facility] ing on the updated policies and services)37	followii A. B. C.	ficiency will be corrected ing actions: The Site Supervisor will eithat all staff are in-service the updated Emergency Preparedness Plan annual This training will be documented. The Lead Site Supervisor monitor and document monthly Qualified Professional with monitor and document emonthly Management will monito document this monthly conducting site review.	ensure ed on ally. will this ill on this	.3.25.2022
	least every 2 years (iv) Periodically reversemergency prepare employees (including	ency preparedness training at it. view and rehearse its edness plan with hospice ing nonemployee staff), with placed on carrying out the						

preparedness training.

others.

procedures necessary to protect patients and

(v) Maintain documentation of all emergency

(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice

	04-122 04:53 FR(T-079 P000)6/0025	5 F-740
		& MEDICAID SERVICES				OMB NO	D. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		(TE SURVEY MPLETED
		34G228	B. WING			01	1/25/2022
NAME OF F	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-CI	REEKWAY				4 CREEKWAY DRIVE IQUAY VARINA, NC 27526		
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E 037	procedures.	ge 3 ng on the updated policies and 1.184(d):] (1) Training	ΕŒ)37			* * * * * * * * * * * * * * * * * * * *
:	(i) Initial training in e policies and proced staff, individuals pro	must do all of the following: emergency preparedness ures to all new and existing oviding services under		,			
:	expected roles. (ii) After initial training preparedness training (iii) Demonstrate sta	olunteers, consistent with their ng, provide emergency ng every 2 years. aff knowledge of emergency		,			: : : : : : : : : : : : : : : : : : : :
	procedures. (iv) Maintain docum preparedness traini (v) If the emergency procedures are sign	entation of all emergency					:
	organization must of (i) Initial training in a policies and proced staff, individuals pro arrangement, contravolunteers, consiste (ii) Provide emerge least every 2 years. (iii) Demonstrate staprocedures, includia	aff knowledge of emergency ng informing participants of					
	what to do, where to case of an emerger (iv) Maintain docum (v) If the emergence procedures are sign	go, and whom to contact in					

	04-122 04:54 FR						F-740
STATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUU A. BUILD		CONSTRUCTION	(X3) DA	D. 0938-0391 TE SURVEY MPLETED
		34G228	B. WING			01	/25/2022
	ROVIDER OR SUPPLIER			424	EET ADDRESS, CITY, STATE, ZIP CODE CREEKWAY DRIVE QUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI	X	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(XS) COMPLETION DATE
E 037	Continued From pa	ge 4	ΕO	37	,	•	
	Program. The LTC following: (i) Initial training in policies and procedstaff, individuals programagement, and vexpected role. (ii) Provide emerge least annually. (iii) Maintain docum preparedness train (iv) Demonstrate starocedures.	aff knowledge of emergency					
	CORF must do all (i) Provide initial tra preparedness policiand existing staff, i under arrangement with their expected (ii) Provide emerge least every 2 years (iii) Maintain docum (iv) Demonstrate signed specthe CORF's emerge their first workday, include instruction alarm systems and equipment. (v) If the emerger procedures are signed signed spectrum in the contraction of the contraction alarm systems and equipment.	lining in emergency lies and procedures to all new Individuals providing services It, and volunteers, consistent I roles. Incy preparedness training at					

02-04-'22 04:54 FROM-T-079 P0008/0025 F-740 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 _ 34G228 R WING 01/25/2022 NAME OF PROVIDER OR SUPPLIER SYREET ADDRESS, CITY, STATE, ZIP CODE **424 CREEKWAY DRIVE VOCA-CREEKWAY FUQUAY VARINA, NC 27526** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) E 037 | Continued From page 5 E 037 procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients. personnel, and quests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement. and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must

demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2

This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure all new staff were trained on the facility's Emergency Preparedness (EP)

<u> UENIER</u>	S FUK MEDICAKE	& MEDICAID SERVICES	·····		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	OI	<u>NB NO</u>	<u>). 0938-0391 </u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRU			TE SURVEY MPLETED
		34G228	B. WING				01	/25/2022
NAME OF F	PROVIDER OR SUPPLIER			\$7	REET ADD	RESS, CITY, STATE, ZIP CODE		
VOCA-C	REEKWAY			42	4 CREEK	WAY DRIVE		
* V W/A-WI	*LLE-1X#97~1			FI	UQUAY V	ARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EA	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD S-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 037 ∃	Continued From pa	.ao 6	۱ رسو	i Nama angar				4
E 001	•	•	. = 1)37				4
	plan. The finding is	¥:						:
	Review on 1/24/22	of the facility's EP plan did not		:				
		d/or existing staff had received						¢
	training on the EP							4
		2 with Staff A and Staff C						<
		ecently started working in the		-				
		ring from another facility. The had not completed training.						
		on 1/25/22, the Qualified						
		ies Professional (QIDP)			10/ 137			
		not be sure if all staff in the I training on the EP plan and			W 137	ficionous will be a series at a.		
		of the training was provided for			followi	ficiency will be corrected by ng actions:	/ the	3.25.2022
	any staff working in		•			· · · · · · · · · · · · · · · · · · ·		3.23.20
W 137	PROTECTION OF		W	137	A.	All ISP's will be reviewed.	•	
	CFR(s): 483.420(a))(12)	;		В.	All ISP's will be updated to		
	me					address the current needs	and	
		nsure the rights of all clients.				techniques to manage		
		ity must ensure that clients tain and use appropriate			C	inappropriate behavior. Client #2's ISP will be revie	wod	•
	personal possession				٠,	to assess her current need		
		s not met as evidenced by:				if there are any restrictions		
		tions, record review and				needed for safety reasons	it Will	
		lity failed to ensure client #2				be documented in her ISP	and	
		ess her personal grooming				include the proper		
		cted 1 of 4 audit clients. The			175	documentation.	.011	•
	finding is:				D.	The Lead Site Supervisor w monitor and document this		
	During observation	s in the home on 1/24/22 at				monthly,	.	
	12:38pm, a staff re	trieved client #2's grooming			E.	Qualified Professional will		
		ed hall closet. The staff				monitor and document or	this	
		ush and tube of toothpaste and				monthly		
		t #2. The client was then			F.	Management will monitor		
	prompted to the ba	throom for toothbrushing.				document this monthly wi	hile	
						conducting site review.		

T-079 P0009/0025 F-740

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TATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		ONSTRUCTION	(X3) DA1	TE SURVEY MPLETED
		34G228	B. WING			01	/25/2022
NAME OF P	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP COL)E	
VOCA-CF	REEKWAY			i	CREEKWAY DRIVE QUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(XS) COMPLETION DATE
W 137	Continued From pa	age 7	W	137 :			`
	Interview on 1/24/2 #2's grooming item will use too much of Additional interview Staff C confirmed to	2 with Staff D revealed client is are kept locked because she of the items or waste them. If on 1/25/22 with Staff A and the client's personal grooming ocked because she will "dump"					
:	Program Plan (IPF	of client #2's Individual ') dated 2/23/21 revealed no ing a restriction of her		:			
W 249	Disabilities Profess #2's grooming iten they will "end up e use them when it's		W	249			
	formulated a clien each client must retreatment program interventions and and frequency to	erdisciplinary team has t's individual program plan, eceive a continuous active n consisting of needed services in sufficient number support the achievement of the ed in the individual program					
	Based on observ interviews, the fac	is not met as evidenced by: ations, record reviews and cility failed to ensure 4 of 4 audit and #6) received a continuous	:				

	04-'22 04:55 FR				T-079 P	0011/0025	
STATEMENT	S FOR MEDICARE OF DEFICIENCIES CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		ONSTRUCTION	(X3) DAT	. 0938-0391 E SURVEY APLETED
		34G228	B. WING			01/	/25/2022
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		424 C	ET ADDRESS, CITY, STATE, ZIP COD REEKWAY DRIVE UAY VARINA, NC 27526		4.54.1.000000000000000000000000000000000
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ζ ,	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
:	interventions and s Individual Program meal preparation, f eyeglasses. The fi A. During observathe home on 1/24 - prepared plates of without their assists prompted or assist participate in family pouring, passing for Interview on 1/25/2 assumes the client dining but she add we do that." Review on 1/25/22 Community/Home 2/8/21 revealed sh independently. Review on 1/25/22 1/1/20 indicated sh independently. Review on 1/25/22 eats family style in Interview on 1/25/2 revealed since sh July '21, she had to	ogram consisting of needed ervices as identified in the Plan (IPP) in the areas of amily style dining and use of ndings are: tions throughout the survey in 1/25/22, various staff food and drinks for each client ance. Clients were not ed to serve themselves or y style dining (i.e. serving, and items). 22 with Staff A revealed she is participate in family style ed, "When it comes to serving, of client #2's Life Assessment (CHLA) dated e eats family style 3 of client #4's CHLA dated he eats family style 4 of client #6's CHLA noted he dependently. 22 with Home Manager (HM) a began working at the home in open told staff should be clates for them. The HM could	W 2		This deficiency will be corrected following actions: A. All ISP's will be reviewed as needed to all objectives are meter as independent as independent as independent as independent as needed their current needs goals. D. All staff will be inserted by an and revised as needed their current needs goals. D. All staff will be inserted by an active treatment and document this monthly F. Qualified Profession monitor and document this monthly G. Management will document this monthly and conducting site reserved.	wed and of ensure that et. will be tunity to be cossible. In the decision of the environment in the environment in the environment this enal will ement on this enotitor and entity while entity while on the environment of the entity while entity while	t d

Interview on 1/25/22 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed all of

02-	∙04-'22 04:55 FR0	\f\ _			T-079 P00		25 F-740
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					JRIVI APPROVED NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		34G228	B. WING				01/25/2022
NAME OF I	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		V 1/EJ/ZVZZ
VOCA-C	REEKWAY				CREEKWAY DRIVE QUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
W 249	Continued From pa	O an		,	7		
*** 1.0		cipate with family style dining	W 2	249			
	and should be assis	sted to do so.		,			
	the home on 1/24 - actively prompted of preparing food item from 11:35am - 12; client #6, Staff B concept preparation tasks suppatties on a pan, containing a large bow and making hambur time, client #4 also area without promptasks. With the except, client #6 was not preparation of food interview on 1/24/22	ons throughout the survey in 1/25/22, client's were not or encouraged to assist with s. For example, on 1/24/22 17pm, while in the kitchen with mpleted various meal uch as placing hamburger toking them in the oven, of instant mashed potatoes, or ger sandwiches. During this entered and exited the kitchen its to participate with cooking eption of putting beans in a cot actively involved with the items.					
	indicated he can may verbal cues and utility and other devices in Review on 1/25/22 of 1/1/20 revealed she pack lunches. Additional control of the pack lunches.	Life Assessment (CHLA) ake and pack lunches with izes measuring/mixing spoons independently. Of client #4's CHLA dated can independently make and fonal review of the CHLA es verbal cues to make foods			\		
	Interview on 1/25/22	with the QIDP indicated staff					

preparation tasks.

should be encouraging clients to assist with meal

02-	04-'22 04:56 FRO	M —			T-079 P0013	/0025	F-740
		& MEDICAID SERVICES	1	*		MB NC	<u>), 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		TE SURVEY MPLETED
		34G228	B. WING			04	/25/2022
NAME OF I	PROVIDER OR SUPPLIER	***************************************		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 01	123/2022
VOCA-C	REEKWAY				4 CREEKWAY DRIVE		
					IQUAY VARINA, NC 27526		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 249	Continued From pa	ae 10	' ነልታ ግ	.40	•		
:		ions in the home on 1/24/22,	W 2	.49			
:	client #1 sat on the	couch in the living area of the	•				
	home sporadically v	vatching television.					•
:	Throughout observa	ations in the home, the client					
	did not wear eyegla	sses. Client #1 was not	•		•		
	prompted or encour	aged to wear eyeglasses.	ı				
; ;	Interview on 1/25/22 #1 does wear eyegi	with Staff C revealed client asses at school.	· ·				;
	12/7/21 revealed sh needed. Additional examination report	of client #1's IPP dated e wears eyeglasses when review of the client's vision dated 9/30/20 noted, "Patient glasses all the time while	: ;	:			:
i	Intoniou 1/05/00						•
	client #1 should wear on the vision report.	2 with the QIDP confirmed ar her eyeglasses as indicated	;	•			
W 252	PROGRAM DOCUM		W 2	52			4
	CFR(s): 483.440(e)			~ 			*
	specified in client in	omplishment of the criteria dividual program plan documented in measurable			•		
	Based on observati interviews, the facili relative to the accor criteria specified in t (IPP) was documen	not met as evidenced by: ons, record review and ty failed to ensure data nplishment of objective he Individual Program Plan ted in measurable terms. This clients (#2). The finding is:	:		,		

02-0	04-122 04:56 FKC	- - -				1-0/9 P0014/		
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I		CONSTRU	CTION	(X3) DAT	0938-0391 FE SURVEY MPLETED
		34G228	B. WING				0.1	/25/2022
VOCA-C	PROVIDER OR SUPPLIER			42	4 CREEKV JQUAY VA	RESS, CITY, STATE, ZIP CODE VAY DRIVE ARINA, NC 27526		12312022
(X4) ID PREFIX YAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	x :	(EA	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD S-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(XS) COMPLETION DATE
	1/24/22 at 10:55am water from the kitch room table, drank a water onto the table observations in the client #2 was seated dining room table e abruptly picked up poured it onto the trobservations in the and 5:24pm, client blocks and threw it Interview on 1/24/2 #2 has a behavior out. Review on 1/25/22 sheets did not reve 1/24/22 had been of Review on 1/24/22 Plan (BSP) dated 7 exhibit 0 episodes of other items per monand to exhibit 0 epiper month for 12 coreview of the plan rand other behaviors behavior data log, of interview on 1/25/2 Disabilities Profess client's behaviors sindicated.	servations in the home on a client #2 retrieved a cup of then faucet, took it to the dining a sip of it and then poured the control of the co	W 2		A. B.	eficiency will be corrected bing actions: The Qualified Professional review all behavioral supplans (BSP) plans with state All Staff will be in-serviced the current BSP's and documenting incidents of behavioral log. Client #Z's BSP will be reviand revised as need to ad all target behaviors. The Lead Site Supervisor via monitor and document the monthly Qualified Professional will monitor and document or monthly.	I will bort on the ewed dress vill is	3.25.2022
TT MUCUI	CFR(s): 483.440(f)		VV Z	UJ				

02-	04- ¹ 22 04:56 FRC	M			T-079 P00		5 F-740
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) C	OO. 0938-0391 DATE SURVEY COMPLETED
		34G228	B. WING				01/25/2022
NAME OF	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE) II ESI EUE E
	REEKWAY			424	CREEKWAY DRIVE QUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 263	Continued From pa The committee sho	uld insure that these programs	W 2	163	W 263 This deficiency will be correcte following actions A. The Qualified Profession	וויאי ובמכ	
	consent of the clien minor) or legal guar This STANDARD is Based on record refailed to ensure rest (BSP) for 3 of 4 aud only conducted with of the legal guardiar. A. Review on 1/24/2 12/6/20 revealed ob aggression, inapproagitation, noncompliand crying. The pla Cogentin, Lexapro, Trazadone. Further consent dated 12/16 "I understand that the 12/6/21 and will not date of my original a not include a curren client #1's BSP from B. Review on 1/24/2 7/28/21 revealed ob	inot met as evidenced by: view and interview, the facility rictive Behavior Support Plan it clients (#1, #2, and #4) was the written informed consent in. The findings is: 2 of client #1's BSP dated jectives to address physical priate verbalizations, PICA, ance, self-injurious behavior, in identified the use of Abilify, Kapvay, Lithium and review of the record noted a b/20. The consent indicated, its authorization will expire on exceed one year from the authorization." The record did t written informed consent for			review all behavioral splans. B. All behavioral support address the current ne technique to manage inappropriate behavioral support address the current needs to manage behavioral support to	upport plans w eds and ; vill be iors. vall proper ed for al dian will this ill this	áll
	clothes and dumping items. The plan ide Amantadine, Ambiel Alprazolam. Further consent dated 9/17/ understand that this 7/30/21 and will not date of my original a	g food, drinks and other ntified the use of Zyprexa.					

client #2's BSP from the guardian.

02-	04 <u>-</u> '22 04:57 FR	<u> </u>		T-079 P0016/0	025 F-740 <u> </u>
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1		(X3) DATE SURVEY COMPLETED	
		34G228	8. WING		04/25/2022
NAME OF	PROVIDER OR SUPPLIEF	***************************************		REET ADDRESS, CITY, STATE, ZIP CODE	01/25/2022
#************************************	REEKWAY			4 CREEKWAY DRIVE IQUAY VARINA, NC 27526	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(XS) E COMPLETION ATE DATE
W 263	Continued From p	age 13	W 263		
W 288	7/13/21 revealed of screaming, self-inj aggression. The pleadditional review of current written info BSP from the guar Interview on 1/25/2 Disabilities Profess written informed of #1, client #2 and of had not been return MGMT OF INAPPI BEHAVIOR CFR(s): 483.450(b). Techniques to man behavior must never an active treatmen This STANDARD Based on observation interviews, the facito manage client # was included in a forogram. This affer finding is: During observation staff retrieved client locked hall closet. toothbrush and tub to client #2. The client for tooth	22 with the Qualified Intellectual sional (QIDP) indicated a consent had been sent to client lient #4's guardians; however, it ned. ROPRIATE CLIENT (3) (3) (3) (a) (a) (b) (c) (c) (d) (e) (e) (e) (e) (e) (e) (e	W 288	W 288 This deficiency will be corrected by following actions: A. The Qualified Professional review all BSP plans with B. All Staff will be in-served of current BSP's and docume incidents in the behavioral control of the professional target behaviors. D. Client #2's BSP will be review assess her current needs at there are any restriction of for safety reasons it will be documented in her ISP and behavioral support plan. E. HRC approval and the professional review and obtain guardial consent. G. The Lead Site Supervisor will monthly. H. Qualified Professional will	at will staff. on the enting at log. 3.25.2022; iewed idress w to and if needed end oper for all will an will
	#2's grooming item	2 with Staff D revealed client is are kept locked because she		monitor and document this monthly.	Ž
MOM CMS-96	67(02-99) Previous Versions	//\	******		

02-	04 <u>-</u> 122 04:57 FR0	M-				7/0025		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G228	B. WING				to m to a m.	
NAME OF PROVIDER OR SUPPLIER VOCA-CREEKWAY				424	REET ADDRESS, CITY, STATE, ZIP CODE 1 CREEKWAY DRIVE QUAY VARINA, NC 27526	<u> 01</u>	/25/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	II D BE	(X5) COMPLETION DATE	
W 288	will use too much o Additional interview Staff C confirmed the	ge 14 f the items or waste them. on 1/25/22 with Staff A and ne client's personal grooming cked because she will "dump"	W 2	88			;	
:	Program Plan (IPP) Support Plan (BSP) objective to address food, drinks and oth the BSP did not incl	of client #2's Individual dated 2/23/21 and Behavior dated 7/28/21 identified an inappropriately dumping of ter items. Additional review of ude a technique of locking oming supplies to address her iters.						
W 323	Disabilities Professi #2's grooming items they will "end up ever use them when it's reconfirmed the techn	ique of locking away the ms was not included in her CES	W 3.	23				
:	The facility must pro examinations of eac includes an evaluati This STANDARD is Based on record re facility failed to ensu	vide or obtain annual physical the client that at a minimum on of vision and hearing, not met as evidenced by: views and interviews, the ire 3 of 4 audit clients (#1, #2 ion and hearing examinations						
	revealed a vision ex	2 of client #2's record amination report dated 3/3/20 ional review of both reports						

02-04-722 04:58 FROM-			T-079 P0018/0025 F-740						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DAT	. <u>0938-0391</u> FE SURVEY MPLETED				
······		34G228	B. WING		04	ine inana			
NAME OF I	PROVIDER OR SUPPLIER		\$	STREET ADORESS, CITY, STATE, ZIP CO	ODE U1/	/25/2022			
	REEKWAY		4:	24 CREEKWAY DRIVE FUQUAY VARINA, NC 27526					
(X4) ID PREFIX TAG	 (EACH DEFICIENC) 	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEPICIENCY)	SHOULD BE	(X5) COMPLETION DATE			
	General Anesthesia record did not reverbeen completed. B. Review on 1/24/2 revealed her last via completed on 9/13/ record did not include examination. Furth Individual Program "Ophthalmology dudyearly)." C. Review on 1/24/2 revealed her last via completed on 9/30/2 "Myopia, astigmatis review of the report needed." D. Review on 1/24/2 revealed no audiological examinaditional review of noted, "Audiology: content of the review of noted in the review of noted and audiological noted these examinations; howered an audiological noted these examinations."	ndation: Eye exam under a". Further review of client #2's real a vision examination had been /19. Additional review of the review of client #4's Plan (IPP) noted, re every 2 years (ordered sion examination had been /20 with a diagnosis of sm, left extropia" Additional inoted, "RTC 1 year, glasses and plant for the review of client #4's record sion examination. No current review of client #4's record sion examination. No current review of client #4's record sion examination. No current review of client #4's IPP dated 2/23/21 complete every 2 years by physician." 2 with the Qualified Intellectual fonal (QIDP) confirmed client #4 were in need of vision ever, these appointments have a so of the date of the survey. confirmed client #4 has not examination. The QIDP reations are generally	W 323	, , , , , , , , , , , , , , , , , , ,	will ensure and annual cheduled and mentioned in efficiencies for 4 will be will monitor weekly. essional will ment this are these completed	3.25.2022			
	completed annually. NURSING SERVICE		W 340						

02-04-322 04:58 FROM-			T-079 P0019/0025 F-740							
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRU		(X3) DATE SURVEY COMPLETED				
		34G228	B. WING_	_,	•		·			
	NAME OF PROVIDER OR SUPPLIER VOCA-CREEKWAY			STREET ADDR	RESS, CITY, STATE, ZIP CODE VAY DRIVE ARINA, NC 27526	j <u>01</u> /	25/2022			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFIGIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	Pi (EAC	ROVIDER'S PLAN OF CORRECT OF CORRECTIVE ACTION SHOT SHOT OF THE APP	MINDE	(XS) COMPLETION DATE			
	other members of tappropriate protection measures that inclustraining clients and health and hygiene. This STANDARD is Based on observatinterviews, the facility sufficiently trained to the Medication Adm The finding is: During observations in the home on 1/25 dispensed medication and immediately sign Client #4 ingested home immediate interview usually does not sign their medications by with client #4 not talknown and medication closet and MAR in advance." Interview on 1/25/22 of medications of the MAR prior to client edications.	ust include implementing with he interdisciplinary team, ive and preventive health ade, but are not limited to staff as needed in appropriate methods. Is not met as evidenced by: ion, record review and ity failed to ensure staff were of appropriately document on an inistration Record (MAR). Is of medication administration of MAR and the MAR. Afterwards, iver medications. If with Staff A revealed she in the MAR before clients take at she doesn't have a problem king their medications. If a note posted inside the re indicated, "Do Not Sign the control of the Program staff should not be signing ents ingesting their DENTAL DIAGNOSTIC	W 352	W 340 This de following A. B. C. D. E.	ficiency will be correcting actions: The nurse will be respin-serving/training staproper way to docum administering medica. The Site Supervisor wand document this work Lead Site Supervidocument on this moon the Qualified Professidocument this month The nurse will docum monthly.	oonsible for off on the nent when tions. ill monitor eekly. sor will nthly. ional will	3.25.2022			
RM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: 831X11		Sacility (1): 921710						

02-	04-'22 04:58 FR0)M-			T-079			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G228	B. WING _				:a = /a a a a	
VOCA-CREEKWAY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		STREET ADDRESS, CITY, STATE, ZIP CODE 424 CREEKWAY DRIVE FUQUAY VARINA, NC 27526 ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO.						
W 352	Continued From pa		W 35	2	W352 This deficiency will be co following actions:	orrected by the	3.25.2022	
:	include periodic ex performed at least This STANDARD i Based on record n failed to ensure clie comprehensive del	amination and diagnosis annually. s not met as evidenced by: eview and interview, the facility			completed. B. The comprehens diagnostic servic the statement of	ents, nd annual e scheduled and sive dental te mentioned in f deficiencies #4	s.	
F h o e li n h	her last dental example to one of the record did no examination.				will be scheduled Any issues with the are to be documed. C. The Site Supervisional document the Cualified Principle.	non-compliance nented. sor will monitor this weekly.		
	revealed client #1 however, no cleaning Additional interview had not been resch			į	monitor and doc monthly. E. The nurse will er appointments are and monitor and	nsure these re completed		
W 356	Disabilities Profess #1 had not received examination as of t	he date of the survey. EDENTAL TREATMENT	W 356	6	them monthly.			
MA	reatment services needed for relief of restoration of teeth, health. This STANDARD is Based on record re	sure comprehensive dental that include dental care pain and infections, and maintenance of dental s not met as evidenced by: eview and interview, the facility nt #4 received comprehensive			·			

02-	04-122 04:59 FR	DM-		T-079 P0021	/0025 F-740
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CAND PLAN OF CORRECTION (DENTIFICATION NUMBER)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		34G228	B. WING		04/05/0000
	PROVIDER OR SUPPLIER REEKWAY		42	REET ADDRESS, CITY, STATE, ZIP CODE 4 CREEKWAY DRIVE IQUAY VARINA, NC 27526	01/25/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIÊNCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
	Continued From pa dental treatment se her dental health. T clients. The finding	rvices for the maintenance of his affected 1 of 4 audit	W 356		3.25.2022
W 382	Review on 1/24/22 of client #4's record revealed a dental examination report dated 3/8/21. Additional review of the report noted, "Diagnosis: #28 needs to be extractedRecommendation: Complete extraction in hospital setting," Further review of the record did not reveal any further dental treatment had been provided to address her dental concerns. Interview on 1/25/22 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed no appointment has been scheduled for client #4's recommended tooth extraction as of the date of the survey. DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(I)(2)				
			W 382		
	The facility must ke locked except when administration. This STANDARD is Based on observatinterviews, the facility and biologicals were	ep all drugs and biologicals	:		
	the Home Manager administration area door to the medicat	e home on 1/24/22 at 4:49pm, (HM) exited the medication to retrieve a client, leaving the ion closet wide open.			
	generally locks the	2 with the HM revealed she medication closet when			

02-	04-122 04:59 FRC	V			T-079 P0022,	/0025	F-740
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRU	(X3) DATE SURVEY COMPLETED		
		34G228	B. WING _				4 (0 E (0000
	PROVIDER OR SUPPLIER			424 CREEK	RESS, CITY, STATE, ZIP CODE WAY DRIVE ARINA, NC 27526	<u> 0</u>	1/25/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD SS-REFERENCED TO THE APPROP DEFICIENCY)	386	(X5) COMPLETION DATE
	6:06am, the door to wide open and no commained open with 6:17am. During this remained unlocked the home. Interview on 1/25/2, had recently given a medications. Addit generally leaves the open if no clients at the home. Review on 1/25/22 Procedure Manual Storage revealed, "have access to the Interview on 1/25/22 Disabilities Professidoor to the medicat open and unattende SPACE AND EQUIF CFR(s): 483,470(g) The facility must fur and teach clients to choices about the unhearing and other cand other devices ic interdisciplinary teal This STANDARD is Based on observat	the home on 1/25/22 at of the medication closet was one was in the room. The door in the area unmonitored until is time, drugs and biologicals and accessible to anyone in 2 with Staff A revealed she a client her morning ional interview indicated she a door to the medication closet re up and walking throughout of the facility's Policy and (rev. 9/12) for Medication Only authorized persons will medication storage area." 2 with the Qualified Intellectual ional (QIDP) confirmed the ion closet should not be left ed. PMENT (2) Inish, maintain in good repair, use and to make informed se of dentures, eyeglasses, ommunications aids, braces.	W 38	W 382 This defi followin A. B. C.	iciency will be corrected by g actions: The nurse will be responsitensuring all staff on the prostorage of medication. The Site Supervisor will mound document this weekly. The Qualified Professional monitor and document the monthly. The nurse will ensure the appointments are compleand monitor and document them monthly.	ole for oper onitor /. I will nis se	3.25.2022

02-04-'22 04:59 FROM-			T-079 P0023/0025 F-740						
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING			(X3) DATE SURVEY COMPLETED			
		34G228	B. WING		~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	01/	/25/2022		
NAME OF	PROVIDER OR SUPPLIER		<u>' </u>	STREET AC	DRESS, CITY, STATE, ZIP CODE	1 017	LUILVEL		
VOCA-C	REEKWAY				KWAY DRIVE VARINA, NC 27526				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIÉS ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION SHOULD SHOULD SS-REFERENCED TO THE APPROPRIES OF THE PROPRIES OF	BE	(X5) COMPLETION DATE		
	and to make inform their eyeglasses. The classes are eyeglasses. The classes are encouraged to weather wearing the home on 1/25/22 and know if client #4 not seen her wearing review of the client report dated 9/13/12 "Plan/Recommendation regreview of the client report dated 9/13/12 "Plan/Recommendation regresies of client report dated 9/13/12 "Plan/Recommendation regression	were furnished, taught to use ed choices about the use of the findings are: ions throughout the survey in 1/25/22, client #4 did not wear ient was not prompted or reyeglasses. 2 with Staff C revealed she did wears eyeglasses and has ag eyeglasses. of client #4's Individual dated 2/23/21 did not include arding eyeglasses. Additional slast vision examination noted, ations: Get new eyeglasses" 2 with the Qualified Intellectual ional (QIDP) indicated he was f4 wearing eyeglasses and did eyeglasses. ions throughout the survey in 1/25/22, client #2 did not wear ient was not encouraged to 2 with Staff C revealed she did wears eyeglasses and has ag eyeglasses. of client #2's IPP dated She has eyeglasses, but	W 436	This difollow A. 6.	eficiency will be corrected by ing actions: The Qualified Professional be responsible for reviewing ISPs to reflect the current nof the consumers to include adaptive equipment needed All staff will be in-serviced of ISP's.	will ng all needs le any ed. on all y em or at nitor	β.25.2022		
	their eyeglasses. T A. During observation home on 1/24 - eyeglasses. The cliencouraged to weat interview on 1/25/22 not know if client #4 not seen her wearing. Review on 1/25/22 Program Plan (IPP) any information regretiew of the client's report dated 9/13/13 "Plan/Recommendation of the client's report dated 9/13/13 "Plan/Recommendation in the lient was not aware of client; not know if she has B. During observation the home on 1/24 - eyeglasses. The client #2 not seen her wearing Review on 1/25/22 2/23/21 revealed, "srequires redirection in the look of the lient #2 not seen her wearing requires redirection."	ions throughout the survey in 1/25/22, client #4 did not wear ient was not prompted or reyeglasses. 2 with Staff C revealed she did wears eyeglasses and has a geyeglasses. of client #4's Individual dated 2/23/21 did not include arding eyeglasses. Additional selast vision examination noted, ations: Get new eyeglasses" 2 with the Qualified Intellectual ional (QIDP) indicated he was f4 wearing eyeglasses and did eyeglasses. ions throughout the survey in 1/25/22, client #2 did not wear ient was not encouraged to		6. C.	The Qualified Professional be responsible for reviewir ISPs to reflect the current nof the consumers to includ adaptive equipment needed. All staff will be in-serviced of ISP's. Client #2 and #4 will be provided the adaptive equipment needed and any issues of refusal to wear the training that occurs to assist them with putting them and keeping them on will be documented. The Site Supervisor will morand document this weekly. The Qualified Professional womenitor and document this	ng all needs le any ed. on all y em or et ad			

putting them on." Additional review of the plan

02-	04-122 05:00 FR()M- .w :v:			0025 F-740
AND PLAN OF CORRECTION I IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION (X3) DATE SURVEY COMPLETED	
		34G228	B. WING		01/25/2022
	ROVIDER OR SUPPLIER		42	TREET ADDRESS, CITY, STATE, ZIP CODE 24 CREEKWAY DRIVE UQUAY VARINA, NC 27526	VIJOZZ
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
	choices between of IPP did not include client's refusal to we Interview on 1/25/2: client #2 has eyegle encouraged to weahe was not aware of client #2 to wear he FOOD AND NUTRI CFR(s): 483.480(a) Each client must rewell-balanced diet is specially-prescribed. This STANDARD is Based on observatinterviews, the facil modified and speciprovided as indicatic clients. The finding During lunch observations.	wear glasses while making bjects" Further review of the any training to address the ear her eyeglasses. 2 with the QIDP confirmed asses and should be them. The QIDP indicated from any formal training to teach reyeglasses. TION SERVICES (1) ceive a nourishing, including modified and diets. Is not met as evidenced by: ions, record reviews and ity failed to ensure client #4's ally-prescribed diet was ed. This affected 1 of 4 audit is: vations in the home on 1/24/22	W 436	W 460 This deficiency will be corrected by following actions: A. The Qualified Professional be responsible for reviewing 1SPs to reflect the current most the consumers to include each individual's diet. B. Client #4 will obtain update speech and nutritional assessments to determine whether a change in her of needed. C. The Qualified Professional update client #4's ISP to refere	will ag all aeeds de ted diet is
	sandwich cut into of salad with dressing With the exception the client consume During dinner obse 1/24/22 at 5:50pm, stir fry with rice and and bites of carrots inch in size, water a breakfast observat	44 consumed a hamburger uarter inch pieces, a tossed, kidney beans and lemonade, of coughing on one occasion, d the meal without difficulty. rvations in the home on client #4 consumed chicken if vegetables mixed in (pease), peach slices about a quarter and Kool-aid. During additional lons in the home on 1/25/22 at		any changes. D. All staff will be in-serviced ISP's. E. The Site Supervisor will mand document this week. F. The Qualified Professional monitor and document the monthly. G. The nurse will observe class at mealtime and document.	nonitor ly. al will his ient #4
		ions in the home on 1/25/22 at onsumed two whole cinnamon	*	at mealtime and docume this monthly.	

02-	-04-'22 05:00 FR0)M			T-079 P0025	5/0025 F-	740
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	LE CONSTRUCTION		(X3) DATE S COMPL	
_		34G228	B. WING			04/25	5/2022
NAME OF PROVIDER OR SUPPLIER VOCA-CREEKWAY			,	STREET ADORESS, CIT 424 CREEKWAY DRIV FUQUAY VARINA, I	/E	1 01/20	1/ZQZZ
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER (EACH CORR	'S PLAN OF CORRECTIC ECTIVE ACTION SHOUL ENCED TO THE APPROF DEFICIENCY)	DBE ((X5) COMPLETION DATE
W 460	quarter inch pieces consumed her dinn without difficulty. Interview on 1/24/2/ #4's food can be pure stated, "It's her choice indicated the client needs to be pureed. Interview on 1/25/2/ #4 consumes a soft up". The staff indice fine without it being. Review on 1/24/22 Individual Program current Physician's evaluation dated 12 Quarterly note date receives a regular." Interview on 1/25/2/ Disabilities Professicient #4's food short consistency as indice interview indicated at Language Patholog.	e links cut into nickel and a milk and water. The client er and breakfast meals 2 with Staff D revealed client preed or regular. The ce." Additional interview will let you know if the food for consumption. 2 with Staff A revealed client to diet with her food "mashed ated the client eats her food pureed. 2 and 1/25/22 of client #4's Plan (IPP) dated 2/23/21, orders, a Nutritional /1/21 and a Speech Therapist of 1/3/19 revealed the client puree" diet. 2 with the Qualified Intellectual onal (QIDP) also confirmed uid be served at a pureed cated. on 1/25/22 with the Dietitian onfirmed client #4 should diet and no changes have not consistency. Additional an assessment by the Speech ist needs to be obtained for no changes need to be made	W 460				