PRINTED: 04/06/2022
FORM APPROVED
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
	34G225	A. BUILDING _____ B. WING _____	03/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 004	Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency	E 004	E 004 This deficiency will be corrected by the following actions: A. The Management will update the EPP preparedness book for the home to include current information for residents and administrative staff contact information. B. Management will monitor and document on this one time a week. C. Management will update all information regarding, consumers, guardians, staff and administrative staff. D. Site Supervisor will monitor and document this monthly. E. Qualified Professional will monitor and document this monthly. F. Management will monitor and document this monthly while conducting site review.	05.27.2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Monica Mack RN
TITLE: Executive Director
(X6) DATE: 4/12/2022

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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E 004	Continued From page 1 Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. This STANDARD is not met as evidenced by: Based on interviews and document review, the facility failed to update the emergency preparedness (EP) with current information. This had the potential to affect all the clients in the home (#1, #2, #3, #4, #5 and #6). The finding is: Review on 3/28/22 of the facility's EP plan revised 4/1/21 did not include any information on all clients who reside currently in the home. Further review revealed the EP did not include any information on guardians, direct care staff or the current list of management. Interview on 3/29/22 with the Site Supervisor (SS) revealed she started her position in May 2021. The SS reviewed the current list of clients in the EP included three previous clients who were deceased. The SS acknowledged there was no list for guardian contacts and the current SS and Qualified Intellectual Disabilities Professional (QIDP) were not listed for emergency contact. Interview on 3/29/22 with the acting QIDP revealed the QIDP and Program Manager (PM) reviews and updates the EP annually. The PM is responsible for making the changes to the information listed.	E 004		
E 015	Subsistence Needs for Staff and Patients CFR(s): 483.475(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)	E 015		

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E 015	Continued From page 2 (1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not	E 015	E 015 This deficiency will be corrected by the following actions A. Emergency food supplies will be replenished. B. Supplies will be monitored with supporting documentation to be completed monthly when during home observations C. Emergency food supplies will be purchased based upon the needs of the people living in the home. D. Site Supervisor will monitor and document this monthly. E. Qualified Professional will monitor and document this monthly. F. Management will monitor and document this monthly while conducting site review	05.27.2022

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E 015	Continued From page 3 limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This STANDARD is not met as evidenced by: Based on observations, document review and interviews, the facility failed to ensure emergency provisions for subsistence needs for clients and staff included adequate water as identified in the emergency preparedness (EP) plan. This potentially affected all clients in the home (#1, #2, #3, #4, #5 and #6). The finding is: During observations in the home on 3/29/22 at 10:15am, a closet had one large covered plastic tote bin with several blankets and packages of canned and boxed foods. One of the boxes of prepared vanilla pudding was not full and had several missing containers. There was no bottled water in the storage area. Review on 3/28/22 of the Emergency/Disaster Preparedness Manual, dated 4/1/21 revealed supplies should be maintained in an area and well marked. Drinking water should included a three-day supply of water per person (1 gallon per person per day) and food should include a three day supply of non-perishable food. Interview on 3/29/22 with the Site Supervisor (SS) revealed that only employees knew where the	E 015		

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E 015	Continued From page 4 emergency provisions were located in the closet. The SS explained that she purchased the canned and boxed food originally in November 2021 and noticed over the time the container had missing food items, but she had not replenished it. The SS also said that she purchased three cases of bottled water for the closet and she noticed about a week ago, that the water disappeared. Interview on 3/29/22 with the acting Qualified Intellectual Disabilities Professional (QIDP) revealed the QIDP and SS should be monitoring the emergency foods supplies. The acting QIDP stated when the SS noticed some of the supplies were missing, they should have been replenished and reported to the supervisor.	E 015		
E 025	Arrangement with Other Facilities CFR(s): 483.475(b)(7) §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC	E 025	E 025 This deficiency will be corrected by the following actions: A. The Management will update the EPP preparedness book for the home to include pre-arranged accommodations for the people being served in the event of emergency relocation. B. Management will update all information as needed regarding, local pre-arranged accommodations. C. Site Supervisor will monitor and document this monthly. D. Qualified Professional will monitor and document this monthly. E. Management will monitor and document this monthly while conducting site review	05.27.2022

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E 025	Continued From page 5 Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This STANDARD is not met as evidenced by: Based on interviews and review of the facility's emergency preparedness (EP) plan, the facility failed to document pre-arranged accommodations for clients in the event services could not be delivered in the home. This potentially affected all clients in the home (#1, #2, #3, #4, #5 and #6). This finding is: Review on 3/28/22 of the facility's EP plan revised on 4/1/21 revealed that there was no listing of accommodations or agreement for emergency purposes. Interview on 3/29/22 with the Site Supervisor	E 025		

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E 025	Continued From page 6 revealed there was no established arrangement but the Executive Director would make a decision on a needed basis to what hotel the clients would go to in an emergency. Interview on 3/29/22 with the acting Qualified Intellectual Disabilities Professional (QIDP) revealed there was no list of accommodations to transport the clients to in an event of an emergency evacuation. The acting QIDP said it would be decided when the emergency occurred.	E 025		
E 036	EP Training and Testing CFR(s): 483.475(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training	E 036	E 036 This deficiency will be corrected by the following actions: A. The Site Supervisor will ensure that all staff are in-serviced on the updated Emergency Preparedness Plan annually. B. This training will be monitor and documented monthly and staff will show competence for evacuation drills. C. Site Supervisor will monitor and document this monthly. D. Qualified Professional will monitor and document on this monthly E. Management will monitor and document this monthly while conducting site review.	05.27.2022

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E 036	Continued From page 7 and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This STANDARD is not met as evidenced by: Based on interviews and review of the facility's	E 036		

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E 036	Continued From page 8 emergency preparedness (EP) plan, the facility failed to ensure staff were adequately trained on the facility EP plan. The finding is: Review on 3/28/22 of the EP revealed no training of direct care staff on the facility's EP plan. Interview on 3/29/22 with the Site Supervisor (SS) revealed that she did not have any documentation of training for staff on the EP. Interview on 3/29/22 with the acting Qualified Intellectual Disabilities Professional (QIDP) revealed monthly training on the EP for staff should be incorporated. Human Resources should retain copies of the EP training.	E 036		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- This STANDARD is not met as evidenced by: Based on record review and interviews, the Qualified Intellectual Disabilities Professional (QIDP) failed to coordinate and monitor the active treatment program for 2 of 5 audit clients (#1 and #3). The findings are: A. Review on 3/29/22 of client #1's record revealed his last vision examination was completed on 5/18/21. Additional review of the examination report noted under Diagnosis, " (1) Optic atrophy - longstanding stable (2) Cataract Right eye - consider surgery, would need approval from POA and general anesthesia...Recommendations: Call POA to discuss possible cataract surgery Right eye..." No	W 159		

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W 159	Continued From page 9 additional information regarding client #1's possible cataract surgery was included in the record. Interview on 3/29/22 with the Site Supervisor (SS) revealed client #1's guardian had given verbal consent for the surgery; however, the doctor's office required "written consent". Additional interview indicated the QIDP was responsible for obtaining written consent from client #1's guardian; however, the consent for the surgery had not been obtained as of the date of this survey. B. Review on 3/29/22 of client #3's record revealed a Nutritional Evaluation completed by the Registered Dietitian (RD); weight is 149 lb, which is noted weight loss x 1 year, some of which may be related to gall bladder removal. He is within his adjusted targeted weight range (TWR) 145-165 lb. Monitor weight trends closely. Healthy weight and safe po intake are nutritional goals. Continue regular calorie, seconds ok. Add Boost VHC 1 container daily po for nutritional support. Review on 3/29/22 of client #3's record revealed a Nutritional Evaluation completed by RD on 7/1/21; weight is 195 lb on 7/1/20. Client #3 is above TWR 165-185 lb. Change diet to 1800 calorie, all food cut into bite size pieces for safety. Monitor weights, labs and po intake. An additional review on 3/29/22 of client #3's record revealed no additional information from the RD regarding weight loss. On 3/25/22, a weekly weight recorded in the medication administration record (MAR) for client #3 was 134	W 159	W159 This deficiency will be corrected by the following actions A. All community / home life assessment will be reviewed/update and revised as needed. B. Nutritionist will complete and assessment on consumers C. Recommendations will be added based upon assessment D. Nutritional assessments will be conducted to ensure proper food consistency E. All people served will receive a nourishing, well-balanced diet including modified and specially prescribed diets. F. RN will update all monthlies and maintain them on a quarterly basis. G. All medical consents for procedures will be obtained, in writing for any consent required procedures. H. All medical procedure will be completed in a timely manner, following all recommendations of the ordering physician I. All assessment will be reviewed, and recommendations discussed in core team, quarterly, or ISP. IF a special team meeting need to take place QP will address. J. All people served will be in service on their diets and food choices K. All staff will be in-service on their diets, supplements and food choices L. RN will monitor monthly M. Qualified Professional will monitor monthly	05.27.2022

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W 159	Continued From page 10 lb. Interview on 3/29/22 with the SS revealed the QIDP never discussed diet changes or supplements with her. The SS was unaware that nutritional supplement drinks should have been ordered for client #3 after 12/27/21. The SS was unaware if anyone was monitoring client #3's diet and continual weight loss.	W 159		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all staff were sufficiently trained to secure client #6's wheelchair on the facility's van. This affected 1 of 5 audit clients. The finding is: During morning observations in the home on 3/29/22 at 8:00am, clients began loading the facility van for transport to the day program. After client #6 operated her wheelchair to position herself on the van, staff secured her wheelchair using two wheelchair tie downs attached to hooks at the rear of the chair. Although two tie downs were located on the floor of the van in front of client #6's wheelchair, no tie downs were secured to the front of the client's wheelchair. The wheelchair was not secured with a seat belt as the facility's van was not equipped with a wheelchair seat belt (or shoulder straps). Immediate interview with the Site Supervisor and	W 189	W189 *This deficiency will be corrected by the following actions* A. *Qualified person will review all ISP.* B. *Community home and life assessments will be reviewed* C. *Physical Therapist will assess appropriate equipment to safety secure wheel chairs while transporting* D. *Physical Therapist will provide guidelines for home of the appropriate way to secure wheelchairs* E. *All assistive devises/training. will be discussed in a team meeting* F. *All people served will be in service on the appropriate equipment to safety secure wheelchairs.* G. *Site Supervisor will monitor the use of equipment and its efficiency weekly* H. *Qualified Professional will monitor the use of equipment and its efficiency weekly*	05.27.2022

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W 189	Continued From page 11 Staff B revealed client #6's wheelchair only requires two tie downs to be secured to the rear of her wheelchair. Additional interview indicated the facility's van was not equipped with a seat belt for wheelchairs. Later interview with the Site Supervisor revealed the client's wheelchair should be secured using two tie downs at the front of her chair and two at the rear. Review on 3/29/22 of client #6's record revealed Physical Therapy (PT) Guidelines for Wheelchair Use dated 4/13/20. Additional review of the guidelines noted, "Once inside the van, staff should secure her wheelchair using the transit system (tie downs)...Staff should also ensure that other means of securement (shoulder strap assembly, if available) are utilized." Interview via phone on 3/29/22 with the PT revealed client #6's wheelchair should be secured to the van using four tie downs attached to the front and rear hooks on her wheelchair. Additional interview indicated she did not think the van was equipped with shoulder straps for the wheelchair but she would recommend that some be installed.	W 189		
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 interview, the facility failed to ensure the Individual Program Plan (IPP) for 2 of 5 audit clients (#1 and #2) was reviewed	W 255		

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W 255	Continued From page 12 and revised as needed after completion of an objective. The findings are: A. Review on 3/28/22 of client #1's Behavior Support Plan (BSP) dated 4/7/21 revealed an objective to display 1 or fewer episodes of agitation per month for 12 consecutive months. Additional review of monthly progress notes dated November '20 - September '21 revealed no documented episodes of agitation. Additional review of the client's behavior data collection book revealed no documented behaviors. Interview on 3/29/22 with the Site Supervisor revealed client #1 has not had any behavioral episodes that she was aware of since she began working at the home in May 2021. Interview on 3/29/22 with the Qualified Intellectual Disabilities Professional (QIDP) revealed he was not aware of any behaviors exhibited by client #1 in over a year; however, his behavior plan remains in place. B. Review on 3/28/22 of client #2's BSP dated 4/1/21 revealed an objective to exhibit 1 or fewer episodes of agitation per month for 12 consecutive months. Additional review of monthly progress notes dated March '20 - August '21 revealed no documented episodes of agitation. Additional review of the client's behavior data collection book revealed no documented behaviors. Interview on 3/29/22 with the Site Supervisor revealed client #2 has not had any behavioral episodes that she was aware of since she began working at the home in May 2021.	W 255	W.255 This deficiency will be corrected by the following actions: A. ISP will be reviewed to assess her current needs and if there are any restriction needed for safety reasons it will be documented in the ISP and behavioral support plan. B. The Qualified Professional will review all BSP plans with staff. C. All Staff will be in-served on the current BSP's and documenting incidents in the behavioral log. D. All BSP will be reviewed and revised as need to address all target behaviors. E. HRC approval and the proper consents will be obtained for all BSP's F. The Site Supervisor will monitor and document this monthly. G. The Qualified Professional will review and obtain guardian consent.	05.27.2022

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W 255	Continued From page 13 Interview on 3/29/22 with the QIDP revealed he was not aware of any behaviors exhibited by client #2 in over a year; however, his behavior plan remains in place.	W 255	W312 This deficiency will be corrected by the following actions: A. All community/ home assessment will be reviewed. B. All behavioral support plans will be reviewed. C. All Behavioral Support Plans will be updated to address the current medication regiment. D. Psychologist will review all plans. E. The IDT will meet to address any reduction or elimination of medications-based behavior documentation. F. IDT will ensure that all proper techniques will be used to manage behaviors. G. Qualified Professional will review and obtain guardian consent for a reduction or elimination of any medications. H. All guardians will be informed of any mediation changes. I. All staff will be in-service on all Behavioral Support Plans and proper documentation. J. Qualified Professional will review all behavior documentation monthly at core team meetings. K. Site Supervisor will monitor one time a week L. Qualified Professional will monitor one time a week	05.27.2022
W 312	DRUG USAGE CFR(s): 483.450(e)(2) be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the interdisciplinary team (IDT) had considered a reduction and/or elimination of restrictive behavior medications after a decrease in target behaviors was identified. This affected 1 of 5 audit clients (#2). The finding is: Review on 3/29/22 of client #2's Behavior Support Plan (BSP) dated 4/1/21 revealed an objective to exhibit 1 or fewer episodes of agitation month for 12 consecutive months. The BSP incorporated the use of Klonopin, Depakote and Zyprexa to address the client's inappropriate behaviors. Additional review of the objective's progress notes from March 2020 - September 2021 indicated the client has had zero behaviors related to this objective. Further review of client #2's current physician's orders revealed orders for Klonopin 1mg to be taken twice daily (origination date 3/10/22), Depakote 250mg, given twice per day (origination date 8/9/12) and Zyprexa 20mg, once at bedtime (origination date 11/13/20). Review of the record did not indicate the IDT had considered a reduction and/or elimination of the drugs based on the absence of	W 312		

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W 312	Continued From page 14 target behaviors over an extended period. Interview on 3/29/22 with the Site Supervisor confirmed client #2 has not had any documented or observed target behaviors since she began working at the home in May 2021. Interview on 3/29/22 with the acting Qualified Intellectual Disabilities Professional (QIDP) indicated most behavior plans remain in place in order to justify the use of behavior medications since drugs used to address a client's inappropriate behaviors must be included in a behavior plan.	W 312		
W 323	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(i) The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 5 audit clients (#2 and #4) obtained an evaluation of their vision and hearing as recommended. The findings are: A. Review on 3/29/22 of client #2's record revealed a visual examination had been completed on 4/1/19. Additional review of client #2's Individual Program Plan (IPP) dated 9/8/21 revealed "vision consults annually" and "She attends all required medical appointments." The plan noted the client's next vision examination was due April '20. Further review of the record did not reveal a visual examination had been completed since 4/1/19. Review on 3/29/22 of an email dated 3/29/22	W 323		

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W 323	Continued From page 15 from the facility's nurse confirmed client #2 had not returned for a vision examination since 4/1/19. B. Review on 3/29/22 of client #2's record revealed an audiological examination had been completed on 11/10/20. Additional review of the client's IPP dated 9/8/21 noted, "She attends all required medical appointments." The plan noted the client's next audiological examination was due April '20. Further review of the record did not reveal an audiological examination had been completed since 11/10/20. Review of an email dated 3/29/22 from the facility's nurse confirmed client #2's last audiological examination had been conducted on 11/10/20. C. Review on 3/28/22 of client #4's record revealed a visual examination was not completed after admission on 7/7/21. In additional, client #4 revealed he did not have an audiological exam performed within a month of his admission. Interview on 3/29/22 with the Site Supervisor (SS) revealed that she did not know that the vision and audiological exams had to be scheduled within 30 days of client #4's admission. The SS has since scheduled an audiological exam for 4/2/22. The SS acknowledged the vision exam had not been scheduled. Interview by phone on 3/29/22 with the Registered Nurse (RN) revealed the referrals to get vision and hearing exams were not performed after client #4's 7/7/21 admission. The RN stated she realized last month the vision exam had not	W 323	W.323 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 team will ensure appointments are schedule and follow up. D. All the appointments will be reviewed and discussed at the monthly core team/quarterlies/annual ISP. E. 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. F. Qualified Professional will consult the guardian of all medical needs and to obtain consent for treatment. G. RN will review monthly H. Site Supervisor will monitor one time a week. I. Qualified Professional will monitor one time a week	05.27.2022

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W 323	Continued From page 16 been completed so she emailed the SS, PM and QIDP twice to firmly remind them to complete the task.	W 323	W331 This deficiency will be corrected by the following actions: A. Nutritionist will assess all dietary needs of the people we serve. B. All people served will be afforded food options within their dietary needs or restrictions. C. ISP will be update modified to meet the current dietary needs D. All people served will be in service on their diets and food choices E. All physician orders and medical consults will be reviewed. F. All medical appointments will be reviewed and completed. G. All dental treatment will be received in a timely manner—follow up with recommendations will be timely H. Consumers wil have all functioning and appropriate size dentures. I. OT will assess the need for the use of adaptive equipment. J. OT will give guideline for the use of equipment K. All dental appointments will be completed and as prescribe. L. All people served will be in service on their adaptive equipment M. All physicians' orders will be reviewed for accuracy. N. RN will do a health service summary on all consumers. Documenting any weight gain or loss. O. RN will monitor all weight loss weekly	05.27.2022
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 observations, record reviews and staff interviews, the facility failed to provide nursing services in accordance with the needs of 1 of 5 audit clients (#3) relative to following recommendations by the interdisciplinary team (IDT). The findings are: A. During observations in the home on 3/28/22 at 4:00pm, client #3 consumed pudding for his afternoon snack, very rapidly. Client #3 asked the Site Supervisor (SS) for a second serving of pudding and was told no, because he was on a 1800 calorie diet and was not allowed seconds. At 4:25pm, client #3 stood next to client #6 and had taken her uneaten container of mandarin oranges and was about to eat it when the SS intervened, removing it. During the dinner observation in the home on 3/28/22 at 4:45pm, client #3 wore his dentures and rapidly ate pureed baked chicken, cooked red beans and carrots. Client #3 asked SS for more food and was told that he could not have second servings. In the kitchen hung dietary orders from 5/19/21 that revealed client #3 was on a regular 1800 calorie puree consistency diet with no second helpings. Client #3 did not receive a nutritional supplement drink during either meal.	W 331		

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W 331	Continued From page 17 During observations in the home on 3/29/22 at 7:20am, client #3 received a puree consistency breakfast. Client #3 asked Staff B and SS several times for extra food but was told no, because he was on a 1800 calories diet. Client #3 did not receive a nutritional supplement drink during the meal. Review on 3/29/22 of client #3's individual program plan (IPP) dated 8/2/21 revealed he was admitted on 6/30/20 with a body weight of 194 lb at 66". He had a history of squamous cell carcinoma on left nasal bridge, which was treated. The targeted weight range (TWR) was 165-185 lb. Interview by phone on 3/29/22 with the Registered Dietitian (RD) revealed client #3's diet was changed from a 1800 regular calorie puree consistency diet with no seconds to a regular calorie puree consistency with seconds allowed and added a nutritional drink for weight gain. Interview on 3/29/22 with the SS revealed no one told her before today that client #3 was no longer on a calorie restriction and needed to have a nutritional supplement drink to boost weight gain. The Program Manager (PM) was responsible for training the SS and the SS trained the staff. B. Review on 3/29/22 of client #3's medical record revealed an email dated 3/14/21 from the OT to the RN and Program Manager (PM), she announced client #3 was supposed to have a Barium Swallow in April. Review on 3/29/22 of a dental consult summary from 9/1/21 revealed client #3 had a sore spot from denture that caused an ulcer. The dentist	W 331	W331 (continue) *This deficiency will be corrected by the following actions:* P. *RN will assess all orders and follow up with all medical orders* Q. *All assessments, medical consult sheets, and recommendations will be reviewed, and discussed in core team, quarterly, or ISP.* R. ISP will be updated, modified to meet the current ADL around hygiene and grooming S. RN will complete Health service summaries T. RN will complete monthly Nursing notes. Addressing all medical appointments that have been completed and upcoming appointments U. All staff will be in-service on their diets and food choice V. Staff will be in-service on the appropriate e care for dentures. W. Staff will be in- serviced on the appropriate documentation if a consumers exhibits intentional or unintentional property damage. X. Site Supervisor will monitor one time a week. Y. Qualified Professional will monitor one time a week	05.27.2022

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W 331	Continued From page 18 made adjustment to dentures and recommended leaving the lower denture out of mouth except to eat. On 9/9/21, the dentist revealed client #3 who's edentulous has been restored with complete dentures. Review on 3/29/22 of an email from the OT to the RN, PM and SS on 9/28/21, revealed it was questioned if client #3 ever had the Barium Swallow and if it was still needed since the OT did not observe any coughing during his meal observation. The RN responded to the OT in an email on 9/29/21 and revealed client #3 wanted to get acclimated to his new set of dentures to explore possibly a more solid texture of intake. The fitting and fabrication of client #3's dentures was almost complete. The RN informed the team the Barium Swallow was not scheduled because she thought client #3 should see his gastrointestinal (GI) doctor first for his annual appointment and determine if the swallow study is recommended. There was no evidence that either a GI exam or Barium Swallow was scheduled. Review on 3/29/22 of a nutritional evaluation dated 12/27/21 revealed client #3 had no teeth but had tough gums. He was on a regular puree consistency for safe PO intake. Client #3 was described as usually eating well, but occasionally did not like puree consistency. Client #3 had weight loss, now weighed 149 lb which may be related to a gall bladder removal. Interview on 3/29/22 with the SS revealed client #3's original top denture was damaged because he sat on them while placed in pocket. Interview on 3/29/22 with the RN revealed client #3 had a tendency to eat too fast and overstuff	W 331		

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W 331	Continued From page 19 his mouth so the puree consistency was the safest texture for him. The RN revealed she was not sure how often client #3 wore his dentures when he ate. The RN confirmed that she did not schedule the Barium Swallow or GI consult. Interview on 3/29/22 with the RD revealed that he was unaware that client #3 has had new dentures for 6 months and was observed wearing them when he ate dinner. The RD commented client #3 could be eligible for a diet upgrade if it is determined that he has been wearing his dentures consistently. C. Review on 3/29/22 of the weekly weights recorded on MARS revealed client #3's weights have been recorded as the following: 9/20/21 at 140 lb, 11/10/21 at 125 lb, 11/17/21 at 140 lb, 12/8/21 at 125 lb, 12/15/21 at 135 lb, 12/22/21 at 128 lb, 1/26/22 at 135 lb, 2/9/22 at 130 lb, 2/23/22 at 132 lb, 3/2/22 at 110 lb and 3/9/22 at 135 lb. The order on the MAR requires for weights 3 lb more or less out of the range to be reported. Interview on 3/29/22 with the SS revealed she started working at the home on 5/1/21 and revealed that she did not notice client #3 had lost a significant amount of weight because he wore the same clothes. The SS later commented that last May, unnamed employees told her that client #3 had lost a lot of weight since his admission. The SS confirmed she was not monitoring client #3's weight and did not share any concerns with the RD or RN. The SS revealed staff always used the same scale in the medication room. The SS confirmed she did not check scale for accuracy or know how to recalibrate it.	W 331		

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W 331	Continued From page 20 Interview on 3/29/22 with the acting QIDP revealed that if staff noted that the weights did not appear to be accurate between client #3's weekly weight, staff should have weighed him again. If the second weight appeared to match the first weight, the nurse should have been notified. The nurse should inform the IDT team at their meetings and a follow up physician exam should have been scheduled to rule out any underline health problem. Interview on 3/29/22 with the RD revealed that the RN had communicated with him several times last year regarding client #3, however he did not know that client #3 had new dentures. The RD stated the RN informed him on 12/27/21 that client #3 was losing too much weight, and was told the current weight was 149 lb. The RD change client #3's diet to a regular puree consistency with seconds allowed and added a nutritional drink for weight gain. The RD was unaware that client #3 lost another 15 lbs in January 2022. The RD stated he would need to re-adjust client #3's TWR. Interview on 3/29/22 with the RN revealed she had access to the computer to review weekly weights for client #3 but did not always monitor them weekly. An additional attempt to interview the RN regarding if she informed the physician of client #3's weight loss. D. Review on 3/29/22 of a new dietary order for client #3 dated 12/27/21 however the order was not posted in the house until today when the RD emailed it to the acting QIDP. The order revealed client #3 had a diet/supplement change and was on a regular calorie diet, with seconds allowed. A	W 331		

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W 331	Continued From page 21 nutritional drink was added for daily consumption. All foods to be puree consistency for safety. Interview by phone on 3/29/22 with the RD revealed he ordered a nutritional supplement drink to be taken daily to help client #3 regain pounds from his weight loss. The RD was unaware the facility had never furnished the supplement. An interview was attempted on 3/29/22 with the nurse to discuss the nutritional supplement ordered for client #3 on 12/27/22. The nurse was not available for phone interview.	W 331		
W 336	NURSING SERVICES CFR(s): 483.460(c)(3)(iii) Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure 4 of 5 audit clients (#1, #2, #3 and #4) received an assessment of their health status at least quarterly. The findings are: A. Review on 3/29/22 of client #1's record revealed a Health Service Summary form. The form indicated assessments of their health status had been completed on 7/23/20, 10/16/20, 1/30/21, and 4/16/21. No current assessments could be located. During an interview via phone on 3/29/22 with the facility's nurse, a request for client #1's current health assessments was made. The nurse	W 336		

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W 336	Continued From page 22 indicated the most current Health Service Summary forms were in client #1's record. B. Review on 3/29/22 of client #2's record revealed a Health Service Summary form. The form indicated assessments of their health status had been completed on 8/2/20, 11/13/20, 2/17/21, and 5/6/21. No current assessments could be located. During an interview via phone on 3/29/22 with the facility's nurse, a request for client #2's current health assessments was made. The nurse indicated the most current Health Service Summary forms were in client #2's record. C. Review on 3/29/22 of client #3's record revealed a Health Service Summary form. The form indicated assessments of their health status had been completed on 5/21/21. No current assessments could be located. During an interview via phone on 3/29/22 with the facility's nurse, a request for client #3's current health assessments was made. The nurse indicated the most current Health Service Summary forms were in client #3's record. D. Review on 3/29/22 of client #4's record revealed a Health Service Summary form. The form indicated assessments of their health status had been completed on 7/7/21. No current assessments could be located. During an interview via phone on 3/29/22 with the facility's nurse, a request for client #4's current health assessments was made. The nurse indicated the most current Health Service Summary forms were in client #4's record.	W 336	W.336 This deficiency will be corrected by the following actions: A. RN will update all quartiles and maintain them on a quarterly basis. B. RN will ensure that all health care summaries are completed on all person served. C. RN will ensure that all assessments, month notes, progress notes and orders are filed in the appropriate location in the Master charts D. All assessment will be reviewed, and recommendations discussed in core team, quarterly, or ISP. IF a special team meeting needs to take place QP will address. E. RN will monitor monthly F. Qualified Professional will monitor monthly– at core team meetings	05.27.2022

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W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on record review and staff interviews, nursing services failed to ensure that staff were sufficiently trained in rechecking 1 of 5 audit clients (#4) weights for accuracy and reporting to the nurse variances of weight loss or gains. The finding is: Review on 3/29/22 of client #4's undated/unsigned physician orders revealed an order on 10/26/20 to weigh him weekly on Wednesday mornings. Instructions to report out of range weights plus or minus 3 pounds. The monthly medication administration records (MAR) from March 21 to March 22 were reviewed. The following weights were indicated on the monthly MAR: Starting weight 3/10/21 at 160 lb, recorded by Staff C. 6/30/21 weight was 163 lb, recorded by Staff C 7/7/21 weight was 150 lb, recorded by Staff C 7/21/21 weight was 142 lb, recorded by Staff C 9/20/21 weight was 140 lb, recorded by Staff A 11/10/21 weight was 140 lb, recorded by Staff B 11/17/21 weight was 125 lb, recorded by Staff B 12/8/21 weight was 125 lb, recorded by Staff B 12/15/21 weight was 135 lb, recorded by Staff B 12/22/21 weight was 128 lb, recorded by Staff B 1/19/22 weight was 128 lb, recorded by Staff B 1/26/22 weight was 135 lb, recorded by Staff B	W 340	W.340 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-serviced on medication procedure and following the guidelines for measuring and dispensing all medications. D. All medication will be dispensed within the designated time frame E. All medications will be secured all at times. F. All assessment will be reviewed, and recommendations discussed in core team, quarterly, or ISP. G. Staff will be in service on Medication Administration procedures, dispensing medication and ensuring that ll medication is secured H. RN will monitor monthly I. Site Supervisor will monitor one time a week. J. Qualified Professional will monitor monthly	05.27.2022

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W 340	Continued From page 24 2/2/22 weight was 133 lb, recorded by Staff B 2/9/22 weight was 130 lb, recorded by Staff C 2/16/22 weight was 134 lb, recorded by Staff C 2/23/22 weight was 132 lb, recorded by Staff B 3/2/22 weight was 110 lb, recorded by Staff B 3/9/22 weight was 135 lb, recorded by Staff B 3/23/22 weight was 135 lb, recorded by Staff B There was no evidence of re-weighs when there were weight discrepancies on the MAR. There was no evidence the nurse was notified for weight discrepancies on the MAR. Interview on 3/29/22 with the Site Supervisor (SS) indicated she was not aware of weight discrepancies for Client #4. The SS stated the nurse had access to the computer where the weekly weights were stored. Interview on 3/29/22 with the Registered Nurse (RN) revealed that she did not always monitor the weekly weights and did not receive any reports from Staff A, Staff B or Staff C when client #4 had a weight fluctuation of 3 pounds. The RN stated that client #4 did not have a medical condition to cause his to retain fluid and if he had large weight loss in a week, then he needed to be seen by his doctor to evaluate the cause. The RN also acknowledged the weights did not seem to be accurate and staff should have re-weighed client #4 on a balancing scale that was located in the office in the facility. Interview on 3/29/22 with the Registered Dietitian (RD) revealed in December, 21 the RN contacted him and expressed concerns that Client #4 was losing too much weight. The RD responded by removing the calorie restriction and added a daily nutritional supplement to help client #4 regain	W 340		

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W 340	Continued From page 25 weight. Interview on 3/29/22 with the acting Qualified Intellectual Disabilities Professional (QIDP) revealed that if staff noticed a weight discrepancy they were supposed to re-weigh client #4. If the weight was accurate, staff should contact the nurse, who should make a doctor's appointment to rule out an underline medical condition to cause weight loss.	W 340		
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 reviews and interviews, the facility failed to administer medication for 2 of 5 audit clients (#4 and #5). The findings are: A. During observations on 3/29/22 at 6:35am, Staff C was observed giving client #4 the following medications: Docusate Sodium 100 mg and Benztropine tab 0.5 mg. Client #4 left the medication room at 6:39am and client #5 entered the room immediately afterwards. Review on 3/29/22 of client #4's physician orders signed on 12/21/21 revealed that he should have received Paliperidone tab ER 6 mg during the 7:00am med pass. B. During observations on 3/29/22 between 6:39am-6:49am, Staff C was observed giving client #5 the following medications: Omeprazole 20 mg, Risperidone 0.5 mg, multi-vitamin,	W 369	W.369 *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-serviced on medication procedure and following the guidelines for measuring and dispensing all medications.* D. *All medication will be dispensed within the designated time frame* E. *All assessments will be reviewed, and recommendations discussed in core team, quarterly, or ISP.* F. *Staff will be in service on Medication Administration procedures* G. *RN will monitor monthly* H. *Site Supervisor will monitor one time a week.* I. *Qualified Professional will monitor monthly*	05.27.2022

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W 369	Continued From page 26 Propranolol Cap 160 mg ER and Fluoxetine Cap 20 mg. Review on 3/29/22 of client #5's physician orders signed on 1/8/21 revealed that he should have received Clobetasol Sol 0.5% during the 7:00am med pass. Interview on 3/29/22 with the acting Qualified Intellectual Disabilities Professional (QIDP) revealed that staff should follow the orders on the medication administration record (MAR).	W 369		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to ensure that medications were secured when not in use. This had the potential to effect all of the clients in the home (#1, #2, #3, #4, #5 and #6). The finding is: During morning observations in the home on 3/29/22 from 6:39am to 6:49am, Staff C left the medication storage closet open and the door to the medication room unlocked twice, to leave the room to bring clients #6 and #3 there to take their medications. Review on 3/29/22 of undated staff instructions posted in the medication room, it revealed staff should "never leave medications unattended." Interview on 3/29/22 with Staff C revealed that she was aware that the both doors should be	W 382	W.382 This deficiency will be corrected by the following actions: A. All staff will be in service on medication procedure and following the guidelines for measuring and dispensing all medications B. Staff will be in service on the importance of not leaving medication unsupervised. C. Staff will be in service on Medication Administration procedures D. RN will monitor monthly E. Residential Manager will monitor one time a week. F. Qualified Professional will monitor monthly	05.27.2022

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W 382	Continued From page 27 locked when leaving the medication room and that she did not intentionally fail to secure the medications. Interview on 3/29/22 with the Site Supervisor (SS) revealed that she also observed Staff C not securing the medications when leaving the medication room today. The SS stated she already informed Staff C that the doors needed to be locked when away from the area. Interview on 3/29/22 with the acting Qualified Intellectual Disabilities Professional (QIDP) revealed staff were expected whenever leaving medications, to secure them under lock and key. Interview by phone on 3/29/22 with the Registered Nurse (RN) revealed staff were expected to never leave medications in the med room unattended.	W 382		
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) and under varied conditions to- This STANDARD is not met as evidenced by: Based on document review and interviews, the facility failed to ensure fire drills were conducted at varying times and conditions. This potentially affected all clients residing in the home (#1, #2, #3, #4, #5 and #6). The finding is: Review on 3/28/22 of facility fire drill reports for April 2021-March 2022 revealed the following: First Shift Drills 7/?/21 at 7:10am 9/8/21 at 7:15am 10/5/21 at 7:20am	W 441		

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W 441	Continued From page 28 Second Shift Drills 4/10/21 at 3:30pm 5/14/21 at 3:05pm 5/15/21 at 4:30pm 9/14/21 at 3:00pm 10/30/21 at 3:45pm 11/25/21 at 4:40pm 12/15/21 at 3:30pm 1/14/22 at 3:40pm 2/16/22 at 3:45pm 3/14/22 at 3:00pm Third Shift Drills 5/23/21 at 10:45pm 6/23/21 at 11:15pm 10/20/21 at 11:00pm 2/7/22 at 11:30pm 3/3/22 at 11:00pm Further record review revealed no evidence of drills held being conducted at varied times on any shift. Interview on 3/29/22 with the Site Supervisor (SS) revealed that she allowed the staff on duty to decide when the drills were conducted. The SS also acknowledged she was unaware that the drills should be conducted under varying conditions, especially while clients slept. Interview on 3/29/22 with the acting Qualified Intellectual Disabilities Professional (QIDP) revealed the Program Manager (PM) was responsible for training the SS how to conduct fire drills; the SS was then responsible for training the direct care staff. The acting QIDP stated that every month the safety committee reviewed the fire drills reports to monitor that variances are	W 441	W.441 This deficiency will be corrected by the following actions: A. Fire drill will be conducted in the home B. Fire drills will be conducted with appropriate documentation, at varied times on 1st, 2nd, and 3rd shifts including weekends C. Fire drill will be conducted monthly D. Disaster Drill will be conducted monthly E. Site Supervisor will monitor one time a week. F. Qualified Professional will monitor one time a week	05.27.2022

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W 441	Continued From page 29 done. The acting QIDP stated drills should not be done only at the beginning or end of the shift.	W 441		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.460(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure 2 of 5 audit clients (#1 and #3) received a modified diet as prescribed. The findings are: A. During observations at the day program on 3/28/22 at 1:10pm, staff served client #1 a whole slice of cake with frosting. Client #1 consumed 3/4 of the cake before throwing the remaining portion into the trash can. Client #1 consumed the cake without difficulty. During dinner observations in the home on 3/28/22 at 4:40pm, client #1 was assisted by Staff A to puree his food (baked chicken with the skin-on, kidney beans and carrots) in a food processor. Once finished, the chicken was moist and lumpy with visible bits of chicken and the beans were watery with visible bits of beans. Client #1 consumed the food without difficulty. Interview on 3/28/22 with three day program staff revealed client #1 consumes a pureed food consistency and his lunches usually come pureed from home. Additional interview indicated the staff who normally works with client #1 was off today.	W 460	W.460 This deficiency will be corrected by the following actions: A. Nutritionist will complete and assessment on consumers B. Recommendations will be added based upon assessment C. Nutritional assessments will be conducted to ensure proper food consistency D. All nutritional assessments will be provided based upon the recommendation of the nutritionist. E. All people served will receive a nourishing, well-balanced diet including modified and specially prescribed diets. F. All staff will be in service on Food consistency orders G. Clinical Manager will review all Diet in Core team H. RN will ensure all orders are current, added to health care summary and address any weight fluctuations. I. Site Supervisor will monitor one time a week. J. Clinical Manager will monitor one time a week	05.27.2022

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W 460	Continued From page 30 Additional interview on 3/28/22 with Staff A revealed client #1 consumes a pureed diet and his food should look like "mashed potatoes". Review on 3/28/22 of client #1's Individual Program Plan (IPP) dated 4/7/21 revealed the client consumes a "Regular, pureed" diet. Additional review of the client's current physician orders noted his diet should be, "Pureed with regular liquids." Additional observation/review on 3/28/22 of pictures of "Texture Modified Diets" posted in the kitchen of the home noted over a picture of pureed food "Blended Smooth". Interview on 3/29/22 with the Site Supervisor confirmed pureed foods should look like "baby food". Interview on 3/29/22 with the Dietitian confirmed client #1 consumes a pureed food diet and his food consistency should be posted in the kitchen of the home. B. During observations at the home on 3/28/22 at 4:45pm, client #3 was presented with a plate of regular kidney beans, sliced cooked carrots and baked chicken. Client #3 was wearing a set of dentures and began to eat his food when the SS informed Staff A that client #3's meal was supposed to be pureed. Client #3 insisted that he was alright eating the food as it was served, however the acting QIDP instructed both Staff A and the SS the meal for client #3 had to a pureed consistency, per his order. Client #3 accompanied Staff A to the kitchen and the chicken was cut off the bone, with skin intact and	W 460		

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W 460	Continued From page 31 placed in a food processor, to be blended. The chicken was moist and had a lumpy texture. The kidney beans were blended until a runny texture. Client #3 consumed the food without difficulty. An additional observation during the survey 3/28/22 to 3/29/22 revealed client #3 was not offered a nutritional supplement drink during breakfast, dinner or two snack observations. Review on 3/28/22 of client #3's dietary orders dated 5/19/21 revealed a 1800 calorie regular diet of pureed consistency with no second helpings allowed. An additional review on 3/29/22 revealed the Registered Dietician (RD) had changed client #3's dietary orders. Client #3 no longer had calorie restrictions, could receive seconds and should receive one container of a nutritional drink daily. His food remained on a pureed consistency. Interview on 3/28/22 with the SS revealed client #3 has been on a pureed diet since last year. The SS revealed client #3 was on a pureed diet because he ate fast and did not consistently wear his dentures. An additional interview with the SS revealed that she was unaware that client #3 had dietary change on 12/27/21. Interview on 3/29/22 with the register nurse (RN) revealed March 2021 the team met and decided to downgrade client #3's bite size pieces diet to pureed because he ate too fast. The team wanted client #3 to have a Barium Swallow study to evaluating his chewing and swallowing but it was never scheduled; and client #3 was kept on a pureed diet. Interview on 3/29/22 with the RD revealed he was contacted by the RN in December 2021 who	W 460		

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W 460	Continued From page 32 expressed concern that client #3 was losing too much weight. The RD was told client #3's current weight was 149 lb. The RD added a nutritional supplement drink to add calories for weight gain, he also eliminated the 1800 calories diet. The RD stated that he sent an email of the new dietary orders on 12/28/21 to the RN and Qualified Intellectual Disabilities Professional (QIDP). The RD further stated that he kept client #3 on a puree diet because he was unaware that client #3 received new dentures six months ago. The RD said it would be possible to re-evaluate client #3's denture use and upgrade his diet since he has experienced a significant weight loss of 10%.	W 460		
W 508	COVID-19 Vaccination of Facility Staff CFR(s): 483.430(f)(1)-(3)(i)-(x) § 483.430 Condition of Participation: Facility staffing. (f) Standard: COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. (1) Regardless of clinical responsibility or client contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its clients: (i) Facility employees; (ii) Licensed practitioners;	W 508	W,508 This deficiency will be corrected by the following actions: A. The facility will develop and maintain policy and procedures addressing person who have not completed a primary vaccination service for COVID-19 A. Strategies will be implemented addressing the COVID-19 emergency situations. B. Staff will be in in serviced on the emergency preparedness plan C. A process will be put in place to address collecting and tracking the COVID-19 vaccinations status. D. The plan will include contingency plans for staff who are not fully vaccinated. E. The policy will include how the organization will track the vaccination status of staff with a temporary delay in obtaining their vaccination F. Management will implement G. Management will have the plan updated annually.	05.27.2022

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G225	A. BUILDING _____ B. WING _____	03/29/2022

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

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W 508	Continued From page 33 (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its clients, under contract or by other arrangement. (2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with clients and other staff specified in paragraph (f)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with clients and other staff specified in paragraph (f)(1) of this section. (3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (f)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its clients; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of	W 508		

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W 508	Continued From page 34 all staff specified in paragraph (f)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be	W 508		

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W 508	Continued From page 35 temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: (ii) A process for ensuring that all staff specified in paragraph (f)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop policies and procedures which include a process for tracking staff with temporary delays with obtaining their COVID-19 vaccination and contingency plans for staff who are not fully vaccinated for COVID-19. The findings are: A. Review on 3/28/22 of the facility's COVID-19 vaccination policy for employees (dated 1/28/22) did not include a contingency plan for staff that are not fully vaccinated, will not get vaccinated and do not qualify for an exemption. Interview on 3/29/22 with the Associate Executive Director (AED) confirmed the facility's current COVID-19 vaccination policy for employees did not include a contingency plan for unvaccinated staff who do not qualify for an exemption.	W 508		

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W 508	Continued From page 36 B. Review on 3/28/22 of the facility's COVID-19 vaccination policy for employees (dated 1/28/22) did not include a process for ensuring the tracking and secure documentation of the vaccination status for staff if their vaccination must be delayed. Interview on 3/29/22 with the AED confirmed the facility's current COVID-19 vaccination policy for employees did not include a process for tracking the vaccination status of staff with a temporary delay in obtaining their vaccination.	W 508		