STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G218	A. BUILDING _____ B. WING _____	06/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-OBIE	322 OBIE DRIVE DURHAM, NC 27713

(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 037	EP Training Program CFR(s): 483.475(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) 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. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures.	E 037		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 037	Continued From page 1 (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) 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. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under	E 037		

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E 037	Continued From page 2 arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) 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 role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) 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. (ii) Provide emergency preparedness training at least every 2 years.	E 037		

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E 037	Continued From page 3 (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and 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 guests, 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	E 037		

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E 037	Continued From page 4 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 years. This STANDARD is not met as evidenced by: Based on interviews and record review the facility failed to ensure direct care staff in the home were adequately trained on the facility's emergency plan (EP). This potentially affected all clients residing in the facility (#1, #2, #3, #4, and #5) The finding is: Review on 6/21/22 of the facility's EP plan dated 3/1/21 revealed there was general pandemic information with no mention of Covid-19 information. No staff training documentation for the full EP plan or Covid-19 could be located. Review on 6/22/22 of the facility's Covid-19 policy dated 1/28/22 revealed relevant information for prevention and precautions. No staff training documentation could be located. During an interview on 6/21/22, the home manager (HM) stated that all staff had been trained on Covid-19 preventive measures and facility policy. During an interview on 6/22/22, the Qualified Intellectual Disabilities Professional (QIDP) stated that staff had been trained on Covid-19 policy and procedures. The QIDP could not provide documentation of staff training for Covid-19 policy and procedures.	E 037		

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E 039	EP Testing Requirements CFR(s): 483.475(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by	E 039		

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E 039	Continued From page 6 a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using	E 039		

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E 039	Continued From page 7 a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.	E 039		

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E 039	Continued From page 8 *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):]	E 039		

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E 039	Continued From page 9 (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to	E 039		

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E 039	Continued From page 10 test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that	E 039		

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E 039	Continued From page 11 is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.	E 039		

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E 039	Continued From page 12 (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared	E 039		

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E 039	Continued From page 13 questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This STANDARD is not met as evidenced by: Based on document review and interviews, the facility failed to ensure facility/community-based or tabletop exercises to test their Emergency Preparedness (EP) plan were conducted. This potentially affected all clients residing within the home (#1, #2, #3, #4, and #5). The finding is: Review on 6/21/22 of the facility's EP plan, did not include a full-scale community-based or tabletop exercise for 2021, which included all staff working in the home.	E 039		

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E 039	Continued From page 14 During an interview on 6/22/22, the Qualified Intellectual Disabilities Professional (QIDP) stated that the EP book contained information relevant to the emergency plan; however, no tabletop exercise could be located.	E 039		
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure privacy for 1 of 5 audit clients (#2) residing in the home. The finding is: During afternoon observations in the home on 6/21/22 at 4:45pm, client #2 was seen exiting the bathroom without any clothes on. Further observations revealed client #2 went into his bedroom, where the door remained opened as he got dressed. Additonal observations revealed as client #2 was exiting the bathroom, there was one staff and another client in the kitchen, which is in direct view of the hallway where the bathroom and client #2's bedroom is. During an interview on 6/21/22, Staff A stated client #2 knows how to independently close doors for his privacy. Staff A was able to show the surveyor client #2's bathrobe, which was hanging in his closet. During an interview on 6/21/22, the Home Manager (HM) stated client #2 requires verbal prompting to close doors for his privacy. During an interview on 6/22/22, the Qualified	W 130		

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W 130	Continued From page 15 Intellectual Disabilities Professional (QIDP) stated at times client #2 will close doors independently and other times he will need a verbal cue.	W 130		
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 staff were sufficiently trained in the area of safety. This potentially affected all clients (#1, #2, #3, #4 and #5) residing in the home. The findings are: A. During morning observations in the home on 6/22/22 Staff D exited the group home and closed the door at 5:44am and did not return until 5:46am. The two surveyors where left in the home with no other staff, while clients #1, #2, #3, #4 and #5 were in the home at the time. During an interview on 6/22/22, the Home Manager (HM) stated Staff D should not have exited the home and left the two surveyors alone in the home with the clients. During an interview on 6/22/22, the Qualified Intellectual Disabilities Professional (QIDP) revealed Staff D should not have left the two surveyors alone in the home with the clients. B. During morning observations in the home on 6/22/22 at 8:12am, three clients were observed sitting on the van alone with no supervision from staff. The staff were inside of the home while the	W 189		

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W 189	Continued From page 16 three clients where on the van. Further observations revealed the van was running while the three clients where sitting on it. During an interview on 6/22/22, the HM revealed staff have been trained not to leave any clients alone on the van; whether it is running or not. During an interview on 6/22/22, the QIDP stated staff are aware they should not leave any clients on the van alone.	W 189		
W 213	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(ii) The comprehensive functional assessment must identify the client's specific developmental strengths. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 3 of 5 audit clients (#2, #3 and #5) Community/Home/Life Skills Assessments had been done. The finding are: A. Review on 6/22/22 of client #3's Individual Program Plan (IPP) dated 2/15/22 revealed he was admitted to the facility on 7/6/10. Further review revealed client #3 does not have a Community/Home Life Skills Assessment. B. Review on 6/22/22 of client #5's IPP dated 9/24/21 revealed he was admitted to the facility on 7/10/10. Further review revealed client #5 does not have a Community/Home Life Skills Assessment. C. Review on 6/22/22 of client #2's Individual Program Plan (IPP) dated 12/1/21 revealed he	W 213		

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W 213	Continued From page 17 was admitted to the facility on 6/30/94. Further review revealed client #2 does not have a Community/Home Life Skills Assessment. During an interview on 6/22/22, the Qualified Intellectual Disabilities Professional (QIDP) confirmed clients #2, #3 and #5 do not have a current Home/Life Skills Assessment.	W 213		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 2 of 5 audit clients (#2 and #3) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of dining skills. The findings are: A. During dinner observations in the home on 6/21/22 at 5:08pm, client #3 began eating ground beef which was loose on his plate with his fingers twelve times. Further observations revealed client #3 had a spoon and fork at this place setting. At no time was client #3 redirected to use his utensils.	W 249		

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W 249	Continued From page 18 During an interview on 6/21/22, the Home Manager (HM) stated the client #3 can use a spoon and fork to eat. During an interview in 6/22/22, the Qualified Intellectual Disabilities Professional (QIDP) revealed client #3 needs verbal prompts to use his utensils. B. During observation on 6/21/22 at 4:59pm, Staff C was observed cutting client #2's food, consisting of taco and salad, at the dining table. The taco was cut into 1/4" to 3" pieces. At 5:01pm, client #2 began eating his food with no beverage and no staff sitting beside him. Staff C stood to the left of client #2 and prompted client #2 to slow down for a total of three times. At 5:04pm, client #2 noticeably coughed on his taco and Staff C offered a juice beverage. The home manager (HM) then prompted client #2 to drink his beverage. No staff was observed to report the coughing to a supervisor. Client #2 finished his taco and salad at 5:06pm (five minutes from beginning) and asked for a second taco. At 5:06pm, Staff A was observed cutting client #2's second taco on his plate at the dining table. Staff A then sat beside client #2 to prompt client #2 for drinking liquids and slowing his pace while eating. During breakfast observation on 6/22/22 at approximately 7:30am, Staff D assisted client #2 to cut his food, consisting of waffles, eggs, and watermelon, in the kitchen. The waffles were cut into 2" to 3" pieces. At 7:41am, client #2 was seated at the dining table with his food items and beverages to begin eating . No staff sat beside him. The home manager stood two seats away	W 249		

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W 249	Continued From page 19 from client #2 and prompted client #2 to slow his pace while eating and drink beverages. Review on 6/22/22 of client #2's Safe Dining Guidelines revealed: All food must be finely chopped to 1/4" maximum All food must be chopped in kitchen prior to bringing food to table Staff must ensure slowing down pace of eating with small bites Staff must ensure alternate bites of solids and liquids are consumed Staff may need to physically prompt to slow pace if necessary Staff should report any coughing or choking to the supervisor Interview on 6/21/22 with the home manager (HM) revealed that client #2 likes to eat fast and has to be reminded to slow down. Interview on 6/22/22 with the Qualified Intellectual Disabilities Professional (QIDP) revealed that staff were trained on client #2's dining guidelines consisting of a 1500 calorie diet cut into 1/4" pieces. When asked if 1/4" was the maximum sized pieces for safety, the QIDP confirmed that this was the appropriate size. The QIDP agreed that food should be cut in the kitchen and that staff should closely monitor.	W 249		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by:	W 263		

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W 263	Continued From page 20 Based on record review and interview, the facility failed to ensure restrictive programs were conducted with the written informed consent of a legal guardian. This affected 5 of 5 audit clients (#1, #2, #3, #4, and #5). The findings are: A. Review on 6/21/22 of client #1's BSP date unknown revealed there was no signed consent by the guardian. Further review revealed client #1's behavior medication is: Invega Sustenna 25mg. B. Review on 6/21/22 of client #3's BSP dated 2/15/22 revealed there was no signed consent by the guardian. Further review revealed client #3's behavior medications are: Luvox CR 15mg, Clonidine 0.1mg and Zyprexa 10mg. C. Review on 6/21/22 of client #4's BSP dated 3/21/22 revealed there was no signed consent by the guardian. Further review revealed client #4's behavior medications are Depakote 250mg, Abilify 30mg and Hydroxyzine 25mg. D. Review on 6/21/22 of client #5's chart revealed he does not have a Behavior Support Plan (BSP) in place. Further review revealed client #5's behavior medications are: Intuniv 1mg, Xanax 10mg and Zyprexa 10mg. E. Review on 6/22/22 of client #2's BSP dated 12/1/21 revealed there was no signed consent by the guardian. Further review revealed client #2's behavior medications are Quetiapine ER 100 mg every morning, Quetiapine ER 100mg every evening, Quetiapine ER 200mg every afternoon, Venlafaxine ER 150 mg every morning, and Lorazepam 2mg prior to dental visits.	W 263		

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W 263	Continued From page 21 During an interview on 6/21/22, the Qualified Intellectual Disabilities Professional (QIDP) confirmed clients #1, #2, #3, #4 and #5 records did not include updated BSP consents, which were signed and dated by their guardians.	W 263		
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 observations, documentation and interview, nursing services failed to ensure that staff were sufficiently trained in the proper medication administration of pills, the wearing of face masks and of taking their temperature. This potentially effected all clients (#1, #2, #3, #4 and #5) residing in the facility. The findings are: A. During morning observations in the home on 6/21/22 at 10:16am, a chair in the office/medication room was relocated to the other side of the room and the surveyor noticed a orange colored pill with "I 2" stamped on it laying on the floor. Further observations revealed it was Quetiapine 200mg for client #2 and according to the physician's orders it is to be given in the afternoon. During an interview on 6/21/22, Staff A stated she did assist with medication administration on 6/20/22. Further interview revealed Staff A does hand over hand with client #2 to ensure he does	W 340		

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W 340	Continued From page 22	W 340		

not drop any of his pills during his medication administration. When asked Staff A stated, she was unsure when the pill was dropped or how long it had been on the floor.

Review on 6/21/22 of the bubble pack for client #2's Quetiapine 200mg revealed there was not a extra pill that was punched out for the month of June.

During an interview on 6/21/22, the Qualified Intellectual Disabilities Professional (QIDP) stated he believed client #2's Quetiapine 200mg discovered on the floor was from 6/20/22.

B. During observations at the home on 6/21/22 from 3:30pm to 5:30pm, Staff C was observed wearing a surgical mask as he prepared dinner and served in dining area. At no time did he wear a N95 mask.

Review on 6/21/22 of the facility staff vaccine status revealed that Staff C was unvaccinated but had received an exemption.

Review on 6/21/22 of the facility Covid-19 Policy dated 1/28/22 revealed that all staff who are unvaccinated, regardless of approved exemption status and providing client care will wear a NIOSH approved N95 mask at all times unless staff are eating or drinking.

Interview on 6/21/22 with the home manager revealed that all staff take Covid precautions. When asked what the expectation was for staff who had been exempt from the vaccine, she stated that exempt staff should wear N95 masks. The home manager then stated that she thought Staff C had gotten his shots after his exemption

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W 340	Continued From page 23 and "that is why he was wearing a mask like everyone else". Interview on 6/22/22 with the QIDP revealed that unvaccinated staff should wear N95 masks. When asked if staff had been trained on the facility Covid policy, the QIDP stated that staff had been trained. When asked to verify with training materials or inservice records, he could not. When asked to resubmit vaccination for Staff C, the QIDP only provided an approved exemption form. C. During observations at the home on 6/22/22 at 5:45am, Staff B entered the home at the beginning of shift without stopping to complete temperature check in. Staff B was observed walking directly to the front den area and picking up the home phone. Staff B then walked briefly to kitchen area before entering the front office to prepare for med pass. At no time did Staff B complete temperature check in. Review on 6/21/22 of the facility Covid-19 Policy dated 1/28/22 revealed that all staff who work or enter an ICF home, regardless of vaccination status, will self-screen daily, including temperature monitoring, before beginning work with clients and document the results. Interview on 6/22/22 with the home manager revealed that preventative measures included washing hands, wearing masks, and daily temperature checks. When asked if all staff were trained to check temperatures daily, the home manager replied yes. Interview on 6/22/22 with the QIDP revealed that staff should perform daily temperature checks	W 340		

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W 340	Continued From page 24 before working. When asked if staff had been trained in Covid-19 prevention and policy, he replied yes. When asked if he could locate training or inservice records, he could not.	W 340		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure medications were administered in compliance with physician's orders. This affected 1 of 5 audit clients (#5). The finding is: During morning medication administration in the home on 6/22/22 at 7:29am, client #5 consumed nine pills. Further observations revealed client #5 did not receive any other medications. During an interview on 6/22/22, Staff B stated she gave all of client #5's medications which are on the electronic Medication Administration Record (MAR). Review on 6/22/22 of client #5's physician's orders (not signed) indicated he also gets the following medications in the morning: Polyeth Glyc Powder and Fluticasone Nasal 50mcg. During an interview on 6/22/22, management staff confirmed client #5 should have received the Polyeth Glyc Powder and Fluticasone Nasal Spray during his morning medication administration.	W 368		
W 441	EVACUATION DRILLS	W 441		

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W 441	Continued From page 25 CFR(s): 483.470(i)(1) and under varied conditions to- This STANDARD is not met as evidenced by: Based on review of fire drill reports and interviews, the facility failed to ensure fire evacuation drills were conducted at varied times. This affected all clients (#1, #2, #3, #4, and #5) residing in the home. The finding is: Review on 6/21/22 of the facility's fire drill reports revealed there were no fire drills conducted July, August, September, November and December 2021 and January, February, March and May 2022. During an interview 6/22/22, the Qualified Intellectual Disabilities Professional (QIDP) revealed he was unaware there where no fire drills conducted during the stated months in 2021 and 2022.	W 441		
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a sanitary environment was provided to avoid transmission of possible infections and prevent possible cross-contamination. This potentially affected all the clients residing in the home (#1, #2, #3, #4 and #5). The finding is: During morning medication administration in the home on 6/22/22 Staff B used a hand held digital	W 455		

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W 455	Continued From page 26 thermometer at 7:11am, 7:19am and 7:30am on three different clients. Further observations revealed Staff B slid the digital thermometer across the forehead of each of the three clients. Additional observations revealed at no time was the digital thermometer cleaned between the three clients. During an interview on 6/22/22, Staff B stated she did not know why she did not clean the digital thermometer between the three clients. During an interview on 6/22/22, the Home Manager (HM) stated the digital thermometer should have been cleaned between the three clients. During an interview on 6/22/22, the Qualified Intellectual Disabilities Professional (QIDP) confirmed the digital thermometer should have been cleaned between the three clients.	W 455		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 1 of 5 audit clients (#2) received their specialty-prescribed diet as indicated. The finding is: During observations at the home on 6/21/22 at 4:59pm, client #2 was observed eating a taco and salad. The taco and salad were cut into 1/4" to 3"	W 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G218	A. BUILDING _____ B. WING _____	06/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-OBIE	322 OBIE DRIVE DURHAM, NC 27713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 460	Continued From page 27 pieces. During the observation, client #2 coughed one time as he ate and was offered a beverage. During breakfast observations on 6/22/22 at 7:40am, client #2 was observed eating waffles, syrup, watermelon and eggs. The waffles were cut into 2" to 3" pieces. During the observation, client #2 coughed at the end of his meal, after finishing his food items. Review on 6/21/22 of client #2's individual program plan (IPP) dated 12/1/21 revealed client #2's prescribed diet to be 1500 calories, with all food cut into bite-sized pieces (1/4") and reminders to slow pace of eating. Review on 6/22/22 of Safe Eating Guidelines revealed that client's 2's food should be finely chopped into 1/4" maximum pieces. Further review of updated nutrition evaluations dated 3/12/22 confirmed that client #2's prescribed diet to be 1500 calories with food finely chopped to 1/4" inch maximum. Interview on 6/21/22 with the home manager revealed that client #2's food should be cut into 1/4" pieces. Interview on 6/22/22 with the Qualified Intellectual Disabilities Professional (QIDP) revealed that staff had been trained on client #2's prescribed diet. When asked about client #2's prescribed texture, the QIDP stated that his food should be cut into 1/4" pieces. When asked if this was the maximum size, the QIDP confirmed that 1/4" was the maximum size for client #2.	W 460		