PRINTED: 01/14/2022
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
	34G282	A. BUILDING _____ B. WING _____	01/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-LAURELWOOD	200 LAURELWOOD DR SMITHFIELD, NC 27577

(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 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure client #6 had the right to personal privacy and dignity regarding the use of incontinence padding. This affected 1 of 4 audit clients. The finding is: During morning observations in the home on 1/13/22 at 9:20am, client #6 was reclined in a chair with a large incontinence pad positioned underneath her and spread across the width of the chair's seat. The incontinence pad was visible to anyone in the home. Review on 1/13/22 of client #6's Community/Home Life Assessment dated 3/1/21 revealed the client requires physical assistance to ensure her privacy and to indicate her need to be toileted. Additional review of the client's Rights Acknowledgement form (signed 3/1/21) noted she has the "right to a humane treatment environment in which personal dignity and self-esteem are promoted." Interview on 1/13/22 with the Home Manager (HM) revealed the incontinence padding had been positioned underneath client #6 because she has heavy urination. The HM acknowledged using the padding in this manner could be a dignity issue.	W 125	W125 This deficiency will be corrected by the following actions: A. All community/ home assessment will be reviewed to look at all current needs of persons served. B. Team will address all privacy issues via written training program. C. All person served will be afforded the opportunity for privacy. D. Adequate supervision will be provided for consumers to ensure privacy of personal items E. staff will be in-service on ensuring that all consumers are being monitored, assess, and provided active treatment and privacy F. Site Supervisor will monitor on time a week. G. Qualified Professional will monitor one time a week.	03.13.2022
W 252	PROGRAM DOCUMENTATION	W 252		

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

Cynthia Bradford Asso. Executive Director 1/25/2022

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

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W 252	Continued From page 1 CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure data relative to the accomplishment of Individual Program Plan (IPP) objectives was documented in measurable terms. This affected 2 of 4 audit clients (#1 and #3). The findings are: A. Review on 1/12/22 of client #3's record revealed a Physical Therapy (PT) annual review dated 7/16/20 which included recommendations to complete seated exercises for her legs, dowel/arm and leg exercises, dowel/exercise video (in sitting position) and group exercises. The review also identified positioning/repositioning options such as sitting in her wheelchair (upright or tilt), transfer to bed, transfer to recliner, exercises, toileting or shower. The evaluation noted the client should "continue exercise program...positioning and repositioning program" Additional review of the exercise log sheet noted, "Staff should encourage [Client #3] to perform 5 to 10 repetitions of each exercise...Staff should encourage [Client #3] to perform exercises daily for her to achieve optimum benefit from exercise." Further review of the client's positioning/repositioning sheet indicated, "As a general guideline - reposition should occur every two hours or more frequently when compromised skin due to pressure is	W 252	W.252 This deficiency will be corrected by the following actions: A. All ISP'S WTP will be reviewed and revise as needed for all Physical Therapy (PT) needs to ensure objectives of are in place regarding need of consumer B. Physical Therapy (PT) will assess consumers for continued need of exercise services. C. Qualified Professional will ensure that all data collected has been reviewed. D. ISP/WTP will be update modified to meet the data collected. E. All WTP will be revised, updated or discontinued if objectives have been met F. All people served will be in service on their WTP G. All staff will be in- service on their WTP objectives and desired outcomes. H. Site Supervisor will monitor one time a week. I. Qualified Professional will monitor one time a week.	03.13.2022

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W 252	Continued From page 2 noted." Review of client #3's record and training book revealed the exercises and positioning/repositioning were last documented in May 2020. The record and training book did not include any current documentation for the client's exercise program. Interview on 1/13/22 with Staff A revealed the client's exercises were done on 2nd shift. Interview on 1/13/22 with the Home Manager (HM) indicated client #3's exercises are being done by staff; however, they are not being documented on paper or in their new electronic system. B. Review on 1/12/22 of client #1's record revealed a PT annual review dated 1/16/20 which included recommendations to complete exercises using a restortor/pedlar (for upper extremities) and stationary bike (for lower extremities) and walking. Additional review of the client's exercise log sheet noted, "Staff should document [Client #1's] participation on the monthly exercise program log." Further review of the record and training book did not reveal any documentation for participation in the client's exercise program. Interview on 1/13/22 with Staff A revealed the client's exercises were done on 2nd shift. Interview on 1/13/22 with the HM indicated client #1's exercises were usually done at the day program but since he has not been attending the day program his exercises are completed using a pedlar device located in the home. The HM noted the exercises are being done; however,	W 252		

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W 252	Continued From page 3 they are not being documented on paper or in their new electronic system.	W 252		
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 client #4's Individual Program Plan (IPP) was reviewed and revised as needed after completion of an objective. This affected 1 of 4 audit clients. The finding is: Review on 1/12/22 of client #4's Behavior Support Plan (BSP) dated 10/6/21 revealed objectives to exhibit 1 or fewer episodes of agitation per month for 12 consecutive months and to exhibit 1 or fewer episodes of Pica per month for 12 consecutive months. Additional review of monthly BSP progress notes dated October '20 - November '21 revealed no documented episodes of Pica. Interview on 1/13/22 with the Home Manager revealed client #4 has not had any episodes of Pica that they were aware of. Interview on 1/13/22 via phone with the Qualified Intellectual Disabilities Professional (QIDP) indicated Pica was added to client #4's BSP around October 2020 after she attempted to consume an inedible object. Additonal interview indicated no further Pica incidents had been	W 255	W.255 This deficiency will be corrected by the following actions: A. ALL ISP will be reviewed and revised as necessary. B. ALL BSP will be reviewed and revised as necessary. C. All behavioral objectives will meet the needs of the person being served. D. All behavioral documentation will be reviewed E. All rights will be reviewed F. If there are any rights restrictions, they will be presented to HRC. G. All behaviors will be documented H. All staff will be in serviced on recording behavioral documentation I. Site Supervisor will monthly weekly J. Clinical Manager will monitor weekly K. Clinical manager will assess all behavioral documentation monthly	03.13.2022

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W 255	Continued From page 4 noted since then.	W 255		
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: Based on record review and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 1 of 4 audit clients (#1). The finding is: Review on 1/12/22 of client #1's Behavior Support Plan (BSP) dated 10/6/21 revealed an objective to exhibit 1 or fewer episodes of self-injurious behavior per month for 12 consecutive months and to display 1 or fewer episodes of non-compliance per month for 12 consecutive months. The BSP incorporated the use of Zyprexa, Cofentin, Tegretol, Celexa, Neurontin and Prolixin. Additional review of the record did not include written informed consent from the guardian for client #1's restrictive BSP. Interview on 1/13/22 via phone with the Qualified Intellectual Disabilities Professional (QIDP) revealed verbal consent had initially been obtained from the guardian on 10/6/21; however, written informed consent had not been received as of the date of the survey.	W 263	W.263 This deficiency will be corrected by the following actions A. An Addendum will be added to ISP to meet the current needs of the people being served. B. All consents will be signed and in place before the implementation of plan. C. All consents will be current and updated annual or as needed for changes in plan. D. Written consent will be obtained before implementing Plan. E. Qualified Professional will monitor monthly F. Qualified Professional will update annual or as needed	03.13.2022
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and	W 460		

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W 460	Continued From page 5 specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 3 of 4 audit clients (#3, #4 and #6) received their modified and specially-prescribed diets. The findings are: A. During breakfast observations in the home on 1/12/22 at 9:08am, client #3 and client #4 consumed sausage links, french toast sticks and applesauce. The sausage and french toast sticks were pureed with visible bits of food throughout. The food items were also dry and thick. Client #3 and client #4 consumed the breakfast meal without difficulty. During lunch observations in the home on 1/12/22 at 11:30am, client #3 and client #4 consumed pureed cold cut sandwiches, macaroni salad and pudding cups. The cold cut sandwich and macaroni salad were pureed with visible bits of food throughout. Additional observations revealed the sandwich was dry and thick while the macaroni salad was moist and chunky. Client #3 and client #4 consumed the lunch meal without difficulty. During breakfast observations in the home on 1/13/22 at 8:35am, client #3 was assisted to pour juice and water into her cups. No thickener was added to the client's liquids prior to consumption. Client #3 consumed the drinks without difficulty. Interview on 1/13/22 with Staff B revealed three clients in the home, including client #3 and client #4, are on pureed diets which is posted on a refrigerator in the kitchen. Additional interview	W 460	W.460 This deficiency will be corrected by the following actions: A. All physicians (dietary) orders will be reviewed. B. The dietitian will review all current orders, modifying as needed. C. There will be current orders for all nutritional services for the person serve records. D. All diet textures will be assessed E. The team will ensure that all orders are implemented F. All the orders will be reviewed and discussed at the monthly core team/quarterlies/annual ISP. G. There will be supporting documentation for all Orders H. All person serve will receive a well balanced diet – supporting the modified or specially - prescribed diets. I. RN will review monthly J. Site Supervisor will monitor one time a week. K. Qualified Professional will monitor one time a week	03.31.2022

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W 460	Continued From page 6 indicated they were trained to make pureed food smooth; however, some foods are more difficult to puree. Further interview revealed client #3's liquids should be thickened as well. Review on 1/12/22 of client #3's Individual Program Plan (IPP) dated 8/20/21 revealed client #3 consumes a "pureed" diet with "thickened liquids". Additional review of a Meal Consistencies list (dated 5/1/20) posted on the refrigerator in the home also indicated client #3 should receive a pureed diet and nectar thickened liquids. Review on 1/12/22 of client #4's IPP dated 10/12/21 revealed she consumes a "pureed" diet. Additional review of a Meal Consistencies list (dated 5/1/20) posted on the refrigerator in the home also indicated client #4 should receive a pureed diet and nectar thickened liquids. Interview on 1/13/22 via phone with the Qualified Intellectual Disabilities Professional (QIDP) acknowledged pureed food should be smooth and resemble "applesauce" or baby food. B. During breakfast observations in the home on 1/13/22 at 8:35am, client #6 consumed pureed cereal with milk. Interview on 1/13/22 with Staff B revealed client #6 consumes a "mechanical soft" diet and her food is not pureed. Review on 1/13/22 of client #6's IPP dated 3/2/21 and a Meal Consistencies list (dated 5/1/20) posted on the refrigerator in the home indicated the client consumes a "mechanical soft (ground)" diet.	W 460		

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W 460	Continued From page 7 Interview on 1/13/22 with the HM confirmed client #6's food is not pureed and should be mechanical soft, ground.	W 460		