STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G216	A. BUILDING _____ B. WING _____	08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-OTIS STREET HOME	2415 OTIS STREET DURHAM, NC 27707

(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 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		

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

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E 039	Continued From page 1 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 2 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 3 *[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 4 (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 5 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 6 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 7 (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 8 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 clients #1, #2, #3, #4, #5, #5 and #6. The finding is: Review on 8/23/22 of the facility's EP plan, did not include a full-scale community-based or tabletop exercise for 2021. During an interview on 8/23/22 with the home	E 039		

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E 039	Continued From page 9 manager (HM) confirmed a table top exercise had not been completed for 2021.	E 039		
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to assure the individual program plan (IPP) for 2 of 4 audit clients (#1 and #2) included objective training to meet the client's money management, meal preparation and self care needs. The findings are: A. Review on 8/22/22 of client #1's IPP dated 6/16/22 revealed she had priority training needs which included: meal preparation and self care. Further review of client #1's IPP confirmed no formal training identified in the areas of meal preparation and self-care. Interview on 8/22/22 with the qualified intellectual disabilities professional (QIDP) confirmed client #1 currently has no formal training in the areas of meal preparation and self-care. B. Review on 8/22/22 of client #2's IPP dated 5/28/22 confirmed he had priority training needs which included: dining and money management. Interview on 8/22/22 with the qualified intellectual disabilities professional (QIDP) confirmed client #2 currently has no formal training in the areas of dining and money management.	W 227		
W 249	PROGRAM IMPLEMENTATION	W 249		

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W 249	Continued From page 10 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 each client received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of structured leisure activities and the use of adaptive splints. This affected 2 of 4 audit clients (#1 and #2). The findings are: A. Throughout observations of leisure activities in the facility on 8/22/22 from 4:35pm-5:00pm client #2, who is legally blind, was at the dining room table with a piece of paper moving a crayon back and forth on the paper with crayons. He was not offered any other leisure options. During continued observations in the facility on 8/22/22 at 5:05pm, staff B asked client #2 to come to the kitchen and help her fill up a water pitcher with water. After assisting staff B, client #2 returned to the dining room table with paper and crayons until 5:30pm when staff A and staff B started setting up for supper. He was not offered any other leisure options.	W 249		

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W 249	Continued From page 11 During observations in the facility on 8/23/22 after breakfast at 8:00-8:30am staff D and E set up paper and crayons for client #2 to sit outside and color on the back patio until it was time to start getting on the van to go out to the vocational workshop after 830am. He was not offered any other leisure options. Review on 8/22/22 of client #2's IPP dated 5/28/22 revealed he has the following diagnoses: Mood Disorder, Profound Intellectual Disabilities and Blindness. Interview on 8/23/22 with the residential manager (RM) and the qualified intellectual disabilities professional (QIDP) confirmed there are leisure activities more appropriate for client #2's skills and abilities in the facility that can be offered to him during structured leisure time. B. Throughout observations at the facility on 8/22/22 from 4:00pm-6:30pm and on 8/23/22 from 6:00am-8:30am staff were not observed to work with client #1 on using her carrot splint. Review on 8/22/22 of client #1's IPP dated 6/16/22 revealed she was admitted to the facility on 5/2/22 after being discharged from a skilled nursing facility after being treated from a stroke that resulted in diagnoses of Dysphagia, Aphasia and Left Hemiparesis. Review on 8/23/22 of a Splint Instruction Sheet in client #1's folder indicated she has a carrot splint that is to be used with gentle stretching exercises daily with the carrot splint placed in the finger of her left hand slowly allowing her to hold onto the carrot splint and to gently relax her hand. Further instructions indicated she was to practice holding	W 249		

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W 249	Continued From page 12 onto the splint at least one hour daily and to increase the time daily until the occupational therapist could see her again to re-evaluate. Interviews on 8/23/22 with the RM and the QIDP confirmed the carrot splint is in the facility and staff should be working with client #1 on holding onto the carrot splint and to relax her hand daily.	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: Based on record review and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 2 of 4 audit clients (#2 and #3). The findings are: A. Review on 8/23/22 of client #3's Behavior Support Plan (BSP) dated 11/26/19 revealed an objective to exhibit zero episodes of failure to cooperate per month for twelve consecutive months. Additional review of client #3's BSP revealed a target behavior for noncompliance. Further review of the BSP revealed written informed consent had not been obtained by the legal guardian since 12/24/19. Interview on 8/23/22 with the qualified intellectual disabilities professional (QIDP) confirmed that written informed consent has not been obtained by the legal guardian. B. Review on 8/23/22 of client #2's BSP dated	W 263		

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	34G216	A. BUILDING _____ B. WING _____	08/24/2022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 263	Continued From page 13 11/20/19 revealed an objective to decrease episodes of self-injury per month for 12 consecutive months. Further review of the BSP revealed this program incorporated the use of Risperidone 0/25mg and Sertraline 50 mg. Review of the BSP consent revealed it was signed by client #2's legal guardian of the person on 12/11/19 and this written informed consent would expire on 11/20/20. Interview on 8/22/22 with the QIDP confirmed the facility had not updated this written informed consent for client #2's BSP from the legal guardian and the BSP was still ongoing.	W 263		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on records review and interviews, the facility failed to provide nursing services in accordance with the needs of 1 of 4 audit clients (#5) relative to ensuring authenticated physician orders were available. The finding is: Review on 8/23/22 of quarterly physician orders revealed client #5 had not had signed physician orders since August 16, 2021. Interview on 8/24/22 with the facility nurse confirmed authenticated physician orders for client #5 were last signed August 16, 2021.	W 331		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team,	W 340		

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	34G216	A. BUILDING _____ B. WING _____	08/24/2022

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W 340	Continued From page 14 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 and interview, nursing services failed to ensure that staff were sufficiently trained in the taking the temperature of visitors in regards to COVID-19 protocol. This potentially effected all clients (#1, #2, #3, #4, #5 and #6) residing in the home. The finding is: During observations at the home on 8/23/22 at 10:00am and 4:00pm, a staff person opened the door to the home and greeted the surveyors. Further observations revealed surveyors' temperature was not taken. During an interview on 8/24/22, the home manager (HM) reported any visitors who enter the home must have their temperature taken. During an interview on 8/24/22, the facility nurse confirmed the surveyors' temperatures should have been taken.	W 340		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure 1 of 4 audit clients (#1) was taught to use and make informed choices about	W 436		

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W 436	Continued From page 15 the use of glasses. The finding is: Throughout observations on 8/23/22 from 4:00pm-6:30pm client #1 was involved in arts and crafts activity drawing on paper, painting a wooden napkin holder as well as dining. During this observation, she was not observed to be offered her eyeglasses. Throughout observations on 8/23/22 from 6:00am-8:30am during dining and preparation to transport to her vocational workshop, client #1 was not offered her eyeglasses. Interview on 8/23/22 with the facility nurse revealed client #1 was seen for a visual assessment in March 2022 prior to her placement at the facility on 5/2/22. Further interview revealed she was seen by the Optometrist and given glasses to wear for reading. Interview on 8/23/22 with the qualified intellectual disabilities professional (QIDP) confirmed client #1 does have glasses but currently does not have formal training to tolerate wearing or learn to care for her eyeglasses.	W 436		
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 3 of 4 audit clients (#1, #2 and #3) received their	W 460		

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W 460	Continued From page 16 specially-modified diet as prescribed. The findings are: A. During observations in the home on 8/22/22 at 5:28pm, client #2 was assisted to serve mechanically ground taco which included lettuce, tomatoes and cheese. He was also assisted to serve mashed potatoes and beverages which included juice and water. During observations of breakfast on 8/23/22 at 6:40am, client #2 was served mechanically ground waffles, unmodified scrambled eggs and unmodified canned fruit. He was also served beverages which included water and juice. Review of client #2's nutritional evaluation dated 3/5/18 revealed client #2's diet is prescribed a regular pureed diet with Ensure prescribed once daily. Review on 8/23/22 of client #2's physician orders dated 6/27/22 revealed client #2's diet is prescribed a regular pureed diet with Ensure prescribed once daily. Interview on 8/23/22 with the facility nurse confirmed that client #2's diet is prescribed as pureed as he wears dentures and sometimes does not completely chew his food. Further interview confirmed that a pureed texture is smooth with broth or water added without lumps in the mixture that is mechanically modified. Interview on 8/23/22 with the qualified intellectual disabilities professional (QIDP) revealed client #2's pureed diet is current and should be followed.	W 460		

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W 460	Continued From page 17 B. During observations in the home on 8/23/22 at 6:42am client #1 was served scrambled eggs that were unmodified, canned fruit that was unmodified and mechanically ground waffles. She was also served juice and water. Review on 8/22/22 of client #1's IPP revealed client #1's IPP dated 6/16/22 revealed she was admitted to the facility on 5/2/22 after being discharged from a skilled nursing facility after being treated from a stroke that resulted in diagnoses of Dysphagia, Aphasia and Left Hemiparesis. Further review of the IPP revealed she is prescribed a pureed diet with Boost three times daily. Review on 8/23/22 of client #1's physician orders dated 6/27/22 revealed her diet was prescribed as a pureed diet with Boost three times daily. Review on 8/22/22 of a dietary note from July 27, 2022 revealed client #1's diet was changed to mechanically ground with Boost clear three times daily as she was refusing meals served at the pureed texture. Interview on 8/23/22 with the facility nurse confirmed client #1 is to be served a mechanically ground diet with all foods modified at meals. Interview on 8/23/22 with the QIDP confirmed client #1's diet is mechanically modified with Boost three times daily. C. During observations in the home on 8/23/22 at 5:27pm, client #3 was served a mechanically ground taco, unmodified mashed potatoes and juice.	W 460		

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W 460	Continued From page 18 During observations in the home on 8/24/22 at 6:15am, client #3 received her morning medications with water. Further observation at 6:40am, client #3 received mechanically softened waffles, scrambled eggs and canned mixed fruit unmodified. Review on 8/23/22 of client #3's nutritional evaluation dated 5/1/20 revealed client #3 is supposed to receive a mechanical soft diet with nectar thick liquids. The evaluation also reveals all foods should be served no thinner than nectar consistency. Staff should make sure not to over process fruits and vegetables and they should be drained before modifying to prevent them from being a watery consistency. Interview on 8/24/22 with Staff C revealed client #3 is supposed to be on mechanical soft and uses thickened liquids sometimes. Staff C also reveled client #3 is not supposed to have watery foods like jello because they make her cough. Interview on 8/24/22 with the home manager (HM) confirmed client #3 is supposed to be on mechanically soft diet with nectar thickened liquids.	W 460		
W 475	MEAL SERVICES CFR(s): 483.480(b)(2)(iv) Food must be served with appropriate utensils. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, staff did not ensure that 1 of 4 audit clients (#3) received the proper adaptive equipment for 2 of 2 meals. The finding is: During dinner observations in the home on	W 475		

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W 475	Continued From page 19 8/23/22 at 5:27pm, client #3 sat at the dining room table and was served mechanichally ground tacos and mashed potatoes On the table in front of client #3 was a plate raiser, high-sided divided plate, weighted cup and built up angled fork. During breakfast observations in the home on 8/24/22, client #3 sat at the dining room table and was served mechanically ground waffles, scrambled eggs and unmodified mixed fruit. On the table in front of client #3 was a plate raiser, a high-sided divided plate, a weighted cup, built up angled spoon and built up angled fork. Client #3 fed herself and ate all of her food. Review on 8/23/22 of client #3's Occupational Quarterly Update dated 4/29/20 revealed client #3 needs a small maroon spoon with universal design built up handle, high sided divided plate, plate raiser, weighted cup, chair with arm rest for for positioning and no forks. Further review revealed fork use not recommended due to mechanical soft diet and likelyhood that due to tremors client #3 could hurt her mouth with fork prongs. Interview with home manager (HM) on 8/24/22 revealed that she was unaware client #3 needed a small maroon spoon and that she should not be using a fork.	W 475		