STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G181	A. BUILDING _____ B. WING _____	02/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-MEADOWOOD DRIVE GROUP HOME	401 MEADOWOOD STREET GREENSBORO, NC 27409

(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 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, record reviews and interviews, the facility failed to ensure privacy was maintained during personal care. This affected 1 of 5 audit clients (#6). The finding is: During observations in the home on 2/14/23 at 6:22am, client #6 was observed in the bathroom standing at the toilet. Client #6 was using the bathroom, and the door to the stall and the bathroom were open. At no time during the observation was client #6 prompted to close the bathroom door. Additional observations in the home on 2/14/23 at 6:26am revealed client #6 to be standing in the middle of the bathroom, completely undressed. The door to the bathroom was open. At 6:28am, Staff C was observed to walk to the bathroom, stand in the door and talk to client #6. Staff C then walked away, and the door remained open. At 6:28am, Staff C returned, went into the bathroom and closed the door. Review on 2/14/23 of client #6's Individual Program Plan (IPP) dated 1/17/23 revealed under the area of supports, "Staff will work with [Client #6] to ensure he understands and is utilizing privacy in all settings (bedroom, bathroom, medication room, etc.)." Interview on 2/14/23 with the House Manager (HM) and Qualified Intellectual Disabilities Professional (QIDP) confirmed staff should have	W 130		

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

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W 130	Continued From page 1 prompted client #6 to close the door or should have closed the door for him.	W 130		
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 that 1 of 5 clients (#5) received a continuous active treatment program as identified in the individual support plan (ISP) relative to wearing a prescribed protective helmet. The finding is: Evening observations in the group home on 2/13/23 at 4:05 PM revealed client #5 to sit in a living room chair wearing a helmet with chin strap unfastened. Continued observation at 4:11 PM revealed client #5 to remove helmet off and on head several times. Further observations revealed client #5 to walk around the home with helmet chin strap unfastened. Subsequent observations at 4:33 PM revealed client #5 to walk up to the home manager (HM) and the HM to fasten the chin strap on the client's helmet. Morning observations in the group home on 2/14/23 at 6:15 AM revealed client #5 to be	W 249		

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W 249	Continued From page 2 dressed, sitting at the dining table and eating the breakfast meal. Continued observation revealed client #5 to not wear prescribed helmet. Further observations at 6:28 AM revealed staff to obtain client #5's helmet and place on head. Review of client #5's record on 2/14/23 revealed an ISP dated 1/12/23. Continued review of ISP revealed adaptive equipment for client #5 to consist of a helmet to be worn daily. Further review of the record revealed a behavior support plan (BSP) dated 3/25/22. Subsequent review of the BSP revealed that client #5 has a protective helmet to be worn throughout the day. Interview with the qualified intellectual disabilities professional (QIDP) verified that ISP is current. Continued interview with the QIDP confirms that client #5 should wear prescribed protective helmet daily with chin strap secured.	W 249		
W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to serve food in a form consistent with the developmental level of 4 of 5 audit clients (#1, #3, #4 and #5). The findings are: A. The facility failed to follow client #3 diet as prescribed. For example: During observations in the home on 2/13/23 at 5:39pm, client #3 was observed eating dinner which consisted of a quesadilla, rice and peas.	W 474		

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Client #3's quesadilla was observed to be cut into long pieces, with some pieces being 2-3 inches or larger in size.

Review on 2/13/23 of client #3's Individual Support Plan (IPP) dated 1/12/23 revealed a diet order consisting of chopped, dime size.

Review on 2/13/23 of client #3's diet order displayed in the kitchen of the home revealed a diet consisting of mechanical soft.

Review on 2/14/23 of client #3's nutritional evaluation dated 10/14/22 revealed a diet order consisting of mechanical soft, nickel size pieces.

Interview on 2/14/23 with Staff C and Staff D revealed client #3's diet is mechanical soft, but revealed they have never heard that client #3's food should be cut into nickel or dime size pieces.

Interview on 2/14/23 with the House Manager (HM) and Qualified Intellectual Disabilities Professional (QIDP) revealed client #3's diet order is mechanical soft, cut into nickel size pieces. The HM and QIDP confirmed the quesadilla should have been cut into nickel size pieces.

B. The facility failed to follow client #1's diet as prescribed. For example:

During observations in the home on 2/13/23 at 5:39pm, client #1 was observed eating dinner which consisted of a quesadilla, rice and peas. Client #1's quesadilla was observed to be cut into 6 long pieces.

Review on 2/14/23 of client #1's IPP dated

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1/11/23 revealed a diet order consisting of chopped, nickel size.

Review on 2/14/23 of client #1's diet order displayed in the kitchen of the home revealed a diet consisting of chopped, nickel size.

Review on 2/14/23 of client #1's nutritional evaluation dated 10/4/22 revealed a diet order consisting of mechanical soft, no concentrated sweets, nickel size bites, thin liquids.

Interview on 2/14/23 with Staff C and Staff D revealed client #1's food should be cut into nickel size pieces.

Interview on 2/14/23 with the HM and QIDP revealed client #1's diet order is mechanical soft, cut into nickel size pieces. The HM and QIDP confirmed the quesadilla should have been cut into nickel size pieces.

C. The facility failed to follow client #4's diet as prescribed. For example:

During observations in the home on 2/14/23 at 6:15 AM, client #4 was observed to sit at the dining room table with a bowl of cereal and milk for the breakfast meal.

Review on 2/14/23 of client #4's IPP dated 1/13/23 revealed a diet order consisting of pureed diet with nutritional drinks for supplemental nutrients.

Review on 2/14/23 of client #4's nutritional evaluation dated 10/4/22 revealed a diet order consisting of pureed, Ensure TID, and no

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W 474	Continued From page 5 grapefruit. Interview on 2/14/23 with the HM and QIDP revealed client #4's diet order is pureed, Ensure TID, and no grapefruit. The HM and QIDP confirmed that client #4 should not have received cereal and milk due to a pureed diet. Continued interview with the HM and QIDP revealed that typically client #4 would be offered yogurt, nutri-grain bar, and oatmeal. D. The facility failed to follow client #5's diet as prescribed. For example: During observations in the home on 2/13/23 at 5:39 PM, client #5 was observed eating dinner which consisted of a quesadilla, rice and peas. Client #5 was observed to have several large scoops of rice during the dinner meal. During observations in the home on 2/14/23 at 6:15 AM, client #5 was observed to eat bananas cut up, cereal and milk. Continued observation at 6:22 AM revealed staff D to pour client #5 a second large bowl of cereal with milk. Review on 2/14/23 of client #5's IPP dated 1/12/23 revealed a diet order consisting of NCS, regular diet without seconds, except for non-starchy vegetables. Review on 2/14/23 of client #5's nutritional evaluation dated 10/4/22 revealed a diet order consisting of regular, NCS, low cholesterol, no seconds. Interview on 2/14/23 with the HM and QIDP revealed client #5's diet order is NCS, regular with no seconds except non-starchy vegetables.	W 474		

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W 474	Continued From page 6 The HM and QIDP confirmed that client #5 was served excessive rice for dinner meal and client should not have received seconds of cereal for breakfast meal.	W 474		