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	34G228	A. BUILDING _____ B. WING _____	02/22/2023

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VOCA-CREEKWAY	424 CREEKWAY DRIVE FUQUAY VARINA, NC 27526

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W 210	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure assessments for 2 of 2 newly admitted clients (#4 and #5) were completed within 30 days after admission. The findings are: A. Review on 2/21/23 of client #4's record revealed he was admitted to the facility on 5/4/22. Additional review of the record did not include Occupational Therapy, Physical Therapy, dental or vision assessments for client #4. B. Review on 2/21/23 of client #5's record revealed he was admitted to the facility on 12/20/22. Additional review of the record did not include Occupational Therapy, Physical Therapy, Speech Language, Nutrition, dental, vision, audiology and self-help/daily living skills assessments for client #5. Interview on 2/22/23 with the facility nurse and the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4 and client #5 were in need of various assessments which had not been completed since their admission.	W 210		
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	W 249		

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

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W 249	Continued From page 1 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 review and interview, the facility failed to ensure client #3 received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) regarding use of her walker. This affected 1 of 4 audit clients. The finding is: During observations in the home on 2/21/23 at 10:40am, client #3 entered the home using a walker. At 10:55am, client #3 and other clients left the home for an outing to a local park. Client #3 exited the home using a walker. Upon returning to the home at 12:18pm, client #3 was prompted to the kitchen to assist with preparing lunch. Client #3 positioned her walker against a wall at the entry way into the kitchen and walked into the kitchen. The client remained in the kitchen without her walker assisting with lunch prep until 12:55pm. Client #3 was not prompted or encouraged to use her walker. During evening observations in the home on 2/21/23 from 3:15pm - 6:30pm, client #3 did not utilize her walker while ambulating throughout various areas of the home. The client was not prompted or encouraged to use her walker. During morning observations in the home on 2/22/23 from 6:05am - 8:30am, client #3 used her	W 249		

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W 249	Continued From page 2 walker inconsistently in the home. The client was not prompted or encouraged to consistently use her walker. Review on 2/21/23 of client #3's IPP dated 2/8/23 revealed she uses a walker to assist her "from falling". The plan noted the walker should be used "every day when moving". Further review of the plan noted, "Staff to monitor her use of walker, when in motion." Interview on 2/22/23 with the Qualified Intellectual Disabilites Professional (QIDP) and the Area Supervisor revealed the walker had been put in place by the Physical Therapist (PT) and intended to be used by client #3 on a trial basis after a fall in 2020. Additional interview confirmed the use of the walker had been continued at the client's 2023 IPP meeting a couple of weeks ago.	W 249		
W 252	PROGRAM DOCUMENTATION 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 specified objectives was documented in measurable terms. This affected 3 of 4 audit clients (#3, #5 and #6). The findings are: A. Review on 2/21/23 of client #3's Individual	W 252		

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W 252	Continued From page 3 Program Plan (IPP) dated 2/8/23 revealed an objective to clean her room (implemented 1/1/23). Additional review of the client's data collection sheets for the objective revealed no documentation for January 2023. B. Review on 2/21/23 of client #5's IPP dated 1/30/23 revealed an objective to participate in the administration of his medications (implemented 1/1/23). Additional review of the client's data collection sheets for the objective revealed no documentation for January 2023. C. Review on 2/21/23 of client #6's IPP dated 12/7/22 revealed objectives to participate with taking his medications (implemented 1/1/23) and to purchase a personal item at the store. Additional review of the client's data collections sheets for the objectives revealed no data collection for January 2023 and February 2023. Interview on 2/22/23 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed all data should be collected for each objective as indicated by the plan.	W 252		
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 a written informed consent was obtained from client #6's guardian for his restrictive Behavior Support Plan (BSP). This affected 1 of 4 audit clients. The finding is:	W 263		

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W 263	Continued From page 4 Review on 2/22/23 of client #6's record revealed a BSP dated 1/4/23 to reduce episodes of target behaviors to 0 per month for 12 consecutive months. Additional review of BSP included the use of Lexapro, Atarax and Risperdal. Further review of the record did not include a written informed consent from the guardian for client #6's BSP. Interview on 2/22/23 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed no written informed consent had been obtained from client #6's guardian for his BSP.	W 263		
W 312	DRUG USAGE CFR(s): 483.450(e)(2) be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure all medications used to address behaviors for 2 of 4 audit clients (#4 and #5) were included in a formal active treatment plan. The findings are: A. Review on 2/21/23 of client #4's current physician's orders dated February 2023 revealed orders for Prozac, Seroquel (For mood and sleep) and Atarax (For agitation). Additional review of the record did not indicate the medications were included in a formal active treatment plan. B. Review on 2/21/23 of client #5's current	W 312		

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W 312	Continued From page 5 physician's orders dated February 2023 revealed an order for Abilify. Additional review of the record did not indicate the medications were included in a formal active treatment plan. Interview on 2/22/23 with the Qualified Intellectual Disablities Professional (QIDP) confirmed client #4 and client #5 are currently taking medications to address mood and other behaviors; however, these medications were not included in a formal active treatment plan.	W 312		
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, interview and record review, the facility failed to ensure staff were sufficiently trained to implement visitation protocols and face mask procedures regarding COVID-19. The findings are: A. Upon arrival to the home on 2/21/23 at 8:50am and on 2/22/23 at 6:00am, the surveyor's temperature was not taken and no COVID-19 screening questions were asked. Review on 2/21/23 of the facility's COVID-19 visitor screening form revealed the visitor's temperature should be taken and three COVID-19 screening questions should asked. Interview on 2/21/23 with the Area Supervisor	W 340		

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W 340	Continued From page 6 (AS) confirmed all visitors to the home should be screened for COVID-19 including having their temperature taken and asked the three screening questions from the form. B. During observations in the home throughout the survey on 2/21 - 2/22/23, Staff A, B and E interacted and worked directly with clients to provide care and services. Throughout the observations, the specified staff were noted to wear a disposable surgical mask covering their nose and mouth. Review on 2/21/23 of the facility's employee COVID-19 proof of vaccination forms revealed Staff A, B and E had been approved for a religious exemption and were not vaccinated against COVID-19. Review on 2/22/23 of the facilty's CMS Vaccine Mandate Procedure (no date) revealed, "For all employees who have an approved exemption; we must implement a process for ensuring additonal precautions are in place to prevent the transmission and spread of COVID-19 for all staff who are not fully vaccinated for COVID-19. After receipt of an approved religious or medical exemption under the CMS Mandate, appropriate Reasonable Accommodations must be documented by the appropriate agency representative and reviewed with the employee. Appropriate Reasonable Accommodations could include, but are not limited to:..Wearing a mask during entire shift - N95 Masks are preferred..." Interview on 2/22/23 with the Program Director confirmed unvaccinated employees should be wearing N95 masks as per the facility's policy.	W 340		

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W 436	Continued From page 7	W 436		
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, record reviews and interviews, the facility failed to ensure 2 of 4 audit clients (#3 and #6) were furnished their necessary adaptive equipment, taught to make informed choices about their use and maintenance. The findings are: A. During observations in the home throughout the survey on 2/21 - 2/22/23, client #3 did not wear eyeglasses. Client #3 was not prompted or assisted to wear eyeglasses. Review on 2/21/23 of client #3's Individual Program Plan (IPP) dated 2/8/23 revealed no information regarding eyeglasses. Additional review of the client's most current vision examination report dated 3/3/22 noted, "Bifocal eyeglasses needed." Interview on 2/22/23 with the Qualified Intellectual Disabilities Professional (QIDP) revealed client #3 did have eyeglasses; however, she had broken them. Additional interview indicated the eyeglasses needed to be replaced. The QIDP noted client #3 has not had any recent training regarding the use of her eyeglasses. B. During observations in the home on 2/21/23 from 10:51am - 1:30pm, client #6 did not wear	W 436		

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W 436	Continued From page 8 eyeglasses. Client #6 was not prompted or assisted to wear eyeglasses. Review on 2/21/23 of client #6's IPP dated 12/7/22 revealed, "[Client #6] wears glasses to help improve his eye site." Additional review of the client's vision examination report dated 5/23/22 noted, "Hyperopia, astigmatism, cataract". Interview on 2/21/23 with the Area Supervisor (AS) revealed client #6 has eyeglasses but usually does not like to wear his eyeglasses and will only wear them for "a little while". Additional interview indicated staff have found "broken ones (glasses) in his room". Interview on 2/22/23 with the QIDP revealed client #6 is supposed to wear his eyeglasses "everyday" but he will just take them off. Additional interview indicated client #6 has not had recent training regarding the use of his eyeglasses.	W 436		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire drills were conducted at least quarterly for each shift. The finding is: Review on 2/21/23 of the facility's fire drill log for February 2022 - February 2023 revealed no documented fire drills for March 2022 - September 2022 and November 2022. No fire drills for these months were available for review.	W 440		

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W 440	Continued From page 9 Interview on 2/22/23 with the Qualified Intellectual Disabilities Professional (QIDP) and Area Supervisor (AS) indicated the fire drill log sheets had been damaged and must have been thrown out by staff.	W 440		
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 review and interviews, the facility failed to ensure client #3's prescribed diet was followed as written. This affected 1 of 4 audit clients. The finding is: During breakfast observations in the home on 2/22/23 at 7:33am, Staff D assisted client #3 to puree two waffles in a food processor and scooped them on her plate. The staff then placed scrambled eggs on the client's plate and used a fork to break up the eggs into smaller pieces. Client #3 then took the plate to the table and consumed the food without difficulty. During an interview on 2/22/23, when asked why client #3's eggs were not pureed, the Staff D initially stated she needed get to her second job. Additional interview revealed the eggs were soft and did not need to be pureed. Review on 2/21/23 of client #3's Individual Program Plan (IPP) dated 2/8/23 and a diet list posted on the refrigerator of the home indicated she consumes a regular pureed diet.	W 460		

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W 460	Continued From page 10 Interview on 2/22/23 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #3 consumes a pureed diet which would include all foods.	W 460		