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	34G270	A. BUILDING _____ B. WING _____	02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-SIXTH STREET GROUP HOME	201 NORTH SIXTH STREET SANFORD, NC 27330

(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 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 review and staff interviews, the facility failed to ensure a psychological assessment for 1 of 2 newly admitted clients (#5) was completed within 30 days after admission. The finding is: Review on 2/23/23 of client #5's record revealed he was admitted to the facility on 8/1/22. Additional review of the record revealed there was a psycholofical evaluation for client #5 dated 2/5/16. Interview on 2/22/23 with Site Supervisor revealed she did not have a current copy of client #3's psychological evaluation. Interview on 2/23/23 with the Program Director-A (PD-A) revealed that their policy included a requirement to receive a psychological evaluation that was newer than 5 years old at the time of a new admission. The PD-A stated that the county agency placing the client would not have approved the placement into the group home if the psychological evaluation was done outside of 5 years. The PD-A acknowledged he was unable to furnish a recent psychological evaluation available to review.	W 210		
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and	W 262		

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

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W 262	Continued From page 1 monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the restrictive behavior techniques for 1 of 4 audit clients (#6) was reviewed and monitored by the human rights committee (HRC). The finding is: Review on 2/22/23 of client #6's Behavior Support Plan (BSP) dated 10/25/22 revealed target behaviors consisting of trouble controlling his anger, non-compliance, elopement, and failure to cooperate with staff's requests. The plan mentioned that client #6 had one suicide attempt in 2022 with medications. There were no revisions to the current BSP. Interview on 2/22/23 with the Site Supervisor (SS) revealed on 1/26/23, client #6 verbalized to staff that he felt like hurting himself and cutting his throat. As a precaution, knives and scissors were removed from the common area and secured in a locked closet. The SS acknowledged that their actions were not reviewed by HRC. Interview on 2/23/23 with the Program Director-B (PD-B) revealed securing the sharp objects was not a rights restriction, it was for client #6's behavior. Interview on 2/23/23 with the PD-A revealed as a precaution the knives were removed for client #6's safety. The PD-A revealed the psychologist who wrote the BSP has been contacted for revision and to include suicidal ideation as a target behavior, but has not taken action yet.	W 262		

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W 289	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(4) The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure a technique to address client #4's inappropriate behaviors were included in a formal active treatment plan, This affected 1 of 4 audit clients (#4). The finding is: Observations on 2/21/23 at 5:00PM, revealed Staff D administering medications to client #4. Staff D explained that Benztropine 1mg and Lithium Carb 300mg were given for behaviors and reviewed the possible side effects. Record review on 2/22/23 of client #4's chart revealed he was admitted to the group home on 8/1/22 and had cumulative diagnoses of schizophrenia and anxiety disorder. A further review of client #4's behavioral note completed by the Qualified Intellectual Developmental Professional (QIDP) dated October 2022, revealed he also took Risperidone and Trazadone for mental mood disorders. There was no behavior support plan (BSP) for client #4 to address any challenging behaviors or medications for mental health conditions. Interview on 2/23/23 with the Site Supervisor revealed the QIDP was responsible for arranging the BSP for client #4.	W 289		

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W 289	Continued From page 3 Interview on 2/23/23 with the QIDP revealed client #4 was receiving monthly online mental health services, but that agency expressed that they could not develop his BSP. Interview on 2/23/23 with the Program Director-A (PD-A) revealed that he was aware that client #4 was on psychiatric medications and did not have a BSP. The PD-A revealed they have been challenged to get the guardian to sign consent for psychological services and to get the psychologist to schedule his evaluation.	W 289		
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 observation, record review and interview, the facility failed to teach client to wear and take care of her prescribed glasses. This affected 1 of 4 audit clients (#2) . The findings is: During observations on 2/21/23 and on 2/22/23, client #2 was not observed to wear glasses. Review on 2/21/23 of client #2's IPP dated 8/24/22 revealed she wore glasses for vision improvement. Staff should remind client #2 to clean and wear her glasses. Interview on 2/22/23 with the Site Supervisor revealed client #2 has a training goal to wear glasses for when she's at the day program,	W 436		

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W 436	Continued From page 4 watching television or in the evening.	W 436		
W 447	EVACUATION DRILLS CFR(s): 483.470(i)(2)(iii) The facility must file a report and evaluation on each evacuation drill. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement corrective measures after problems with fire drills evacuations for 1 of 4 audit clients (#1) was repeatedly identified. The finding is: Review on 2/21/23 of the fire drill reports revealed the following transportation difficulties exiting the front door of the home with client #1 seated in her wheelchair: On 4/11/22 at 5:00PM, Staff A recorded trouble getting wheelchair over the threshold. On 4/18/22 at 10:15PM, Staff C and Staff D recorded trouble getting wheelchairs out the door. One 6/9/22 at 3:00AM, Staff recorded trouble getting wheelchair out the door. On 2/11/23 at 10:37AM, Staff recorded the wheelchair got stuck in doorway. On 2/14/23 at 10:00PM, Staff C and Staff D recorded it took longer to get client #1's wheelchair out the door. Interview on 2/21/23 with Staff B revealed the front door has a difficult threshold to cross over for wheelchairs, because it was raised. Staff B revealed the wheelchair had to be tilted back to get over the hump. Interview on 2/22/23 with Staff D revealed client #1's wheelchair would sit too low to the ground,	W 447		

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W 447	Continued From page 5 and would drag across the threshold. Interview on 2/22/23 with the Site Supervisor (SS) revealed that she reviews the fire drill reports. The SS acknowledged that client #1's wheelchair had to be tilted to exit the front door. The SS revealed there was an exit door next to client #1's bedroom but the side walk was partial and did not extend to the driveway and would have to be pushed over grass. Interview on 2/22/23 with Program Director-A revealed she was unaware there were problems crossing the threshold to the front door during fire drills. The PDA acknowledged that after reviewing all of the doorways in the home, she noticed the front door had the most raised surface to crossing with a wheelchair.	W 447		
W 508	COVID-19 Vaccination of Facility Staff CFR(s): 483.430(f)(1)-(3)(i)-(x) § 483.430 Condition of Participation: Facility staffing. (f) Standard: COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. (1) Regardless of clinical responsibility or client contact, the policies and procedures must apply to the following facility staff, who provide any	W 508		

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care, treatment, or other services for the facility and/or its clients:
(i) Facility employees;
(ii) Licensed practitioners;
(iii) Students, trainees, and volunteers; and
(iv) Individuals who provide care, treatment, or other services for the facility and/or its clients, under contract or by other arrangement.
(2) The policies and procedures of this section do not apply to the following facility staff:
(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with clients and other staff specified in paragraph (f)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with clients and other staff specified in paragraph (f)(1) of this section.
(3) The policies and procedures must include, at a minimum, the following components:
(i) A process for ensuring all staff specified in paragraph (f)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its clients;
(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the

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transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;
(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (f)(1) of this section;
(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;
(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;
(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;
(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the

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W 508	Continued From page 8 recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: (ii) A process for ensuring that all staff specified in paragraph (f)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure their COVID-19 Vaccination Policy and procedures were implemented as written. The findings are: 1. Review on 2/22/23 of the facility's COVID-19 Vaccine Immunization Requirements for Staff in ICFs/IDD (Intermediate Care Facilities and Intellectual Developmental Disabilities) dated 3/23/22 revealed "For all employees who have an approved exemption; we must implement a process for ensuring additional precautions are in place to prevent the transmission and spread of COVID-19 for all staff who are not fully	W 508		

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W 508	Continued From page 9 vaccinated for COVID-19...Appropriate reasonable accommodations could include, but are not limited to: Wearing a mask during entire shift - N95 masks are preferred Weekly or monthly COVID Testing Any other PPE (Personal Protective Equipment) that could be deemed necessary. Review on 2/22/23 of the list of the staff who were granted religious exemptions included 13 staff who worked with clients #1, #2, #3, #4, #5 and #6 in the home. Interview on 2/22/23 with the Site Supervisor revealed she was granted religious exemption and independently performed weekly COVID-19 tests however, no manager had required her to submit the results for review. Interview on 2/22/23 with Program Director-A (PD-A) revealed she was granted religious exemption and indepently took a COVID-19 test last quarter, however had never been asked to perform weekly or monthly testing. Interview on 2/22/23 with the Program Director-B (PD-B) revealed that he did not think that anyone was required to weekly or monthly COVID-19 testing anymore and that they would need to revise their policy. 2. Review on 2/22/23 of the facility's list of staff and contractors who have submitted vaccine or exemption requests revealed they did not collect information from the Day Program Manager and day program Staff F, Staff G or Staff H.	W 508		

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W 508	Continued From page 10 Interview on 2/22/23 with PD-B revealed the facility did not realize they needed to obtain vaccine information from day program staff who serviced the clients in the home.	W 508		