STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G225	A. BUILDING ______ B. WING ______	04/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-GENTRY	2219 GENTRY DRIVE DURHAM, NC 27705

(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 111	CLIENT RECORDS CFR(s): 483.410(c)(1) The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to maintain current records for physician orders for 1 of 4 audit clients (#4). The finding is: Review on 4/12/23 of client #4's record revealed his last physician orders were signed on 12/21/21. Further review there were no current signed physician orders for client #4. During an interview on 4/12/23, the facility's nurse confirmed the last signed physician orders for client #4 were signed on 12/21/21. Further interview client #4 has been refusing to go to his medical doctor appointments and that is preventing the medical doctor from signing the physician orders.	W 111		
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 record review, observation and interviews, the facility failed to ensure a client had the right to a legal guardian. This affected 1 of 4 audit clients (#4). The finding is:	W 125		

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

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 125	Continued From page 1 Review of 4/12/23 of client #4's record revealed he had been admitted to the home on 7/7/21. The client's Individual Program Plan (IPP) dated 9/16/22 indicated the client acted as his own guardian. Additional review of the record indicated the client was 61 years old and had a diagnosis of Mild Intellectual Disability. Review on 4/12/23 of client #4's Individual Program Plan dated 9/16/22 stated, "[Client #4's name] has limited money management skills". Further review revealed he can only carry ten dollars. Review on 4/12/23 of client #4's Community/Home Life Assessment dated 9/16/22 revealed he is dependent on staff in all areas of money management (spending, understanding denominations, making change, shopping independently and using banking services). Further review revealed he needs verbal cues to recognize his own address and phone number. During an interview on 4/12/23, the Home Supervisor (HS) stated that client #4 does understand the reason why he takes some of his medications, like his behavior medications but not the other medications that he is required to take. Further interview revealed client #4 has been refusing to go to his medical doctor to receive his annual physical. During an interview on 4/12/23, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4 is his own guardian. The QIDP revealed it is currently not in client #4's best interest to be his own guardian seeing that he is refusing to obtain an annual physical to receive preventive medical care.	W 125		

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W 186	DIRECT CARE STAFF CFR(s): 483.430(d)(1-2) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on documentation, and interviews, the facility failed to provide sufficient direct care staff to manage and supervise the six clients residing in the home (#1, #2, #3, #4, #5, and #6) in accordance to the facility's Staff Ratio Policy. The finding is: Review on 4/11/23 of the facility's fire drills for 2022 and 2023, revealed there was only one staff working during second shift on twenty-two days. Further observations revealed all six clients where present in the home. Review on 4/11/23 of the facility's Staff Ratio policy dated 1/17 stated, "...two staff present for every four or more individuals present...." During an interview on 4/11/23, the Home Supervisor (HS) confirmed there should be two staff on duty during second shift. Further interview revealed the HS was the main staff person working by themselves during the fire drills on second shift. During an interview on 4/11/23, the Area Coordinator stated there should have been two staff on duty during second shift.	W 186		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)	W 249		

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W 249	Continued From page 3 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 1 of 4 audit clients (#4) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of adaptive dining equipment. The finding is: During observations in the home on 4/11/12 from 3:08pm until 5:25pm, client #4 was observed sitting at the dining room table playing UNO, putting together a puzzle, coloring and eating dinner. Further observations revealed client #4's feet was not on the foot stool which was located underneath the table. Additional observations revealed at no time was client #4 prompted by staff to put his feet on the foot stool. Review on 4/12/23 of client #4's IPP dated 9/16/22 revealed his adaptive equipment is a foot stool. Review on 4/12/23 of client #4's Occupational Therapy evaluation dated 12/21/22 revealed, his adaptive dining equipment is a foot stool. Client #4 is short in stature and the therapist is	W 249		

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W 249	Continued From page 4 recommending that he uses a foot stool to provide a stable base of support under his feet at dining table. During an interview on 4/12/23, Staff A reported client #4 is suppose to use his foot stool while he is sitting at the dining table. During an interview on 4/12/23, the Area Supervisor stated client #4 uses the foot stool so that his feet do not dangle and to prevent swelling of his feet. During an interview on 4/12/23, the Qualified Intellectual Disabilities Professional (QIDP) revealed client #4 should be using the foot stool whenever he is sitting at the dining table. Further interview revealed staff should remind client #4 about using his foot stool.	W 249		
W 322	PHYSICIAN SERVICES CFR(s): 483.460(a)(3) The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 4 audit clients (#4) obtained an annual physical. The finding is: Review on 4/12/23 of client #4's record revealed the last physical he received was in May 2021. Further review indicated there was no documentation of any physicals for 2022 or 2023. During an interview on 4/12/23, the Home Supervisor (HS) confirmed client #4 has not had a physical since they have been working in the home. Further interview revealed the HS has	W 322		

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W 322	Continued From page 5 been working in the home since January 2022. During an interview on 4/12/23, the facility's nurse confirmed client #4 has not had a physical since May 2021.	W 322		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations, document review and interviews, the facility failed to ensure medications remained locked except when being prepared for administration. The finding is: During observations in the home on 4/11/23 from 4:11pm until 4:14pm, the home supervisor (HS) walked out of the medication room and left medications on the desk. Further observations revealed the door to the medication room was left open. Review on 4/12/23 of the facility's Medications Administration policy dated 3/20 stated, "All medications, prescription and over-the-counter, shall be maintained in a secure, locked location". During an interview on 4/11/23, the HS stated all medications should be locked when not in use. During an interview on 4/12/23, the Qualified Intellectual Disabilities Professional (QIDP) revealed all medications should be locked when not being administered.	W 382		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1)	W 440		

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W 440	Continued From page 6 at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on review of fire drill reports and interviews, the facility failed to ensure fire evacuation drills were conducted at varied times. This potentially affected all clients (#1, #2, #3, #4, #5 and #6) residing in the home. The finding is: During review on 4/11/23 of the facility's fire drill reports revealed there were no fire drill conducted on first shift in 2022 and 2023. During an interview on 4/11/23, the Home Supervisor (HS) confirmed no fire drills were conducted on first sift for 2022 and 2023. During an interview on 4/12/23, the Qualified Intellectual Disabilities Professional (QIDP) was unaware that no fire drills were conducted during first shift during 2022 and 2023.	W 440		