DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G282	A. BUILDING _____ B. WING _____	C 06/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-LAURELWOOD	200 LAURELWOOD DR SMITHFIELD, NC 27577

(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 000	INITIAL COMMENTS A complaint survey was completed on 6/22/23 for intake #NC00203146. The complaint was substantiated. A deficiency was cited related to the allegations.	W 000		8/22/23
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 1 audit client (#1) relative to ensuring prescribed medical treatment was received. The finding is: During review on 6/22/23 of the facilty's medical log it was revealed client #1 was admitted to the hospital on 5/3/23 with low sodium levels. Further review revealed client #1 was again admitted to the hospital on 5/26/23 with low sodium levels. During an interview on 6/22/23, the facility nurse revealed fluid intake/output documentation was not started for client #1 to determine if she was getting enough fluid to assist with preventing the possibility of her having low sodium levels.	W 331	This deficiency will be corrected by completing the following tasks: A. The team will assess the needs of the individual upon return to the group home. B. Management will implement an intake/output document to track fluid intake. C. Team will ensure the completion of medical appointments as recommended by physician. D. A member of the Laurelwood Team will follow up with guardian monthly. E. RN to monitor monthly. F. QIDP to monitor monthly. G. AS or SS to monitor monthly.	

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

Monica Harrelson MSW, MPA | Program Manager | 6/30/23

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.