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 _____	05/08/2024

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 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 observation, record review and interview the facility failed to ensure data relative to the accomplishment of objectives specified in the individual program plan (IPP) was documented in measurable terms. This affected 1 of 4 audit clients (#2). The finding is: During dinner observation on 5//7/24 at 4:45pm, client #2 sat at the kitchen table and repeatedly grabbed client #3's wrist during the meal. The Site Supervisor (SS) provided redirection several times throughout the dinner. Further observation revealed, client #2 invading the SS's personal space in attempt to fist bump her hand. The SS informed client #3 that she did not want to fist bump and asked him to back away on at least 4 occasions. During breakfast observations on 5/8/24 at 6:47pm, client #2 was carrying his plate of food to the table to sit down. He stopped in front of the Qualified Intellectual Disabilities Professional (QIDP) and repeatedly tried to grab her. The QIDP and Area Supervisor repeatedly provided redirection. Client #2 eventually sat down at the table. Review on 5/8/24 of client #2's data sheets revealed no documentation regarding client #2's	W 252		

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

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W 252	Continued From page 1 behaviors exhibited on 5/7/24 and 5/8/24. Review on 5/8/24 of client #2's Behavior Support Plan (BSP) dated 3/11/24 revealed client #2 has a history of aggressive and threatening behaviors towards others. Client #2's BSP identifies inappropriate touching to be one of his targeted behaviors. Staff are to document all behaviors on client #2's data sheet. Interview on 5/8/24 with the Program Manager confirmed client #2's behaviors should have been documented on the data sheet prior to the end of the shift.	W 252		
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 and interview, nursing services failed to ensure that staff were sufficiently trained in the area medication administration Record (MAR). The findings are: Observations of medication administration on 5/7/24 at 4:00pm revealed, the Site Supervisor (SS) prepared and administered client #6 the following medications: Buspar, Docusate Sodium, Baclofen and Miralax. The SS did not provide education to the client or inform the client of the medication being administered. Observations of medication administration on	W 340		

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W 340	Continued From page 2 5/7/24 revealed, the SS prepared and administered client #5 the following medications: Docusate Sodium, Benztropine, and Invega. The SS did not provide education to the client or inform the client of the medication being administered. Observations of medication administration on 5/7/24 revealed, the SS prepared and administered client #1 Clonazepam, Melatonin, Divalproex and Tinactin Powder. The SS did not provide education to the client or inform the client of the medication being administered. Observations of medication administration on 5/7/24 revealed, the SS prepared and administered client #4 the following medications: Oyster Shell, and Buspirone. The SS did not provide education to the client or inform the client of the medication being administered. The Program Manager (PM) and Area Supervisor (AS) stated staff were supposed to inform each client of the medication being administered.	W 340		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all medications were administered without error. This affected 3 of 4 clients (#3, #5 and #6) observed receiving medications. The findings are:	W 369		

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W 369	Continued From page 3 A. During medication administration observations on 5/8/24 at 6:38am, client #3 ingested Omeprazole 20mg, Fluoxetine 20mg, Risperidone 0.5mg, Propranolol 60mg and Propranolol 160mg. Review on 5/8/24 of client #3's record revealed no current physician's order. Interview on 5/8/24 with the Program Manager (PM) revealed client #3's guardian takes him to all of his medical appointments. They have reached out to her several times requesting the physician's orders however she had not returned the orders to the facility as of yet. B. During observations of medication administration in the home on 5/7/24, client #4 ingested Docusate Sodium, Benztropine and Invega. During this time, the client was not observed to receive any other medications or treatments. Review on 5/8/24 of client #4's physician's orders dated 2/13/24 revealed an order for Haloperidol 5mg 1/2 tablet by mouth three times daily am, noon and 5pm. Interview on 5/8/24 with the Director of Nursing (DON) revealed the 5pm dose of Haloperidol is not transcribed on the electronic MAR (medication administration record). It is unknown how long the medication has not been on the MAR. It is the responsibility of the pharmacy ensure all medications are transcribed in accordance to the doctors order. The nurses should have caught that this medication was missing. The DON called the pharmacy and this should be corrected soon.	W 369		

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W 369	Continued From page 4 C. During medication observation in the home on 5/7/24 at 4:00pm, the Site Supervisor (SS) poured 8oz of water into a regular plastic drinking cup. She then mixed in Miralax 17gm into the water and interchangeably mixed it with back and forth with another cup to ensure it was mixed. The SS then gave the liquid to client #6 to drink. Client #6 drank 1/2 of the cup. The SS asked if she was going to drink any more. Client #6 handed the SS the other 1/2 of the liquid, which was then poured out. Further observation revealed client #6 did not receive the full dose of medication as prescribed. At no time did the SS notify the nurse. Immediate interview on 5/7/24 with the SS revealed client #6 receives 2 other medications that "make her use the bathroom" so it is ok if she doesn't take the full dose of Miralax. On 5/8/24, the SS stated she thought client #6's Miralax was ordered on an as needed basis. During medication administration observation on 5/8/24 at 7:16am, staff B mixed client #6's Miralax in 8oz of water. Client #6 initially refused however agreed to take 1/2 of the medication after reinforcement from staff B. Client #6 refused to drink the other half. At no time did staff notify the nurse. Interview with the Program Manager on 5/8/24 confirmed that client #6 should drink all of the fluid to ensure she is receiving the medication as prescribed. If client refuses the medication, the staff should contact the nurse and document it on the quick Mar.	W 369		
W 460	FOOD AND NUTRITION SERVICES	W 460		

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W 460	Continued From page 5 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 observation, record review and interview the facility failed to ensure clients received a modified and specially-prescribed diet as indicated. This affected 2 or 4 audit clients (#4 and #6). The findings are: A. During dinner observations on 5/7/24 at 4:45pm revealed client #4 consumed pork chop prepared in a food processor, which was moist and lumpy. Client #4 coughed several times throughout the meal. During breakfast observations on 5/8/24 at 6:47am revealed client #4 consumed waffles prepared in a food processor, which was moist and lumpy. Client #4 did not display any difficulty eating during the meal. Review on 5/8/24 of client #4's Individualized Program Plan (IPP) dated 4/4/24 revealed a Puree diet consistency. Interview with the Program Manager and Site Supervisor confirmed client #4 should have received a Puree diet as prescribed. B. During breakfast observations on 5/8/24 at 6:47am client #6 was provided 2 whole waffles. Staff C cut client #6's waffles to approximately 1/4 inch. Client #6 consumed the waffles without difficulty.	W 460		

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W 460	Continued From page 6 Review on 5/7/24 of client #6's IPP dated 2/1/24 revealed a Puree diet consistency. Interview with the Program Manager and Site Supervisor confirmed client #4 should have received a Puree diet as prescribed.	W 460		
W 484	DINING AREAS AND SERVICE CFR(s): 483.480(d)(3) The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure needed adaptive equipment was provided for 1 of 4 audited clients (#6). The finding is: During dinner observations on 5/7/24 at 4:30pm and breakfast observations on 5/8/24 at 6:47am revealed client #6 was provided a high-sided plate with no dividers. During observations on 5/7/24 and 5/8/24 revealed client #6 was provided a regular plastic drinking cup during medication pass. Review on 5/7/24 of client #2's Individualized Program Plan (IPP) dated 2/1/24 revealed the following adaptive equipment: high-sided divided plate and modified drinking cup with lid. Interview on 5/8/24 with the Program Manager confirmed staff should have provided client #6 with the adaptive equipment identified in the IPP.	W 484		