STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G279	A. BUILDING _____ B. WING _____	R 07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-OLIVE HOME	**707 EAST OLIVE STREET APEX, NC 27502**

(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 revisit was conducted on 7/25/24 for deficiencies previously cited on 5/6 - 5/7/24. Two deficiencies were not corrected. The facility remains out of compliance.	W 000		
{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, record reviews and interviews, the facility failed to ensure staff were sufficiently trained regarding all aspects of medication administration. This affected 2 of 5 audit clients (#1 and #5). The findings are: A. During morning observations of medication administration in the home on 5/7/24 at 7:23am, client #1 was assisted by Medication Technician (MT) to apply Sodium Flouride 5000 Plus toothpaste on his toothbrush in the medication room. The client then left the room and went down the hall to the bathroom with the toothbrush in his hand. The MT remained in the medication room and proceeded to assist another client with their medications. Client #1 was not observed by the MT to use the prescribed toothpaste. B. During morning observations of medication administration in the home on 5/7/24 at 8:00am, client #5 was assisted by the MT to retrieve Perioguard .12% mouth rinse and pour it into a medication cup. The client was also assisted to	{W 340}		

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

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{W 340}	Continued From page 1	{W 340}		

receive Lortisone cream on his face while in the medication room. After applying the cream, the MT took client #5 to a bathroom down the hall to wash his face. On his way to the bathroom, client #5 placed the cup containing the Perioguard on a dresser in his bedroom. After washing his face, the MT left the bathroom and returned to the medication area. Client #5 was not observed by the MT to use the prescribed mouth rinse.

Interview on 5/7/24 with the MT revealed she normally does not watch clients while applying prescribed mouth rinses and toothpastes because they know how to use those items.

Review on 5/7/24 of client #1's physician's orders dated 3/1/24 revealed an order for Sodium Flouride 5000 Plus toothpaste twice daily at 7am and 8pm. The order noted, "Brush teeth twice daily for 2 min..."

Review of client #5's physician's orders dated 3/1/24 noted an order for Chlorlex Glu Solution .12% at 7a and 9p. The order indicated, "...swish 1/2 ounce by mouth every morning and every evening for antigingival rinse (Do Not Swallow)..."

Interview on 5/7/24 with the Director of Nursing Services acknowledged the MT should observe medications, including prescribed mouth rinses and toothpastes, from the time they are dispensed until applied.

During a follow-up survey in the home on 7/25/24 at 6:45am, client #3 and other clients began serving themselves and consuming their breakfast meal. At 7:42am, the MT assisted client #3 to dispense her morning medications. At

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{W 340}	Continued From page 2 the medication pass, client #3 ingested Prilosec 40mg along with five other medications, two eye drop solutions and a nasal spray. Review on 7/25/24 of client #3's physician's orders dated 3/1/24 revealed an order for Prilosec 40mg, take 1 capsule by mouth "every morning before breakfast" for acid reflux..." between 6:00am to 7:00am. Interview on 7/25/24 with the MT revealed she normally gives client #3's medications after breakfast. Interview on 7/25/24 with the Site Supervisor and the Qualified Intellectual Disabilities Professional (QIDP) indicated there was a discrepancy with the time noted on the Quick MAR (Medication Administration Record) and the written orders. However, the QIDP acknowledged the MT should be following the orders as written.	{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 1 of 4 clients (#1) observed receiving medications. The finding is: During observations of medication administration in the home on 5/7/24 at 7:23am, client #1 ingested Synthroid, Pepcid, Catapres, Latuda Vitamin D3 and Vitamin B-12. No topical	{W 369}		

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{W 369}	Continued From page 3 medications were administered at this time. Review on 5/7/24 of client #1's physician's orders dated 3/1/24 revealed an order for Protopic .1%, apply a thin layer to affected areas twice daily 7am, 8pm. Interview on 5/7/24 with the Medication Technician revealed she thought client #1 had applied the cream when he came in the room for his medications this morning. Interview on 5/7/24 with the Director of Nursing Services acknowledged the omission of client #1's cream would be a medication error. During a follow-up survey in the home on 7/25/24 at 7:42am, the Medication Technician (MT) assisted client #3 to dispense her morning medications. At the medication pass, client #3 ingested Cymbalta 60mg along with five other medications, two eye drop solutions and a nasal spray. Review on 7/25/24 of client #3's physician's orders dated 3/1/24 revealed she receives Cymbalta (Duloxetine) 60mg, "take 1 capsule by mouth every morning for antidepressant (take along with 30mg cap for total dose of 90mg..." between 7:00am to 8:00am and Cymbalta 30mg, "take 1 capsule by mouth every morning for antidepressant (take along with 60mg for total of 90mg..." between 7:00am to 8:00am. Interview on 7/25/24 with the MT confirmed client #3 should have taken the Cymbalta 30mg capsule along with the 60mg capsule.	{W 369}		

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{W 369}	Continued From page 4 Interview on 7/25/24 with the Site Supervisor and Qualified Intellectual Disabilities Professional (QIDP) confirmed the physician's orders were current and both doses of Cymbalta should have been administered during client #3's med pass.	{W 369}		