STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G280	A. BUILDING _____ B. WING _____	05/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-SECOND AVENUE GROUP HOME	**49 SECOND AVENUE SE TAYLORSVILLE, NC 28681**

(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 242	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(iii) The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on observation, staff interview and review of records, the facility failed to ensure the individual support plan (ISP) included objective training to address dining needs for 1 of 3 sampled clients (#3), the finding is: Observations in the group home on 5/8/18 at 7:30 AM revealed a staff member assisting client #3 by hand over hand cutting pancakes and strawberries into bite size pieces with the client's large handle fork, as well as pouring syrup. Continued observations through 7:45 AM revealed the client to eat the pancake and strawberry pieces with his fingers on multiple occasions. Staff were not observed prompting client #3 to use a fork until the end of the meal. Review of the record for client #3 on 5/8/18 revealed an ISP dated 7/18/17. The ISP indicated that client #3 needs prompting and encouragement to use utensils. The ISP contained a community/home life assessment dated 7/17/18 which indicated client #3 was assessed as being being independent with using an adaptive fork and spoon. Continued review of	W 242		

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

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W 242	Continued From page 1 the record did not reveal any current or discontinued programming related to proper use of utensils. Interview with the qualified intellectual disabilities professional (QIDP) on 5/8/18 revealed she had noticed recently, that client #3 had started sometimes using his fingers to eat items that should be eaten with a utensil. The QIDP confirmed client #3 does not currently have programming related to the use of dining utensils and indicated the client could benefit from programming.	W 242		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) 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 observation, record review and staff interview, the team failed to assure the behavior support plan (BSP) was implemented as prescribed for 1 of 3 sampled clients (#4). The finding is: Observation in the group home on 5/7/18 at 5:50 PM revealed staff to supervise client #4 on the front porch of the group home. Continued observation revealed client #4 to raise her arms	W 249		

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W 249	Continued From page 2	W 249		

in the air, make loud vocalizations and slide down in her wheelchair. Staff was observed to assist the client two times with sitting back up in her wheelchair while the client continued to slide down in her chair after each adjustment. Subsequent observation revealed after readjusting the client two times to sit up in her wheelchair, that staff stood in front of the client placing her knees against the clients knees and applying pressure to keep the client from sliding down in her chair. Client #4 was observed to continue to keep her arms raised while making loud vocalizations. At 6:00 PM staff was observed to assist client #4 to the facility van for a dinner outing. Observation in the group home on 5/8/18 at 8:15 AM revealed client #4 to sit in her wheelchair in the living room waiting to go to the day program. Client #4 was observed to raise her arms and begin making vocalizations while sliding down in her chair. Staff assisting client #4 was observed to watch the client, without offering any option of leisure or readjustment in her chair, until the group home manager (GHM) walked by assisting client #4 out of her wheelchair. The GHM was then observed to walk the client to the facility van for transport to the day program.

Review of record for client #4 on 5/8/18 revealed an individual support plan (ISP) dated 7/20/17. Review of the ISP revealed a behavior support plan (BSP) dated 7/18/17 for target behaviors of inappropriate food taking, non-compliance and agitation: twirling around, vocalizing loudly, posturing (placing hands high in the air), and body rocking. Continued review of the BSP revealed interventions for agitation to include staff offering choices of different tactile activities to include holding/manipulating putty, soft puzzles and arts/crafts that do not have sharp objects.

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W 249	Continued From page 3 The BSP further revealed if client #4 continues to demonstrate agitation that staff may switch out, allowing the client the opportunity to work with someone new and minimizing further disruptive behavior. Interview with the facility qualified intellectual disabilities professional (QIDP) verified client #4 demonstrates agitation with raising her arms, loud vocalizations and sliding down in her wheelchair. Additional interview with the QIDP verified when client #4 demonstrated agitation she should have been offered tactile objects as indicated in the BSP. The QIDP further verified at no time should staff stand in front of the client and place their knees against the clients knees to prevent the client from movement. Therefore the BSP was not implemented as prescribed relative to agitation for client #4.	W 249		