STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G197	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-ST. JOHN'S CHURCH ROAD GROUP HOME	2220 ST. JOHN'S CHURCH ROAD CHARLOTTE, NC 28215

(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
E 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This STANDARD is not met as evidenced by: The facility failed to develop and maintain an emergency preparedness plan that identified and addressed the specific needs of the clients in the group home as evidenced by interview and verified by review of record. The finding is: Review of the facility's Emergency Plan (EP) on	E 006	PLEASE SEE ATTACHED PLAN OF CORRECTION DHSR NHL & C Black Mountain MRO Received APR 12 2018 by: SKH	05/21/18

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-ST. JOHN'S CHURCH ROAD GROUP HOME	2220 ST. JOHN'S CHURCH ROAD CHARLOTTE, NC 28215

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E 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This STANDARD is not met as evidenced by: The facility failed to develop and maintain an emergency preparedness plan that identified and addressed the specific needs of the clients in the group home as evidenced by interview and verified by review of record. The finding is: Review of the facility's Emergency Plan (EP) on	E 006	PLEASE SEE ATTACHED PLAN OF CORRECTION	05/21/18

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

PROGRAM MANAGER 04.20.18

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.

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
	34G197	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-ST. JOHN'S CHURCH ROAD GROUP HOME	2220 ST. JOHN'S CHURCH ROAD CHARLOTTE, NC 28215

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E 006	Continued From page 1 3/21/18 revealed the facility had developed a facility-based and community-based risk assessment utilizing an all-hazards approach as required. However, further review of the EP revealed the only client information included in the plan was an "Annual Consumer Profile" for each client that was pulled from each client's chart that includes basic information on the client. Further review of the EP, substantiated by interview with the qualified intellectual disabilities professional (QIDP), revealed no additional specific client information is included in the EP to direct any volunteers or those unfamiliar with the clients in the group home in how to assist the client in case of an evacuation or disaster identified in the EP. In addition, further review of the EP revealed as part of the group home emergency disaster supplies, "client identification cards or wrist bands" are included to provide specific information on each client such as diets, allergies and behaviors. Further interview with the QIDP revealed as of the 3/21-22/18 survey those client identification cards had not been developed. However, continued interview with the QIDP revealed a plan to gather needed supplies and information for each client in a backpack to ensure specific client needs would be able to be met during an emergency.	E 006		
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.	W 227	PLEASE SEE ATTACHED PLAN OF CORRECTION	05/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 227	Continued From page 2 This STANDARD is not met as evidenced by: The facility failed to assure the individual support plan (ISP) for 1 of 3 sampled clients (#5) included objective training to meet the client's dressing needs as evidenced by observation, interview and record verification. The finding is: Afternoon observations in the group home at 4:00 PM on 3/21/18 revealed client #5 finishing in the bathroom and opening the bathroom door. The client was noted to be dressed except for his pants being unbuttoned and unzipped. Further interviews revealed the client's father, who was visiting the facility, to notice client #5 and assist the client to button and zip his pants. Continued morning observations at 6:05 AM on 3/22/18 revealed the client to again open the bathroom door with his pants unbuttoned and unzipped. Staff noticed client #5 and assisted the client with buttoning and zipping his pants. Interview with staff revealed client #5 does have a lot of trouble buttoning his pants and often gets frustrated. Review of client #5's ISP dated 2/1/18 revealed a community/home life assessment dated 1/26/18 which notes the client requires physical assistance to work all closures when dressing. Further review of the ISP, substantiated by interview with the qualified intellectual disabilities professional (QIDP), revealed the client currently does not have any training to learn to button and zip his pants but could benefit from formal training.	W 227		
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi)	W 247	Please see Attached Plan of Correction	05/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 247	Continued From page 3 The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: The facility failed to individual support plan (ISP) for 1 of 3 sampled clients (#5) included opportunities for choice and self-management regarding care of his eyeglasses as evidenced by observation, interview and record verification. The finding is: Afternoon observations in the group home on 3/21/18 revealed the client to wear his glasses throughout the afternoon. However, morning observations on 3/22/18 revealed the client to exit the bathroom at 6:05 AM not wearing his glasses. The client was noted to prepare breakfast and eat breakfast without his glasses before getting his medications at 6:55 AM. During observations of the medication pass staff was observed to give client #5 his glasses from a case kept in the medication closet. Interview with staff revealed the client gives staff his glasses at night during the evening medication pass and they are returned to him during the morning medication pass. Review of client #5's ISP dated 2/1/18 revealed an objective for the client to clean and keep his glasses in good repair. The program further states that client #5 will wear his glasses during all waking hours and place his eyeglasses in his case upon going to sleep. Interview with the qualified intellectual disabilities professional (QIDP) revealed client #5 is good about keeping up with his glasses and the intention of the program was for the client to keep his glasses and glasses case in his room to complete this objective. As the client was not allowed to care	W 247		

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W 247	Continued From page 4 for his glasses to best of his ability, the facility failed to provided client #5 with an opportunity for choice and self-management.	W 247		
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observations and interviews, the system for drug administration failed to assure 3 of 4 clients observed during drug administration received training in medication administration (clients #4, #5 and #6). The findings are: A. Observations conducted on 3/22/18 at 6:18 AM revealed client #6 to enter the medication room with staff. Continued observation revealed staff to punch all of client #6's medications into a medication cup to include Depakote 250 mg.- 1 tab, Risperidone 2 mg.-1 tab, Cetrazine 10 mg. -1 tab, and Depakote 500 mg.- 1 tab. Further observations revealed client #6 was handed the medication cup by staff and water with which to take his medications. Client #6 proceeded to take all of the above mentioned medications from the medication cup. Continued observations revealed client #6 to then receive Fluticasone Nasal Spray- 2 sprays in each nostril. Further observations revealed client #6 to then leave the medication room. Subsequent observations revealed at no time during the medication pass	W 371	Please See Attached Plan of Correction	05/21/18

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W 371	Continued From page 5 was client #6 given the opportunity to punch out his medications, obtain his water for taking his medications, nor was training provided for client #6 related to the name of his medications, the purpose or possible side effects of his medications. Interview conducted with the nurse and on 3/22/18 revealed staff should provide training for each client during medication administration including the name, purpose, and possible effect of each medication. Continued interview the Qualified Intellectual Disabilities Professional (QIDP) stated each client should be given an opportunity to identify and obtain his medication basket, obtain water for taking medications, and be provided an opportunity to punch his medications into his medication cup. B. Observations conducted on 03/22/18 at 6:37 AM in the group home revealed client #4 to enter the medication room with staff. Continued observation revealed staff to punch all of client #4's medication in a medication cup, to included Doxycycline 10 mg. Further observation revealed client #4 was handed the medication cup and water cup by staff with which to take his medications. Client #4 proceeded to take the above mentioned medication and exit the medication room. Subsequent observations revealed at no time during the medication pass was client #4 give the opportunity to identify and obtain his medication basket, to punch his medications into his medication cup or to obtain water with which to take his medications. Continued observation revealed at no time during the medication pass was client #4 provided with training related to the name of his medication, or the purpose and possible side effect of his	W 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 371	Continued From page 6 medications. Interview conducted with the nurse on 3/22/18 revealed staff should provide training for each client during medication administration including the name, purpose, and possible side effect of each medication. Continued interview with the QIDP confirmed each client should be given an opportunity to identify and obtain his medication basket, obtain water for taking medications, and be provided an opportunity to punch his medications into his medication cup. C. Observations conducted on 3/22/18 at 6:55 AM revealed client #5 to enter the medication room with staff. Further observation revealed staff to give client #5 one aspirin-81 mg. and a cup of water with which to take his medication. Continued observation revealed client #5 was not given the opportunity to obtain his medication basket or water for taking his medication, nor was client #5 provided teaching about the name, purpose, or side effect of his medication. Subsequent observation revealed client #5 to leave the medication room. Interviews conducted with the QIDP on 3/22/18 revealed client #5 should have been given an opportunity by staff to obtain his medication basket and his water. Continued interview with the nurse revealed staff should provide training for each client during medication administration including the name and purpose and possible side effects of all medications.	W 371		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals	W 382	Please See Attached Plan of Correction	05/21/18

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W 382	Continued From page 7 locked except when being prepared for administration. This STANDARD is not met as evidenced by: The facility failed to assure the medication closet door was keep locked as required as evidenced by observation and interview. The finding is: Morning observations in the group home at 7:10 AM on 3/22/18 revealed the medication closet containing all client medications to be unlocked. Interview with staff administering morning medications on 3/22/18 at 7:16 AM verified the medication closet door, along with the cabinets in the closet, were left unlocked but should have remained locked except when giving medications.	W 382		

Provider Plan of Correction for VOCA-St. John's Church Group Home
2220 St. John's Church Road
Charlotte, NC 28215
Provider # 34G197
Date of Annual On-Site Survey: March 21-22, 2018

E 006 PLAN BASED ON ALL HAZARDS RISK ASSESSMENT CFR(s): 483.475(a)(1)-(2)

1. For ICF/IID's Hazard Risk Assessments must be based on and include a documented, facility based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.

2. Include strategies for addressing emergency events identified by the risk assessment.

Community Alternatives of NC, specifically the St. John's Group Home, will develop and maintain an emergency preparedness plan that identifies and addresses the specific needs of the clients in the group home.

The QIDP will develop picture ID tags and a folder that will include demographic information with picture, diets, adaptive equipment, consumer needs, behavioral challenges, communication needs and any non-negotiable items needed. This information will be placed in back packs to include clothing.

The Residential Manager will complete a weekly walkthrough of the home to ensure all back packs are in the designated area. The QIDP will update the information as needed inspect the back packs on a monthly basis to ensure all information is current. The Program Manager will ensure the back packs are in the designated area during monthly site reviews.

Person Responsible: Residential Manager, QIDP, Program Manager
Date to Be Completed: May 14, 2018.

W227 INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4)

The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.

Community Alternatives of NC, specifically the St. John's Group Home, will ensure the individual support plan (ISP) for client (#5) include an objective training to meet the client's dressing needs for buttoning and zipping his pants.

The QIDP will implement a formal dressing training program for client #5 to button and zip his pants. The QIDP will train the RM and DCP's on the implementation, methodology, and frequency of documentation.

The Residential Manager will conduct observations 3 x weekly to ensure the training is implemented and documented as prescribed. The QIDP will conduct weekly observations to ensure the training is implemented and documented as prescribed. The Program Manager will conduct observations during monthly site reviews to ensure the training is implemented and documented as prescribed.

Person Responsible: Residential Manager, QIDP, Program Manager
Date to Be Completed: May 14, 2018

W247 INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi)

The individual program plan must include opportunities for client choice and self-management.

Community Alternatives of NC, specifically the St. John's Group Home, will ensure the individual support plans for all clients include opportunities for choice and self-management regarding care of his eyeglasses.

The QIDP will implement a formal training program for client #5 to store his eyeglasses when sleeping. The QIDP will train the RM and DCP's on implementation, methodology, and frequency of documentation. This this program will promote independence with self-management with care for his eyeglasses.

The Residential Manager will conduct observations 3 x weekly to ensure the training is implemented and documented as prescribed. The QIDP will conduct weekly observations to ensure the training is implemented and documented as prescribed. The Program Manager will conduct observations during monthly site reviews to ensure the training is implemented and documented as prescribed

Person Responsible: Residential Manager, QIDP, Program Manager
Date to Be Completed: May 14, 2018.

W371 DRUG ADMINISTRATION CFR(s): 483.460(k)(4)

The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.

Community Alternatives of NC, specifically the St. John's Group Home, will assure the clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.

The Nurse will in-service The Residential Manager, QIDP, and all DCP's on following the eight rights of medication administration to ensure opportunities for education and participation with their medication administration. The DCP assigned to administer medication will educate each client on the name, purpose, and possible side effects of each medication prior to administration. They will encourage the client to participate as much as possible in administering their own medication.

The Residential Manager will conduct observations 3 x weekly to ensure the training is implemented and documented as prescribed. The QIDP will conduct weekly observations to ensure the training is implemented and documented as prescribed. The Program Manager will conduct observations during monthly site reviews to ensure the training is implemented and documented as prescribed.

Person Responsible: Nurse, Residential Manager, QIDP, Program Manager
Date to Be Completed: May 14, 2018.

W382 DRUG ADMINISTRATION AND RECORDKEEPING CFR(s): 483.460(l)(2)

The facility must keep all drugs and biologicals locked except when being prepared for administration.

Community Alternatives of NC, specifically the St. John's Group Home, will ensure the facility ensure the medication closet door remains locked as required except for drug administration for consumers receiving training in medication administration.

The Nurse will re-train the Residential Manager, QIDP, all DCP's to keep the medication closet door is locked at all times except during medication administration.

The Residential Manager will conduct observations 3 x weekly to ensure the medication closet door is locked except during medication administration. The QIDP will conduct weekly observations ensure the medication closet door is locked except during medication administration. The Program Manager will conduct monthly site reviews to ensure the medication closet door is locked except during medication administration.

Person Responsible: Nurse, Residential Manager, QIDP, Program Manager
Date to Be Completed: May 14, 2018.