STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL018-041	A. BUILDING: _____ B. WING _____	09/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-FOREST RIDGE	4959 FOREST RIDGE DRIVE HICKORY, NC 28602

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V 000	INITIAL COMMENTS An annual survey was completed on September 11, 2018. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL018-041	A. BUILDING: _____ B. WING _____	09/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-FOREST RIDGE	4959 FOREST RIDGE DRIVE HICKORY, NC 28602

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V 118	Continued From page 1	V 118		

This Rule is not met as evidenced by:
Based on record review, observation and interviews, the facility failed to keep the MAR current for 3 of 3 sampled clients (Client #1-#3) and failed to ensure physician-prescribed medication was available at the facility to administer to clients affecting 2 of 3 sampled clients (Client #1 and #2). The findings are:

Record review on 9-7-18 for Client #1 revealed:
Admission date: 4/15/08
Diagnoses: Moderate Intellectual Developmental Disability (IDD), Psychotic Disorder, Major Depressive Disorder, Seizure Disorder, Dementia, Pseudobulbar Affect (PBA), Gastroesophageal Reflux Disease (GERD), Overactive Bladder with incontinence
-2/1/18 physician-ordered medications included:
- VIMPAT 200 milligram (mg), 1 tablet twice daily to treat partial-onset seizures;
- donepezil (Aricept) 5 mg, 1 tablet at bedtime with order changed on 7/25/18 to 10 mg, 1 tablet at bedtime for Alzheimer's-related dementia;
- Melatonin 1mg, 1 tablet at bedtime with order changed on 7/25/18 to 3 mg, 1 tablet at bedtime for sleep;
-8/8/18 physician-ordered medications included:
-clonazepam (Klonopin) 0.5 mg, 1 tablet at bedtime to treat seizure and panic disorders;
-Calcium D 600/400 mg, 1 tablet once daily;
-escitalopram (Lexapro) 20 mg, 1 tablet once daily for depression;
-famotidine (Pepcid) 20 mg, 1 tablet twice daily;
-Ibuprofen 800 mg, 1 tablet twice daily;
-lamotrigine (Lamictal) 100 mg, 2 tablets (200

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL018-041	A. BUILDING: _____ B. WING _____	09/11/2018

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VOCA-FOREST RIDGE	4959 FOREST RIDGE DRIVE HICKORY, NC 28602

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V 118	Continued From page 2	V 118		

mg) every morning and 3 tablets (300 mg) at bedtime for seizures;
-memantine (Namenda) 28 mg, 1 capsule once daily to treat Alzheimer's dementia;
-Nuedexta 20-10 mg, 1 capsule twice daily to treat involuntary outbursts of crying or laughing;
-pantoprazole (Protonix) 40 mg, 1 tablet every morning 30 minutes before breakfast for acid reflux;
-topiramate (Topamax) 200 mg, 1 tablet twice daily to treat seizures;
-Vesicare 10 mg, 1 tablet once daily for an overactive bladder;
-Vitamin D 50000 units, 1 capsule every week on Monday.

Review on 9/7/18 of Client #1's MARS for July 2018 and September 2018 revealed:
-Printed out copies of 7/2018 and 9/2018's electronic medication administration records (EMARs) with electronic staff initials;
-Paper copies of Client #1's 7/2018 and 9/2018 MARS with original staff initials;
-clonazepam was coded on the 7/2018 EMAR as "out of facility" on 7/9/18 and blank on 7/13/18;
-donepezil 5 mg was initialed as administered from 7/25/18-7/31/18 (7 doses) after physician's order to increase to 10 mg on 7/25/18;
-donepezil 10 mg was not initialed as administered from 7/25/18 to 7/31/18;
-Melatonin 1mg was blank on 7/13/18 and was initialed as administered from 7/25/18-7/31/18 after physician's order to increase to 3 mg on 7/25/18;
-Melatonin 3 mg was not initialed as administered from 7/25/18 to 7/31/18;
-VIMPAT 200 mg was:
-initialed as administered on 6/13/18;
-coded on the 7/2018 EMAR as "out of facility" on 7/9/18 (1 day);

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL018-041	A. BUILDING: _____ B. WING _____	09/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-FOREST RIDGE	4959 FOREST RIDGE DRIVE HICKORY, NC 28602

(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) COMPLETE DATE
V 118	Continued From page 3 -coded on the 9/2018 EMAR system from 9/1/18-9/7/18 (6 days) as "medication has not arrived at facility yet" and "out of the facility." Review on 9/7/18 of facility incident reports revealed: -6/14/18, Client #1's VIMPAT dose was reported still in medication pack and was logged in the EMAR as administered by staff on 6/13/18; -No documentation on the 6/2018 EMAR of a medication error; -No paper copy of 6/2018 MARS with original staff initials made available for review. Further review on 9/10/18 of Client #1's MARS for June 2018- September 2018 revealed: -Printed out EMAR copies of 6/2018- 9/2018 with electronic staff initials; -Paper copies of Client #1's 7/2018- 9/2018 MARS with original staff initials; -No paper copy of 6/2018 MARS with original staff initials made was made available for review; -6/3/18, donepezil, famotidine, Ibuprofen, lamotrigine 300 mg, Melatonin 1 mg and topiramate was blank; -6/25/18, Calcium, donepezil, escitalopram, famotidine (8 am and 8 pm), lamotrigine (8 am and 8 pm), Melatonin 1 mg, memantine, Nuedexta (8 am and 8 pm), pantoprazole, topiramate (8 am and 8 pm), Vesicare and Vitamin D was blank; -7/13/18, clonazepam, donepezil 5 mg, famotidine, lamotrigine (8 pm), Melatonin 1mg and topiramate (8 pm) was blank; -7/25/18-7/31/18, donepezil 10 mg and Melatonin 3 mg was blank; -7/25/18-7/31/18, donepezil 5 mg and Melatonin 1 mg with staff initials and stop date of 7/25/18; -8/1/18 and 8/2/18 at 8 am, Calcium, escitalopram, famotidine, lamotrigine 200 mg,	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL018-041	A. BUILDING: _____ B. WING _____	09/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-FOREST RIDGE	4959 FOREST RIDGE DRIVE HICKORY, NC 28602

(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) COMPLETE DATE
V 118	Continued From page 4	V 118		

memantine, Nuedexta, pantoprazole, topiramate and Vesicare was blank;
-8/31/18 at 8 pm, donepezil (10 mg), famotidine, lamotrigine 300 mg, Melatonin 3 mg, Nuedexta and topiramate was blank.

Record review on 9/7/18 for Client #2 revealed:
Admission date: 11/20/09
Diagnoses: Organic Personality Disorder, Recurrent Depression, Severe Psychotic Features, Left-sided Hemiparesis, Mild Intellectual Developmental Disability, Gastritis, Epilepsy, Hypothyroidism, Reflux, Osteoporosis, Explosive Depressive Disorder, History of Right Breast Malignancy
-1/31/18 physician-ordered medication included:
-aripiprazole (Abilify) 10 mg, 1/2 tablet (5 mg) twice daily for depression with a physician order to discontinue 8/8/18;
-8/8/18 physician-ordered medications included:
-alendronate (Fosamax) 70 mg, 1 tablet every week on Monday to treat osteoporosis;
-Aspirin Chewable 81 mg, 1 tablet once daily;
-Calcium D 600/400 mg, 1 tablet twice daily;
-divalproex (Depakote) 250 mg Extended Release (ER), 1 tablet every evening for epilepsy;
-divalproex 500 mg ER, 1 tablet twice daily for epilepsy;
-docusate sodium (Colace) 100 mg, 1 capsule twice daily to soften stool;
-duloxetine (Cymbalta) 30 mg, 1 capsule once daily for depression;
-fexofenadine (Allergy Relief) 180 mg, 1 tablet once daily;
-Gold Bond Powder, apply to groin, abdomen and under breasts once daily;
-levothyroxin (Synthroid) 100 micrograms (mcg), 1 tablet once daily 30 minutes before meal in the morning on an empty stomach for Hypothyroidism;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL018-041	A. BUILDING: _____ B. WING _____	09/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-FOREST RIDGE	4959 FOREST RIDGE DRIVE HICKORY, NC 28602

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V 118	Continued From page 5 -Natural Fiber Powder 28.3%, 2 teaspoons in food or drink twice daily; -One-Daily Multi Vitamin, 1 tablet once daily; -Nexium 40 mg, 1 capsule every morning to treat GERD; -ranitidine (Zantac) 300 mg, 1 tablet once daily for heartburn; -risperidone (Risperdal) .25 mg, 1 tablet every morning to treat irritability and bipolar disorder; -topiramate (Topamax) 200 mg, 2 tablets (400 mg) at bedtime to treat seizures; -Vesicare 10 mg, 1 tablet once daily for overactive bladder; -Vitamin D3 400 Unit, 1 tablet twice daily. Review on 9/7/18 of Client #2's 8/2018 MAR revealed: -Printed out copy of 8/2018 EMAR with electronic staff initials and paper copy of 8/2018 MAR with original staff initials; -Client #2 was not administered her aripiprazole 10 mg, 1/2 tablet (5 mg) twice daily from 8/1/18 to 8/7/18 (7 days) as physician-ordered as indicated by: -8/1/18, 8/2/18, 8/6/18 and 8/7/18 at 8 am was blank; -8/1/18, 8/5/18, 8/6/18 and 8/7/18 at 8 pm was blank; -Initialed as administered on 8/2/18 and 8/3/18 at 8 pm; -EMAR exception codes on 8/3/18, 8/4/18 and 8/5/18 identified the aripiprazole 10 mg was "out of the facility"; -Client #2 was not administered her risperidone .25 mg, 1 tablet every morning as physician-ordered from 8/8/18-8/14/18 (6 days) as indicated by: -8/8/18-8/13/18 was blank; -8/14/18, an EMAR exception code on 8/14/18 identified the risperidone .25 mg had "not arrived	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL018-041	A. BUILDING: _____ B. WING _____	09/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-FOREST RIDGE	4959 FOREST RIDGE DRIVE HICKORY, NC 28602

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V 118	Continued From page 6	V 118		

at facility yet."

Further review on 9/10/18 of Client #2's 6/2018-9/2018 MARS revealed:
-Printed out EMAR copies of 6/2018- 9/2018 with electronic staff initials;
-Paper copies of Client #1's 7/2018- 9/2018 MARS with original staff initials;
-No paper copy of 6/2018 MARS with original staff initials made was made available for review;
-6/3/18 at 8 pm, aripiprazole, Calcium D, divalproex 500 mg, docusate sodium, Natural Fiber, ranitidine, topiramate and Vitamin D3 was blank;
-6/25/18, alendronate (7 am), Aspirin Chewable, divalproex 250 mg (4 pm), docusate sodium, duloxetine, fexofenadine, Gold Bond Powder, levothyroxine, Nexium, One-Daily Multi Vitamin, ranitidine, topiramate, Vesicare , and aripiprazole was blank;
-8 am and 8 pm dose times, divalproex 500 mg, Natural Fiber, and Vitamin D3 was blank
-7/31/18, Natural Fiber (8 pm) and ranitidine was blank;
-8/1/18-8/2/18, Aspirin Chewable, Calcium D, divalproex 500 mg, docusate sodium, duloxetine, Gold Bond, levothyroxine, Natural Fiber, Nexium, One-Daily Multi Vitamin, Vesicare and Vitamin D3 was blank;
-8/8/18, Natural Fiber was blank;
-8/31/18 at 8 pm dose times, Calcium D, divalproex 250 mg, divalproex 500 mg, docusate sodium, Natural Fiber, ranitidine, topiramate, and Vitamin D3 was blank;
-9/2/18, Vitamin D3 was blank.

Record review on 9/7/18 of Client #3's record revealed:
Admission date: 4/15/08
Diagnoses: Attention-deficient Hyperactivity

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL018-041	A. BUILDING: _____ B. WING _____	09/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-FOREST RIDGE	4959 FOREST RIDGE DRIVE HICKORY, NC 28602

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V 118	Continued From page 7 Disorder, Impulse Control Disorder, Moderate Mental Retardation, History of Seizures -8/8/18 physician-ordered medications included: -cetirizine (Zyrtec) 10 mg, 1 tablet once daily to treat allergy symptoms; -fluticasone (Flonase) spray 50 mcg, 2 squirts in each nostril once daily to treat allergies; -Multi-vitamin, 1 tablet once daily; -paroxetine (Paxil) 40 mg, 1 tablet once daily for depression and anxiety; -risperidone .5 mg, 1 tablet twice daily to treat irritability; -topiramate 50 mg, 1 tablet once daily to treat seizures. Review on 9/7/18 of Client #3's 6/2018-9/2018 MARS revealed: -Printed out EMAR copies of 6/2018- 9/2018 with electronic staff initials; -Paper copies of Client #1's 7/2018- 9/2018 MARS with original staff initials; -No paper copy of 6/2018 MARS with original staff initials made was made available for review; -6/3/18, cetirizine and risperidone (8 pm) was blank; -6/25/18 at 8 am and 8 pm dose times, cetirizine, risperidone and topiramate was blank; -8/1/18-8/2/18, fluticasone, Multi-vitamin, paroxetine and risperidone was blank. Interview on 9/7/18 with Client #1 revealed: -She took medication but did not know what her medications were for; -Staff gave her medications. Interview on 9/7/18 with Client #2 revealed: -She took medication; -Staff gave her medication every day; -One of her medications was for seizures; -"I have Epilepsy."	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL018-041	A. BUILDING: _____ B. WING _____	09/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-FOREST RIDGE	4959 FOREST RIDGE DRIVE HICKORY, NC 28602

(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) COMPLETE DATE
V 118	Continued From page 8 Interview on 9/7/18 with Client #3 revealed: -She took medication but did not know what they were for; -Staff gave her medication. Interview on 9/7/18 with Staff #1 revealed: -She was a Direct Care Staff; -Had worked at the facility since 6/2016 on 1st shift; -Her training included Medication Administration; -Her duties as a Direct Care staff included ensuring clients kept their medical appointments, administering medication Clients #1- #3 during her work shift, and calling the pharmacy and doctors about medication refills; -Client #1's VIMPAT medication was for the prevention of seizures and a controlled medication that required a new prescription at refill; -Client #1's VIMPAT was not at the facility because the pharmacy said it had not received a new prescription from the doctor and the doctor's office said a new prescription was sent in 8/2018; -She had called Client #1's doctor on 9/5/18 to re-send a prescription for the VIMPAT; -Staff were waiting for the medication to be refilled and delivered by the pharmacy to the facility; -She did not have notes about her contacts with Client #1's doctor or the pharmacy; -She had informed the Group Home Manager that Client #1 was without the VIMPAT for 9/2018; -Client #1 had shown no adverse signs or symptoms by not having her VIMPAT medication; -She stated that Client #1 had not had a seizure she was aware of since she started work 2 years ago. Interview on 9/7/18 and 9/10/18 with the Group	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL018-041	A. BUILDING: _____ B. WING _____	09/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-FOREST RIDGE	4959 FOREST RIDGE DRIVE HICKORY, NC 28602

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V 118	Continued From page 9	V 118		

Home Manager (GHM) revealed:
-She started work as the GHM in 4/2018;
- The EMAR computer system started at the facility in 1/2018;
-Staff was trained on use of the EMAR by a registered nurse employed by the licensee when trained in Medication Administration;
-The pharmacy was responsible for keeping the medications current on the EMARS and delivery of the medications;
-A paper copy of the MAR for each client was printed out every month for staff to use as a backup procedure to the EMAR to document medication administration in case the EMAR system was not working;
-The blank dates on Clients #1- #3 MARS occurred because either staff had not logged into the EMAR to initial that they gave clients their medication or staff had forgotten to initial on the paper MARs if EMAR was not working properly;
-She looked on the back of clients' medication packs for staff initials and dates and reviewed the MARS if an issue came up about whether a client was given their medication;
-Direct care staff from the sister facilities had provided coverage for the 2 vacant positions at the facility;
-Client #1's VIMPAT was a controlled medication to prevent seizures and required a new prescription for refill;
-Client #1 had been without the VIMPAT since 9/1/18 (7 days) because the pharmacy had not received a new prescription from Client #1's doctor to refill the VIMPAT;
-Staff #1 had contacted Client #1's doctor numerous times to get a new prescription sent to the pharmacy;
- Client #1's doctor was last contacted on 9/5/18 about the medication refill;
-"Staff are not keeping their notes where they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL018-041	A. BUILDING: _____ B. WING _____	09/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-FOREST RIDGE	4959 FOREST RIDGE DRIVE HICKORY, NC 28602

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V 118	Continued From page 10	V 118		

talk to the doctor about the medicine"
-The GHM consulted with an on-call physician during the survey and asked about the possible adverse effects of Client #1 not having her VIMPAT for 7 days;
-Client #1 was on Lamotrigine 200 mg in the morning and Lamotrigine 300 mg in the evening as 2 additional anti-seizure medications;
-GHM stated the on-call physician advised that Client #1's other anti-seizure medications should "cover" for seizure prevention until the VIMPAT could be refilled and administered and Client #1 was to be administered her scheduled next dose of VIMPAT;
-Client #1 received her prescribed donepezil 10 mg from 7/25/18-7/31/18 by staff having administered 2 tablets of 5 mgs per day;
-Client #2's legal guardian had requested Client #2 be removed from the aripiprazole completely;
-7/2018, Client #2's doctor decreased the aripiprazole to 2.5 mg daily to prevent withdrawal symptoms;
-Client #2's supply of aripiprazole lasted until 7/31/18;
-Client #2 was without aripiprazole from 8/1/18-8/8/18 because her insurance denied payment for the decreased milligrams;
-No response to the documented variances on the 8/2018 EMAR for the aripiprazole which was initialed as administered on 8/2/18 and 8/3/18 at 8 pm dosage and the medication was "out of the facility" on 8/3/18 at 8 am;
-8/8/18, Client #2's doctor prescribed risperidone .25 mg once daily;
-The risperidone was not at the facility from 8/8/18 until 8/14/18 because the pharmacy had not delivered the medication until 8/14/18;
-Client was started on the risperidone .25 mg on 8/15/18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL018-041	A. BUILDING: _____ B. WING _____	09/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-FOREST RIDGE	4959 FOREST RIDGE DRIVE HICKORY, NC 28602

(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) COMPLETE DATE
V 118	Continued From page 11 Interview on 9/7/18 and 9/10/18 with the Qualified Professional (QP) revealed: -She was hired as the QP for the facility 8/1/18 and started work as the QP the middle part of 8/2018; -She had worked on the Intermediate Care Facility for the Mental Retarded (ICF/MR) service side prior to her current position; -Her duties included work with the Home Manager to ensure facility staffing, clinical supervision to the group home staff, ensuring staff documentation was accurate and gathered client progress data related to their service goals and helped with staff training on client diagnoses and behaviors; -New client medication added to the EMAR by the pharmacy required lead staff (GHM, QP, Program Manager) to "release"the medication in the system before a new medication was filled and delivered to the facility; -An email alert was sent out to lead staff whenever there was a missed medication administration on the EMAR so that there was someone to follow up on the reason the medication was missed for a client; -She and the GHM were responsible for the follow up with staff when client medications were not at the facility or medications were not administered as ordered; -No email alerts were sent to lead staff if direct care staff circled their initials on the EMAR because an exception code would generate at the end of the EMAR as to the reason the medication was not administered; -There was a section in the EMAR system that allowed staff to add notes about any changes in client medications and communications with client physicians or the pharmacy; -Staff had an alternative method to use a paper MARS if the EMAR system was not working;	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL018-041	A. BUILDING: _____ B. WING _____	09/11/2018

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V 118	Continued From page 12 -The QP provided no documentation of email alerts or follow up notes on missed medications for Clients #1- #3; -Staff who discovered a medication error was responsible for completing an incident report; -Client #1's VIMPAT medication for 9/2018 was not at the facility because the pharmacy was waiting on the physician to sign and transmit the refill order; -She stated she did not know "where the gap is" in the communication between the pharmacy and physician's office to ensure client medications are filled and delivered to the facility; -She did not know the possible effects on Client #1 not having had her VIMPAT for 7 days; -She had not communicated with Client #1's physician or the pharmacist about possible adverse effects on Client #1 with not having had this seizure medication. - Client #2 had to have new prescriptions written for her psychotropic medications because she changed psychiatrist when her former psychiatrist moved away; -Client #2's guardian wanted Client #2 completely taken off the aripiprazole and the psychiatrist lowered the medication dosage amount to prevent Client #2 from having withdrawal symptoms; -Client's insurance denied payment of the aripiprazole 2.5 mg; -Client #2 was prescribed risperidone on 8/8/18 by the psychiatrist; -The QP had not made contact with the psychiatrist or pharmacist about potential adverse effects of Client #2 not having her aripiprazole or risperidone medication from 8/1/18-8/14/18. Interview on 9/7/18 with the pharmacist regarding possible effects on Client #1 not being administered VIMPAT 200 mg, 1 tablet twice daily	V 118		

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V 118	Continued From page 13 for 7 days revealed: -Client #1's physician needed to be contacted for consult because there could be reactions of dizziness and headaches associated with not having had the medication for 7 days and the dosage may have to be "titrated up." Interview on 9/7/18 with a Registered Nurse to Client #2's psychiatrist revealed: -Client #2 was tapered down on 7/5/18 with the aripiprazole from 5 mg twice daily to 2 mg twice daily; -The aripiprazole was to be discontinued with start of the risperidone .25 mg in 8/2018; -The risperidone was prescribed on 8/8/18 to Client #2 for anger and emotional outbursts; -She stated that Client #2 was not treated for these symptoms by not having the medication. Observation on 9/7/18 of Client #1's medication at the facility between 10:30-11:00 on 9/7/18 revealed: -No VIMPAT medication pack 200 mg, 1 tablet twice daily was at the facility for Client #1 for administration as ordered. Due to the failure to accurately document medication, it could not be determined if Clients #1- #3 received their medications as ordered by the physician from 6/1/18 through 9/6/18. A Plan of Protection was reviewed on 9/11/18 and signed by the Program Manager on 9/11/18 revealed: "What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? Physician's Orders that were signed in July of 2018 will immediately be faxed to Pharmacy Alternatives to update all consumers prescriptions. Lead staff will contact Pharmacy	V 118		

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V 118	Continued From page 14 Alternatives to ensure they have received the updated Physician's Orders. In the future as Physician's Orders are signed quarterly, staff will immediately fax the new Physician's Orders to Pharmacy Alternatives. This should ensure that all scripts are "re-newed," current and up to date. As soon as 365 orders come through via e-mail (approximately 15 days prior to the new medication cycle), lead staff, home supervisor or program coordinator will contact doctor to ensure a new prescription has been sent to Pharmacy Alternatives. Describe your plans to make sure the above happens. Phone calls will be made daily for 2 days until able to speak with someone concerning the prescription or a message is returned (this gives the doctor's office 48 hours to return our initial call). If, after 2 days, no one has been able to be reached via phone by staff, the home supervisor and/or clinical supervisor will reach out to the doctor's office with authority. If after 5 days, still no one has been able to be reached via phone - an in-person visit will be made to request a physical copy of prescription which CANC-West staff will then fax to Pharmacy Alternatives themselves. This 7-day period will still allow time for the medication to arrive overnight in facility before the new cycle of medication is scheduled to begin. All phone calls, conversations, visits, fax transmittals, emails, etc. will be documented via ResCare's Release of Information Tracking form which documents date, time, whom, method (verbal, written, e-mail, etc.) and what information was discussed. This will ensure that there is a paper trial of the communication being done between staff, supervisors, doctors and the pharmacy. Once we have learned that the doctor has faxed	V 118		

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V 118	Continued From page 15	V 118		

a new script over to Pharmacy Alternatives (or once we ourselves fax the prescription), we will then contact the Pharmacy to ensure they received the faxed prescription. Again, these phone calls will be documented.
In the event that medications are not in the home when they are supposed to be given, staff will immediately contact the on-call supervisor who will assist in getting the medications in to the home as soon as possible and then they will document via incident report each time medication dosage is missed as well as fill out a medication variance form that will immediately be sent to doctor each time the medication is missed.
All staff will be in-serviced on all the above immediately, at hire and on a quarterly basis.
Group home supervisor (Kristen Auton) will review documentation of communication, incident reports and medication variance reports on a weekly basis. She will also check the Quick Mar daily to ensure medications are being logged as given or if any exceptions have been noted and to also confirm there are no holes in the documentation of medication administration being given. Program Coordinator (Kristin Frye) will also check the documentation of communication, incident reports and medication variance reports on a bi-monthly basis and the Quick Mar documentation on a weekly basis. This creates a check and balances type of system.
Lead staff and home supervisor will also be electronically checking medications in each cycle using the Quick Mar program to guarantee documentation of when and what medications received is always available."

Client #1 was prescribed VIMPAT 200 mg, twice daily by her physician for treatment of her seizure disorder. She had been administered this

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V 118	Continued From page 16 medication by staff twice daily from 6/1/18 through 8/31/18. From 9/1/18 to 9/7/18, the seizure medication was not available to Client #1 at the facility to take and staff was not aware of potential risks to Client #1's health by her not having the medication for 7 days. Client #2 was without her psychotropic medication of aripiprazole for 14 days (8/1/18-8/14/18) until the risperidone was started (8/15/18). While the pharmacy used by the licensee had significant delays in making the ordered medications available to clients at the facility, the facility did not follow doctor orders or keep their MARS current. As a result, clients with medical and psychiatric conditions were at risk of not receiving their medications as prescribed which was detrimental to their health, safety and welfare. This deficiency constitutes a Type B rule violation. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 118		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures	V 366		

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V 366	Continued From page 17 to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as	V 366		

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V 366	Continued From page 18 follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and	V 366		

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V 366	Continued From page 19 (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement their response to client incidents of medication errors. The findings are: Review on 9/10/18 of the facility's policy and procedures dated 6/2009 on medication errors revealed: -All medication variances or errors were to be reported immediately to the physician or pharmacist; -Medication variances or errors was defined as "a deviation" from the "right" client, medication, dosage, dosage time, administration route and/or client record; -Staff who discovered a medication error was responsible for documentation of physician's and/or pharmacist's comments when notified about the medication error; -A registered nurse (RN) was available as a "medical resource 24 hours/day, 7 days/week" for clients served in group home settings. -Staff was responsible for filing the aforementioned documentation in the client's record. Review on 9/7/18 of the facility's incident reports from 6/1/18-9/7/18 revealed: -1 written medication error report dated 6/14/18 revealed; -Client #1's 6/13/18 VIMPAT 200 milligrams (mg) 7:00 pm dose was in Client #1's medication	V 366		

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V 366	Continued From page 20	V 366		

pack on 6/14/18 but was "logged" on the electronic medication administration record (EMAR) as administered by staff on 6/13/18;
-Staff who discovered the medication error notified the Group Home Manager (GHM) and asked what steps needed to be taken with a comment "No issues noted from missed dose";
-Staff documented the GHM comment as "Give next dose as scheduled";
-No documentation that the medication error was reported to a physician or pharmacist or that an RN was consulted;
-No medical or pharmacy assessment whether Client #1's missed dosage of seizure medication posed a threat to her health and safety and what steps the facility needed to follow regarding Client #1's next VIMPAT dose;
-With exception of the aforementioned incident report, no additional incident reports or other type of facility monitoring reports provided for review that contained medication variances or errors.

Review on 9/7/18 and 9/10/18 of Clients #1- #3's MARS for 6/1/18- 9/7/18 revealed:
-Refer to V 118 for detailed information on Clients #1-#3 medication administration records;
-No documentation that staff reported medication variances or errors to a physician or pharmacist or that an RN was consulted as a medical resource;
-No documentation made available beyond the EMAR exception codes of "out of the facility" and "medication has not arrived at the facility yet" that contained information about staff actions or responses to the coded incidents.

Interview on 9/7/18 with Clients #1- #3 revealed:
-Each client stated they took medication;
-Staff at the facility provided their medications to them.

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V 366	Continued From page 21 Interview on 9/7/18 with the GHM revealed: -She started work as the GHM in 4/2018; -She supervised 2 additional group homes under the licensee; -She worked various shifts as direct care staff; -An EMAR computer system was started at the facility in 1/2018; -Staff was trained on use of the EMAR system by a registered nurse employed by the licensee when trained in Medication Administration; -The pharmacy was responsible for keeping the medications current on the EMARS and delivery of the medications; -A paper copy of the MAR for each client was printed out every month for staff to use as a backup procedure to the EMAR to document medication administration in case the EMAR system was not working; -The blank dates on Clients #1- #3 MARS occurred because either staff had not logged into the EMAR to initial that they gave clients their medication or staff had forgotten to initial on the paper MARs if EMAR was not working properly; -She looked on the back of clients' medication packs for staff initials and dates and reviewed the MARS if an issue came up about whether a client was given their medication; -Client medication packs where the medication was discontinued by doctor order or packs were empty of medication were disposed of and not maintained at the facility; -A statement "Staff are not keeping their notes where they talk to the doctor about the medicine." Interview on 9/7/18 and 9/10/18 with the Qualified Professional (QP) revealed: -She was hired as the QP for the facility 8/1/18 and started work as the QP the middle part of 8/2018;	V 366		

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V 366	Continued From page 22 -She and the GHM were responsible for the follow up with staff when client medications were not at the facility or medications were not administered as ordered; -Staff who discovered a medication error was responsible for completing an incident report; -She did not know the possible effects on Client #1 not having had her VIMPAT for 7 days in 9/2018; -She had not communicated with Client #1's physician or the pharmacist about possible adverse effects on Client #1 with not having had this seizure medication. This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type B rule violation and must be corrected within 45 days.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL018-041	A. BUILDING: _____ B. WING _____	09/11/2018

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V 367	Continued From page 23 (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL018-041	A. BUILDING: _____ B. WING _____	09/11/2018

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V 367	Continued From page 24 .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report and document missed medication doses as part of an incident monitoring system for determinations to be made as to the level of threat to the client's health and safety. The findings are: Review on 9/10/18 of the facility's policy and procedures dated 6/2009 on medication errors revealed: -"All medication variances or errors will be reported and documented as part of the incident monitoring system."	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL018-041	A. BUILDING: _____ B. WING _____	09/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 367	Continued From page 25 Review on 9/7/18 of the facility's incident reports from 6/1/18-9/7/18 revealed: -1 written medication error report dated 6/14/18 and pertained to Client #1 regarding a missed, controlled medication dose used for treatment of seizures; -No documentation that staff reported the missed medication dose to a physician or pharmacist; -No written indication whether Client #1's missed dosage of seizure medication was a threat to her health and safety. Review on 9/7/18 and 9/10/18 of Clients #1- #3's MARS for 6/1/18- 9/7/18 revealed: -Refer to V 118 for detailed information on Clients #1-#3 medication administration records; -No documentation that staff reported medication variances or errors to a physician or pharmacist; -No documentation made available beyond the electronic medication administration record (EMAR) exception codes of "out of the facility" and "medication has not arrived at the facility yet" that contained information about staff actions or responses to the coded incidents. Interview on 9/7/18 and 9/10/18 with the Qualified Professional (QP) revealed: -She was responsible for reviewing the facility's incident reports; -She was aware that medication administration errors included missed medication doses and required notification to a physician or pharmacist; -She and the Group Home Manager (GHM) had communicated with the pharmacy prior to 9/7/18 about the reason Client #1's seizure medication was not getting refilled and knew staff had contacted Client #1's doctor on 9/5/18 to get a prescription re-sent to the pharmacy;	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 367	Continued From page 26 -No documentation or notes made available to support the aforementioned medication incident or staff interventions related to Client #2's missed psychotropic medication (aripiprazole and risperidone) doses from 8/1/18 through 8/14/18; -An in-service training with staff on medication documentation could be done at a monthly staff meeting. This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type B rule violation and must be corrected within 45 days.	V 367		