| DEPART | MENT OF HEALTH AN | ND HUMAN SERVICES | | | F | PRINTED: 01/29/20 FORM APPROVE |
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| STATEMENT (| CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | · , | PLE CONSTRUCTION | | OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED |
| | | 34G262 | B. WING | | _ | 01/23/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | • | - | STREET ADDRESS, CITY, ST | TATE, ZIP CODE | |
| VOCA-WO | OODLAND | | | 123 WOODLAND DR RUTHERFORDTON, NC | ; 28139 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRE CROSS-REFERE | S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIAT DEFICIENCY) | |
| W 189 | STAFF TRAINING PI CFR(s): 483.430(e)(1 | | W 1 | 89 | | |
| | initial and continuing | vide each employee with training that enables the his or her duties effectively, etently. | | | | |
| | Based on observation interview, the facility employee with neede employee to effective | not met as evidenced by: on, record review and failed to provide each ed training to enable each ely and competently perform o reporting injuries for 1 of 4 The finding is: | | | | |
| | 1/23/19 survey revea | ted throughout the 1/22/19 - led client #4 had numerous is left forearm between the | | | | |
| | 1/23/19, verified by ir intellectual disabilities revealed no documer abrasions on client # | 4's left forearm was available Ind no incident report had | | | | |
| | and the nurse, reveal bumps/scrapes his a doorways as he is se These interviews furt discussed initiating th | d on 1/23/19 with the QIDP led client #4 often rm on the threshold of lf-propelling his wheelchair. her indicated the team had he use of a protective sleeve | | | | |

program participation.

intervention.

to prevent injury to client #4's arms, however, this intervention had not been put in place and no documentation was available related to this

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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

TITLE

(X6) DATE

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 34G262 B. WING 01/23/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 123 WOODLAND DR VOCA-WOODLAND **RUTHERFORDTON, NC 28139** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) INDIVIDUAL PROGRAM PLAN W 248 CFR(s): 483.440(c)(7) A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to make current individual support plans (ISPs) available to all relevant staff for 3 of 4 sampled clients (#2, #3 and #4). The finding is: Review of records, conducted at the day program on 1/22/19 at 12:45 PM, revealed client information provided for staff at the day program included an ISP for client #2 dated 6/27/17; for client #3 dated 6/30/17: and for client #4 dated 9/19/17. Continued review of client records, conducted at the group home on 1/22/19 and 1/23/19, revealed documentation indicating the current ISP for client #2 was dated 6/18/18; for client #3 was dated 6/7/18: and for client #4 was dated 9/17/18. Interview conducted with the qualified intellectual disabilities professional on 1/23/19 verified the ISP's provided for staff providing services to clients at the day program was not current and had not been updated during the past survey year.

As soon as the interdisciplinary team has

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CFR(s): 483.440(d)(1)

PROGRAM IMPLEMENTATION

W 249

DEPARTMENT OF HEALTH AND HUMAN SERVICES

(X4) ID

PREFIX

TAG

W 248

Event ID: R5E711

Facility ID: 942795

W 249

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PRINTED: 01/29/2019

FORM APPROVED

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 34G262 B. WING 01/23/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 123 WOODLAND DR VOCA-WOODLAND **RUTHERFORDTON, NC 28139** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 249 Continued From page 2 W 249 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 sufficient interventions to address the behavioral needs for 1 sampled client (#1). The finding is: Observation of client #1 on 1/22/19 at 1:00 PM at his day program revealed the client to shred paper using a shred machine when the machine stopped working. Continued observation revealed client #1 to become agitated with the inability to use the shredder with yelling, getting up and down from his seat walking around the room he was in, returning to his seat and slapping another client beside him, kicking at a client that walked near client #1's chair space and chewing on his thumb. Staff were observed to address client #1's physical aggression with "No, that's not nice. We don't do that." Staff was further observed to verbally request client #1 to sit down when the client was observed to get up from his seat and walk around. Continued observations of staff revealed efforts to get client #1's shredder working again and offering the client paper to tear by hand until the shredder was working. Client #1 was observed to verbalize "no" and throw paper on a table with staff request to tear paper by hand. At 1:15 PM staff was observed to walk client #1 from the classroom to get a drink. Client

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING 34G262 B. WING 01/23/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 123 WOODLAND DR VOCA-WOODLAND **RUTHERFORDTON, NC 28139** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 249 Continued From page 3 W 249 #1 was observed to return to the classroom continuing to walk around, yelling various verbalizations to include "go home". No further activity choice was provided to client #1 until the day program director offered the client a piece of gum and a choice of folding papers at 1:20 PM. Client #1 was observed to engage in yelling, wandering behavior, physical aggression and chewing on his hands for 20 minutes before the client was provided an opportunity to engage in an activity that interested the client. Review of client #1's record on 1/23/19 revealed a behavior support plan (BSP) dated 10/24/18. Review of the BSP revealed client #1 to have target behaviors that included physical aggression, verbal aggression, property destruction, self injurious behavior, anxiety/agitation, habilitation refusal and attempted AWOL. Further review of the BSP revealed prevention and interaction strategies for client #1 to include: helping client #1 maintain attention due to a limited attention span and providing opportunities to participate in as many activities as possible; Staff should keep client busy. The BSP further identified self injurious behavior of client #1 as chewing on thumb, placing thumb in mouth. The BSP identified no intervention strategies to address physical aggression. Interview with the qualified intellectual disabilities professional (QIDP) verified client #1 should have been actively provided opportunities to keep the client busy after the shredder at the day program stopped working. Further interview with the QIDP revealed the client's BSP should include specific strategies for staff to address client #1's physical aggression.

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO A. BUILDING | | (X3) DATE SURVEY COMPLETED |
| | | 34G262 | B. WING | | 01/23/2019 |
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| W 382 | DRUG STORAGE AN CFR(s): 483.460(I)(2) | ND RECORDKEEPING | W 382 | | |
| | The facility must keep locked except when b administration. | o all drugs and biologicals being prepared for | | | |
| | Based on observatio failed to assure all dru | not met as evidenced by: ns and interview, the facility ugs were kept locked except for administration. The | | | |
| | revealed client #1 ent administration area lo home. Staff responsi | bcated in the office of the ble for medication en observed to remove | | | |
| | medication closet and counter. Further obse controlled drug box w the counter as well. | d placed them on the ervation revealed the ras unlocked and open on Continued observation at | | | |
| | administration area, r medications. Ongoin revealed staff left the down the hallway of t client to come to the r | g observation at 6:50 AM medication area and walked he home to prompt another medication administration | | | |
| | | e door open with client #1's s the open controlled drug nter unattended. | | | |
| | revealed staff respon- medications were exp | locked at all times except | | | |
| W 436 | SPACE AND EQUIPM | MENT | W 436 | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 942795

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 34G262 B. WING 01/23/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 123 WOODLAND DR VOCA-WOODLAND **RUTHERFORDTON, NC 28139** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 436 Continued From page 5 W 436 CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to maintain a wheelchair in good repair and failed to furnish and provide teaching relative to adaptive equipment for 3 of 4 sampled clients (#4, #1 and #2) and 1 non-sampled client (#5). The findings are: A. The facility failed to maintain a wheelchair in good repair and teaching relative to glasses for client #4. For example: Observations conducted throughout the 1/22/19-1/23/19 survey revealed client #4 was not ambulatory and relied on a wheelchair for all transportation needs. Continued observations conducted during the 1/22/19-1/23/19 survey revealed the right anti-tipping device was missing from the back of client #4's wheelchair. Interview on 1/22/19 with the gualified intellectual disabilities professional (QIDP) and direct care staff in the home revealed the anti-tipping device was located in client # 4's bedroom, however, the device was observed to be damaged and could not be attached to the wheelchair. Continued staff interview revealed the anti-tipping device had been damaged and dysfunctional for at least

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 942795

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| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | PRINTED: 01/29/2019 FORM APPROVED OMB NO. 0938-0391 |
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| W 436 | Continued From page one week. | 6 | W 436 | | | |
| | survey revealed an at above the backrest of a hard plastic knob or observed to bump the knob at intervals throu On-going observation 7:35 AM, revealed clia onto the facility van fo program with the right from his wheelchair, a knob located on an at backrest of his wheeld with the back of client Additional observation medication area on 1/ cubicle with various p to include glasses for 1/23/19 at 7:15 AM re #4 about his glasses a was going to wear his to his vocational prog observed at anytime of to wear glasses, even wear them on the curf Review of the record 1/22/19 and 1/23/19, support plan (ISP) dar review of the ISP reve client #4 was depended further documented h tilting mechanism whi | s, conducted on 1/23/19 at ent #4 was assisted to load or transportation to the day a anti-tipping device missing as well as the hard plastic tachment above the chair coming into contact #4's head at intervals. In in the group home 22/19 revealed an unlocked ieces of adaptive equipment client #4. Observation on vealed staff to prompt client and the client indicated he glasses on the current day ram. Client #4 was not during the 1/22-23/19 survey after indicating he would rent day. for client #4, conducted on revealed an individual ted 9/17/18. Continued ealed documentation stating ent on his wheelchair, and is wheelchair included a ch should be utilized at | | | | |
| | intervals throughout th | ch should be utilized at ne day to change client #4's hair in order to provide | | | | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | D: 01/29/2019 MAPPROVED D. 0938-0391 | |
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| VOCA-WC | JODLAND | | | R | RUTHERFORDTON, NC 28139 | | | |
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| W 436 | Continued From page | 27 | w | 436 | | | | |
| | Continued From page 7 Further review of the ISP revealed client #4 to have additional adaptive equipment that included glasses. Continued review of client #4's record on 1/23/19 revealed a health summary assessment dated 1/11/19 that further identified the client's need for glasses. Additional review of client #4's record revealed a dignity of risk consent by the guardian dated 9/17/18. Review of the dignity of risk consent revealed client #4 does not wear his glasses due to: "does not like to wear them; hurt". Review of training objectives for client #4 revealed no current or past training for client #4 to address desensitization or taking care of glasses. Interview with the QIDP on 1/23/19 following client #4's departure for the day program revealed the knob that was present above the backrest of client #4's wheelchair was intended to support a headrest. Subsequent observation on 1/23/19 revealed the headrest for client #4's wheelchair was located in his bedroom and had been inadvertently left behind. This interview further verified both the anti-tipping device and the headrest for client #4's wheelchair should be maintained and present on client #4's wheelchair to promote his comfort and provide safety when his wheelchair is in a tilted position. Additional interview with the facility nurse verified client #4 has had past training to address the need of wearing glasses although the client has not had training to address caring for adaptive equipment. Further interview with the QIDP | | | | | | | |

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| | MEDICAID SERVICES | | | | | | APPROVED . 0938-0391 |
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| Continued From page | 8 | W 4 | 36 | | | | |
| accessibility to adaptivi glasses and hearing a | ve equipment relative to | | | | | | |
| revealed client #2 to p and to complete daily home. Observations of survey revealed the cl repeat themselves wh the group home media revealed an unlocked of adaptive equipment client #2. Client #2 wa during the 1/22-23/19 | articipate at a day program living activities in the group of client #2 during the ient to often ask staff to en talking. Observation in cation area on 1/22/19 cubicle with various pieces t to include glasses for as not observed at anytime | | | | | | |
| revealed an ISP dated ISP revealed client #2 equipment that include glasses. Further revie 1/23/19 revealed a he dated 1/11/19 that furth need for hearing aides review of client #2's re- risk consent by the gu Review of the dignity of client #2 does not wea glasses due to: "does Review of training obj revealed no current or address training the cl adaptive equipment. | d 6/18/18. Review of the to have adaptive ed hearing aides and ew of client #2's record on alth summary assessment ther identified the client's is and glasses. Additional ecord revealed a dignity of ardian dated 6/18/18. of risk consent revealed ar his hearing aides or not like to wear them; hurt". ectives for client #2 past training for client #2 to lient to wear or take care of | | | | | | |
| | CORRECTION DVIDER OR SUPPLIER DULAND SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page B. The facility failed to accessibility to adaptiv glasses and hearing a example: Observation througho revealed client #2 to p and to complete daily home. Observations of survey revealed the cl repeat themselves whi the group home medic revealed an unlocked of adaptive equipment client #2. Client #2 was during the 1/22-23/19 aides or glasses. Review of records for revealed an ISP dated ISP revealed client #2 equipment that include glasses. Further revie 1/23/19 revealed client #2 equipment that include glasses. Further revie fisk consent by the gu Review of the dignity of client #2 does not weag glasses due to: "does Review of the dignity of client #2 does not weag glasses due to: "does Review of the dignity of client #2 does not weag glasses due to: "does Review of the dignity of client #2 does not weag glasses training the client adaptive equipment. Interview with the facil | CORRECTION IDENTIFICATION NUMBER: 34G262 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 B. The facility failed to ensure teaching and accessibility to adaptive equipment relative to glasses and hearing aids for client #2. For example: Observation throughout the 1/22-23/19 survey revealed client #2 to participate at a day program and to complete daily living activities in the group nome. Observations of client #2 during the survey revealed the client to often ask staff to repeat themselves when talking. Observation in the group home medication area on 1/22/19 revealed an unlocked cubicle with various pieces of adaptive equipment to include glasses for client #2. Client #2 was not observed at anytime during the 1/22-23/19 survey to wear hearing aides or glasses. Review of records for client #2 on 1/22/19 revealed an ISP dated 6/18/18. Review of the ISP revealed al ISP dated 6/18/18. Review of the ISP revealed al health summary assessment dated 1/11/19 that further identified the client's need for hearing aides and glasses. Additional review of client #2's record revealed a dignity of risk consent by the guardian dated 6/18/18. Review of the dignity of risk consent revealed client #2 does not like to wear them; hurt". Review of the dignity of risk consent revealed client #2 does not wear his hearing aides or glasses due to: "does not like to wear them; hurt". Review of the dignity of risk consent revealed client #2 does not wear his hearing aides or glasses due to: "does not like to wear them; hurt". | IDENTIFICATION NUMBER: A. BUILDIN 34G262 B. WING | DENTIFICATION NUMBER: A. BUILDING 34G262 B. WING DUDER OR SUPPLIER STI DDLAND T22 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 8 W 436 B. The facility failed to ensure teaching and accessibility to adaptive equipment relative to glasses and hearing aids for client #2. For example: W 436 Observation throughout the 1/22-23/19 survey revealed client #2 to participate at a day program and to complete duily living activities in the group nome. Observations of client #2 during the survey revealed the client to often ask staff to repeat themselves when talking. Observation in the group home medication area on 1/22/19 revealed an unlocked cubicle with various pieces of adaptive equipment to include glasses for Client #2. Client #2 was not observed at anytime during the 1/22-23/19 survey to wear hearing aides or glasses. Review of records for client #2 to 1/22/19 revealed an ISP dated 6/18/18. Review of the ISP revealed client #2 to have adaptive equipment that included hearing aides and glasses. Further review of client #2's record on 1/23/19 revealed a health summary assessment dated 1/11/19 that further identified the client's need for hearing aides and glasses. Additional review of the dignity of risk consent revealed client #2's record revealed a dignity of risk consent by the guardian dated 6/18/18. Review of the dignity of risk consent revealed client #2's record revealed a dignity of risk consent by the guardian dated 6/18/18. Review of the dignity of risk consent revealed client #2 does not like to wear or t | JORRECTION IDENTIFICATION NUMBER: A. BUILDING 346262 B. WING DVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, TAG STREET ADDRESS, CITY, STATE, TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDER'S FLA (EACH OPERICINCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 W 436 B. 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For example: Observation throughout the 1/22-23/19 survey revealed a client #2 to participate at a day program and to complete duily living activities in the group home. Observations of client #2 duing the survey revealed the client to observe at anytime duing the duily living activities in the group home. Observations of client #2 duing the survey revealed the client to beserve at anytime duing the 1/22-23/19 survey to wear hearing aids or glasses. Review of records for client #2 on 1/22/19 Review of for client #2 to nave adaptive equipment to include glasses and hearing aids and glasses. Further review of client #2 to have adaptive equipment to include glasses and hearing aids and glasses. Review of for client #2 to nave adaptive equipment to include glasses and glasses. Review of for client #2 to nave adaptive equipment to include glasses and hearing aides and glasses. Further review of client #2 to nave adaptive equipment to include glasses and glasses. 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Facility ID: 942795

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 34G262 B. WING 01/23/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 123 WOODLAND DR VOCA-WOODLAND **RUTHERFORDTON, NC 28139** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 436 Continued From page 9 W 436 need for hearing aides and glasses. Interview with the QIDP revealed client #2 has had past training to address the need of wearing adaptive equipment although the client has not had training to address caring for adaptive equipment. Further interview with the QIDP verified past training programs for client #2 relative to adaptive equipment was not available. Additional interview with the QIDP verified client #2's hearing aides could not be located as of the current survey. C. The facility failed to ensure teaching relative to adaptive equipment specific to dentures for client #1. For example: Observation in the group home medication area on 1/22/19 revealed an unlocked cubicle with various pieces of adaptive equipment to include dentures for client #1. Observation of the evening meal on 1/22/19 and the breakfast meal on 1/23/19 did not reveal client #1 to wear dentures or to be prompted by staff to wear dentures. Client #1 was not observed at any time during the 1/22-23/19 survey to wear dentures. Review of records for client #1 on 1/23/19 revealed an ISP dated 10/30/18. Review of the ISP revealed client #1 to have adaptive equipment that included dentures. Further review of client #1's record on 1/23/19 revealed a health summary assessment dated 1/11/19 that further identified the client's need for dentures. Additional review of client #1's record revealed a dignity of risk consent by the guardian dated 10/30/18. Review of the dignity of risk consent revealed client #1 does not wear his dentures due to: "does not like to wear them; hurt". Review of training objectives for client #1 revealed no current or past training for client #1 to address

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | FOR | ED: 01/29/2019 MAPPROVED O. 0938-0391 |
|--------------------------|---|--|--------------------------------|---|------------------------------|---|
| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE C A. BUILDING | (X3) DAT | E SURVEY IPLETED | |
| | | 34G262 | B. WING | | 01 | /23/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | STF | REET ADDRESS, CITY, STATE, ZIP COL | DE | |
| VOCA-WO | OODLAND | | | WOODLAND DR THERFORDTON, NC 28139 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| W 436 | desensitization or tak Interview with the faci- has dentures and nee Interview with the faci- has had past training wearing dentures alth training to address ca interview with the QIE programs for client #1 dentures was not ava D. The facility failed fa adaptive equipment si dental partial for client Observation through revealed client #5 to p and to complete daily home. Observation in medication area on 1, cubicle with various p to include a dental pa #5. Observation of th and the breakfast me client #5 to wear a de prompted by staff to v #5 was not observed 1/22-23/19 survey to partial. Review of records for revealed an ISP date ISP revealed client #5 equipment that includ glasses. Further revir revealed a health sun 1/11/19 that further id | ing care of dentures. ility nurse verified client #1 eds them to improve eating. ility QIDP revealed client #1 to address the need of rough the client has not had aring for dentures. Further DP verified past training 1 relative to using/wearing ilable. to ensure teaching relative to pecific to glasses and a t #5. For example: but the 1/22-23/19 survey participate at a day program living activities in the group in the group home /22/19 revealed an unlocked ieces of adaptive equipment rtial and glasses for client the evening meal on 1/22/19 al on 1/23/19 did not reveal ntal partial or to be vear a dental partial. Client at any time during the wear glasses or a dental client #5 on 1/23/19 d 9/17/18. Review of the | W 436 | | | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | PRINTED: 01/2 FORM APPF OMB NO. 0938 | ROVED |
|---|---|---|--|--------------------------------------|--|--|-----------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVE COMPLETED | |
| | | 34G262 | B. WING | | | 01/23/20 ² | 19 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, S | TATE, ZIP CODE | | |
| VOCA-WO | OODLAND | | | 123 WOODLAND DR RUTHERFORDTON, NO | 28139 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRE CROSS-REFERE | S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY) | E COMP | X5) PLETION ATE |
| W 436 | client #5's record reve consent by the guard of the dignity of risk c does not wear his der "refuses to wear; hurd objectives for client # past training for client desensitization or tak equipment such as the glasses. Interview with the fac has a dental partial a the facility QIDP reve training to address th and a dental partial a had training to address adaptive equipment. QIDP verified past training | ealed a dignity of risk ian dated 9/17/18. Review onsent revealed client #5 intal partial or glasses due to: ". Review of training 5 revealed no current or t #5 to address ing care of adaptive te client's dental partial or ility nurse verified client #5 ind glasses. Interview with aled client #5 has had past e need of wearing glasses Ithough the client has not ss caring for the identified Further interview with the aining programs for client #5 use of a dental partial and | W 43 | 5 | | | |

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