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
	34G263	A. BUILDING ______ B. WING ______	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-YOUNG GROUP HOME	**211 YOUNG STREET SHELBY, NC 28150**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure sufficient interventions to address the medication administration needs for 1 of 3 clients sampled (#4). The finding is: Observations in the group home on 1/30/19 at 4:32 PM during medication administration revealed client #4 to enter the medication room and sit in a chair. The staff member assisting with medication administration was observed to retrieve Reguloid powder and Systane eye drops from a closet and then use the electronic medication administration record (MAR) to scan the medications. The staff member was then observed to assist the client with sanitizing his hands, pour water into a cup, put three teaspoons of Reguloid into the cup, and then mix the solution. Client #4 drank the Reguloid solution and then the staff member administered the Systane eye drops. Client #4 was not observed to assist with any part of the medication administration process. Review of the record for client #4 on 1/31/19	W 249		

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.

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W 249	Continued From page 1 revealed an individual service plan (ISP) dated 5/9/18. Continued review of the ISP revealed a current medication administration program. The medication administration program indicated the client was supposed to complete the steps of the program with 65% accuracy for three consecutive months. Review of the program methods indicated client #4 should be allowed to be as independent as possible. The program tasks included: washing/sanitizing hands; getting the medication box from the closet and scanning the medications into the electronic MAR. Interview with the qualified intellectual disabilities professional on 1/31/19 confirmed the medication administration program is current and, and client #4 should have been offered the opportunity to complete the program tasks and to be as independent as possible.	W 249		