STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G139	A. BUILDING _____ B. WING _____	02/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-NORWICH ROAD GROUP HOME	1006 NORWICH ROAD CHARLOTTE, NC 28227

(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 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. This STANDARD is not met as evidenced by: Based on record review and interview, the team failed to ensure the individual support plan (ISP) for 1 of 3 sampled clients (#1) included objective training to address identified needs relative to fire drill evacuation. The finding is: A review of internal documentation on 1/31/19 relative to fire drill reports revealed a total of 12 fire drills were conducted for the review year. Further review of the fire drill reports revealed on 1/17/18, 2/15/18, 3/17/18, 6/18/18, 7/2/18, 8/2/18, 9/4/18, 11/16/18 and 12/20/18 client #1 was in need of assistance, extra assistance or two staff assistance during the drill. Review of the record for client #1 on 2/1/19 revealed an ISP dated 9/20/18. Continued review of the ISP revealed client #1 to have had a past program to address fire evacuation that was discontinued in 2/2018 due to met criteria. Additional record review revealed no additional documentation of client #1's need for support with fire evacuations. Interview with the facility home manager (HM) on 1/31/19 revealed client #1 often needs additional support during fire drills due to non-compliance. Further interview with the HM revealed client #1 did not have current programming to address	W 227	See attached. RECEIVED FEB 25 2019 DHSR NH L & C Black Mountain / WRO	4/2/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Program Manager | (X6) DATE: 2/21/19

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 227	Continued From page 1 non-compliance with fire drill participation and confirmed the client's behavior often created both client coordination and supervisory problems for the staff running the group home fire drill. Interview with the facility qualified intellectual disabilities professional (QIDP) and the operations manager revealed a lack of knowledge as to why client #1's past program to address fire evacuation was discontinued in 2/2018 specifically when the client was still demonstrating fire drill non-compliance. Additional interview verified client #1 could benefit from additional interventions relative to increasing tolerance and participation in emergency drills.	W 227		
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 observations, record review and staff interviews, the facility failed to ensure an objective contained in the individual support plan (ISP) was implemented as prescribed for 1 of 3 sampled clients (#1) related to communication. The finding is: Observations in the group home on 1/31-2/1/19 revealed client #1 to participate in various	W 249		

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W 249	Continued From page 2 activities to include loading the facility van for an outing, completing a morning routine, eating breakfast, medication administration, leisure activity and preparing for a vocational program with walking to the facility van. Continued observation throughout the 1/31-2/1/19 survey revealed staff to assist client #1 with engagement and completion of tasks with verbal cues. It should be noted that no pictures or a picture board were observed to be used in communication with client #1. Review of records for client #1 on 1/31/19 revealed a receptive communication goal implemented 1/1/19. Review of the 1/1/19 communication objective revealed with 2 verbal and 2 gestural prompts per task, client #1 will take the picture with her to the location and initiate the activity in 80% of trials over three consecutive months. Further review of the 1/1/19 objective revealed when client #1 needs to complete activities (eat/brush teeth), staff will take her to the schedule board with pictures and begin the program. Additional review of records for client #1 on 2/1/19 revealed an expressive communication objective implemented 8/2016. Review of the 8/2016 communication objective revealed given an initial prompt, client #1 will use the pictures to request what she wants in 80% of trials over 3 consecutive months. Interview with the facility home manager (HM) on 2/1/19 revealed client #1 did not have pictures or a communication board in the group home to be used to address communication deficits. Further interview with the facility HM revealed client #1 has never had a communication board in the	W 249		

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W 249	Continued From page 3 home. Interview with qualified intellectual disabilities professional (QIDP) on 2/1/19 revealed client #1's expressive communication objective implemented 8/2016 should have been discontinued in 1/2019. Further interview with the QIDP revealed client #1's receptive communication objective was implemented in 1/2019 when the expressive communication objective should have been discontinued. Additional interview with the QIDP verified client #1 should have pictures in the group home to be used with the current communication objective while she did not know why the client never had a communication board in the group home to support the expressive communication objective. The QIDP further confirmed she did not know how client #1's expressive communication objective could have been implemented in the group home since 8/2016 without a communication board.	W 249		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility's drug administration system failed to assure all drugs were administered without error for 1 of 3 sampled clients (#6). The finding is: Client #6 did not receive medications as prescribed.	W 369		

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W 369	Continued From page 4 Morning medication observations on 2/1/19 at 6:40 AM revealed client #6 received her One-Daily Vitamin, Divalproex ER, Escitalopram, Doxycycline Hyclate, and Docusate Sodium with prune juice. Review on 2/1/19 of client #6's current physician's orders dated 11/23/18 and dated signed by the provider 12/5/18 revealed "Natural Fiber Pow 28.3% Mix 1 scoop with 8 oz of water and drink by mouth once daily for constipation [Equiv To: Metamucil Smooth Texture]" and is scheduled "Daily at 07:00." Review on 2/1/19 of client #6's medication administration record (MAR) dated 2/1/19 revealed Natural Fiber Pow 28.3% initialed by the involved medication technician as given on 2/1/19. Interview on 2/1/19 with the Director of Nursing (DON) verified after a telephone call with the involved medication technician client #6 did not receive her Natural Fiber Pow 28.3% as ordered. Further interview verified the involved medication technician should not have initialed the medication as given on client #6's MAR.	W 369		
W 436	SPACE AND EQUIPMENT 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.	W 436		

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W 436	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure a recommended wheelchair was accessible for 1 of 3 sampled clients (#1). The finding is: Observation of client #1 on 1/31/19 at the client's day program revealed the client to wear a gait belt and to sit in a chair at a table participating in a connect four game activity. Further observation revealed a wheelchair to be available in the day program classroom that had client #1's coat hanging on the back of the chair. Observation in the group home on 1/31/19 at 5:10 PM revealed client #1 to prepare for a dinner outing and to be assisted onto the facility van with no wheelchair. Further observation of the facility van revealed no wheelchair to be available for client #1. Review of records for client #1 on 2/1/19 revealed the client to have a diagnosis of kyphosis scoliosis. Further record review revealed a physical therapy (PT) consult dated 11/11/15. Review of the 11/11/15 PT consult revealed an in service for staff was provided for the protocol to ambulate with wheelchair and the use of a gait belt. Additional record review revealed a PT consult dated 11/3/16. Review of the 11/3/16 consult revealed a recommendation for the facility to purchase bungee cords to secure wheelchair in transport. Interview with day program staff on 1/31/19 revealed client #1 uses a wheelchair at the day program when going down long hallways. The day program staff further revealed client #1 uses a wheelchair that belongs to the vocational program while the client is at the program and	W 436		

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W 436	Continued From page 6 does not bring her own chair. Interview with the facility home manager (HM) on 1/31/19 revealed client #1 uses a wheelchair for long distance outings because the client gets tired. Further interview with the HM revealed a wheelchair was not currently accessible for the client at the group home due to client #1's wheelchair getting left on the facility van that was getting repaired. The HM further verified the van with client #1's wheelchair had been in the repair shop for over a month. Interview with the facility nurse on 2/1/19 verified client #1 uses a wheelchair due to a diagnosis of kyphosis scoliosis. The facility nurse further verified client #1 should have a wheelchair available at the group home to be used as needed by the client.	W 436		

Norwich Group Home
1006 Norwich Road
Charlotte, NC 28227

Plan of Correction
Date of Recertification Survey: 1/31/19-2/1/19
MHL# 060-102

W 227 483.440(c)(4) Individual Program Plan

Community Alternatives of NC, specifically the Norwich Group Home will ensure that all clients will include objective training to address identified needs relative to fire drill evacuation. QP will review fire drills for all clients including client #1 to determine needed objective training relative to fire drill evacuation and implement any needed training relative to fire drill evacuation.

To prevent further episodes: The QP will review fire drills monthly to determine if any objective training is needed to address identified needs relative to fire drill evacuation. The Program Manager will review fire drills monthly to determine if any objective training is needed to address identified needs relative to fire drill evacuation during monthly site review.

To be completed by: 4/2/2019
Person(s) Responsible: Program Manager

W249 483.440(d)(1) Program Implementation

Community Alternatives of NC, specifically the Norwich Group Home will ensure that all objectives contained in the individual support plan to be implemented as prescribed related to communication. Program Manager will inservice QP to implement all objectives contained in the individual support plan to be implemented as prescribed related to communication including materials needed for the implementation of objectives. QP will inservice staff to train objectives as prescribed.

To prevent further episodes: The QP will monitor objective training weekly to ensure training occurs as prescribed. Program Manager will monitor objective training during monthly site review to ensure training occurs as prescribed.

To be completed by: 4/2/2019
Person(s) Responsible: Program Manager

W 369 483.460(k)(2) Drug Administration

Community Alternatives of NC, specifically the Norwich Group Home will ensure all drugs are administered without error. Nursing will inservice staff on the six rights including the right medication to prevent any further medication error.

To prevent further episodes the QP and Residential Manager will make weekly observations at group home to ensure medications will be administered without error. Program Manager will complete a monthly site review to ensure medications will be administered without error.

To be completed by: 4/2/2019
Person(s) Responsible: Program Manager

W436 483.47(g)(2) Space and Equipment

Community Alternatives of NC, specifically the Norwich Group Home will ensure recommended wheelchair is accessible for clients. QP will inservice Residential Manager to have any recommended wheelchair accessible to clients to be used as needed including wheelchair for client#1.

To prevent further episodes: The Residential Manager and QP will make weekly observations to ensure any recommended wheelchair is accessible to client to be used as needed including wheelchair for client#1. Program Manager will complete a monthly site review to ensure any recommended wheelchair is accessible to client to be used as needed including wheelchair for client#1