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 _____	R-C 03/15/2019

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 000	INITIAL COMMENTS A complaint and follow up survey was completed on 3/15/19. The complaint was unsubstantiated. 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 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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 _____	R-C 03/15/2019

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 112	Continued From page 1	V 112		

This Rule is not met as evidenced by:
Based on record review, observation and interview, the facility failed to implement treatment strategies that addressed the individual needs of 1 of 3 clients (Client #1) and failed to develop and implement treatment strategies that addressed the needs of 1 of 3 clients (Client #2). The findings are:

I. Review on 3/5/19 of Client #1's record revealed:
-Date of admission: 4/15/08
-Diagnoses: Moderate Intellectual Developmental Disability (IDD), Seizure Disorder, Schizoaffective Disorder, Depressive Type, Psychotic Disorder by history, Major Depressive Disorder-recurrent type, Anxiety Disorder, Gastroesophageal Reflux Disease (GERD), Parkinson's Disease, Dementia, Arthritis, Osteoporosis, Overactive Bladder with incontinence, Bilateral Cataract;
-Behaviors included escalated anger and aggression toward staff and housemates (yelling, kicking, screaming profanities and racial slurs at staff, arguments with her housemates and physical fights with Client #3 that resulted in physical injuries);
-1/10/19 treatment plan revealed:
-Increased dementia and depressive episodes;
-Treatment goals included encouragement and an outlet to express anger in a constructive way with strategies for Client #1 to take deep breaths to self-calm, and for staff to take time to listen to what is bothering Client #1 and continue the process as needed until her "agitation had dissipated."

Review on 3/4/19 of written facility incident reports of Client #1 from 12/10/18 through 2/14/19 revealed:

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 _____	R-C 03/15/2019

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 112	Continued From page 2	V 112		

-12/12/18 at 5 pm, Client #1 "suddenly upset and started kicking" Staff #4 while she was helped into shower and "bumped" her leg on the bathroom cabinet that resulted in a "gash" on her leg;
-There was no information about precipitating events that led to Client #1's behaviors or whether Staff #4 used de-escalation strategies to help reduce Client #1's aggression;
-There was no information how Staff #4 responded to Client #1's leg injury;
-1/15/19 at 7 pm, Client #1 refused to take her nighttime (pm) medications three times and she argued with Staff #4 about not wanting to take her medications and began calling Staff #4 names;
-There was no information that indicated how Client #1 was helped by Staff #4 to identify and process the reason(s) for her medication refusals;
Staff #4 used two, 10 to 15 minute intervals in which she did not ask Client #1 to take her medications with no further information that indicated why Client #1 was angry and refused her medications;
-2/13/19 at 5 pm, a physical fight occurred between Clients #1 and #3 while Staff #4 prepared dinner;
-There was no additional information provided in this report that made reference to or about the precipitating events earlier on 2/13/19 that were documented in Client #1's "Challenging Behavior Log."

Review on 3/5/19 of Client #1's"Challenging Behavior Log" from 1/4/19 to 2/23/19 revealed:
-The log contained written staff notes that pertained to Client #1's behaviors;
-1/4/19 about 12:00 noon, Staff #2's statements that Client #1 "acting like she doesn't understand" about being assisted to the bathroom and "like

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 _____	R-C 03/15/2019

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 112	Continued From page 3	V 112		

she didn't know how to put her clothes on," followed by Client #1 having "spit her food onto the floor;"

-There was no further documentation beyond Staff #2's observations of Client #1's behaviors or whether any interventions were taken in response to her behaviors;

-1/5/19 at 2:30 pm, screamed and yelled at Staff #4 for being taken out of bed and to the bathroom for a shower, refused her 3 pm and 7 pm prescribed medications, "threw her food across the room" as she sat at the table, started taking off her clothes and cried;

-Staff #4's response to her was "to clean up her mess and get dressed" with Client #1 responded, "Hell no;"

-No documented staff strategies that Client #1 was helped to de-escalate her anger and staff time was taken to process what was bothering her;

-1/14/19 at 9 am, ignored Staff #7's prompts to get out of bed and get dressed with statements that Client #1 "acted like she passed out... threw trash in the floor and pulled items off the dining table" after she was taken to the bathroom and assisted with a shower;

-Staff #7 told Client #1 she "needed to listen to staff and respect others' property" which resulted in Client #1 continuing to ignore Staff #7's prompts;

-There were no additional notes that indicated whether Staff #7 used Client #1's treatment strategies with her such as asking her to take deep breaths and/or listen to her concerns and feelings about having to get out of the bed;

-1/15/19 at 9 am, a statement by Staff #2 that Client #1 "made herself fall on the bathroom two times and wouldn't help get herself up," followed by calling Staffs #2 and #4 "monkeys," and "acted like she passed out;"

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 _____	R-C 03/15/2019

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 112	Continued From page 4	V 112		

-"At lunch she took 2 bites of food, pretended to choke and cough" and she "spit her food all over herself and on the floor" while crying and cursing;
-3:00 pm, Staff #4's observation of Client #1's statement that she was going to die because no one cared about her and Staff #4's response was she left Client #1 alone in her room for 10 to 15 minutes and followed up by asking Client #1 if she was ready to take her medications and eat;
-No additional notes from Staffs #2 and #4 whether they used any strategies to help de-escalate Client #1's agitation at the onset or whether they took time with her to process what was bothering her;
-2/10/19 at 6 pm, Clients #1 and #3 were in a verbal argument, and Client #1 threw her plate off the table and locked herself in her room;
-No documentation found that indicated Staff #6's interventions with Clients #1 and #3 beyond her observations of these two clients;
-2/13/19, she took a nap in her bed until 1:30 pm and responded with yelling, screaming and kicking at Staff #4 when prompted to get up from her nap and complete her activities for the day (changing her clothes, toileting, lunch, medication);
-Staff #4's statement that Client #1 "made herself fall out of the bed" and was "still yelling and screaming" at Staff #4 with the names "B***h, n****r, Heffa Cow, Ugly and Slave;"
-Client #1 was helped up off the floor by Staff #4 and to the bathroom where she "started to be forceful and ugly" toward Staff #4 and fell on the floor and "slid around the floor for almost 2 hours" while she refused Staff #4's help up off the floor;
-Client #1 locked herself in the bathroom for about 15 seconds until Staff #4 pried the door open;
-Client #1 was told by Staff #4 that she needed to cooperate and follow her directions;

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 _____	R-C 03/15/2019

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 112	Continued From page 5	V 112		

-Staff #4 left Client #1 alone in the bathroom and "went to see if she was ready to get up off the bathroom floor and follow directions" and "she was finally ready to listen and follow staff orders;"
-Client #1 "then started to fight with [Client #3] which led to bruises" and Clients #2 and #3 were removed by Staff #4 to their rooms;
-There was no documentation that indicated what treatment strategies were used by Staff #4 to try and de-escalate Client #1's verbal and physically aggressive behaviors at the onset of her behaviors and during the afternoon hours;
-2/14/19 at 9:30 am, yelled and screamed that she wanted to go back to bed and at 2:45 pm, she kicked her bedroom door open and was redirected into the living room by Staff #2 to watch movies;
-There was no documented statements whether Client #2 received positive feedback by having followed staff redirection;
-2/22/19 in morning hours, Client #1 had a crying episode that was observed by Staff #8;
-Client #1 provided no reason she was crying and Staff #8 responded by giving Client #1 time alone to calm herself and after 5 minutes, Staff #8 observed Client #1 with her coat on and asleep in her wheelchair;
-There was no further documentation about how long Client #1 slept in her wheelchair or what happened when she woke up.

Interview on 3/4/19 with Client #1 revealed:
-She did not want to get up and out of the bed every morning and did not want to be bothered by staff trying to get her up when she was tired or did not feel good;
-She identified Staff #2, #4 and #5 by name and stated these staff always wanted her up and out of bed in the mornings;
-"Sometimes they will try to drag me out of the

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 _____	R-C 03/15/2019

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 112	Continued From page 6	V 112		

bed but I will tell them off if I don't want to get up;"
-She initially stated she had "bumps and bruises" on her arms and legs where a "black, heavy-set woman" whom she identified as Staff #4 stepped on her little toe and "busted her lip;"
-Staff #4 had hit her in the mouth in her bedroom and when Staff #4 tried to get her up after a nap;
-She did not know an approximate date or time this incident occurred or if anyone else was around;
-She stated Staff #4 "said she killed my family and I told her not to bring my family up;"
-She later made statements that she and Client #3 had argued and fought and her bruises probably came from Client #3 because they fought when they were mad at each other;
-She got mad when Client #3 was loud and yelled because she did not like loud people;
-Whatever staff was present when they fought would tell them to stop their fighting and go to their rooms;
-She was not afraid of the staff or her housemates;
-Staff treated her "okay" and fixed her meals and gave her medications daily.

Interview on 3/4/19 with Staff #2 about Client #1 revealed:
-She usually worked first shift with Client #1 and was a Lead Direct Support Staff;
-Client #1's dementia seemed worse as she was more forgetful and confused about daily activities (getting dressed) and events (outings for lunch or to appointments), and had increased emotional outbursts of yelling, screaming, cursing and use of racial name-calling toward her and Staff #4;
-She went with Client #1 to her 2/14/19 doctor's appointment where Client #1 made statements to the doctor that "a nurse drug her out of bed and

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 _____	R-C 03/15/2019

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 112	Continued From page 7	V 112		

hit her" which caused her to be bruised and have a "busted lip;"
-She saw Client #1's bruises and injured lip the morning of 2/14/19 when she helped Client #1 with her shower and did not know what happened to her;
-Client #1 told her Staff #5 had stepped on her toes and then told the doctor a nurse had drug her around the home and caused her bruises;
-She reported Client #1's injuries to the Group Home Manager (GHM) who instructed her to document her observations in an incident report;
-She talked with Staff #4 on 2/14/19 to determine what caused Client #1's injuries and was told by Staff #4 that Clients #1 and #3 had gotten into a fight the day before;
-She later talked with Client #3 who confirmed she and Client #1 had a fight the day before and both had bruises from the fight;
-Staff #2 stated that whenever Clients #1 and #3 fought, she and the other staff knew the outcome was going to be scratches, scrapes and bruises on both the clients because "when you work alone and they're all (Clients #1, #2 and #3) here, you can't keep [Client #1]and [Client #3] apart;"
-She stated that Clients #1 and #3 can be "best of friends one minute" and "fighting the next minute" and sometimes staff did not know what triggered them to start their fights.

Interview on 3/4/19 with Staff #5 revealed:
-She usually worked as direct support staff on 3rd shift and Clients #1-#3 were in their beds for the night when she started her shift;
-She checked on each client when she came on shift but did not do "body checks" of them until the next morning;
-On the morning of 2/14/19 at around 8:00 am, she saw Client #1 with a "busted lower lip" that was not bleeding but "scabbed" and did not see

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 _____	R-C 03/15/2019

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 112	Continued From page 8	V 112		

bruises on her at that time;
-Client #1 did not remember why her lip was busted and seemed confused;
-She contacted the GHM about Client #1's lip and was instructed to apply first aid to her lip;
-She did not know what happened to Client #1's lip;
-She had returned to 3rd shift from having been out of work the week before;
-She worked 1 week on and was off 1 week;
-Client #1 was more forgetful and confused about things that happened with her than she was in 2018;
-Some mornings Client #1 had no problems with getting out of bed to do her personal hygiene (toileting and showering) and other mornings, Client #1 refused to get out of bed no matter how much she was encouraged;
-She worked over, at times, for a few hours after her shift ended in the mornings to pick up additional hours and if there were 2 clients at the facility.

Interviews on 3/4/19 and 3/5/19 with Staff #4 revealed:
-She worked 2nd shift (2:00 pm-10:00 pm) most of the time and was direct support staff;
-She came into work the morning of 2/13/19 to relieve a 3rd shift staff and was told Client #1 was "in one of her moods;"
-She went into Client #1's bedroom and talked with her and Client #1 seemed confused as she stated, They didn't come get me last night" but was unable to explain what she meant;
-She helped Client #1 transfer from her bed into her wheelchair and Client #1 went to the bathroom and to the table where she ate breakfast and took her medications without any problems;
-Client #1 went back to bed after her

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 _____	R-C 03/15/2019

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 112	Continued From page 9	V 112		

medications were given to nap;
-At around noon when she awakened Client #1 for her lunch and Client #1 told her she felt tired, wanted to stay in bed and did not want to be bothered;
-Client #1's refusal to get out of bed after her nap was a "temper tantrum" as she "flailed her arms around, repeatedly turned back and forth in her bed to the point the bedrail fell from her movements" and Client #1 fell out of her bed and onto the floor;
-When she attempted to help Client #1 up off the bedroom floor, Client #1 "smacked" her hand and refused to be helped up so Staff #4 left her alone in her bedroom for a few seconds before she returned and asked if she wanted to get up from the floor and into her wheelchair;
-She told Client #1 that all she had to do was to get up out of the bed and cooperate;
-Client #1 pulled on her shirt and began physically fighting her in the bathroom while she helped Client #1 transfer from the wheelchair to the toilet and Client #1 "slid off the potty and onto the floor;"
-Client #1 was "dead weight" whenever she tried to lift her but Client #1 refused her help up off the floor and she "scooted around" on the bathroom floor for about 2 hours during which time she locked herself inside the bathroom for 15 seconds while Staff #4 pried the door open and Client #1 agreed to get up and back into her wheelchair;
-Client #1 was told by Staff #4 that all she had to do was "get up, use the bathroom, and take her medication;"
-At around 4:00 pm, Clients #1 and #3 began arguing as they sat at the dining table and they began fighting by throwing objects at each other;
-Client #1 threw her shoe at Client #3 and Client #3 threw a napkin holder in Client #1"s face which

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 _____	R-C 03/15/2019

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 112	Continued From page 10	V 112		

caused Client #1's injured lip;
-Client #1's bruises and scrapes came from being turned over in the wheelchair by Client #3 and Client #3 having stepped on her legs;
-The fight was broken up by Staff #4 having stepped physically between both clients to block further hitting and throwing objects and Client #3 was told to go into another room to calm down;
-Staff #4 blamed herself for the onset of the fight between the two clients as she stated Client #3 kept asking to use the telephone while she was dealing with Client #1's behaviors and she told Client #3 "not right now"which made Client #3 mad because Client #3 kept "mumbling under her breath" and took her anger out on Client #1;
-Staff #4's attention was on preparing the dinner meal and not stopping to intervene between Clients #1 and #3 until they began fighting;
-Client #1 had a tendency to yell scream, curse and use racial names toward her and other staff when they attempted to help with her daily activities she did not want to do or not ready to do;
-She tolerated Client #1's behaviors, including the accusations and racial name calling, because she believed it was from her worsening dementia;
-She did not always know the triggers for Clients #1 and #3's agitation or anger because other work duties such as meal preparation, cleaning and medication administration on 2nd shift that took some of her attention away from keeping direct eyesight on Clients #1 and #3.

Interviews on 3/4/19-3/6/19 with the GHM revealed:
-She acknowledged Client #1's increased forgetfulness and confusion about things and situations during the day and waking up from being asleep;

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 _____	R-C 03/15/2019

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 112	Continued From page 11	V 112		

-Staff #2 contacted her the morning of 2/14/19 about Client #1's injuries and she came to the home and checked on Client #1;
-She observed Client #1's lip injury and a scrape on her leg which "just needed first aid applied;"
-She reported her findings to the Qualified Professional (QP);
-She talked with Staffs #2, #4 and #5 and learned that Clients #1 and #3 had gotten into a fight on 2/13/19 and Client #3 threw a napkin holder and hit Client #1 in the mouth which caused the lip injury and both clients had bruises on them from the fight.

Interviews on 3/4/19-3/6/19 with the QP revealed:
-Client #1's dementia had "gradually gotten worse" with increased forgetfulness, increased accusations that different staff had harmed her and changing her story when asked about the incidents, and she had increased her racial slurs toward 2 staff (Staffs #2 and #4) which knew Client #1's dementia had worsened and they did not take the racial slurs personally;
-Clients #1 and #3 have had a decrease in the number of their physical fights since 10/2018 but their physical fights like the one on 2/13/19 had resulted in continued physical injuries to both of them;
-A treatment team meeting was held in 1/2019 with Client #1, her legal guardian, Care Coordinator and staff which included discussions of Client #1's behaviors and a higher level of care;
-The legal guardian did not want Client #1's placement changed due to Client #1's long-term friendship with Client #2;
-Team recommendations were for Client #1 to be seen by a new psychiatrist for any new or different treatment and to be seen by her primary medical doctor regarding her weight loss, which

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 _____	R-C 03/15/2019

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 112	Continued From page 12	V 112		

were both done in 1/2019;
-1/29/19, Client #1's psychiatrist changed Client #1's antidepressant medication with her primary care physician having prescribed an appetite stimulant medication and continued the order on the liquid nutritional supplement twice daily;
-Client #1 had no behavior support plan staff have tried explaining to Client #1 why she needed to be out of bed each day as it related to showering, dressing, eating her meals, and taking her medications;
-Client #1's aggressive behaviors were responded to by staff using the "I'm safe, Your Safe" method of standing between Clients #1 and #3 when they fought and verbally redirected them to prevent any injuries to them.

II. Review on 3/5/19 of Client #2's record revealed:
-Date of admission: 11/20/09
-Diagnoses: Mild Intellectual Developmental Disability (IDD), Mood Disorder-Moderate, Organic Personality Disorder, Recurrent Depression, Epilepsy, Insomnia, GERD, Hypothyroidism, Osteoporosis, History of Right Breast Malignancy; Left Femur Fracture and Anemia diagnosed in 12/2018;
-Behaviors included kicking staff and making faces when she got angry and did not get her way, demanding the staff assist her in activities she was capable of doing herself (feeding and brushing her hair) which began after she returned to the facility from an inpatient rehabilitation facility on 1/31/19 as part of her recovery from a fractured left leg that resulted from a fall on 12/15/18;
-9/1/18 her treatment plan that revealed:
-Prior to 12/15/18, she had difficulty with her lifts and transfers in and out of bed and wheelchair and to and from toilet, continued weakness in her

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 _____	R-C 03/15/2019

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 112	Continued From page 13	V 112		

legs that hindered her ability to transfer independently, and increased forgetfulness for which she needed staff reminders to complete her daily care activities;
-Behavioral support was identified as a need to help Client #2 with anger control;
-There were no treatment goals and strategies that addressed helping Client #2 with anger control when "she does not get her way" and no additional strategies that addressed Client #2's increased need for lower body strengthening.

Review on 3/5/19 through 3/6/19 of Client #2's medical and rehabilitation notes in her record and dated from 12/2018 through 2/2019 revealed:
-12/15/18 to 12/24/18, a medical note that Client #2 was hospitalized for treatment of a left fractured femur that occurred from a fall on 12/15/18 and had received a diagnosis of anemia;
-12/24/18 to 1/31/19, a medical note that she was inpatient at a local rehabilitation facility where she received Occupation Therapy (OT) and Physical Therapy (PT);
-1/22/19, a staff-signed in-service training form that indicated staff received training by OT and PT staff from the rehabilitation facility on lifting and transferring Client #2 from the bed to her chair and toilet and included instructions and suggestions to "successfully" assist with Client #2's transition back to the facility;
-The GHM, the QP and direct care staff signed the in-service form that they received the training;
-1/31/19, Client #2 returned to the group home and began receiving OT and PT services from 2/1/19 to 2/18/19 with therapeutic strategies provided for lower body strengthening and included:
-2/6/19, a staff-signed PT written note of a leg exercise program to be used 2-3 times daily by

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 _____	R-C 03/15/2019

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 112	Continued From page 14	V 112		

Client #2 with staff encouragement and a recommendation for increased staff prompts for Client #2 to "shift" more of her weight onto her left leg;
-2/15/19, a staff-signed PT note that indicated PT worked with a staff member at the facility on safe lifting and transfer techniques when Client #2 "scooted" off the toilet and was assisted by a PT with a "controlled descent" to the floor followed by a 2-person lift up and transfer back to the toilet and lower body dressing;
-2/18/19, a staff-signed OT note that the GHM agreed with OT that Client #2's inconsistency with keeping her feet on the floor was more a "behavioral issue as opposed to a physical issue" and Client #2 would benefit from a positive-reinforcement program to complete her transfers;
-A written medical consultation report dated 2/18/19 and signed by the OT and Group Home Manager (GHM) that contained a recommendation for a "moveable grab bar in bathroom to allow for patient (Client #2) to reach grab bar more easily-current bar is far away from the toilet."

Review on 3/4/19 of written facility incident reports about Client #2 from 12/15/18 through 2/25/19 revealed:
-12/15/18 at 7 pm, Client #2 fell in the bathroom while being assisted by Staff #6 with a transfer to the toilet and which resulted in a fracture of her left femur;
-She fell on her left leg and "rolled" her ankle which caused the fracture;
-Non-emergency medical service (NEMS) was called by Staff #6 for assistance with lifting Client #2 off the floor and she was transported by NEMS to a local hospital for a medical evaluation after NEMS staff observation of her ankle that

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 _____	R-C 03/15/2019

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 112	Continued From page 15	V 112		

appeared swollen;
-2/9/19 at 7:20 am, Client #2 was assisted by 2 staff (Staffs #7 and #8) with transfer from a seated position on the toilet to a standing position when her left foot "started bending toward the floor" and staff guided her down onto the floor without injury;
-NEMS was called by Staff #7 and Client #2 was assisted up off the floor;
-2/17/19 at 3:30 pm, fell in the bathroom while assisted by Staff #4 during a transfer from the wheelchair to the toilet and guided to floor without injury;
-Client #2 was assisted up off the floor from Staff #4 having called NEMS and received the additional assistance to lift Client #2;
-2/17/19 at 11:15 pm, fell in the bathroom while assisted by Staff #5 with a transfer off the toilet and into her wheelchair due to leg weakness which resulted in her having "landed on her legs" without injury;
-Client #2 was assisted up off the floor from Staff #5 having called NEMS and received the additional assistance to lift Client #2;
-2/25/19 at 11:15 am, fell in the bathroom when prompted by Staff #8 to take a step back before sitting on the toilet and Client #2 began to sit instead of stepping back;
-Client was lowered to the floor by Staff #5 with no injury;
-The GHM was present at the facility at the time of this incident and NEMS was called to the facility to provide additional assistance to lift Client #2;

Review on 3/5/19 of Client #2's"Challenging Behavior Log" for the month of 2/2019 revealed:
-2/11/19 at 4 pm, yelled, screamed and complained she could not do her PT exercises, verbally communicated threats to Clients #1 and

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 _____	R-C 03/15/2019

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 112	Continued From page 16 #3 and was told by Staff #4 to quit yelling and being aggressive toward others; -2/12/19 at 9:30 am, yelled, shook her fist at Staff #2 and "demanded" to be moved to the bathroom and at 12 noon, yelled, shook her fist at Staff #2 and "demanded" to be assisted by this staff to get to the dining table for her meal; -2/13/19 at 6 pm, "demanded" Staff #4 to help her eat and complained no one helped her; -2/24/19 at undated time, refused to wash areas of her body she could bathe, refused to brush her own hair and refused to follow Staff #8's prompts to help with her transfers in and out of her wheelchair and on and off the toilet; -Staff #8's statement that Client #2 "flops down in chair and on the toilet." Observation on 3/6/19 at 9:10 am of Clients #1 and #2's shared bathroom revealed: -The grab bar in the bathroom was attached to the wall directly across from the toilet and was not moveable; -There was a measured distance of approximately 37 inches from the wall grab bar to the front of the toilet. Interview on 3/4/19 with Client #2 revealed: -She had been in the hospital because she fell at the group home when she missed the toilet and "busted her leg wide open" which had to be "sewed up;" -She stated she was able to stand on her own, put weight on the leg that was injured, and staff allowed her to care for herself; -She was not receiving physical therapy at the facility to strengthen her legs; -She had her own exercise of lifting one leg up and putting one leg down and did this exercise daily; -She did not need to be helped her out of her	V 112		

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 _____	R-C 03/15/2019

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 112	Continued From page 17	V 112		

wheelchair but if she asked, staff helped her into and out of her wheelchair;
-She held onto the rail in the bathroom when she used the toilet;
-She fell one time in the bathroom since she came home from the hospital because she missed the toilet and when staff tried to lift her and could not," the ambulance people came and helped her up;"
-She made a statement that people had talked about her going to a nursing home and she said she was not going and would fight back if she were made to go there.

Interview on 3/5/19 with Client #2's legal guardian revealed:
-Client #2 was her younger sister with whom she had a close relationship;
-She was involved in Client #2's care at the facility through telephone calls with Client #2 almost daily, and she communicated with facility staff, which included the GHM, QP and Program Manager (PM), and the Local Management Entity (LME) Care Coordinator and Client #2's physicians;
-She was aware of Client #2's fall on 12/15/18 that resulted in a fractured femur and hospitalization;
-She blamed Client #2 for her fall and injury as Client #2 told her she had let go of the handrail before Staff #6 had "steadied her;"
-Client #2 had been "lazy all her life" and relied on other people, including the guardian, to care for her instead of Client #2 attempting to help herself;
-She was aware Client #2 had fallen at least twice in 2/2019 and understood that both times, Client #2 had released her hand from the grab bar in the bathroom before staff steadied Client #2's balance;
-She was not aware that Client #2 was

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 _____	R-C 03/15/2019

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 112	Continued From page 18	V 112		

discharged from PT services on 2/22/19 and was concerned because Client #2 needed the therapy awhile longer to gain more strength;
-Her plan for Client #2's compliance with lifts and transfers was for staff to call her when Client #2 did not want to help and she would tell Client #2 she had to cooperate or she would have to be moved.

Interviews on 3/4/19 with Staff #2 #4, #5 about Client #2 revealed:
-Client #2 was given verbal prompts with her lifts and transfers but her left leg "gave out"2 or 3 times last month which resulted in her being lowered to the floor but unable to stand back up;
-The grab bar in the bathroom required Client #2 to be "stepped back" to reach the toilet and she tended to release her hold on the bar before being prompted to do so;
-They usually notified the GHM or QP when Client #2 fell and were instructed to call non-emergency EMS for the additional assistance with lifting her from the floor;
-Client #2 was "dead weight" when they tried to lift her by themselves;
-The last time Client #2 fell was on 2/25/19 while being helped with toileting and because her leg "gave out;"
-PT had Client #2 on a leg exercise program to strengthen her legs but Client #2 refused more than she cooperated with her exercise program;
-They had not seen PT in a couple of weeks and did not know the status of Client #2's PT service in the home;
-Additional staff were needed on duty when Clients #1, #2 and #3 were at the facility together because Clients #1 and #2's daily care needs have increased.

Interview on 3/5/19 with Client #2's Care

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 _____	R-C 03/15/2019

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 112	Continued From page 19 Coordinator revealed: -Client needed more than 1-person assistance with her transfers from bed to wheelchair and while toileting and showering. Interviews on 3/4/19-3/6/19 with the GHM and QP about Client #2 revealed: -PT continued to work with Client #2 on strengthening her lower extremity and they were not aware Client #2 was discharged from PT on 2/22/19; -They were concerned about Client #2's continued weakness in her legs and stated she had fallen on 2/25/19; -They were aware of the 4 NEMS calls to the facility in 2/2019 for additional assistance to be provided to lift Client #2 from the bathroom floor when staff could not lift her alone; -3/6/19, the GHM had picked up Client #2's bedside toilet and planned to take it to her today; -3/6/19, they were waiting on a doctor order for a mechanical lift for Client #2 to have additional assistance in and out of bed; -There was not a behavior modification program in place for Client #2; -Client #2's Behavioral Challenge Log notes were shared with Client #2's psychiatrist and medical doctor at scheduled appointments for recommendations or orders needed in her treatment; -The sliding board provided to Client in 5/2018 for assistance with transfers had not been previously used because it was not adaptable for use from wheelchair to the toilet inside the bathroom. Interview on 3/6/19 with the Executive Director (ED) revealed: -He was aware of Clients #1 and #2's behaviors and needs; -He acknowledged these clients' care needs were	V 112		

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 _____	R-C 03/15/2019

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 112	Continued From page 20 higher than when they were when admitted to the facility 10 years ago; -The management staff, including himself, was seeking a larger size home to relocate the facility and better accommodate Clients #1 and #2's daily care needs; -He stated the facility "was able at this point" to continue serving Clients #1 and #2. This deficiency is cross referenced into 10A NCAC 27G .5602 (V290) for a Type A1 rule violation and must be corrected within 23 days.	V 112		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the	V 290		

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 _____	R-C 03/15/2019

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 290	Continued From page 21 emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to staff the facility to meet the individual needs of 3 of 3 clients (Clients #1, #2 and #3). The findings are: CROSS-REFERENCE: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112) Based on record review, observation and interview, the facility failed to implement treatment strategies that addressed the individual needs of 1 of 3 clients (Client #1) and failed to develop and implement treatment strategies that addressed the needs of 1 of 3 clients (Client #2).	V 290		

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 _____	R-C 03/15/2019

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 290	Continued From page 22	V 290		

Review on 3/5/19 of Client #3's record revealed:
-An admission date of 1/2/15 and diagnosed Moderate IDD, Attention-Deficit Hyperactivity Disorder (ADHD), Impulse Control Disorder and Seizure Disorder;
-2/19/19, a psychiatric note that Client #3 still had "explosive behaviors," with "no effect yet" from a physician-ordered antidepressant medication once daily;
-She attended her day program Monday through Friday from around 8:30 am to 2:00-2:30 pm.

Review on 3/4/19 of 2 written facility incident reports of Client #1 revealed:
-12/10/18 at 5:00 pm, Clients #1 and #3 had a "physical altercation" that resulted in Client #1 having a 2-inch scratch down her front leg;
-No documentation on the incident report that indicated the facility's on-call system was used for notification and/or to receive instruction about the physical altercation between these two clients which resulted in Client #1 having a physical injury;
-2/13/19 at 5:00 pm, Clients #1 and #3 had a physical fight with one another while Staff #4 prepared dinner;
-The fight between these two clients resulted in Client #1 having been physically injured;
-Staff #4 notified the GHM at 4:30 pm and the QP at 5:00 pm that Client #1 had a busted lip;
-The notification of the GHM by Staff #4 was marked through and initialed by Staff #4;
-A written statement signed and dated 2/18/19 by the GHM indicated she was not made aware of Client #1's injury until the injury was reported to her on 2/14/19 by 1st shift staff.

Review on 3/4/19 of 4 written facility incident reports of Client #2 for the month of 2/2019 revealed:

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 _____	R-C 03/15/2019

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 290	Continued From page 23 -2/9/19 at 7:20 am, Staff #7 notified the GHM and QP that Client #2 could not be lifted up from the floor and she had called the non-emergency medical service (NEMS) to assist with lifting Client #2 and Staff #7 was instructed to "sit with her until (NEMS) arrived;" -2/17/19 at 11:15 am, Staff #5 called the GHM and an "on-call staff" that Client #2 "landed on her legs" and was on the floor after a transfer off the toilet; -Staff #5 received the on-call staff's instruction to call NEMS; -2/17/19 at 3:30 pm, Staff #4 called the GHM, the QP and an "on-call staff" and then called NEMS to come to the facility and assist with lifting Client #2 up from the floor. -2/25/19, the Group Home Manager (GHM) was present in the facility with Staff #8 when Client #2 fell in the bathroom while being assisted with toileting and non-emergency EMS was called for assistance to help lift Client #2 up from the floor and with a transfer to the toilet. Review on 3/4/19 of a written facility incident reports of Client #3 revealed: -12/10/18 at 5:00 pm, Clients #1 and #3 had a "physical altercation" that resulted in Client #3 having scratches on her legs and face; -No documentation that indicated the facility's on-call system was used for notification and/or to receive instruction about the physical altercation between these two clients which resulted in Client #1 having a physical injury; -2/13/19 at 5:00 pm, Clients #1 and #3 had a physical fight with one another while Staff #4 prepared dinner and Client #3 was checked for injuries and none noted. Review on 3/5/19 of the facility's staffing schedule from 12/1/18 to 3/1/19 revealed:	V 290		

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 _____	R-C 03/15/2019

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 290	Continued From page 24 -Manual changes were made on a paper copy of the staff work schedule and was provided by the GHM to reflect more accuracy of the staff work schedule during this timeframe; -The work schedule provided reflected: -3 work shifts: 1st shift from around 8 am to 2pm -3pm, 2nd shift from around 2pm-10 pm, and 3rd shift from 10pm-8 am with some staff time overlap time on 1st and 2nd shifts of 2-4 hours and 3rd shift usually held at 1 staff per 3 clients; -12/1/18 to 12/31/18 (31 days), 1st shift had 19 days with 1 staff, 2nd shift had 20 days with 1 staff and 3rd shift had 31 days with 1 staff; -12/1/18 to 12/15/18 at 7 pm (15 days), which was the date and time of Client #2's fall that resulted in a fractured left femur, 1st shift had 10 days with 1 staff and 2nd shift had 11 days with 1 staff; -1/1/19 to 1/30/19 (30 days) and 2 clients (Clients #1 and #3) in the facility, 1st and 2nd shifts had 26 days with 1staff, and 3rd shift had 28 days with 1 staff; -On 1/31/19, which was the day Client #2 returned to the facility from her inpatient rehabilitation admission, the facility had 1 staff on 2nd and 2 staff on 3rd shift; -2/1/19 to 2/28/19 (28 days), 1st shift had 24 days with 1 staff, 2nd shift had 22 days with 1 staff and 3rd shift had 27 days with 1 staff; -On 2/9/19, there was 2 staff on 1st shift at the time Client #2 had her 1st fall in 2/2019 and 2nd and 3rd shifts were maintained at a staff to client ratio of 1:3; -On 2/17/19 at 3:30 pm, there was 1 staff on 2nd shift when she had her 2nd fall in 2/2019; -On 2/17/19 at 11:15 pm, there was 1 staff on 3rd shift when she fell her 3rd time in 2/2019; -On 2/25/19 at 11:15 am, there was 2 staff (included was the GHM) on 1st when when Client	V 290		

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 _____	R-C 03/15/2019

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 290	Continued From page 25 #2 had her 4th fall in that same month. Interviews with Clients #1, #2 and #3 on 3/4/19 revealed: -There was usually 1 staff at the facility every day when they were there; -They saw the GHM sometimes in the mornings and in the afternoons as "she checked on everybody;" -They were never left alone at the facility; -Client #1 stated a daytime staff took her to paint at her ceramics class, to the doctor and out to eat lunch but she was uncertain how often she went on these outings; -Client #2 stated she fell one time in the bathroom since she came home from the hospital because she missed the toilet and when staff tried to lift her and could not, the ambulance people came and helped her up. Interviews on 3/4/19 with Staff #2 #4, #5 revealed: -A 3rd shift staff, which was 1 staff person, "might" remain at the facility a couple of hours as the 1st shift staff person came on duty around 8:00 am and helped Clients #2 and #3 out of bed and prepared them for their day program; -There was no requirement for a 3rd shift staff person to stay over the following morning; -Client #1's one-on-one (1:1) staff occurred 3 of 5 weekdays from a 1st shift person but Client #1 usually napped after her morning breakfast and medications and tended to stay asleep until early afternoon hours around 1:00-2:00 pm; -Client #2 was at the facility with Client #1 on Mondays and Wednesdays and at her day program on Tuesdays, Thursdays and Fridays from 9:00 am until 2:00-2:30 pm; -Client #3 attended her day program 5 days a week and returned back to the facility around	V 290		

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 _____	R-C 03/15/2019

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 290	Continued From page 26 2:00-2:30 pm; -More than one staff was needed on 1st shift when Clients #1-#3 needed to be awake in the mornings for their bath and dressing, breakfast meal, medication administration, and Clients #2 and #3's preparation to go to their day program, as well as when both Clients #2 and #3 remained at the facility for the day together; -2nd shift needed more than one staff to: -Monitor Clients #2 and #3 after they returned from their day program to address any problems these two clients might have had during their day along with Client #1's transition from being asleep to awake from her nap and the transition of Clients #1-#3 being back together; -Make certain Clients #1-#2 are provided with safe lifts and transfers during their personal care assistance; -Individual attention and time with Client #2 to work with and encourage her to complete her leg exercises; -Increase monitoring and supervision of Clients #1 and #3's triggers that might lead to onsets in their arguments and prevent their fights and risk for continued injuries. Interviews on 3/5/19 and 3/6/19 with the GHM, the Qualified Professional (QP) and the Program Manager (PM) revealed: -3/5/19, the QP's statement, "We try to have 2 staff at the home. Typically here, there is 1 staff on each shift;" -The GHM stated the days and shifts where 2 staff were identified on the staff schedule, one of the clients was usually receiving "periodic services", which meant a staff was with a client in the community for an appointment and a staff remained at the facility if another client was present at the facility; -If a fire occurred at the facility while 1 staff was	V 290		

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 _____	R-C 03/15/2019

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 290	Continued From page 27 working a shift, Client #1 would be assisted in the evacuation by Client #3 because Client #2 would have to be assisted in the evacuation by the staff on duty. Interview on 3/6/19 with the Executive Director revealed: -He stated Client #1's and #2's daily care needs have increased due to their increased medical conditions, physical limitations, and their continued difficulty managing anger and outbursts; -Staff conducted regularly scheduled fire and disaster drills and he felt comfortable Clients #1, #2 and #3 had the ability to evaluate the facility quickly; -There was an on-call procedure facility staff were knowledgeable of and used in the event of an emergency and/or needed additional support with Clients #1, #2 and #3; -Clients #1 and Client #2 had a long-term friendship and both clients would be devastated if they had to be separated; -His plan was to increase staffing on 2nd shift at the facility until staff coordinated care with the Care Coordinators and made adjustments to Clients #1-#3's yearly treatment plans. Review on 3/6/19 of an initial Plan of Protection completed by facility staff (GHM, QP and Program Manager) and signed and dated by the Executive Director on 3/6/19 revealed: "Plan of Protection- Completed by Facility Staff Type A1-Neglect Facility Name: VOCA- Forest Ridge MHL Number: 018-041 What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm.	V 290		

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 _____	R-C 03/15/2019

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 290	Continued From page 28 Bed side toilet for [Client #2]'s room with sliding board to assist with transfer. Get an order for hoyer lift to be utilized in [Client #2]'s bedroom as needed. Set up a fire drill evacuation plan for third shift Wake up [Client #1] first and assist in her chair and prompt her to evacuate, wake up [Client #2] and assist her to her chair, if [Client #3] has not gotten up then get [Client #3]up and out of bed. They all meet at the end of the driveway. Follow up with care coordinator again in regards to a behavior support plan for [Client #3] Increase staffing on 2nd as needed. Utilizing the on call system as well. An extender for the grab bar in the bathroom Staff will continue to utilize the 3 level on call system to access assistance when needed. Contact all care coordinators to assist with implementing behavioral goals in their treatment plan. Describe your plans to make sure the above happens. Staff will be trained on sliding board and bedside toilet at staff meeting on 3/7/2019. Program manager, [PM], is purchasing and delivering the bed side toilet no later than 3/6/2019. [GHM], home supervisor, will contact the doctor and get the order no later than 3/6/2019. [GHM], home supervisor, will create a thorough chart in regards to evacuation and train all staff. This will be reviewed at the staff meeting on 3/7/2019. Program coordinator, [QP], will set up training with company RN on proper hoyer lift use. Will contact company RN on 3/6/2019. Program Coordinator, [QP], is contacting care coordinator for [Client #3] again in regards to behavior support plan. Will email the care coordinator and leave a message by 3/6/2019.	V 290		

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 _____	R-C 03/15/2019

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 290	Continued From page 29 Home supervisor, [GHM], will follow up with staff/review schedule and staff with extra staff as needed. Program manager, [PM], submitted a maintenance request install a grab bar extender in the bathroom by 3/6/2019. It will be reviewed at the staff meeting the 3 level on call system on 3/7/2019. Program Coordinator, [QP], will contact all care coordinators in regards to behavioral goals for the treatment plan." Review on 3/6/19 of a 2nd Plan of Protection completed by facility staff (GHM, QP and Program Manager) and signed and dated by the Executive Director on 3/6/19 revealed: What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? "Bed side toilet for [Client #2]'s room with sliding board to assist with transfer. Get an order for hoyer lift to be utilized in [Client #2]'s bedroom as needed. Set up a fire drill evacuation plan for third shift Wake up [Client #1] first and assist in her chair and prompt her to evacuate, wake up [Client #2] and assist her to her chair, if [Client #3] has not gotten up then get [Client #3] up and out of bed. They all meet at the end of the driveway. Follow up with care coordinator again in regards to a behavior support plan for [Client #3] Increase staffing on 2nd shift for when all three clients are in the home until we are able to coordinate care in regards to behaviors with the care coordinators and make adjustments to the yearly plans to address behavioral concerns. An extender for the grab bar in the bathroom Staff will continue to utilize the 3 level on call system to access assistance when needed. The on call system consists of an on call 1st level	V 290		

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 _____	R-C 03/15/2019

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 290	Continued From page 30	V 290		

supervisor that has access to staffing lists to call in additional staff as needed, a 2nd level supervisor and a 3rd level supervisor to assist and back up the 1st level supervisor. Staff has access to all supervisor phone numbers and the schedule as to who is on call.
Contact all care coordinators to assist with implementing behavioral goals in their treatment plan.
Contact PCP (Primary Care Physician) in regards to immediate medical concerns."
Describe your plans to make sure the above happens revealed:
"Staff will be trained on sliding board and bedside toilet at staff meeting on 3/7/2019.
Program manager, [PM], is purchasing and delivering the bed side toilet no later than 3/6/2019.
[GHM], home supervisor, will contact the doctor and get the order no later than 3/6/2019.
[GHM], home supervisor, will create a thorough chart in regards to evacuation and train all staff. This will be reviewed at the staff meeting on 3/7/2019.
Program coordinator, [QP], will set up training with company RN on proper hoyer lift use. Will contact company RN on 3/6/2019.
Program Coordinator, [QP], is contacting care coordinator for [Client #3] again in regards to behavior support plan. Will email the care coordinator and leave a message by 3/6/2019.
Home supervisor, [GHM], will follow up with staff/review schedule and staff with extra staff as needed.
QP will contact all 3 PCP in regards to immediate medical concerns no later than 03/08/2019.
Program manager, [PM], submitted a maintenance request install a grab bar extender in the bathroom by 3/6/2019.
It will be reviewed at the staff meeting the 3 level

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 _____	R-C 03/15/2019

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 290	Continued From page 31	V 290		

on call system on 3/7/2019.
Program Coordinator, [QP], will contact all care coordinators in regards to behavioral goals for the treatment plan."

Client #1 was admitted on 4/15/08 and Client #2 was admitted on 11/20/09 and had histories of aggressions and emotional outbursts and diagnoses of various medical conditions that included Dementia, Parkinson's Disease, Osteoporosis, and Epilepsy. They each used a wheelchair for mobility inside and outside the facility. Client #1's refusals to be helped by different staff with her daily care (transfer out of bed, showering, toileting) occurred by her ignoring staff prompts, yelling, kicking, spitting her food, and using profanity and racial slurs toward staff. There were at least 5 occasions between 12/12/18 and 2/13/19 (12/12/18, 1/5/19, 1/14/19, 1/15/19 and 2/13/19) in which Client #1 had aggressive behaviors toward staff (Staffs #2, #4, #7) and 2 occasions (12/10/18 and 2/13/19) of physical fighting between Clients #1 and #3 that resulted in physical injuries on both clients. On each occasion, Client #1's was not helped by staff to use her de-escalation strategies to prevent or reduce her aggression and refusals for staff assistance. Client #2, on 12/15/18 while being assisted by Staff #6 with a transfer during toileting, fractured her left leg. She received physical and occupational rehabilitation (PT and OT) therapies from 12/24/18 to 2/18/19. She returned to the facility on 1/31/19 with an increased need with lifting and transferring to complete her daily care activities. She had a tendency to resist her therapies when she did not want to participate and was hesitant to bear weight on her legs. She had OT and PT written recommendations that included a moveable grab bar in the bathroom, a written leg-strengthening

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 _____	R-C 03/15/2019

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 290	Continued From page 32 exercise program to use daily, and a positive reinforcement program for her to be self-motivated to help complete her transfers in and out of bed, wheelchair and toilet. Her treatment plan did not change to include these recommendations and the facility did not staff the facility based on the increased behaviors and needs of Clients #1 and #2. The facility remained at their required staffing ratio of 1 staff to 3 clients (Clients #1, #2 and #3). Even after Client #2 returned to the facility on 1/31/19 and had 4 additional falls in the bathroom (once on 2/9/19, twice on 2/17/19, and once on 2/15/19) staffing to meet the individualized needs was not adjusted. Further, the facility did not consider staffing to address Client #1 and #3's aggressive behaviors toward each other in order to prevent continued physical injuries as a result of their fighting. This deficiency constitutes a Type A1 rule violation for neglect and must be corrected within 23 days. An administrative penalty of $2,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 290		
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	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 _____	R-C 03/15/2019

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 367	Continued From page 33	V 367		

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:
(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

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 _____	R-C 03/15/2019

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 367	Continued From page 34 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 .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 a Level II incident report to the Local Management Entity (LME) within 72 hours of becoming aware of the incident. The findings are:	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 _____	R-C 03/15/2019

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 367	Continued From page 35 Review on 3/4/19 of facility incident reports for the months of 12/2018 and 1/2019 and 2/2019 revealed: -No Level II written incident report that contained information about the involvement of a local county department of social services (DSS) with regard to a 2/14/19 allegation of suspected abuse of Client #1 by a staff. Review on 3/4/19, 3/5/19, and 3/14/19 of the North Carolina Incident Response Improvement System (IRIS) for 12/1/18 through 3/14/18 revealed: -No IRIS report found for Client #1 that contained the 2/14/19 allegation of physical abuse of her by a staff and DSS involvement. Interview on 3/4/19 with Client #1 revealed: -An initial statement that the "bumps and bruises" on her arms and legs came from a "black, heavy-set woman" whom she identified as Staff #4; -Staff #4 stepped on her little toe and "busted her lip;" -Staff #4 had hit her in the mouth when she was in her bedroom and when Staff #4 tried to get her up after a nap; -She did not know an approximate date or time this incident occurred or if anyone else was there with her; -Her later statements were she and Client #3 had argued and fought and her bruises probably came from Client #3 because they fought when they were mad at each other; -She got mad when Client #3 was loud and yelled because she did not like loud people. Interview on 3/5/19 with Client #1's primary medical provider revealed:	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 _____	R-C 03/15/2019

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 367	Continued From page 36	V 367		

-She had seen Client #1's multiple bruises on 2/14/19 and the bruises were "in different stages of healing;"
-Client #1 told her a nurse tried to get her out of her bed, she did not want to get up, was drug out of the bed by the nurse and fell;
-She was aware there was DSS involvement with Client #1's allegation of physical abuse by staff as she (the primary medical provider) had been contacted by DSS staff and asked questions.

Interview on 3/6/19 with Client #1's Local Management Entity Care Coordinator revealed:
-She received a telephone call from DSS Adult Protective Services (APS) in 2/2019 regarding an allegation Client #1 had been harmed by a staff;
-She had no concerns about Client #1's care at the facility and Client #1's legal guardian did not want Client #1 moved from the facility.

Interview on 3/4/19 with the Group Home Manager (GHM) revealed:
-She was contacted on the morning of 2/14/19 by Staff #2 and told Client #1 had a cut on her lip and scrape on her leg;
-She went to the facility and checked on Client #1 who was treated with first aid, and she reported her findings to the Qualified Professional (QP) on 2/14/19.

Interview on 3/4/19 with the QP revealed:
-She conducted an "internal inquiry" into Client #1's allegation of physical abuse by a staff on 2/13/18 which consisted of her interviews with Clients #1, #2 and #3, all staff who worked around 2/13/19-2/14/19 and she concluded her inquiry on 2/15/19;
-Her internal inquiry included:
  -The allegation made by Client #1 that a staff drug her out of bed the day before (2/13/19),

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 _____	R-C 03/15/2019

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 367	Continued From page 37	V 367		

kicked her in the face, arms, and legs and caused the bruises on her arms and legs;

-Staff #2 called the GHM on the morning of 2/14/19 and reported her observations of Client #1's injured lip and bruising;

-The GHM called her on 2/14/19 after she checked on Client #1 at the facility and reported Client #1 had a cut on her lip and bruises;

-Client #1's statements about what happened kept changing and included her 2/14/19 report to her doctor that she was drug out of bed and around the house by a staff, told Staff #2 on 2/14/19 that it was Staff #5 who had hit her, told DSS on 2/15/19 that Staff #4 drug her out of bed and around the house and hit her, and in her interview with Client #1 on or about 2/15/19, Client #1 was uncertain how she got her lip hurt and said her bruises came from her bedrail;

-Clients #2 and #3's interview statements were that Clients #1 and #3 physically fought one another on 2/13/19 and Client #3 threw a napkin holder and hit Client #1 in the mouth that caused Client #1's lip injury;

-Staff #4's interview was Client #1 screamed, yelled and kicked at Staff #4 when Staff #4 tried to get her up from a nap to eat lunch, and when she was able to get Client #1 up from having fallen from her bed onto the floor and to the bathroom, Client #1 remained angry and started yelling at Client #2 who was at the facility and which was followed by a physical altercation that same evening between Clients #1 and #3;

-She reported her inquiry findings to the Program Manager (PM) and Executive Director (ED) that Client #1's injuries came from the physical altercation between Clients #1 and #3 on 2/13/19 and there was no evidence that supported the allegation of physical abuse of Client #1.

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 _____	R-C 03/15/2019

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 367	Continued From page 38 Interview on 3/5/19 with the QP and PM revealed: -The QP's statement that an internal inquiry was different from an internal investigation and was considered a "pre-investigative process" to determine if there were any findings that supported the allegation; -An internal inquiry was conducted if it was not the first time the client made accusations against a staff and the client's mental health diagnoses was considered; -Client #1 had made multiple accusations over the years of staff abuse and her accusations against staff have increased over the years; -The ED made the decision as to whether an internal inquiry or internal investigation was to be conducted regarding client allegations; -The PM's statement that DSS did an investigation that pertained to Client #1's allegation of physical abuse on 2/14/18 and he did not know the agency's outcome of their investigation; -He stated that Staff #4, who had worked with Clients #1-#3 on 2/13/19, was not suspended from work during the internal inquiry because the QP's interview with Staff #4 occurred prior to Staff #4's next scheduled work time; -The QP interviewed Staff #4 on 2/15/19 and worked again on 2/16/19. Interview on 3/15/19 with the PM revealed: -No incident report had been completed in IRIS that pertained to Client #1's allegation of physical abuse by staff with DSS involvement and included the facility's documentation on the internal inquiry.	V 367		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND	V 736		

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 _____	R-C 03/15/2019

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 736	Continued From page 39 EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observations and interviews, the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are: Observations on 3/4/19 at approximately 9:10 am and on 3/6/19 at 9:10 am of the facility revealed: -3/4/19, a large dark colored stain on the living room carpet that remained visible on 3/6/19; -Clients #1 and #2's shared a bathroom located between their separate bedrooms appeared small in physical size and there was a measured distance of 35 inches on 3/6/19 from the front of the toilet that had an adaptive toilet seat with handrails to the attached and unmovable grab bar; -3/4/19 and 3/6/19, the hallway walls that joined Clients #1 and #2's bedrooms and their shared bathroom had multiple black-colored marks with an indention in the wall outside Client #2's bedroom and multiple black-colored marks on the bathroom door and Clients #1 and #2's bedroom doors; -3/6/19, the hallway between Clients #1 and #2's bedrooms appeared narrow, seemed difficult for wheelchair movements and measured approximately 5 feet in length between the 2 bedrooms; -The hallway outside the shared bathroom to the wall directly across from it appeared narrow, seemed difficult for wheelchair movements and	V 736		

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 _____	R-C 03/15/2019

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 736	Continued From page 40	V 736		

measured approximately 3 feet, 4 inches to the First Aid closet.

Interview on 3/14/19 with a staff from the Construction section of the Division of Health Service Regulation (DHSR) revealed:
-A DHSR Construction completed a Biennial Survey on 3/14/19 at the facility;
-The facility was first licensed on 7/31/96 for 3 ambulatory clients and on 3/14/19, there were 2 non-ambulatory clients living in the home;
-Their survey findings contained evidence of scuff marks on the walls and doors that indicated a certain level of difficulty when clients are transferred in their wheelchairs in the home, carpet stains, one bedroom window was difficult to open, a bedroom dresser was damaged, there was mold growing along a bathroom window, and one of the smoke detectors between two client bedrooms was inoperable;
-The aforementioned survey findings were cited deficiencies by DHSR Construction.

Interview on 3/5/19, 3/6/19 and 3/15/19 with the Group Home Manager (GHM), Qualified Professional (QP), Program Manager (PM) and the Executive Director (ED) revealed:
-They all agreed the facility was small in size to accommodate Clients #1 and #2 who were non-ambulatory adult clients with increased daily care needs;
-The black marks on Clients #1 and #2's hallway and indention on the wall outside Client #2's bedroom came from the wheelchairs;
-The stain on the living room carpet may have been made by Clients #1 and #2's wheelchair tires as the carpet had been cleaned in 10/2018;
-The licensee's Regional Director had visited the facility within the year and was aware that the facility size needed to be larger;

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 _____	R-C 03/15/2019

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 736	Continued From page 41 -They were working with a realtor and searching for a 4-bedroom home in the geographical area to relocate the facility and Clients #1-#3 but had not found a suitable location.	V 736		