STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G220	A. BUILDING _____ B. WING _____	02/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-WILSON AVENUE GROUP HOME	2103 WILSON AVENUE CHARLOTTE, NC 28208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure 6 of 6 clients in the home (#1, #2, #3, #4, #5 and #6) received a continuous active treatment, and failed to assure 1 of 3 sampled clients (#5) received sufficient interventions to address communication needs. The findings are: A. The team failed to assure clients #1, #2, #3, #4, #5 and #6 received continuous active treatment on 2/26/19 during the 2/25-26/19 survey. For example: 1. Observations in the group home on 2/26/19 from 6:20 AM to 6:45 AM revealed client #5 to be up and dressed for the day. The client was standing in the living area, and occasionally singing and dancing while watching music videos on the television. Further observations from 6:45 AM to 7:05 AM revealed the client to be in the bathroom for 3-4 minutes and otherwise in his bedroom. Continued observations from 7:05 AM to 7:40 AM revealed client #5 to be in the bathroom for 2-3 minutes and otherwise walking throughout the home occasionally watching the	W 249	Please see attached Plan of Correction RECEIVED MAR 26 2019 DHSR NH L & C Black Mountain / WRO	04/17/19

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Program Manager 03.20.19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 249	Continued From page 1	W 249		

television. Further observations at 7:40 AM revealed the client to be in the medication room. From 7:45 AM to 7:50 AM, the client assisted staff with taking a bag of trash outside. Further observations from 7:50 AM to 8:05 AM revealed client #5 to be standing in the dining area with staff waiting to get on the van. At 8:05 AM, the client got on the van, and waited for other clients to get onto the van before leaving at 8:15 to go to day programming. In total, client #5 was noted to spend approximately 95 minutes of 115 minutes not engaged in active programming, or prompted with choices for different activities.

Review of the record on 2/26/19 for client #5 revealed an individual service plan (ISP) dated 10/1/18. Review of the ISP revealed a non-negotiable to be choices of activities, as well as a need to provide a variety of recreational and exercise activities. Review of the current programing revealed objectives for brushing teeth, cleaning room, laundry, lunch and dinner preparation, identifying coins, bathing, and communication. Further review of the record revealed a behavior support plan (BSP) which included a section for proactive prevention and intervention strategies. The section indicated client #5 should be encouraged to participate in a variety of activities daily and should be provided with choices.

Interview with the qualified intellectual disabilities professional (QIDP) on 2/26/19 revealed that all clients in the home except for client #4 had awakened earlier than normal and as a result staff assisted clients with completing the morning routine early, except for medication administration which could not start before 7:00AM. Continued interview with the QIDP confirmed all clients in

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W 249	Continued From page 2 the home could have been involved with, or offered the choice of program objectives or different activities prior to leaving the home for day programming. 2. Observations in the group home on 2/26/19 from 6:20 AM to 6:45 AM revealed client #1 to be up and dressed for the day. The client was sitting in the living area watching television and occasionally talking to staff. Continued observations from 6:50 AM to 7:05 AM revealed the client to be in her room playing with a fidget spinner, talking to staff and being prompted by staff to put on warmer clothing. Further observations from 7:05 AM to 7:30 AM revealed client #1 to be in the living area watching television or talking to staff. From 7:30 AM to 7:40 AM the client was assisted with medication administration. Further observations from 7:40 AM to 8:00 AM revealed client #1 to be in the living area sitting on the couch and waiting by the door to leave for day programming. From 8:00 AM to 8:15 AM, the client was observed getting on the van and then waiting for other clients to get on the van before leaving to go to day programming. In total, client #1 was noted to spend approximately 100 minutes of 115 minutes not engaged in active programming, or prompted with choices for different activities. Review of the record on 2/26/19 for client #1 revealed an ISP dated 8/29/18. Review of the ISP revealed current program objectives for bathing, laundry, meal preparation, toothbrushing, exercise, name writing, cleaning bedroom, and an expressive communication program designed to assist with correctly pronouncing words. Further review of the record revealed a current BSP which included a section for proactive prevention	W 249		

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W 249	Continued From page 3 and intervention strategies. The section indicated client #1 needs to be kept engaged throughout the day and offered opportunities for a variety of choices. Interview with the QIDP on 2/26/19 revealed that all clients in the home except for client #4 had awakened earlier than normal and as a result staff assisted clients with completing the morning routine early, except for medication administration which could not start before 7:00AM. Continued interview with the QIDP confirmed all clients in the home could have been involved with, or offered the choice of program objectives or different activities prior to leaving the home for day programming. 3. Observations in the group home on 2/26/19 from 6:20 AM to 6:35 AM revealed client #4 to be eating breakfast. Continued observations from 6:35 AM to 7:35 AM revealed the client to stand in the living area watching television and talking, except for going to the bathroom for approximately 5 minutes. From 7:35 AM to 7:45 AM client #4 was assisted with medication administration. Further observations from 7:45 AM to 8:00 AM revealed client #4 to again stand in the living area watching television. At 8:00 AM, the client was observed getting on the van and waiting on the van until 8:15 AM before leaving to go to day programming. In total, client #4 was noted to spend approximately 75 minutes of 115 minutes not engaged in active programming, or prompted with choices for different activities. Review of the record on 2/26/19 for client #4 revealed an ISP dated 12/5/18. Review of the ISP revealed current program objectives for meal preparation, oral hygiene, exercise, medication	W 249		

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W 249	Continued From page 4 administration, toileting, identifying coins, toothbrushing, bedroom checklist, name writing and writing phone numbers. Further review of the record revealed a BSP dated 11/29/18 which included a section for proactive prevention and intervention strategies. The section indicated client #4 should be kept involved in activities at all times and indicated the client should be offered choices whenever possible. Interview with the QIDP on 2/26/19 revealed that all clients in the home except for client #4 had awakened earlier than normal and as a result staff assisted clients with completing the morning routine early, except for medication administration which could not start before 7:00AM. Continued interview with the QIDP confirmed all clients in the home could have been involved with, or offered the choice of program objectives or different activities prior to leaving the home for day programming. 4. Observations in the group home on 2/26/19 from 6:20 AM to 6:50 AM revealed client #6 to be up and dressed for the day and sitting in the living area watching television and talking. Continued observations from 6:50 AM to 7:20 AM revealed the client to be in her room watching television or talking to staff. Further observations from 7:20 AM to 7:35 AM revealed the client being assisted with medication administration. Continued observations from 7:35 AM to 8:10 AM revealed client #6 to be in her room watching television. At 8:10 AM, the client was observed getting on the van for transport to day programming. In total, client #6 was noted to spend approximately spend 100 minutes of 115 minutes not engaged in active programming, or prompted with choices for different activities.	W 249		

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W 249	Continued From page 5 Review of the record on 2/26/19 for client #6 revealed an ISP dated 4/12/18. Review of the ISP revealed current program objectives for brushing teeth, assisting in the kitchen, bathing, laundry, exercise, money, writing her name and medication administration. Interview with the QIDP on 2/26/19 revealed that all clients in the home except for client #4 had awakened earlier than normal and as a result staff assisted clients with completing the morning routine early, except for medication administration which could not start before 7:00AM. Continued interview with the QIDP confirmed all clients in the home could have been involved with, or offered the choice of program objectives or different activities prior to leaving the home for day programming. 5. Observations in the group home on 2/26/19 from 6:20 AM to 6:50 AM revealed client #2 to be up and dressed for the day and sitting in her wheelchair in the living area, occasionally talking with staff. Continued observations from 6:50 AM to 7:20 AM revealed the client to sitting in her room, occasionally taking with staff when they checked on her. Further observations from 7:20 AM to 7:30 AM, revealed client #2 to be in the bathroom. From 7:30 AM to 7:55 AM client #2 was observed sitting in her room. Continued observations from 7:55 AM to 8:10 AM revealed the client being assisted with medication administration and was then observed getting on the van for transport to day programming. In total, client #2 was noted to spend approximately 90 minutes of 115 minutes not engaged in active programming, or offered the choice of program objectives or different activities prior to leaving	W 249		

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W 249	Continued From page 6 the home for day programming. Review of the record on 2/26/19 for client #2 revealed an ISP dated 6/21/18. Review of the ISP revealed current programming objectives for trimming finger and toenails, calling 911, speaking her full name and where she lives, toileting and bathing. Interview with the QIDP on 2/26/19 revealed that all clients in the home except for client #4 had awakened earlier than normal and as a result staff assisted clients with completing the morning routine early, except for medication administration which could not start before 7:00AM. Continued interview with the QIDP confirmed all clients in the home could have been involved with, or offered the choice of program objectives or different activities prior to leaving the home for day programming. 6. Observations in the group home on 2/26/19 from 6:20 AM to 8:05 AM revealed client #3 to be up and dressed for the day and sitting in a wheelchair in the living area. During this period of time, the client was observed watching television, looking around or talking with staff. Continued observations at 8:05 AM revealed client #3 being assisted to the medication room for medication administration. In total, client #3 was noted to spend approximately 105 of 115 minutes not engaged in active programming, or offered the choice of program objectives or different activities. Review of the record on 2/26/19 for client #3 revealed an ISP dated 6/11/18. Review of the ISP revealed the client enjoys playing with yarn and bubbles and included providing the client with	W 249		

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W 249	Continued From page 7 choices related to routine and activities. The ISP also included current program objectives for bathing, drying body, meal preparation, oral hygiene, hand sanitizing and use of deodorant. Interview with the QIDP on 2/26/19 revealed that all clients in the home except for client #4 had awakened earlier than normal and as a result staff assisted clients with completing the morning routine early, except for medication administration which could not start before 7:00AM. Continued interview with the QIDP confirmed all clients in the home could have been involved with, or offered the choice of program objectives or different activities prior to leaving the home for day programming. B. The team failed to assure client #5 received sufficient interventions to address communication needs. For example: Observations in the group home on 2/25/19 and 2/26/19 revealed client #5 to be mostly non-verbal. Continued observations on 2/26/19 from 6:20 AM to 8:00 AM revealed the client to be in the living area watching television, in the bathroom, in his room, in the medication room, helping with taking out the trash and otherwise walking around the home. No communication tools were observed being used during this time. Review of the record for client #5 on 2/26/19 revealed an ISP dated 10/1/18. The ISP included a current communication program for the client to use a schedule. The directions for the program included instructions for staff to use the program when the client was not otherwise engaged. Instructions included providing a schedule with pictures of tasks and the client making choices	W 249		

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W 249	Continued From page 8 using the pictures. Interview with the QIDP on 2/26/19 confirmed client #5 has a current communication program using a schedule with pictures. The QIDP confirmed the communication program should have been used as described when the client was not otherwise engaged.	W 249		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the system for drug administration failed to assure all drugs were administered in compliance with the physician's order for 1 of 3 clients observed during drug administration (client # 4). The finding is: Observations conducted in the group home on 2/26/19 at 6:20 AM revealed client #4 was seated to the dining table eating breakfast consisting of waffles with syrup and beverages. Further observations conducted in the group home on 2/26/19 at 7:35 AM revealed client #4 was prompted to enter the medication administration area where he was assisted by staff to receive medications including: Aspirin EC 81 mg., Divalproex 500 mg., Lisinopril 5 mg., Ziprasidone 60 mg., one-daily multivitamin, Vitamin D-3 2000 units and Gemfibrozil 600 mg. Review of the record for client #4 revealed	W 368	Please See Attached Plan of Correction	04/17/19

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W 368	Continued From page 9 current physician's orders dated 1/30/19 which documented client #4 should receive Gemfibrozil 600 mg.- one tablet twice daily before breakfast and dinner. Interview conducted on 2/26/19 with the nurse revealed client #4 should have received the Gemfibrozil 600 mg. before eating breakfast as ordered by the physician.	W 368		
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observations and interview, the facility's system for medication administration failed to assure 3 of 3 clients observed during medication administration were provided with teaching related to self-administration of medication (clients #1, #4 and #6). The findings are: A. Observations conducted in the group home on 2/26/19 at 7:20 AM revealed client #6 was prompted by staff to come to the medication administration area where the client was assisted by staff to receive medications which included Carbamazepine 200 mg.-two capsules, Calcium-D 600/400mg., Docusate sodium 100 mg., one-daily multivitamin, Vimpat 100 mg., and Fiberlax 2 tablespoons. Continued observations	W 371	Please see attached Plan of Correction	04/17/19

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W 371	Continued From page 10 revealed staff informed client #6 that one of the medications provided was for seizures, however, no further information was provided to client #6 regarding the name, purpose for which it was given, or possible side effects of the medications received. Interview conducted with the nurse on 2/26/19 revealed staff administering medications are expected to provide each client with the names, purpose for which it was given, and possible side effects of each medication administered to client #6. B. Observations conducted in the group home on 2/26/19 at 7:30 AM revealed client #1 was prompted by staff to come to the medication administration area where the client was assisted to receive medications which included Clonazepam 0.5 mg., Sertraline 100 mg.-two tablets, one-daily multivitamin, Oxcarbazepine 300 mg., and Fluticasone nasal spray 50 mcg. -two sprays to each nostril. Continued observations revealed client #1 stated the purpose of the nasal spray independently, however, staff was not observed to provide any further information to client #1 regarding the name, purpose for which it was given, or side effects of the medications received. Interview conducted with the nurse on 2/26/19 revealed staff administering medications are expected to provide each client with the names, purpose for which it was given, and possible side effects of each medication administered to client #1. C. Observations conducted in the group home on 2/26/19 at 7:35 AM revealed client #4 was	W 371		

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W 371	Continued From page 11 prompted by staff to come to the medication administration area where the client was assisted by staff to receive medications which included Aspirin EC 81 mg., Divalproex 500 mg., Lisinopril 5 mg., Ziprasidone 60 mg., one-daily multivitamin, Vitamin D-3 2000 units and Gemfibrozil 600 mg.. Continued observations revealed staff did not provide any information to client #4 regarding the name, purpose or possible side effects of the medications received. Interview conducted with the nurse on 2/26/19 revealed staff administering medications are expected to provide each client with the names, purpose for which it was given, and possible side effects of each medication administered to client #4.	W 371		
W 383	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) Only authorized persons may have access to the keys to the drug storage area. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure only authorized persons have access to the keys to the drug storage area. The finding is: Observation conducted on 2/26/19 at 7:20 AM revealed client #6 entered the medication administration area to receive morning medications, accompanied by staff responsible for administering medications and the surveyor. Continued observations at 7:20 AM revealed staff used a key to unlock the medication storage closet, then closed the closet leaving the key	W 383	Please see Attached Plan of Correction	04/17/19

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W 383	Continued From page 12 inside the lock while staff exited the medication administration area, leaving the door to the room open with client #6 and the surveyor remaining in the room. Staff was subsequently observed to return to the drug administration area with a container of hand sanitizer, retrieve the key to the medication storage area, and continue with medication administration for client #6. Interview conducted with the nurse on 2/26/19 revealed staff responsible for medication administration should keep the key to the medication storage closet on their person at all times, and should assure all medications remain locked when not being prepared for administration.	W 383		

W 249: PROGRAM IMPLEMENTATION: As soon as the interdisciplinary team has formulated a client's individual program plan, Each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

Community Alternatives of NC, specifically the Wilson group home, will ensure as soon as the interdisciplinary team has formulated a client's individual program plan, each client will receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

A. The Clinical Supervisor will train staff and ensure that they are aware of the active treatment expectations. Furthermore, the Clinical Supervisor and Residential Manager will ensure that active treatment is continuously happening, specifically in the morning hours in between breakfast and time to leave for the day program. The consumers will be offered different activities in the morning that coincides with their individual program plan and supports needed. The Residential Manager and Clinical Supervisor will complete weekly observations to ensure active treatment is occurring. The Program Manager will conduct observations during monthly site reviews to ensure active treatment is occurring.

B. The Clinical Supervisor will retrain all staff on Client #5's formal communication objective. Training will include, but not be limited to, methodology and frequency of data collection. The objective will be implemented throughout the day in all environments. Staff will ensure that his picture schedule is available, so he is able to make choices and is aware of tasks to be completed. The RM will conduct observations 3 x weekly to ensure the objective is implemented. The QIDP will conduct observations 2 x weekly to ensure the objective is implemented. The Program Manager will conduct observations during monthly site reviews to ensure the objective is implemented.

To be completed by: 4.17.19
Person(s) Responsible: QIDP, Residential Manager, Program Manager

W 368 DRUG ADMINISTRATION:
The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the system for drug administration failed to assure all drugs were administered in compliance with the physician's orders.

Community Alternatives of NC, specifically the Wilson group home, will ensure that all mediations are administered in compliance with the physician's orders. Additionally, staff will be in-serviced on how to correctly read the Medication Administration Record and will be re-trained on the proper medication administration techniques.

The staff member who administered medication on the day of the survey, was immediately decertified from administering medication until she completed the medication training class again. The staff member completed this medication training on February 27, 2019. Furthermore, staff were in-serviced on ensuring that medications are given per doctor order. The Residential Manager and Clinical Supervisor will conduct random medication administration observations on a weekly basis to ensure all medications are administered p compliance with the physician's orders.

To be completed by: 4.17.19
Person(s) Responsible: QIDP, Residential Manager, Program Manager

W 371 DRUG ADMINISTRATION CFR(s): 483.460(k)(4)
The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.

Community Alternatives of NC, specifically the Wilson group home, will ensure that all staff are following self-medication programs as written by the QIDP. Furthermore, staff will be in-serviced and trained on providing medication education while administering medications.

A, B, C The QIDP and Nurse will in-service all staff on providing education when administering medication to enhance the individual's ability to participate independently in their medication process. The Residential Manager and QIDP will conduct random weekly observations of medication administration to ensure that education is provided to the individuals.

To be completed by: 4.10.19
Person(s) Responsible: Residential Manager, QIDP, Nurse

W 383: DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2)
Only authorized persons may have access to the keys to the drug storage area.

Community Alternatives of NC, specifically the Wilson group home, will ensure that the Direct Support Professional, whom administered medications during the survey observation is retrained on Medication Administration. Furthermore, the Residential Manager and the Clinical Supervisor are conducting random weekly observations of medication administration to ensure that all policies and procedures are met.

The QIDP and nurse will retrain all staff on access to medications and the protocol with the medication keys. The staff member assigned to administer medication will keep the key to the medication closet on them at all times during their shift. The keys will be passed to the next staff member assigned to administer medication at shift change. The medication closet is to be locked at all times unless the staff member assigned to administer medication is preparing to administer medication. The Residential Manager will complete observations 2x weekly and the Clinical Supervisor will complete observations 1x weekly. The Program Manager will conduct observations during monthly site reviews.

To be completed by: 4.17.19
Person(s) Responsible: Residential Manager, QIDP, Program Manager