	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3		(X3) DATE SURVEY COMPLETED	
74101 1214	or contraction	IBENTII IOMINOMBEIX	A. BUILDING: _	A. BUILDING:		
		mhl018-050	B. WING		R 08/14/2	019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
VOCA-8TI	H AVENUE		VENUE N W			
		HICKORY	, NC 28601			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	BE C	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
	An annual, complaint completed on 8/14/19 unsubstantiated (Intal Deficiencies were cite	ke #NC00154053).				
	category: 10A NCAC Living for Individuals	d for the following service 27G .5600C Supervised of all disability evelopmental Disabilties.				
V 108	27G .0202 (F-I) Perso	onnel Requirements	V 108			
	(g) Employee training provided and, at a min following: (1) general organiza (2) training on client delineated in 10A NC 10A NCAC 26B; (3) training to meet to client as specified in the plan; and (4) training in infection bloodborne pathogen (h) Except as permitted. 5602(b) of this Subchmember shall be avait times when a client is member shall be trainincluding seizure mark to provide cardiopulm trained in the Heimlichtechniques such as the the American Heart A.	tion shall be documented. It programs shall be nimum, shall consist of the stional orientation; rights and confidentiality as AC 27C, 27D, 27E, 27F and the mh/dd/sa needs of the treatment/habilitation bus diseases and s. The staff lable in the facility at all present. That staff ladded in basic first aid langement, currently trained langement lang				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		mhl018-050	B. WING	· · · · · · · · · · · · · · · · · · ·	08/14/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
VOCA-8TI	1 AVENUE		VENUE N W			
	CUMMA DV CT		, NC 28601	DDOWNERS BLANCE CORRECTIO	N	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
V 108	Continued From page	: 1	V 108			
	reporting, investigatin	d procedures for identifying, g and controlling infectious seases of personnel and				
	failed to ensure each to meet the needs of and intellectual develo	ew and interview the facility employee received training the client for mental health opment disabilities as nent plan for 1 of 3 staff				
	#2 revealed: -Hire date of 2/22/19	he personnel record for Staff as direct support staff. specifics based on the ent's 1-3.				
	revealed: -The Former Qualified locate the client speci	with the Program Manger I Professional could not fic training for Staff #2. wining was completed on				
V 118	27G .0209 (C) Medica	ation Requirements	V 118			
	only be administered					

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STATE FORM 6899 TNR611 If continuation sheet 2 of 12

	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R	
		mhl018-050	B. WING		08/14/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
VOCA-8TI	H AVENUE		ENUE N W			
	-	HICKORY,	NC 28601			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 118	clients only when auticlient's physician. (3) Medications, incluadministered only by unlicensed persons transmissers or other leprivileged to prepare (4) A Medication Admall drugs administered current. Medications are corded immediately MAR is to include the (A) client's name; (B) name, strength, a (C) instructions for add (D) date and time the (E) name or initials of drug. (5) Client requests for checks shall be recorded.	be self-administered by horized in writing by the ding injections, shall be licensed persons, or by rained by a registered nurse, egally qualified person and and administer medications. Inistration Record (MAR) of d to each client must be kept administered shall be after administration. The following:	V 118			
	failed to maintain the prescription drugs we	as evidenced by: and record review the facility MAR current and ensure are administered as ordered of 3 audited clients (#2, #3).				
	revealed: -Admission date of 10 Moderate Intellectual	he record for Client #2 0/31/91 with diagnoses of Development Disability, sorder, Dementia with				

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STATE FORM 6899 TNR611 If continuation sheet 3 of 12

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:		1 ' '	SURVEY PLETED
		mhl018-050	B. WING		08	R 8/ 14/2019
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	1 33	
			AVENUE N W	,		
VOCA-8TI	H AVENUE	HICKOR	Y, NC 28601			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From page	3	V 118			
	Parkinson, Schizoaffe and Hypercholesterol -Physician order date 15mg ½ tablet in the night.	ce, Neuroleptic Induced ective Disorder-unspecified emia. d 5/9/19 for Olanzapine morning and 1 ½ tablets at he record for Client #3				
	revealed: -Admission date of 6/ -Diagnoses of Mild In	29/19. tellectual Developmental				
	Hyperactivity Disorde Disorder, Hearing Los	order, Attention Deficit r, Mood Disorder, Seizure es, Chronic Obstructive Hypertension, Asthma and effux with Esophanitis				
	Review on 8/7/19 of t Client #3 included: -Aripiprazole 30mg ½ -Buspirone 10mg 1 tal -Cetirizine 10mg 1 tal -Citrucel Powder, mix water 2 times daily. -Omeprazole DR 20m -Oxcarbazepine 300n	he physician orders for tablet 2 times daily.				
	for Client #2 revealed -The 8am and 8pm de administered on 8/1/1 -The 8am dose of Ola administered on 8/2/1 -The documentation of 2019 indicated the me	ose of Olanzapine were not 9. anzapine was not 9. on the back of the August edication had not arrived.				
	Review on 8/7/19 of t	he May-August MAR 2019				

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STATE FORM 6899 TNR611 If continuation sheet 4 of 12

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			_			
		mhl018-050	B. WING		08/14/20	19
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
VOCA-8TH	1 AVENUE		VENUE N W , NC 28601			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE CC	(X5) DMPLETE DATE
V 118	-No documentation of administered on 8/1/1 medications: Aripipra Citrucel, Omeprazole Symbicort.	f the 8pm dose being 9 for the following azole, Buspirone, Cetirizine, , Oxcarbazepine or	V 118			
	Interview on 8/8/19 with Client #3 revealed: -No concerns regarding medicationsHe always received his medications and could not recall missing any medications.					
	Director revealed: -The staff who checked medications did not respectively not included in the most included in th	ealize the Olanzapine was onthly refill order. Client #2 did not arrive at the Client #3 were administered it was possibly a problem AR. tutes a re-cited deficiency				
V 123	and significant advers reported immediately pharmacist. An entry and the drug reaction	9 MEDICATION Drug administration errors seed rug reactions shall be	V 123			

Division of Health Service Regulation

STATE FORM 6899 TNR611 If continuation sheet 5 of 12

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURV	
AND PLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _	A. BUILDING:		D
		mhi018-050	B. WING		R 08/14/2	019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	•	
		212 8TH A	VENUE N W			
VOCA-8TH AVENUE HICKO		HICKORY	, NC 28601			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE C	(X5) COMPLETE DATE
V 123	V 123 Continued From page 5		V 123			
	failed to notify a phanimmediately of medicaudited clients (#2). Review on 8/7/19 of trevealed: -Admission date of 10 Moderate Intellectual Obsessive Control Di Behavioral Disturbance Parkinson, Schizoaffe and Hypercholesterol-Physician order date 15mg ½ tablet in the	ew and interview the facility macist or physician ation errors for 1 of 3 The findings are: the record for Client #2 0/31/91 with diagnoses of Development Disability, sorder, Dementia with ce, Neuroleptic Induced ective Disorder-unspecified emia. d 5/9/19 for Olanzapine morning and 1.5 at night.				
	for Client #2 revealed -The 8am and 8pm de administered on 8/1/1 -The 8am dose of Ola administered on 8/2/1 -The documentation of 2019 indicated the me Interview on 8/8/19 at Director revealed: -The staff who checke	ose of Olanzapine were not 9. anzapine was not 9. on the back of the August edication had not arrived. and 8/12/19 with the Clinical				
	not included in the monormal and included in					

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DIVISION	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			B. WING		R
		mhl018-050 B. WING			08/14/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
			AVENUE N W		
VOCA-8TI	H AVENUE		, NC 28601		
		HICKORT	, NC 20001		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(-1-)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
IAG	REGOEMONT ON E	iso is a rive in ordination,	IAG	DEFICIENCY)	,
V 123	Continued From page	e 6	V 123		
	4	_			
	the missed medication	n.			
V 133	G.S. 122C-80 Crimina	al History Record Check	V 133		
	G.S. §122C-80 CRIM	INAL HISTORY RECORD			
	CHECK REQUIRED I	FOR CERTAIN			
	APPLICANTS FOR E	MPLOYMENT.			
	(a) Definition As use	ed in this section, the term			
	"provider" applies to a	an area authority/county			
	program and any prov	vider of mental health,			
		lity, and substance abuse			
	•	able under Article 2 of this			
	Chapter.				
	•	offer of employment by a			
	provider licensed und				
	•	tion that does not require the			
		occupational license is			
		nt to a State and national			
		d check of the applicant. If			
		n a resident of this State for			
		hen the offer of employment			
	_	sent to a State and national			
		d check of the applicant. The			
	national criminal histo				
		e applicant's fingerprints. If			
		n a resident of this State for			
		en the offer is conditioned			
		criminal history record			
	check of the applicant				
		who refuses to consent to a			
	_	d check required by this			
		nerwise provided in this			
		business days of making			
		of employment, a provider			
		t to the Department of			
	Justice under G.S. 11				
		d check required by this			
		it a request to a private			
	entity to conduct a Sta	ate criminal history record			

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Division of	of Health Service Regu	lation			FURIVI APPROV	בט
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		mhl018-050	B. WING		R 08/14/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		212 8TH	AVENUE N W			
VOCA-8TI	H AVENUE	HICKOR	Y, NC 28601			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLET	ſΕ
V 133	Continued From page	e 7	V 133			
	check required by this	s section. Notwithstanding				
		Department of Justice shall				
		ational criminal history				
		ployment positions not				
	covered by Public Lav	w 105-277 to the and Human Services,				
	Criminal Records Che					
		eipt of the national criminal				
		the Department of Health				
		Criminal Records Check				
		rovider as to whether the				
		may affect the employability				
		case shall the results of the				
		ory record check be shared				
	-	viders shall make available tion that a criminal history				
		pleted on any staff covered				
	-	nty that has adopted an				
		nance and has access to				
	the Division of Crimin	al Information data bank				
		lf of a provider a State				
		d check required by this				
	·	ovider having to submit a				
		ment of Justice. In such a				
	_	I commence with the State I check required by this				
	section within five bus					
		nployment by the provider.				
		ormation received by the				
		al and may not be disclosed,				
	-	nt as provided in subsection				
	(c) of this section. For	purposes of this				
	subsection, the term '	'private entity" means a				

Division of Health Service Regulation

business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency. (c) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all

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DIVISION	n nealth Service Regu	lation				—
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R	
		mhl018-050	B. WING		08/14/2019	
NAME OF D		STDEET AD	DRESS, CITY, STA	ATE ZID CODE		
NAIVIE OF PI	ROVIDER OR SUPPLIER		, ,	AIE, ZIP CODE		
VOCA-8TH AVENUE		VENUE N W				
		HICKORY	, NC 28601			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		E
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE DATE	
			1	DEI ICIENCT)		
V 133	Continued From page	2.8	V 133			
	_	s in determining whether to				
	hire the applicant:					
	(1) The level and serie					
	(2) The date of the cri					
	(3) The age of the per	rson at the time of the				
	conviction.					
	(4) The circumstance	s surrounding the				
	commission of the cri	me, if known.				
	(5) The nexus between	en the criminal conduct of				
	the person and the jo	b duties of the position to be				
	filled.	·				
	(6) The prison, jail, pr	obation, parole.				
		ployment records of the				
		the crime was committed.				
		ommission by the person of				
	a relevant offense.	ommodern by the percent of				
		of a relevant offense alone				
		employment; however, the				
		· · ·				
		considered by the provider.				
		ifies an applicant after				
		elevant factors, then the				
		information contained in				
	_	cord check that is relevant				
	to the disqualification,	, but may not provide a copy				
	of the criminal history	record check to the				
	applicant.					
	(d) Limited Immunity.	 A provider and an officer 				
	or employee of a prov	rider that, in good faith,				
	complies with this sec	ction shall be immune from				
	civil liability for:					
	(1) The failure of the	provider to employ an				
		s of information provided in				
		cord check of the individual.				
		n employee's history of				
		e employee's criminal				
		s requested and received in				
	_					
	compliance with this s					
		- As used in this section,				
	"reievant offense" me	ans a county, state, or	1			

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Division o	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			B. WING		R
		mhl018-050			08/14/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
		212 8TH /	AVENUE N W		
VOCA-8TI	H AVENUE	HICKORY	, NC 28601		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	lp.	PROVIDER'S PLAN OF CORRECTIO	N (VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(- /
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI	RIATE DATE
				DEFICIENCY)	
V 133	Continued From page	2 Q	V 133		
			1.00		
		y of conviction or pending			
		whether a misdemeanor or			
	felony, that bears upo	on an individual's fitness to			
	have responsibility for	r the safety and well-being of			
	persons needing mer	ital health, developmental			
	disabilities, or substar	nce abuse services. These			
	crimes include the cri	minal offenses set forth in			
	any of the following A	rticles of Chapter 14 of the			
	General Statutes: Arti	icle 5, Counterfeiting and			
	Issuing Monetary Sub	ostitutes; Article 5A,			
	Endangering Executiv	ve and Legislative Officers;			
		rticle 7A, Rape and Other			
		8, Assaults; Article 10,			
	Kidnapping and Abdu	ction; Article 13, Malicious			
	Injury or Damage by	Use of Explosive or			
		Material; Article 14, Burglary			
	_	kings; Article 15, Arson and			
		e 16, Larceny; Article 17,			
	•	Embezzlement; Article 19,			
	False Pretenses and				
	Obtaining Property or				
		edit Device or Other Means;			
	Article 19B, Financial	Transaction Card Crime			
		s; Article 21, Forgery; Article			
	26, Offenses Against				
		Adult Establishments;			
	_	n; Article 28, Perjury; Article			
		, Misconduct in Public			
		enses Against the Public			
		iots and Civil Disorders;			
	Article 39, Protection				
	Protection of the Fam				
		ele 60, Computer-Related			
		also include possession or			
		ion of the North Carolina			
		s Act, Article 5 of Chapter			
		tutes, and alcohol-related			
		to underage persons in			
	violation of G.S. 18B-	• .			

Division of Health Service Regulation

STATE FORM 6899 TNR611 If continuation sheet 10 of 12

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
		mhl018-050	B. WING	B. WING	
NAME OF D	ROVIDER OR SUPPLIER				08/14/2019
NAME OF PI	ROVIDER OR SUPPLIER		ODRESS, CITY, STA AVENUE N W	TE, ZIP CODE	
VOCA-8TI	H AVENUE		, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 133	G.S. 20-138.5. (f) Penalty for Furnish applicant for employm supplies, or otherwise an employment applic criminal history record shall be guilty of a Cla (g) Conditional Employemploy an applicant obtaining the results of check regarding the afollowing requirement (1) The provider shall prior to obtaining the criminal history record subsection (b) of this fingerprint cards as re (2) The provider shall criminal history record business days after the conditional employments.	ing False Information Any ment who willfully furnishes, a gives false information on cation that is the basis for a dicheck under this section ass A1 misdemeanor. Syment A provider may conditionally prior to of a criminal history record applicant if both of the sare met: not employ an applicant applicant for dicheck as required in section or the completed equired in G.S. 114-19.10. Submit the request for a dicheck not later than five the individual begins ent. (2000-154, s. 4; 124, ss. 10.19D(c), (h);	V 133		
	failed to submit the re record check to include five business days aft	ew and interview the facility quest for a criminal history le fingerprints no later than er the individual begins ent for 1 of 3 staff audited			
	Review on 8/8/19 of t	he personnel record for Staff			

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#1 revealed:

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R
		mhl018-050	B. WING		08/14/2019
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	
VOCA-8T	H AVENUE		VENUE N W NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
V 133	-Hire date of 2/27/19 and a resident of the state -Background check date fingerprints. Interview on 8/12/19 arevealed: -The fingerprints were background check was	as direct support staff. e for less than 5 years. ated 9/20/18 did not include with the Program Manager e an oversight when the	V 133		

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