STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G281	A. BUILDING ______ B. WING ______	06/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-GREENWOOD GROUP HOME	**105 GREENWOOD CIRCLE SMITHFIELD, NC 27577**

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E 020	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.475(b)(3) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical	E 020	DHSR-Mental Health JUL 0 3 2019 Lic. & Cert. Section	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Executive Director (X6) DATE: 6/27/19

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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E 020	Continued From page 1 Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop specific policies and procedures to address emergency preparedness, considering risk assessment in case of an emergency evacuation of the clients in the facility. The findings are: Facility Management failed to develop a specific plan for the clients to relocate to another shelter away from the facility and to include this information in their disaster plan and the facility did not complete an all hazards risk assessment for the facility. Review on 6/10/19 of the facility's disaster preparedness plan dated 6/25/18 indicated a local hotel would be utilized for shelter in the event the clients needed to be evacuated from the facility. Further review of the EP revealed there was not an agreement with a local hotel to be utilized as a shelter for the clients. Additional review also revealed there was no all hazards risk assessment included in the EP to identify specific hazards the clients may encounter given the specific geographic location where the facility is located. During an interview on 6/11/19, management staff acknowledged their disaster plan did not include all of the components outlined in the emergency	E 020	E 020 This deficiency will be corrected by the following actions: A. A relocation plan will be developed to identify the current hotel and shelter identified for our evacuation. B. The county vulnerability assessment will be added to the current Emergency Disaster Manual C. Risks will be reviewed in staff meetings including the re-location plan D. All staff will be provided in-service training on relocation plan, vulnerabilities and risks in the area.	8/1/19

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E 020	Continued From page 2 preparedness plan including an all hazards risk assessment and an agreement with a local hotel where the clients would relocate in the event of an emergency.	E 020		
W 120	SERVICES PROVIDED WITH OUTSIDE SOURCES CFR(s): 483.410(d)(3) The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure outside services met the needs of 1 of 3 audit clients (#6). The findings are: Client #6 did not use the proper adaptive equipment at lunch at the day program. During lunch observation on 6/10/19 at 11:15 am, client #6 had her meal placed on a high-sided divided plate, with a dycem (non-slip) pad under plate, with built up regular spoon and cup with handles, lid with built in straw. The good grip bendable teaspoon was not used. Review on 6/10/19 of client #6's of the individual program plan (IPP) dated 3/21/19 specified the adaptive equipment to be used as: high-sided divided plate, weighted built up spoon with foam handle, plate raiser, spill proof cup with lid and built in straw, and dycem pad. An additional review of the Occupational Therapy Quarterly Note, dated 5/23/19 revealed that the adaptive equipment was updated to: high-sided divided plate, good grip teaspoon (bendable), two	W 120	W 120 To correct this citation, the following will be completed: 1. CANC RM/CS will provide in-service Wake Enterprise staff regarding the proper use of adaptive equipment, including use of correct spoons during lunch meals 2. The Program Director of Wake Enterprises will inform all staff of the correct use of adaptive equipment to ensure that services at that facility meet the needs of all clients attending services. 3. RM will randomly monitor Wake Enterprises staff monthly for appropriate use of adaptive equipment 4. RM and QP will inform QP at Wake Enterprise of any issues observed. 5. RM will assure that appropriate equipment is located both in the home and in the day program 6. The team will review current drinking guidelines and revise as needed. 7. All staff will receive in-service training on drinking guidelines for any residents who have these in place. 8. All staff will be in-serviced on current BSPs	8/1/19

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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W 120	Continued From page 3 handled spouted cup with a lid, rocker knife, dycem/non slip mat. Interview with day program Staff H on 6/10/19 revealed that about a month ago, client #6 started to use a different spoon. Interview with residential manager (RM) on 6/11/19 at 10:30 am revealed that client #6 did have a change to adaptive spoon last month and it was her understanding that the home had sent all appropriate adaptive equipment to the day program for the client to use.	W 120		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to follow drinking guidelines for 1 of 3 audit clients (#6). The finding is: Direct care staff failed to follow client #6's drinking guidelines. a. During observation at dinner on 6/10/19 at 7:00 pm, client #6 was provided with a full cup of milk	W 249	W 249 This citation will be corrected by the following: 1. QP will retrain all staff across all settings regarding proper program implememntation and active treatment. This training will include, but not be limited to, the needs/abilities of each individual and reasses mealtime goals. 2. QP will in-service staff on client specific training needs especially as they relate to mealtime goals/guidelines/assistance, with reminders to monitor the pace of food and liquid intake due to chocking hazards. 3. RM will monitor meals twice per week to ensure meals are served per diet orders 4. QP will monitor meals once a week.	8/1/19

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W 249	Continued From page 4 and started to immediately guzzle the beverage from a two handled spouted cup with lid. Client #6 showed no interest and eating her meal and was getting loud vocalizing and rocking in her chair. The residential manager (RM) poured water into another cup, nearly filling the container. Client #6 started to rapidly drink the water, and was given verbal and physical prompts to slow down, she complied. Then client #6 picked back up the cup and finished drinking the water. Client #6 still would not eat her food, therefore RM heated a cup of broth for client #6. She drank the entire contents rapidly. b. During observation at breakfast, on 6/11/19 at 8:00 am, client #6 sat at dining room table, waiting to be served breakfast. The RM filled client #6's small cup with water. Client #6 drunk all of it rapidly and was not given any prompts to slow down. The RM was conversing with someone else at the table. RM refilled client #6's cup with water, filling the container. Client #6 drunk all of the water from cup. Client #6 had eaten only her cereal and had not touched the diced fruit or applesauce, when she consumed another full cup of water. Review on 6/11/19 of client #6's behavior support plan (BSP) dated 3/21/19, revealed that client #6's thirst was rarely satiated and tried to drink excessive amounts. Client #6 was not on a fluid restriction but staff should provide frequent small amounts of fluids. Interview with the RM on 6/11/19 acknowledged that client #6 would drink all of the contents of fluids, if given the full amount. The RM did not offer how staff should have handled the situation.	W 249		

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W 257	Continued From page 5	W 257		
W 257	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(iii) The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by: Based on observations, record reviews and interview, the facility failed to ensure the individual program plan (IPP) and behavior support program (BSP) was reviewed and revised as necessary. This affected 1 of 3 audit clients (#5). The findings are: Client #5's BSP was not reviewed and revised as needed to include all updated components of her active treatment program. Review on 6/11/19 of client #5's record revealed she had 2 inpatient hospital admissions due to behavioral crises where she posed a danger to herself. For example: Record review revealed an involuntary commitment order by a local magistrate on 4/16/19 when she told facility staff she was going to attempt to hang herself with a wire hanger, wrapped the hanger around her neck and walked into the living room. She was hospitalized in the behavioral unit at a local hospital and discharged several days later back to the facility. Review on 6/10/19 of a core team entry dated 4/24/19 revealed client #5 was admitted to a behavioral unit of the local hospital .	W 257	W257 This deficiency will be corrected by the following actions: A. The clients BSP will be revised to reflect the challenges in behaviors that lead to hospitalization. This will include recognizing non-compliance and other signal behaviors. The BSP will identifysteps for staff to take to assure client safety B. Staff will be in-serviced on all components of the new BSP C. QP will monitor behaviors and notify psychologist when revisions are needed to BSP to reflect behavior changes and needed interventions.	8/1/19

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W 257	Continued From page 6 Interview on 6/10/19 with the Residential manager (RM) revealed before client #5 returned to the facility after her admission on 4/24/19 to the hospital, all wire hangers were removed from her bedroom and anything that she could use to harm herself. Staff were instructed to keep her within their line of sight except when she was sleeping and to check her every 15 minutes. There were also changes made to her medication regimen. Review on 6/10/19 revealed a second inpatient hospital admission on 4/29/19-5/3/19 for a behavioral crisis when client #5 began to write on her arm in pink ink and she told staff the auditory hallucinations she was hearing, were telling her to harm herself. The facility Nurse was contacted and client #5 was transported to the hospital and admitted. Prior to discharge, client #5's physician discontinued Hydroxyzine 50 mg. (1), Lorazepam 1 mg. (1). Further interview on 6/10/19 with the RM revealed staff were instructed to contact the Nurse if client #5 began to write on her arms, became non-compliant, engaged in self-injury, so a decision could be made about administering a prn (as needed) medication. Client #5 was also referred to a therapist to see weekly for psychotherapy and staff were instructed to work with her on a workbook helping her to better express her feelings. Review of behavioral data for client#5 revealed : 5/9/19: Client #5 stated she wanted to harm herself and wrote on her forearm in pink magic marker. 5/19/19 Client #5 refused to take her pills. very	W 257		

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W 257	Continued From page 7 upset, Staff used redirection to calm her and contacted the facility nurse. 5/19/19: Client #5 walked out of a store and refused to get on the facility van. Staff used redirection to get her to comply. Interview on 6/10/19 with staff F revealed all wire hangers have been removed from client #5's bedroom and she is to be in their visual supervision at all times and checked every 15 minutes when sleeping. Observation on 6/10/19 of client #5's bedroom confirmed there are no wire hangers or belts in her bedroom. Interview on 6/11/19 with staff C revealed all wire hangers have been removed from client #5's bedroom and she is to be in their visual supervision at all times and checked every 15 minutes when sleeping. Further interview revealed there have been no further attempts to harm herself except for banging her head which is addressed by redirection and contacting the nurse for a prn medication. Further interview revealed on third shift the night before, client #5 came out of her bedroom naked, urinated on herself in the kitchen, began head banging and tried to turn the stove on. Direct care staff stated they were able to redirect her and contacted the nurse. Staff C indicated client #5 received a prn medication about 3am and went back to sleep. Review on 6/10/19 of her BSP dated 4/18/19 revealed that only self injurious behavior is listed as a target behavior. Self injurious behavior is described as: hitting, biting, scratching herself. There is information in this plan that gives a history of suicidal ideations. The only	W 257		

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W 257	Continued From page 8 interventions that are listed are her psychotropic medications which include: Thorazine, Neurontin, Ativan, Hydroxyzine, and Trazedone(for sleep). The interventions for inappropriate behaviors include: Use a firm voice to redirect, attempt to determine communicative intent, block attempts to her hitting herself and provide verbal praise to her for stopping the behavior. Further review on 6/11/19 of this program revealed that head banging, writing on her arms, non-compliance and verbal threats to harm herself are not included in this program. Information about increased levels of supervision, items that are restricted from her bedroom, weekly psychotherapy appointments and recent medication adjustments are not included in this BSP. There is no information in this BSP about her recent hospital admissions or specific instructions to staff about contacting the facility nurse to administer prn medications in a crisis plan. Interview on 6/10/19 with the executive director/acting qualified intellectual disabilities professional (QIDP) confirmed there have not been revisions to this program since client #5's most recent hospital admission on 5/3/19 to provide instructions to staff on how to intervene with client #5's target behaviors of self-injury, auditory hallucinations and non-compliance.	W 257		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.	W 263		

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W 263	Continued From page 9	W 263		
	This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure restrictive behavior support plans were only conducted with the written informed consent of client legal guardians. This affected 1 of 3 audit clients (#5). The findings are: 1. The qualified intellectual disabilities professional (QIDP) failed to obtain written informed consent for client #5's psychotropic medication and crisis medications. Review on 6/10/19 of client #5's behavior support program (BSP) dated 4/18/19 revealed she has target behaviors of: self-injurious behaviors. This program incorporates the use of several psychotropic medications to include: Thorazine, Gabapentin, Zyprexa, Ativan and Trazedone for sleep. Review on 6/10/19 of the informed consent for this program dated 4/22/19 indicates client #5 signed as her own legal guardian. Review on 6/11/19 of client #5's record indicates a local agency was appointed client #5's legal guardian following a recent inpatient hospital admission in April 2019. Interview on 6/11/19 with the Residential Manager and the Executive Director/Acting qualified intellectual disabilites professional (QIDP) revealed there is not an updated written consent from client #5's legal guardian for client #5's BSP.		W 263 This deficiency will be corrected by the following actions: A. The QP will obtain all new consents signed by the new legal guardian. B. IF/when there is a change in legal guardian, the QP will obtain new consents from the new guardian.	7/15/19
W 267	CONDUCT TOWARD CLIENT CFR(s): 483.450(a)(1)	W 267		

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W 267	Continued From page 10 The facility must develop and implement written policies and procedures for the management of conduct between staff and clients. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to assure a policy managing conduct between staff and clients was developed and implemented. This effected 3 of 6 clients (#3. #4, #5). The finding is: Staff did not respect the privacy of 3 of 6 clients in the facility when asking about their bowel elimination in front of other staff and clients in the home. During observations in the facility on 6/11/19 at 8:30am clients #3, #4 and #5 were in the living room area preparing to leave for the vocational workshop . Staff #A asked clients #3, #4 and #5 out loud in the living room area if they had a bowel movement that morning and if it was large or small in size. The residential manager (RM) was walking through the living room area and staff #C was assisting another client in the living room area. Interview on 6/11/19 with the RM and the Executive Director/ acting qualified intellectual disabilities professional (QIDP) revealed direct care staff should respect the privacy of other clients and not discuss clients personal care in public areas where other clients and staff were congregating.	W 267	W 267 This deficiency will be corrected by the following actions: A. CANC Policy 4.11 (Privacy) will be revised to address privacy of communication. B. All staff will receive in-service training on the new, revised policy. C. RM will re-train all staff in individual rights to privacy D. RM will monitor to assure that all staff respect the privacy of communication with residents.	08/01/19
W 312	DRUG USAGE CFR(s): 483.450(e)(2)	W 312		

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W 312	Continued From page 11 Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure medications were not ordered on a PRN basis and that there were policies to address the maximum number of times a medication can be used prior to incorporating it into the medication regimen via the plan for 1 of 3 audit clients (#5). The finding is: Client # 5 received prn doses of a medication on a routine basis which was not incorporated into her active treatment program. During observations on 6/10/19 at 5:25 pm, the residential manager (RM) asked client #5 if she needed a PRN when she arrived home. Client #5 responded, " I do not know, I'm sorry," then started crying. The RM contacted the nurse, leaving a voicemail message. An additional observation revealed that Staff G contacted the nurse at 5:50 pm to get consent for the PRN medication. At 5:53 pm client #5 received Hydroxine 50 mg. (1) tablet by mouth every 6 hours PRN (as needed). During observations on 6/11/19 at 6:50am client #5 received Hydroxyzine 50 mg. (1) tablet by mouth during the morning medication pass after staff #F contacted the Nurse. Client #5 told staff	W 312	W 312 This deficiency will be corrected by the following actions: A. RN will review the medication orders monthly to ensure prn psychotropic medications are not ordered. B. If PRN medication is ordered, the QP or RN will contact the prescribing doctor to have the order discontinued. C. For client #5, the psychiatrist and psychologist will be notified of the need to discontinue the PRN medication. D. Client #5 will meet with prescriber to review current use of PRN medication and determine if a change in medication regimen is needed to support client. E. BSP will be revised to reflect change in medication protocol. F. All staff will be in-serviced on all BSP and medication changes	08/01/19

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W 312	Continued From page 12 #F that she was hearing auditory hallucinations which were telling her to harm herself and she needed staff to administer the prescribed prn medication. Review on 6/11/19 of the medication administration record for client #5 revealed received prn medications on the following dates: 4/4/19, 4/24/19 at 5pm, 4/25/19 at 8pm, 5/9/19 at 1:55pm, 5/10/19 at 11:45pm, 6/10/19 and 6/11/19 at 7am. Review on 6/10/19 of client #5's individual program plan (IPP) dated 4/5/19 indicated she has a behavior support plan (BSP) to address client #5's target behavior of self-injurious behaviors. Review of the BSP dated 4/18/19 revealed Hydroxyzine 50mg. was to be given as needed for anxiety. Further review of this plan revealed no crisis plan to indicate when this medication was to be given, whether the facility nurse needed to be contacted and when the interdisciplinary team would meet to discuss the medication's continued use. Interview on 6/11/19 with the executive director/acting quality intellectual disabilities professional (QIDP) and the residential manager (RM) confirmed client #5 received Hydroxyzine for self injurious behaviors. When asked for a company policy indicating how many times this PRN medication could be used before it was incorporated into her plan as a medication both stated the company did not have such a policy. Additional interview confirmed the interdisciplinary team has not met to discuss the many prn administrations of medication given to client #5 to see if additional revisions need to be made to her BSP.	W 312		

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	34G281	A. BUILDING ______ B. WING ______	06/11/2019

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VOCA-GREENWOOD GROUP HOME	105 GREENWOOD CIRCLE SMITHFIELD, NC 27577

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W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide nursing services in accordance with the needs for 1 of 3 sampled clients (#5) relative to ensuring current physician orders were updated. The findings are: Nursing services failed to keep client #5's physician orders updated from a recent inpatient hospital admission. During observation of the medication administration pass on 6/11/19 at 6:50am client #5 was administered Lorazepam 0.5 mg. (1), Thorazine 50 mg. 91), Colace 100 mg. (1), Neurontin 300 mg. (1), Lopid 60 mg. (1), Multivitamin with Folic Acid (1), Vitamin D3 (1), Zoloft 50 mg. (1), Seroquel 100mg. (1), Protonix 40 mg. (1), Olanzapine 10 mg. (1), Linzess 145mcg. (1), Hydroxyzine 50mg. (1), Miralax 3350 (1 packet in 8 ounces of water) and her Bria Inhaler. Review on 6/11/19 of the physician's orders dated 5/6/19 revealed the following: Lorazepam 0.5 mg. (1), Thorazine 50 mg. 91), Colace 100 mg. (1), Neurontin 300 mg. (1), Lopid 60 mg. (1), Mutivitamin with Folic Acid (1), Vitamin D3 (1), Zoloft 50 mg. (1), Seroquel 100mg. (1), Protonix 40 mg. (1), Olanzapine 10 mg. (1), Linzess 145mcg. (1), Miralax 3350 (1 packet in 8 ounces of water) and her Bria Inhaler.	W 331	W 331 This citation will be corrected by the following actions: A. RN will print and review all medicaition orders monthly to ensure they accurately reflect any changes that have occurred. B. Client #5 will meet with psychiatrist to clarify specific orders and to correct and clear all current orders. C. When a resident returns from a hospital visit, the RN will review all discharge paperwork to identify any changes in medicaitions or other orders. The RN will modify the MAR to correctly reflect any changes made. D. The RN will in-service all staff regarding changes in any orders when a client returns to the home	08/01/19

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W 331	Continued From page 14 Further review of the physician orders on 6/11/19 revealed a recent inpatient hospital discharge for client #5 dated 5/3/19 which stated, "Your medications have changed. Stop taking Acetaminophen 325mg., Bacitracin ointment, Cerovite advanced formula oral, Vitamin D3 400 unit tablet, Clindamycin 1% external ointment, Ferrous Sulfate 325mg. tablet, Hydroxyzine 50 mg. tablet (Atarax), Lorazepam 1 mg. tablet, Ventolin Inhaler 90mcg. /actuation inhaler." The current physician order for Hydroxyzine 50 mg. tablet (Atarax) could not be located since client #5's inpatient hospitalization on 5/3/19. Interview on 6/11/19 with the residential manager (RM) and the acting qualified intellectual disabilities professional (QIDP)/executive director (ED) revealed a more recent physician order for client #5's Hydroxyzine 50 mg. tablet (Atarax) could not be located. Additional interview revealed Nursing is responsible for updating client physician orders after hospital admissions to ensure any medication changes are kept current in the facility.	W 331		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to assure all medications were administered without error for 1 of 3 audit clients (#5). The findings are:	W 369		

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	34G281	A. BUILDING ______ B. WING ______	06/11/2019

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W 369	Continued From page 15 Client #5 was administered Hydroxyzine 50 mg.without physician orders for this medication. During observation of the medication administration pass on 6/11/19 at 6:50am client #5 was administered Lorazepam 0.5 mg. (1), Thorazine 50 mg. 91), Colace 100 mg. (1), Neurontin 300 mg. (1), Lopid 60 mg. (1), Mutivitamin with Folic Acid (1), Vitamin D3 (1), Zoloft 50 mg. (1), Seroquel 100mg. (1), Protonix 40 mg. (1), Olanzapine 10 mg. (1), Linzess 145mcg. (1), Hydroxyzine 50mg. (1), Miralax 3350 (1 packet in 8 ounces of water) and her Bria Inhaler. Review on 6/11/19 of the physician's orders dated 5/6/19 revealed the following: Lorazepam 0.5 mg. (1), Thorazine 50 mg. 91), Colace 100 mg. (1), Neurontin 300 mg. (1), Lopid 60 mg. (1), Mutivitamin with Folic Acid (1), Vitamin D3 (1), Zoloft 50 mg. (1), Seroquel 100mg. (1), Protonix 40 mg. (1), Olanzapine 10 mg. (1), Linzess 145mcg. (1), Miralax 3350 (1 packet in 8 ounces of water) and her Bria Inhaler. Further review of the physician orders on 6/11/19 revealed a recent inpatient hospital discharge for client #5 dated 5/3/19 which stated, "Your medications have changed. Stop taking Acetaminophen 325mg., Bacitracin ointment, Cerovite advanced formula oral, Vitamin D3 400 unit tablet, Clindamycin 1% external ointment, Ferrous Sulfate 325mg. tablet, Hydroxyzine 50 mg. tablet (Atarax), Lorazepam 1 mg. tablet, Ventolin Inhaler 90mcg. /actuation inhaler." The current physician order for Hydroxyzine 50 mg. tablet (Atarax) could not be located since	W 369	W 369 This citation will be corrected by the following actions: A. The RN will review all consumer charts in order to establish that all needed medical records are accurate and up to date, including but not limited to orders for all medications. B. If necessary, RN will establish a monthly review to document the accuracy of the medical records. C. Clinical supervisor & RN will monitor progress monthly at Core Team Meeting D. Psychiatrist was contacted regarding conflicting orders and a new correct order was received.	08/01/19

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W 369	Continued From page 16 client #5's inpatient hospitalization on 5/3/19. Interview on 6/11/19 with the residential manager (RM) and the acting qualified intellectual disabilities professional (QIDP)/executive director (ED) revealed a more recent physician order for client #5's Hydroxyzine 50 mg. tablet (Atarax) since 5/3/19 could not be located.	W 369		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to provide the correct diet texture to 1 of 3 audited clients (#2). The findings is: Client #2 was not given a pureed diet at breakfast. During breakfast observation on 6//11/19 at 7:20 am, the residential manager (RM) brought client #2 into the kitchen to assist her with grinding up raisin bran cereal in the blender. Afterwards, the cereal flakes and raisins became fine crumbs. Client #2 returned to the table, and the RM poured milk over the cereal crumbs stirring until it became a pureed texture. Client #2 also received applesauce for breakfast and was given diced mixed fruit cocktail. Client #2 consumed all of her food without any noticeable difficulty. Review on 6/11/19 of client #2's individual	W 460	W 460 This deficiency will be corrected by the following actions: A. Clinical Supervisor/RM will in-service and train staff across all settings regarding proper diet textures ordered for all residents and proper protocol for food prep to meet orders. B. RM will monitor X2 weekly. C. QP will monitor monthly	08/01/19

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W 460	Continued From page 17 program plan (IPP) dated 1/9/19 revealed that she was on a 1500 calorie pureed diet. On 6/11/19 at 10:45 am, it was relayed to the RM and Executive Director that client #2's diet was not followed at breakfast. The RM offered no explanation for placing diced fruit on client #2's plate.	W 460		
W 475	MEAL SERVICES CFR(s): 483.480(b)(2)(iv) Food must be served with appropriate utensils. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, staff did not ensure that 1 of 3 audit clients (Client #6) received the proper adaptive equipment for 1 of 2 meals. The findings is: Client #6 did not use the correct adaptive spoon at breakfast and lacked a current order to use a plate raiser. a. During observation at dinner, on 6/10/19 at 6:45 pm, client #6 sat at dining room table and was served cooked carrots, baked pork chop, wheat noodles and water. On the table in front of client #6 was a plate raiser, high-sided divided plate, a small and medium sized two handled spouted cup with lid, dycem/non slip mat, good grip bendable teaspoon, rocker knife. b. During observation at breakfast, on 6/11/19 at 8:00 am, client #6 sat at dining rom table and was served cereal, apple sauce and diced fruit. On the table in front of client #6 was a plate raiser, a high-sided divided plate, a small two handled	W 475	W 475 This citation will be corrected by the following actions: A. QP will clarify with OT the use of plate riser and secure orders as needed for accurate adaptive equipment B. RM will in-service staff on all adaptive equipment needed/used for all residents to update any order changes C. RM will monitor the use of appropriate adaptive equipment at 1 meal per week D. QP and RM will develop checklist of adaptive equipment used/ordered for each resident to be used during observation/ monitoring.	8/1/19

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W 475	Continued From page 18	W 475		

spouted cut with lid, dycem mat, a long teaspoon with foam handle with a discharged client's name on it. Client #6 fed herself and ate all of her food. At the end of the meal, client #5 who sat nearby told Staff A that client #6 was using the wrong spoon. Staff A responded that client #6 had three spoons and had started out using the spoon used today at breakfast.

Review on 6/10/19 of client #6's of the individual program plan (IPP) dated 3/21/19 specified the adaptive equipment to be used as: high-sided divided plate, weighted built up spoon with foam handle, plate raiser, spill proof cup with lid and built in straw, and dycem pad. An additional review of the Occupational Therapy Quarterly Note, dated 5/23/19 revealed that the adaptive equipment was updated to: high-sided divided plate, good grip teaspoon (bendable), two handled spouted cup with a lid, rocker knife, dycem/non slip mat. The plate raiser was not listed.

Interview with residential manager (RM) on 6/11/19 at 10:30 am revealed that client #6 did have a change to adaptive spoon last month and that she was now using the good grip bendable teaspoon. It was not clarified whether or not client #6 should still be using the plate raiser, since she did not use it at the day program.

1600 W. Thomas Street
Rocky Mount, NC 27804

252-446-1965

DHSR-Mental Health

JUL 03 2019

Lic. & Cert. Section

June 27, 2019

Kimberly McCaskill
Facility Compliance Consultant I
Mental Health Licensure & Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

RE: Plan of Correction for Recertification Survey Conducted June 11, 2019
VOCA Greenwood, 105 Greenwood Circle, Smithfield, NC 27577
MHL #051-036

Dear Ms McCaskill,
Thank you for your time and the feedback given during the survey you completed on June 11, 2019. We appreciate your diligence in assisting us in providing the best care possible to the consumers we serve. We look forward to making the recommended changes that will improve the service we provide.

Enclosed, you will find the Plan of Correction. If you have any questions, please call me at 252-446-1965 ext. 203. Again, thank you for your time and patience.

Sincerely,

Kimberly Hale, MA, CSW
Executive Director, CANC

Enclosures