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 _____	R 09/12/2019

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

(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 000	INITIAL COMMENTS A revisit was conducted on 9/12/19 for all previous deficiencies cited on 6/11/19. Several deficiencies were corrected. Tag W263 was recited.	W 000		
{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. 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 guardian. This affected 1 of 2 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 9/12/19 of client #5's revised behavior support program (BSP) dated 8/1/19 revealed she has target behaviors of: self-injurious behaviors. This program incorporated the use of several psychotropic medications to include: Thorazine, Gabapentin, Zyprexa, Ativan and Trazedone for sleep. This program also included a crisis plan which incorporated contacting the Physician for crisis medications. Review on 9/12/19 of client #5's record revealed a legal document from the clerk of court	{W 263}		

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

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 263}	Continued From page 1 confirming client #5 was appointed a Guardian of the Person on 5/24/19 to act on her behalf. Review on 9/12/19 of the informed consent for this program dated 8/1/19 indicates there is no written consent for this BSP from the legal Guardian of the Person. Interview on 9/12/19 with the Residential Manager (RM) confirmed the legal guardian for client #5 should sign all consents on her behalf. Further interview revealed there is not verbal consent or an updated written consent from client #5's legal guardian for her BSP.	{W 263}		