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

PRINTED: 09/13/2019 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		DENTIFICATION NUMBER:	A. BUILDING	LC CONSTRUCTION	COMPLETED	
		34G281	B. WING		R 09/12/2	R 09/12/2019
•	ROVIDER OR SUPPLIER	, , , , , , , , , , , , , , , , , , ,		STREET ADDRESS, CITY, STATE, ZIP CODE 108 GREENWOOD CIRCLE SMITHFIELD, NC 27577	1 0011,000	
(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 SHOUND CROSS-REFERENCED TO THE APPRIDEFICIENCY)	ULD BE CO	(X5) MPLEYION DATE
W 000	A revisit was conduct previous deficiencies	ed on 9/12/19 for all cited on 6/11/19. Several rected. Tag W263 was	W 00	0		
(W 263)	recited. PROGRAM MONITO CFR(s): 483.440(f)(3) The committee should	RING & CHANGE (ii) I insure that these programs	{W 263	W.263 I recite) This deficiency will be corrected following actions:	by the  10.23	.2019
		ith the written informed parents (if the client is a en.		All behavior support plate be reviewed—for all people being served.      B. All consent for said plane.	pple	
	Based on record revisitable to ensure restrict were only conducted to consent of client legal 2 audit clients (#5). The qualified inteller professional (QIDP) for informed consent for comedication and crisis.  Review on 9/12/19 of support program (BSP she has target behaviors this program to consent psychotropic of the consent psychotro	ctual disabilities filled to obtain written client #5's psychotropic medications.  client #5's revised behavior b) dated 8/1/19 revealed fors of: self-injurious fill incorporated the use of medications to include: fill Zyprexa, Ativan and This program also included proporated contacting the		c. All consent will be curre coincide with the date of plan.  D. All guardians will be information of plans.  E. All consent will be signed guardian before the implementation of plans.  F. Clinical personnel will remonthly in core team monthly in core team as needed to meet their the person being served.  RECEIVED  OHSR-MH Licensure Sect	of the  cormed of  cod by the  coview  nnual or  need of	
ur .		client #5's record revealed		Licensure Sect		
ABORATORY	DIRECTOR'S OR PROVIDER/S	UPPLIER REPRESENTATIVES SIGNATURE		TITLE	(X6) DA	YE .

Any deficiency statement ending with an asterisk (\*) denotes a definition 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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		34G281		B. WING		R 09/12/2019		
NAME OF PROVIDER OR SUPPLIER  VOCA-GREENWOOD GROUP HOME					1	STREET ADDRESS, CITY, STATE, ZIP CODE 165 GREENWOOD CIRCLE BMITHFIELD, NC 27577	1 09/	722019
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		,	ID FROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE OF CORRECTIVE ACTION SHOULD DEFICIENCY)			(X5) COMPLETION DATE	
{W 263}	the Person on 5/24/18 Review on 9/12/19 of this program dated 8/ written consent for thi Guardian of the Perso Interview on 9/12/19 v Manager (RM) confirm client #5 should sign a Further interview reve	as appointed a Guardian of a to act on her behalf.  the informed consent for 1/19 indicates there is no a BSP from the legal on.  with the Residential ned the legal guardian for all consents on her behalf, alled there is not verball d written consent from client		{W 2	63)			
							ĺ	

Community Alternatives – NC Southeast Region 1001 Navaho Drive Suite 101 Raleigh, NC 27609

Phone: 984-205-2630 **FAX:** 984-205-2643

FAX

To: Kim Maskell	From Ti Keams
Fax: 919-7158078	Pages: 3
Phone: 9/9 855 3795	Date: 10/18/19
Re:	CC:
Urgent For Review Please Commen	Please Reply Please Recycle
Comments: Mank GW	
el apolyny	gathe dely



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## October 18, 2019

Kimberly C. McCaskill, MSW
Facility Survey Consultant I
Mental Health Licensure and Certification section
NC Division of Health Services Regulations
2718 Mail Service Center
Raleigh NC 27699–27118
919.855.3795 office
919.715.8078 fax

RE: Follow-up Survey Conducted: September 12, 2019 VOCA-Greenwood 05 Greenwood Circle, Smithfield NC 27577 Provider Number 34G281 MHL# 051-036

Kimberly C. McCaskill, MSW

We appreciate the courtesy extended by you while surveying the VOCA-Greenwood Home, North Carolina.

As indicated on the Plan of Correction, we will have the Standard Level Deficiencies corrected for, the Complaint Survey conducted on September 12, 2019 it will be completed October 23, 2019.

We are committed to providing the highest possible care for the people we serve at VOCA-Greenwood Home

If you have questions, please contact JerMaine Kearney, Program Manager 984.205.2633. I will be functioning as the Program Manager. Marika Whack as the Exective Director.

Sincerely,

Marika Whack, Executive Director

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