

117

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL012-110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/24/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILSON HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 428 LOST CORNER ROAD MORGANTON, NC 28655
--	--

(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) COMPLETE DATE
V 000	INITIAL COMMENTS An annual survey was completed on 10/24/19. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G.5600F Supervised Living for Individuals of all Disability Types - Alternative Family Living.	V 000		
V 364	G.S. 122C- 62 Additional Rights in 24 Hour Facilities § 122C-62. Additional Rights in 24-Hour Facilities. (a) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-61, each adult client who is receiving treatment or habilitation in a 24-hour facility keeps the right to: (1) Send and receive sealed mail and have access to writing material, postage, and staff assistance when necessary; (2) Contact and consult with, at his own expense and at no cost to the facility, legal counsel, private physicians, and private mental health, developmental disabilities, or substance abuse professionals of his choice; and (3) Contact and consult with a client advocate if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each adult client may exercise these rights at all reasonable times. (b) Except as provided in subsections (e) and (h) of this section, each adult client who is receiving treatment or habilitation in a 24-hour facility at all times keeps the right to: (1) Make and receive confidential telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Receive visitors between the hours of 8:00	V 364	DHSR-Mental Health NOV 19 2019 Lic. & Cert. Section	

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

TITLE

(X6) DATE

Kelly Eswee QDMA
11/13/19

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL012-110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/24/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WILSON HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 428 LOST CORNER ROAD MORGANTON, NC 28655
--	--

(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) COMPLETE DATE
V 364	<p>Continued From page 1</p> <p>a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over therapies;</p> <p>(3) Communicate and meet under appropriate supervision with individuals of his own choice upon the consent of the individuals;</p> <p>(4) Make visits outside the custody of the facility unless:</p> <p>a. Commitment proceedings were initiated as the result of the client's being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found not guilty by reason of insanity or incapable of proceeding;</p> <p>b. The client was voluntarily admitted or committed to the facility while under order of commitment to a correctional facility of the Division of Adult Correction of the Department of Public Safety; or</p> <p>c. The client is being held to determine capacity to proceed pursuant to G.S. 15A-1002;</p> <p>A court order may expressly authorize visits otherwise prohibited by the existence of the conditions prescribed by this subdivision;</p> <p>(5) Be out of doors daily and have access to facilities and equipment for physical exercise several times a week;</p> <p>(6) Except as prohibited by law, keep and use personal clothing and possessions, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002;</p> <p>(7) Participate in religious worship;</p> <p>(8) Keep and spend a reasonable sum of his own money;</p> <p>(9) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes; and</p> <p>(10) Have access to individual storage space for</p>	V 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL012-110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/24/2019
NAME OF PROVIDER OR SUPPLIER WILSON HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 428 LOST CORNER ROAD MORGANTON, NC 28655		
(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) COMPLETE DATE
V 364	Continued From page 2 his private use. (c) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-57 and G.S. 122C-59 through G.S. 122C-61, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to have access to proper adult supervision and guidance. In recognition of the minor's status as a developing individual, the minor shall be provided opportunities to enable him to mature physically, emotionally, intellectually, socially, and vocationally. In view of the physical, emotional, and intellectual immaturity of the minor, the 24-hour facility shall provide appropriate structure, supervision and control consistent with the rights given to the minor pursuant to this Part. The facility shall also, where practical, make reasonable efforts to ensure that each minor client receives treatment apart and separate from adult clients unless the treatment needs of the minor client dictate otherwise. Each minor client who is receiving treatment or habilitation from a 24-hour facility has the right to: (1) Communicate and consult with his parents or guardian or the agency or individual having legal custody of him; (2) Contact and consult with, at his own expense or that of his legally responsible person and at no cost to the facility, legal counsel, private physicians, private mental health, developmental disabilities, or substance abuse professionals, of his or his legally responsible person's choice; and (3) Contact and consult with a client advocate, if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each minor client may exercise these rights at all reasonable times. (d) Except as provided in subsections (e) and (h) of this section, each minor client who is receiving	V 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL012-110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/24/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WILSON HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 428 LOST CORNER ROAD MORGANTON, NC 28655
--	--

(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) COMPLETE DATE
V 364	<p>Continued From page 3</p> <p>treatment or habilitation in a 24-hour facility has the right to:</p> <p>(1) Make and receive telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party;</p> <p>(2) Send and receive mail and have access to writing materials, postage, and staff assistance when necessary;</p> <p>(3) Under appropriate supervision, receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over school or therapies;</p> <p>(4) Receive special education and vocational training in accordance with federal and State law;</p> <p>(5) Be out of doors daily and participate in play, recreation, and physical exercise on a regular basis in accordance with his needs;</p> <p>(6) Except as prohibited by law, keep and use personal clothing and possessions under appropriate supervision, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002;</p> <p>(7) Participate in religious worship;</p> <p>(8) Have access to individual storage space for the safekeeping of personal belongings;</p> <p>(9) Have access to and spend a reasonable sum of his own money; and</p> <p>(10) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes.</p> <p>(e) No right enumerated in subsections (b) or (d) of this section may be limited or restricted except by the qualified professional responsible for the formulation of the client's treatment or habilitation plan. A written statement shall be placed in the client's record that indicates the detailed reason for the restriction. The restriction shall be</p>	V 364		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL012-110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/24/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WILSON HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 428 LOST CORNER ROAD MORGANTON, NC 28655
--	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

V 364	<p>Continued From page 4</p> <p>reasonable and related to the client's treatment or habilitation needs. A restriction is effective for a period not to exceed 30 days. An evaluation of each restriction shall be conducted by the qualified professional at least every seven days, at which time the restriction may be removed. Each evaluation of a restriction shall be documented in the client's record. Restrictions on rights may be renewed only by a written statement entered by the qualified professional in the client's record that states the reason for the renewal of the restriction. In the case of an adult client who has not been adjudicated incompetent, in each instance of an initial restriction or renewal of a restriction of rights, an individual designated by the client shall, upon the consent of the client, be notified of the restriction and of the reason for it. In the case of a minor client or an incompetent adult client, the legally responsible person shall be notified of each instance of an initial restriction or renewal of a restriction of rights and of the reason for it. Notification of the designated individual or legally responsible person shall be documented in writing in the client's record.</p> <p>This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that restriction of clients' rights (privacy) were implemented, documented, and reviewed as required effecting 2 of 2 clients (Clients #1 and #2). The findings are:</p> <p>Review on 10/24/19 of Client #1's record revealed: -admission date of 3/29/12.</p>	V 364	<p><i>VocA dba Community Alternatives of NC Policies & procedures that support the same findings cited by the state</i></p>	
-------	---	-------	---	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL012-110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/24/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WILSON HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 428 LOST CORNER ROAD MORGANTON, NC 28655
--	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

V 364	<p>Continued From page 5</p> <p>-diagnoses of Severe Intellectual Developmental Disability, Epilepsy, Hypothyroidism, Oppositional Defiant Disorder, Attention-Deficit Hyperactivity Disorder, Intermittent Explosive Disorder, Mood Disorder and History of Behavior Problems.</p> <p>Review on 10/24/19 of Client #2's record revealed: -admission date of 3/29/12. -diagnoses of Mild Intellectual Developmental Disability, Adjustment Disorder, Major Depressive Disorder, and Recurrent Impulsive Control Disorder.</p> <p>Observation on 10/18/19 at approximately 3:20 p.m. revealed: -Clients #1 and #2 had the entire living space in the downstairs part of the facility. -a large open living room where a television and couch sat at one end, and two twin beds at the opposite end of the room. -there was no partition between the living room area and the bedroom area. -two cameras were located in the living room area. -one camera above the television, facing toward the two twin beds. -another camera above the two twin beds, facing toward the television area. -a second room was adjacent to the beds that included the dining room/kitchen/laundry room. -a camera was located at the entrance of the dining room facing the dining room/kitchen/laundry room area.</p> <p>Interview on 10/18/19 with the AFL provider revealed: -the cameras had been present for approximately 2 years, not long after they moved to the new location (2017).</p>	V 364	<p>Both Behavior Support Plans for each client are being amended by the psychologist responsible for the original plans. Expected completion date is 11/20/19 with Kellie Elliott responsible for assuring completion. Addendum to ISP is being completed by Care Coordinator and expected to be completed by 11/20/19. Kellie Elliott, GP, responsible for timely completion. Both ISPs & BSPs are expected to be signed by guardians by 11/30/19. At that time Kellie Elliott will submit review of both plans and BSPs to a multi-agency Human Rights Committee. This committee meets in December. Kellie Elliott will assure submission</p>	
-------	--	-------	---	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL012-110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/24/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILSON HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 428 LOST CORNER ROAD MORGANTON, NC 28655
--	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

V 364	<p>Continued From page 6</p> <ul style="list-style-type: none"> -they were there for the safety of the clients. -there was also the capability for audio with the camera system. -they could hear and talk to the client's through the system. <p>Interview on 10/24/19 with the Qualified Professional revealed:</p> <ul style="list-style-type: none"> -the guardians for the clients were aware of the cameras, however there were no signed consents to this fact. -client rights had not reviewed the necessity of the cameras or other least restrictive alternatives. -the cameras were in place for Client #2's protection as Client #1 tended to pick at her. -they were also helpful if one of the client's got up in the middle of the night they could easily be checked on. 	V 364	<p>and completion.</p> <p>Upon approval of BOPs and planned restrictions, Kellie Elliott, AP, will keep a written statement regarding the reason reason for the restriction in each client's file. Weekly, Kellie will evaluate need for restriction. If need continues, Kellie will note every seven days it's need to continue. If after 30 days the need of cameras continues, Kellie Elliott, AP, will contact LRP's for both consumers will be notified of the renewal of the restriction. Kellie Elliott will record said notification in each client's medical record.</p> <p>Kelly Ersever, Program Manager will conduct training with all APs that are responsible for AFH homes of client rights and process for any den restrictions that may seem necessary. This will occur on or before 12/20/19.</p>	
-------	---	-------	--	--



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

November 5, 2019

Kelly Ersever, Residential Manager
VOCA Corporation of NC dba Community Alternatives-NC 1
617 South Green Street, Ste 201
Morganton, NC 28655

Re: Annual Survey Completed October 24, 2019
Wilson Home, 428 Lost Corner Road, Morganton, NC 28655
MHL#012-110
E-mail Address: Kersever@rescare.com
Kdelliott@rescare.com

Dear Ms. Ersever:

Thank you for the cooperation and courtesy extended during the annual survey completed October 24, 2019.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- All tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiency must be *corrected* within 60 days from the exit of the survey, which is December 23, 2019.

What to include in the Plan of Correction

- Indicate what measures will be put in place to *correct* the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to *prevent* the problem from occurring again.
- Indicate *who will monitor* the situation to ensure it will not occur again.
- Indicate *how often* the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. *Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.*

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603
MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718
www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

November 5, 2019
VOCA Corporation of NC dba Community Alternatives-NC I
Kelly Ersever, Residential Manager
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call. If we can be of further assistance, please call Ms. Sonia Eldridge, Mountains Team Leader, at 828-200-6605.

Sincerely,

A handwritten signature in cursive script that reads "Sally Thayer, MSW".

Sally Thayer, MSW
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Enclosures

Cc: QM@partnersbhm.org
Pam Pridgen, Administrative Assistant