STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G262	A. BUILDING _____ B. WING _____	02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-WOODLAND	123 WOODLAND DR RUTHERFORDTON, NC 28139

(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 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure all drugs and biological's were kept lock except when being prepared for administration. The finding is: Observations in the group home on 2/5/20 at 6:55 AM revealed a staff member (A) who was assisting client #6 with medication administration, to ask the program manger (PM) to get an insulin pen out of the kitchen refrigerator. Further observations at that time revealed the PM to retrieve a plastic bag with insulin pens inside it and take it to the medication room. Continued observations at 8:45 AM, revealed the plastic bag to contain two pre-filled Novolog Mix 70/30 insulin pens for client #6. Review of the record for client #6 on 2/5/20 revealed quarterly physician orders dated 11/21/19 which included Novolog Mix 70/30 -Prefill, inject 15 units subcutaneously in the AM, and inject 22 units in the evening before dinner. Interview with the PM on 2/5/20 revealed the Novolog Mix 70/30 insulin pens for client #6 were being kept in the kitchen refrigerator because the refrigerator located in the medication closet in the medication room was not working. The PM indicated staff had recently defrosted the refrigerator and it had stopped working at that time. The PM confirmed, group home staff should not have temporarily stored medication in the kitchen refrigerator without it being kept in a	W 382	① Home Supervisor will purchase a lock box to to place in the fridge. To place insulin in by February 7th 2020. ② Program Manager will place order for new fridge to be put in place through Aramark services by February 10, 2020. 3) CS will inservice staff on proper Medication storage by February 28, 2020.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Program Manager — (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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G262	A. BUILDING _____ B. WING _____	02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-WOODLAND	123 WOODLAND DR RUTHERFORDTON, NC 28139

(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 382	Continued From page 1 locked container.	W 382		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure 1 of 4 sampled clients (#2) was taught to use and make informed choices about the use of a hearing aid. The finding is: Observations in the group home on 2/5/20 at 7:08 AM, revealed client #2 entering the medication room for morning medication administration. Further observations in the medication room at 7:20 AM revealed staff member A to obtain a hearing aid from the medication closet and then assist client #3 with placing it on his left ear. Interview with staff A at that time revealed she was not sure why the hearing aid was kept locked in the medication closet, but indicated it may be because the client could lose or damage the hearing aid. Review of client #2's individual service plan (ISP) dated 6/17/19 revealed an adaptive equipment section which included a hearing aid for the left ear to improve hearing. Further review of the ISP revealed a audiology follow-up on 9/24/19 which	W 436	2) CS will put a program in place for client on proper use of hearing aids and proper Storage of hearing aids by February 28, 2020. 3) Clinical Supervisor will inservice all staff on new programs by February 28, 2020. 4) CS will Monitor programs and document on the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G262	A. BUILDING _____ B. WING _____	02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-WOODLAND	123 WOODLAND DR RUTHERFORDTON, NC 28139

(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 436	Continued From page 2 included recommendation for a left hearing aid to be used daily. Continued review of the ISP did not reveal any training objectives related to the use, care or storage of the hearing aid. Review of the behavior support program did not reveal any restrictions related to the use or storage of the hearing aid. Interview with the program manager (PM) on 2/5/20 confirmed client #2's hearing aid was being stored in the medication room to avoid loss or damage. The PM also confirmed client #2 did not have any current or past program objectives related to training the client on the skills necessary for the use, care and storage of the hearing aid.	W 436	Monthly Q notes. This must be done monthly.	

Community Alternatives of NC

301 10th Street NW, Suite B101
Conover NC 28163
Phone: (828) 466-6023 Fax: (828) 466-6025

February 11, 2020

Mental Health Licensure & Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 28699-2718
Attention: Cliff Compton

Dear Mr. Compton:

Please find the enclosed Plan of Correction for the deficiencies cited during the annual recertification survey at our Woodland group home in Rutherfordton, NC. Hopefully our corrections will be acceptable. Please accept our invitation to return to our facility on April 5, 2020 to follow up and ensure compliance. If you have any questions please contact me either via email at tfinger@rescare.com or office phone 828-466-6023 or by cell phone at 704-349-2376.

Sincerely,

Tracey Norris, QIDP
Program Manager

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

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

February 10, 2020

Mr. Mike Penland, Executive Director
Community Alternatives of North Carolina
301 10th Street NW, Suite B 101
Conover, NC 28613

Re: Recertification Completed 2/4/20 and 2/5/20
VOCA-Woodland
Provider Number 34G262
MHL# 081-016
E-mail Address: mpenland@rescare.com

Dear Mr. Penland:

Thank you for the cooperation and courtesy extended during the recertification survey completed 2/5/20. This survey was required for continued participation in the Medicaid program.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form (CMS-2567). The purpose of the Statement of Deficiencies is to provide you with specific details of the practices that do not comply with regulations. You must develop one Plan of Correction that addresses each deficiency listed on the CMS-2567 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 and what to include in the Plan of Correction.

Type of Deficiencies Found

- Standard level deficiencies were cited.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is 4/5/20.

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 CMS-2567 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
Raleigh, NC 27699-2718

Please be advised that additional W tags may be cited during the Life Safety Code portion of the recertification survey.

A follow up visit will be conducted to verify all deficient practices have been corrected. If we can be of further assistance, please call me at 828.750.2703.

Sincerely,

Cliff Compton, MSW
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Enclosures

Cc:
QM@partnersbhm.org