STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G287	A. BUILDING _____ B. WING _____	01/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-LAUREL GROUP HOME	51 LAUREL STREET GRANITE FALLS, NC 28630

(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 218	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include sensorimotor development. This STANDARD is not met as evidenced by: Based on observations, interview, and record review, the individual support plans (ISPs) for 2 of 5 sampled clients (#3 and #5) failed to include an occupational therapy (OT) re-assessment, and for 1 of 5 sampled clients (#1) failed to include a physical therapy (PT) re-assessment. The findings are: A. The ISP failed to include an OT re-assessment for client #5. For example: Observation throughout the 1/28-29/20 survey revealed client #5 to have significant contractures in both hands. Further observation of the morning meal on 1/29/20 at 7:35 AM revealed client #5's place setting to include a regular plate, bowl, and regular utensils. The breakfast meal consisted of a chopped banana, toast with jelly and cereal. Continued observations revealed staff B used hand over hand in assisting client #5 with scooping banana pieces onto a spoon. The client was observed eating the toast pieces and cereal without hand over hand assistance. Review of the record for client #5 on 1/29/20 revealed an ISP dated 2/19/19 which included documentation indicating the client uses a scoop plate to assist with eating for meals and for snacks. Further review of the ISP revealed quarterly physician orders dated 12/6/19 which included a scoop plate. Continued review of the record did not reveal an OT assessment.	W 218	1) Nurse will contact the PCP for new referrals for OT and PT for all clients to receive new assessments. 2) HS will ensure clients are taken to scheduled appointments and obtain necessary paperwork/ and or reccomendations. Completed by: As referralls come in by PCP 3) Nurse will review paperwork from OT and PT appointments and put in place any reccomendations Completed by: as appointments are Completed	Feb 28, 2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Program Manag — (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 218	Continued From page 1 Interview with the facility nurse on 1/29/20 revealed an OT assessment had not been completed since 2004 and that assessment was not available for review. Interview with the home manager and the qualified intellectual disabilities professional on 1/29/20 confirmed no current OT assessment, and confirmed client #5 needs an OT re-assessment. B. The ISP failed to include a PT re-assessment for client #1. For example: Observations on 1/28/20 revealed client #1 to use a wheelchair and requiring assistance transferring to and from the wheelchair. Further observations at 4:15 PM and 4:30 PM revealed staff D and staff C assisting the client with transfers and were observed using a gait belt. Continued observations on 1/29/20 did not reveal the client wearing a gait belt during the observations in the home or when the client left to go to day programming. Review of the record for client #1 on 1/29/20 revealed an ISP dated 10/14/19. Further review of the ISP revealed a health care summary section which indicated a PT assessment should be completed annually, and included a wheelchair and a gait belt as adaptive equipment. Continued review of the ISP revealed the last time a PT assessment was completed was 8/10/17, and it did not contain documentation related to a gait belt. Gait belt guidelines also were not available in the record. Interview with the facility nurse and home manager on 1/29/20 confirmed the last physical therapy assessment was more than two years	W 218	4) HS and/or CS will Complete Weekly observations to ensure proper adaptive equipment is being utilized and document on weekly observation forms. 5) Hs and/or CS will inservice all staff regarding: clients adaptive equipment and how to utilize the adaptive equipment by February 11, 2020 6) CS will updat annualy at the clients ISP regarding OT/PT	

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W 218	Continued From page 2 old, and confirmed a physical therapy assessment should be completed annually for client #1. C. The ISP failed to include an OT assessment for client #3. For example: Observations of the breakfast meal on 1/29/20 at 7:50 AM revealed client #3 to sit at the dining table eating a chopped banana and toast with jelly with staff assistance. Further observation revealed client #3's place setting to include a fork, large spoon, and a scoop plate. Review of the record on 1/29/20 for client #3 revealed an ISP dated 5/8/19. Further review of the ISP listed adaptive equipment for client #3 to include a scoop plate, bell on bedroom door, and plate guard. Continued review of the ISP for client #3 did not reveal an OT assessment included in the client record. Interview with the facility nurse and home manager (HM) on 1/29/20 verified that the whereabouts of the OT assessment for client #3 were unknown. Further interview with the facility nurse and HM confirmed that a current OT assessment is necessary for client #3. Interview with the qualified intellectual disabilities professional (QIDP) verified that client #3 did not have an OT assessment in the client record. The QIDP further confirmed during the interview that a current OT assessment for client #3 should be completed.	W 218	needs and/or appointments/ reccomendations. If Client does not need OT/PT services annually it mee be documented assuch on The plan.	
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR	W 288		

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W 288	Continued From page 3 CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure all techniques to manage inappropriate behavior were included in an active treatment program for 1 of 3 sampled clients (#3). The finding is: Morning observations on 1/29/20 from 6:45 AM to 8:15 AM revealed various clients (#1, #2, #3, #4, #5, #6) being prompted by staff to use both facility bathrooms and take showers. Further observations on 1/29/20 at 8:30 AM of both hallway bathrooms in the facility revealed no toilet paper located on the toilet paper dispensers and throughout morning observations. Continued observations revealed the toilet paper supply in both facility bathrooms were stored in plastic bins and inaccessible to clients. Review of the client record for client #3 revealed an individual support plan (ISP) dated 5/8/19 which included a behavioral support plan (BSP). Review of the BSP for client #3 identifies target behaviors including: rips and tears clothing, throwing or in some way destroying property, physical aggression, shirt in mouth, self-injurious behavior (SIB), compulsively arranging and rearranging things, rearranging trash, and invasion of privacy. Review of the BSP and ISP revealed no target behaviors relative to stuffing and flushing objects in the toilet drain or throwing non-trash items into the trashcan.	W 288	1) HS will purchase free standing toilet paper holders for bath bathrooms and put in place by February 9th, 2020. 2) HS will inservice all staff that toilet paper Must be accessible at ~~for~~ TW 2 times all times to the clients by February 11, 2020. 3) Clients who have a tendency to not use the toilet paper appropriately will have a program put in place by CS by Feb 28, 2020 4) Client's 3 Behavior Support Plan will be updated to reflect property destruction	

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W 288	Continued From page 4 Interview with the House Manager (HM) on 1/29/20 confirmed a supply of toilet paper located in a plastic bin underneath the sink of the second bathroom. Continued interview with the HM revealed client #3 has a history of stuffing and flushing objects down the toilet drain and throwing non-trash items away, therefore toilet paper products are not kept on toilet paper dispensers in either bathroom of the facility. Further interview with the HM verified client #3's behavior of stuffing paper and flushing objects down the toilet drain and throwing away non-trash items is not listed in the BSP. The HM subsequently verified no formal interventions have been implemented for client #3 except to remove toilet paper from dispensers and store toilet paper in plastic bins. Interview with the qualified intellectual disabilities professional (QIDP) on 1/29/20 confirmed client #3's behavior of stuffing and flushing toilet paper and inappropriate objects in the toilet drain, and throwing non trash objects away are not included in the client's active treatment plan. Interview with the QIDP further verified that removing toilet paper from the bathroom dispensers restricts access to needed supplies which affects all clients in the facility.	W 288	to include that non trash items thrown into the trash in the description by February 28, 2020. 5) Staff will be inserviced on client 3 updated BSP by February 28, 2020 by CS.	
W 484	DINING AREAS AND SERVICE CFR(s): 483.480(d)(3) The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. This STANDARD is not met as evidenced by: Based on observation, interview and record	W 484		

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W 484	Continued From page 5 review, the facility failed to provide prescribed adaptive dining equipment for 1 of 5 sampled clients (#5). The finding is: Observation throughout the 1/28/20-1/29/20 survey revealed client #5 to have significant contractures in both hands. Further observation of the morning meal on 1/29/20 at 7:35 AM revealed client #5's place setting to include a regular plate, bowl, and regular utensils. The breakfast meal consisted of a chopped banana, toast with jelly and cereal. Continued observations revealed staff B to use hand over hand in assisting client #5 with scooping banana pieces onto a spoon. The client was observed eating the toast pieces and cereal without hand over hand assistance. Review of the record for client #5 on 1/29/20 revealed an ISP dated 2/19/19 which included documentation indicating the client uses a scoop plate to assist with eating for meals and for snacks. Further review of the ISP revealed quarterly physician orders dated 12/6/19 which included a scoop plate. Interview with the qualified intellectual disabilities professional and the home manager on 1/29/20 confirmed client #5 had a prescribed scoop plate and should have been using it at every meal or snack.	W 484	1) HS will inservice staff on all adaptive equipment of the clients by February 11, 2020. 2) HS and/or CS will complete observations weekly to ensure adaptive equipment for the clients are being utilized.	

Community Alternatives of NC

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

February 11, 2020

Clarissa Henry, MHSA, QP
Facility Compliance Consultant I
Mental Health Licensure & Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh NC 27699-2718

Dear Ms. Henry,

Please find the enclosed Plan of Correction for the deficiencies cited during the annual recertification survey at our Laurel Street home in Granite Falls, NC. Hopefully our corrections will be acceptable. Please accept our invitation to return to our facility on March 28, 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 7, 2020

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

Re: Recertification Completed January 29, 2020
VOCA-Laurel Group Home, 15 Laurel Street, Granite Falls, NC 28630
Provider Number 34G287
MHL# 014-031
E-mail Address: mpenland@rescare.com

Dear Mr. Penland:

Thank you for the cooperation and courtesy extended during the recertification survey completed January 28, 2020 through January 29, 2020. 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 March 28, 2020.

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 Clarissa Henry at 704-589-2523.

Sincerely,

Clarissa Henry, MHSA, QP
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Enclosures

Cc: QM@partnersbhm.org
dhhs@vayahealth.com