

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

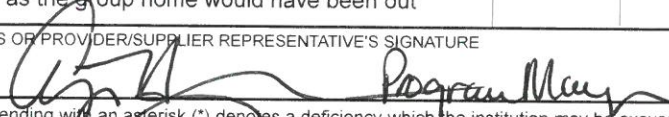
PRINTED: 04/08/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G220</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/04/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>VOCA-WILSON AVENUE GROUP HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2103 WILSON AVENUE CHARLOTTE, NC 28208</b>
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(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
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W 157	<p><b>STAFF TREATMENT OF CLIENTS</b> CFR(s): 483.420(d)(4)</p> <p>If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>This STANDARD is not met as evidenced by: Based on record review and verified by interviews, the facility failed to show evidence of timely corrective action related to a verified allegation of neglect. The finding is:</p> <p>Review of internal records on 3/3/20 revealed an internal investigation dated 2/10-2/19/20. Review of the internal investigation revealed on 2/8/20 client #6 was transported by emergency services to a local emergency room due to behaviors of threatening elopement, exhibiting physical aggression and property destruction. Continued review of the internal investigation revealed client #6 was not accompanied by staff to the hospital for emergency evaluation or care.</p> <p>A review of factual findings relative to the 2/10/20 internal investigation revealed medics transported client #6 to the hospital around 6:30 PM on 2/8/20 and no staff accompanied the client to the hospital or while at the hospital. Continued review of findings revealed client #6 returned to the group home around 2:54 AM on 2/9/20. Subsequent review revealed the home manager (HM) of the group home was on call during the incident and did not answer telephone calls in a timely manner and responded to missed phone calls through text messages with staff.</p> <p>Additional review revealed staff assigned to client #6 on 2/8/20 did not accompany client #6 to the hospital as the group home would have been out</p>	W 157	<p><i>Please see attached plan of correction</i></p> <p style="text-align: center;">DHSR-Mental Health JUN 15 2020 Lic. &amp; Cert. Section</p>	05/04/20
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Program Manager</b>	(X6) DATE <b>03.20.2020</b>
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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 157	<p>Continued From page 1</p> <p>of ratio with other client's still at home. Ongoing review of findings revealed the group home had an outdated on-call list, the BSP for client #6 included target behaviors exhibited on 2/8/20 and the home manager submitted a resignation during the investigation. Findings relative to the investigation also noted on 1/4/20 the facility submitted a 60 day discharge notice to the LME for client #6 due to incidents of property destruction and elopement.</p> <p>A review of conclusions relative to the 2/10/20 internal investigation revealed a substantiated finding of neglect for the HM. Neglect was substantiated as phone calls were not answered timely, client #6 was not accompanied by a staff to the hospital and a current on-call schedule was not posted in the group home.</p> <p>A review of recommended corrective actions relative to the 2/10/20 internal investigation of substantiated neglect revealed the termination of the HM, who resigned 2/19/20 and trainings to be conducted by the qualified intellectual disabilities professional (QIDP) and director of nursing (DON). Continued review of the recommended corrective actions revealed the QIDP was to in-service staff on the on-call protocols of the facility and in-service staff on protocols regarding individuals transported to the hospital. The DON was to in-service nursing staff to answer calls when on-call and ensure voicemail is not full when on-call.</p> <p>Interview with the QIDP on 3/3/20 revealed she had not conducted in-services relative to the 2/10/20 internal investigation of client #6 as she had not been informed of recommended actions. Interview with administration staff on 3/4/20</p>	W 157		
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W 157	Continued From page 2 revealed in-services relative to the 2/10/20 investigation had not been completed as of the current survey date of 3/4/20. Further interview with administration staff verified the recommended actions had not been conducted timely after an internal investigation that resulted in a substantiated finding of neglect.	W 157		
W 227	<p><b>INDIVIDUAL PROGRAM PLAN</b> CFR(s): 483.440(c)(4)</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>This STANDARD is not met as evidenced by: Based on observations, review of records, and staff interview, the individual support plan (ISP) failed to include sufficient objectives to address identified needs relative to rate of eating and drinking for 1 of 3 sampled clients (#1). The finding is:</p> <p>Afternoon observations in the group home on 3/3/20 at 5:45 PM revealed client #1 to sit at the dining table and to participate in the dinner meal. Client #1 was observed to eat a pureed meal that included zucchini chicken stew, couscous, cornbread, applesauce, and a sugar free drink. Further observation revealed client #1 used the following adaptive equipment during the dinner meal: angled spoon, high sided dish, spout cup and a shirt protector. Continued observations revealed staff to redirect client #1 several times to slow his rate of eating and drinking in between bites throughout the dinner meal.</p>	W 227	<p><i>Please see attached plan of correction</i></p>	<p><i>05/04/20</i></p>

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W 227	<p>Continued From page 3</p> <p>Morning observations in the group home on 3/4/20 at 7:10 AM revealed client #1 to sit at the dining table and to participate in the breakfast meal. The breakfast meal consisted of cereal, cut up banana pieces, water and juice. Client #1 was observed to eat a bowl of cereal placed on top of a shirt protector which was fastened around his neck. During the breakfast meal, staff were observed continuously redirecting client #1 to slow his rate of eating and drinking.</p> <p>Review of records for client #1 on 3/4/20 revealed an individual support plan (ISP) dated 6/18/19. Review of the ISP for client #1 revealed adaptive equipment to include: a gait belt, wheelchair, scoop/divided plate, spout cup, teaspoon for meals, adult briefs, thick-it and a puree diet due to history of choking. Further review of records for client #1 revealed an Adaptive Behavior Inventory (ABI) dated 5/14/19 that indicated client #1 can chew food and use a napkin neatly and independently. Subsequent review of the client record revealed a choking assessment dated 2/18/19 that indicated client #1 has a fast rate of drinking and requires supervision. Review of records for client #1 revealed no programming or guidelines relative to rate of eating or drinking during meals.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on 3/4/20 revealed client #1 had no current programming or guidelines to prevent choking and slow his rate of eating and drinking during meals. Continued interview with the QIDP confirmed that client #1 could benefit from programming relative to rate of eating and drinking during meals to prevent choking.</p>	W 227		
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<p>W 247</p> <p>W 247</p>	<p>Continued From page 4</p> <p><b>INDIVIDUAL PROGRAM PLAN</b> CFR(s): 483.440(c)(6)(vi)</p> <p>The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide opportunities for choice and self-management for 1 of 4 clients (#4) residing in the home relative to bathroom choice. The finding is:</p> <p>Observation in the group home on 3/3/20 at 4:35 PM revealed client #4 to walk to a hallway bathroom of the group home and attempt to enter the bathroom. Staff B was observed to immediately intervene with the client by stating "No, client #1 is in there, you will have to wait" and redirected client #4 to her bedroom. Client #4 was observed to verbalize "I have to go to the bathroom" before entering her bedroom. Subsequent observation revealed client #4 to go to the bathroom after client #1 exited.</p> <p>Interview with the interim home manager (HM) on 3/3/20 revealed there were two bathrooms in the home that client's utilize. Continued interview with the HM revealed the alternate bathroom on 3/3/20 was inaccessible due to a maintenance issue. Interview with the qualified intellectual disabilities professional (QIDP) on 3/3/20 at 6:40 PM verified the group home had three bathrooms with only two bathrooms having a shower/bathtub. Further interview with the QIDP verified client #4 should have been offered the choice to use an alternate bathroom in the group home at 4:45 PM as an additional bathroom was accessible for toileting at that time. Additional</p>	<p>W 247</p> <p>W 247</p>	<p><i>Please see attached plan of correction</i></p>	<p><i>05/04/20</i></p>
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W 247	Continued From page 5 interview with the QIDP verified the bathroom in the group home without a shower/bathtub is often thought of as the "staff bathroom" although client's should be able to use any bathroom in the group home.	W 247		
W 340	<p><b>NURSING SERVICES</b> CFR(s): 483.460(c)(5)(i)</p> <p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview, the interdisciplinary team failed to provide staff training of appropriate hygiene practices relative to meal preparation and client care. The finding is:</p> <p>Observation in the group home on 3/3-3/4/20 revealed the dinner and breakfast meals to be prepared in the kitchen of the group home. Continued observation on 3/3-3/4/20 revealed various clients to be involved with dinner and breakfast meal preparation at various times and to throw items in the trash during meal preparation activities. Observation of the kitchen trash can revealed residue from multiple meals and a flip top lid that required touching the trash can lid to throw away trash during meal preparation. Observation on 3/4/20 at 7:35 AM revealed the facility qualified intellectual disabilities professional (QIDP) to reach her hand into the trash can to push trash deeper into the</p>	W 340	<p><i>Please see attached plan of correction</i></p>	<p><i>05/04/20</i></p>

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W 340	Continued From page 6 trash can so trash would not over flow into the floor, touching trash and the top of the trash can without gloves.  Interview with the QIDP on 3/4/20 verified the kitchen trash can in the group home was dirty and had residue from various past meals indicating the trash can had not been cleaned for an undetermined amount of time. Continued interview with the QIDP on 3/4/20 confirmed staff should have washed their hands, and prompted clients to wash their hands, each time after touching the trash can. Additional interview with the QIDP confirmed the condition of the kitchen trash can was not acceptable and created hygiene concerns for the group home.	W 340		
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 observations and interviews, the facility failed to assure wheelchairs were clean and in good repair for 1 of 3 sampled clients (#1). The finding is:  Afternoon observations in the group home on 3/3/20 at 5:45 PM revealed client #1 to be seated at the dining table and to participate in the dinner meal. Continued observation revealed client #1	W 436	Please see attached plan of correction	05/04/20

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W 436	<p>Continued From page 7</p> <p>had a tear in his wheelchair headrest cover of approximately 2" inches wide. Further observation revealed client #1 had dried food particles and spillage around his wheelchair lap belt, seat, and alongside the wheelchair frame.</p> <p>Morning observations in the group home on 3/4/20 from 6:45 AM to 8:00 AM revealed client #1 to sit at the dining table and to participate in various activities such as a game activity with staff. Continued observation revealed client #1 to also participate in the breakfast meal. Further observation revealed client #1 to have dried food particles around the wheelchair frame and lap belt of his wheelchair as noted in previous observations.</p> <p>Interview with the home manager (HM) on 3/4/20 revealed client #1 did not have a current wheelchair cleaning schedule. The qualified intellectual disabilities professional (QIDP) on 3/4/20 further verified a wheelchair cleaning schedule for client #1 was not available. Subsequent interview with the QIDP revealed the previous HM was responsible for a cleaning schedule of client #1's wheelchair and the wheelchair had not been thoroughly cleaned since the previous HM's departure, approximately three weeks ago.</p> <p>Interview with the QIDP further verified that she was aware of the tear in client #1's headrest cover. Additional interview with the QIDP confirmed that a replacement headrest cover was needed for the wheelchair. Subsequent interview with the QIDP verified a wheelchair cleaning schedule for client #1's wheelchair was needed to ensure consistent cleaning.</p>	W 436		
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W157 STAFF TREATMENT OF CLIENTS  
CFR(s): 483.420(d)(4)

If the alleged violation is verified, appropriate corrective action must be taken.

Community Alternatives of NC, specifically the Wilson Avenue Group Home governing body, will take corrective action if an alleged violation is verified.

As soon as an investigation is completed, the Program Manager will review the summary and make recommendations. The Program Manager will meet with the Clinical Supervisor to discuss the recommendations by the next business day. This may include training, system changes, and corrective action. The Clinical Supervisor will ensure the recommendations are immediately documented and addressed. Copies of training will be filed in the employee's training file and corrective action will be filed in the personnel file. The Quality Assurance Manager will review all investigations to ensure appropriate corrective action and other recommendations are completed in a timely manner.

Person(s) Responsible: Program Manager, Clinical supervisor, Quality Assurance Manager  
Date to Be Completed: 05.04.2020

W227 INDIVIDUAL PROGRAM PLAN  
CFR(s): 483.440(c)(4)

The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive functional assessment required by paragraph (c)(3) of this section.

Community Alternatives of NC, specifically the Wilson Avenue Group Home, will ensure the individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive functional assessment required by paragraph (c)(3) of this section.

The Clinical Supervisor will develop a formal training objective for client #1 to slow his rate of eating and drinking during meal to prevent choking. The Clinical Supervisor will retrain all staff and the Site Supervisor on all client's dietary needs and review the training objective for client #1. Training will include methodology and frequency of data collection. The objective will be implemented at all mealtimes. The Site Supervisor will conduct 3 mealtime observations per week to ensure staff are implementing the objective to slow his rate of eating and drinking. The Clinical Supervisor will conduct mealtime observations 2 x weekly to ensure staff are implementing the objective to slow his rate of eating and drinking. The Program Manager will

observe mealtime during monthly site reviews to ensure staff are implementing the objective to slow his rate of eating and drinking.

Person(s) Responsible: Clinical Supervisor, Program Manager, Site Supervisor  
Date to Be Completed: 05.04.2020

W247      INDIVIDUAL PROGRAM PLAN  
CFR(s): 483.440(c)(6)(vi)

The Individual program plan must include opportunities for client choice and self-management.

Community Alternatives of NC, specifically the Wilson Avenue Group Home, will ensure the Individual program plan must include opportunities for client choice and self-management.

The Clinical Supervisor will retrain all staff to provide an alternative when an individual makes a request to use the bathroom and the one they choose is occupied. There are 3 bathrooms in the group home and all are available for anyone to use. The Clinical Supervisor will remind all staff that there is no designated "staff" bathroom and they are available for anyone to use. If a bathroom is occupied, staff will offer one of the other bathrooms to the individual. The Site Supervisor will conduct observations 3 x weekly to ensure choice of bathrooms are offered to individuals. The Clinical Supervisor will conduct observations 2 x weekly to ensure choice of bathrooms are offered to individuals. The Program Manager will conduct monthly site reviews in the home to ensure choice of bathrooms are offered to individuals.

Person(s) Responsible: Clinical Supervisor, Program Manager, Site Supervisor  
Date to Be Completed: 05.04.2020

W340      NURSING SERVICES  
CFR(s): 483.460(c)(5)(i)

Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventative health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.

Community Alternatives of NC, specifically the Wilson Avenue Group Home Nurse, will include implementing with other members of the interdisciplinary team, appropriate protective and preventative health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.

The Clinical Supervisor and Nurse will train all Wilson staff to implement good hygiene practices. Training will include washing hands after throwing trash in the trash can. Staff will be

assigned to support the consumer to clean out the trash can and place a clean bag in it after taking out the trash. Staff and consumer will wear gloves while cleaning the trash can and taking out the trash. Following the task, they will wash their hands. Training will include proper handwashing technique. The Site Supervisor will conduct observations 3 x weekly to ensure the trash cans are clean and staff and consumers are practicing proper hygiene/handwashing. The Clinical Supervisor will conduct observations 2 x weekly to ensure the trash cans are clean and staff and consumers are practicing proper hygiene/handwashing. The Program Manager will conduct monthly site reviews in the home to ensure the trash cans are clean and staff and consumers are practicing proper hygiene/handwashing.

Person(s) Responsible: Clinical Supervisor, Nurse, Program Manager, Site Supervisor  
Date to Be Completed: 05.04.2020

W436

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 communication aids, braces, and other devices identified by the interdisciplinary team as needed by the client.

Community Alternatives of NC, specifically the Wilson Avenue Group Home, will furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communication aids, braces, and other devices identified by the interdisciplinary team as needed by the client.

The Clinical Supervisor will develop a cleaning schedule/checklist for client #1's wheelchair. They will ensure all staff and the Site Supervisor are trained on the expectations and data collection. Staff assigned to support consumer #1 will ensure his wheelchair is cleaned daily and wiped down after meals. They will document the checklist when completed. The Site Supervisor will conduct observations 3 x weekly to ensure client #1's wheelchair is clean, and the checklist is documented. The Clinical Supervisor will conduct observations 2 x weekly to ensure client #1's wheelchair is clean, and the checklist is documented. The Program Manager will conduct monthly site reviews in the home to ensure client #1's wheelchair is clean, and the checklist is documented.

Person(s) Responsible: Clinical Supervisor, Program Manager, Site Supervisor  
Date to Be Completed: 05.04.2020



March 20, 2020

Kaila Mitchell  
Facility Compliance II  
Mental Health Licensure and Certification Section  
952 Old US Highway 70  
Black Mountain, NC 28711-4501

Dear Kaila,

Please find the enclosed plan of correction for the deficiencies cited during the recent recertification and complaint survey at the Wilson Group Home on March 04, 2020. Implementation is currently in progress for all deficiencies they will be corrected by May 04, 2020.

Thank you for all of your assistance that you and your team provide to us in helping meet the needs of the people that we serve.

Sincerely,

A handwritten signature in black ink, appearing to read "Angie Hughes", with a long horizontal line extending to the right.

Angie Hughes  
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

March 17, 2020

Ms. Denise Derkowski, Executive Director  
Community Alternatives of North Carolina  
818 Tyvola Road, Suite 104  
Charlotte, NC 28217

Re: Recertification and Complaint survey completed March 4, 2020  
VOCA-Wilson  
Provider Number 34G220  
MHL# 060-145  
E-mail Address: [dderkowski@rescare.com](mailto:dderkowski@rescare.com)  
Intake #: NC00161045, NC00161563

Dear Ms. Derkowski:

Thank you for the cooperation and courtesy extended during the recertification and complaint survey completed March 4, 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 May 4, 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.

MENTAL HEALTH LICENSURE & CERTIFICATION SECTION  
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](http://www.ncdhhs.gov/dhsr) • TEL: 919-855-3795 • FAX: 919-715-8078

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

March 17, 2020  
Ms. Denise Derkowski  
VOCA-Wilson Avenue Group Home

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) 750-2664.

Sincerely,



Kaila Mitchell  
Facility Compliance Consultant II  
Mental Health Licensure & Certification Section

Enclosures

Cc: [qmemail@cardinalinnovations.org](mailto:qmemail@cardinalinnovations.org)