STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G194	A. BUILDING _____ B. WING _____	C 08/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-FREEDOM GROUP HOME	5911 FREEDOM DR CHARLOTTE, NC 28208

(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 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide nursing services in accordance with the needs of 1 of 3 sampled clients (#5) relative to nutrition and weight loss. The finding is: Review of records on 8/11/20 for client #5 revealed an individual support plan dated 1/7/20. Further record review of client #5 revealed quarterly nutritional assessments dated 1/29/20 and 4/13/20. Review of the 1/2020 and 4/2020 nutritional assessments for client #5 revealed a diet order of: 2200 kcal, high fiber, 1/2"chopped, whole milk with meals. Continued review of the 4/13/20 nutritional assessment revealed an ideal body weight range of 149-122 lbs. A review of client #5's weight chart revealed: 132 lbs. in 1/2020, 129 lbs in 2/2020, 126 lbs in 3/2020, 127 lbs in 4/2020, 122 lbs in 5/2020, 120 lbs in 6/2020 and 117 lbs in 7/2020. Further review of records for client #5 revealed no documented nursing assessment, intervention or follow-up related to client #5's consistent weight loss since 1/2020. A review of core team meetings from 1/2020 through 7/2020 noted no nutritional or medical concerns. A review of current physician orders for client #5 revealed psychotropic medications to include Seroquel and Abilify with identified side effects of increased appetite and weight gain. A review of client #5's individual support plan dated 1/7/20 revealed a behavior plan to include target	W 331		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G194	A. BUILDING _____ B. WING _____	C 08/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 331	Continued From page 1 behaviors of food stealing. Interview with group home staff A on 8/11/20 revealed client #5 was currently hospitalized due to Covid-19 symptoms. Further interview with staff A verified client #5 is prescribed a nutritional supplement. (It should be noted an observation of the group home was conducted on 8/11/20 that revealed a stock of Ensure in a closet of the group home.) Additional interview with staff A revealed she was unaware of the last time the facility nurse had been to the facility to assess or monitor any client in the group home. Further interview with staff A revealed she was the person that would monthly weigh each client and then provide nursing with the documentation. Interview with the facility qualified intellectual disability professional on 8/11/20 verified the facility nurse is a part of the core team meetings for each client. Interview with the facility nurse on 8/11/20 revealed she did not physically visit clients in the group homes unless staff reported a health problem that she needed to evaluate. Further interview with the facility nurse revealed she was unsure of the last time she had seen client #5 to monitor or evaluate weight loss.	W 331		