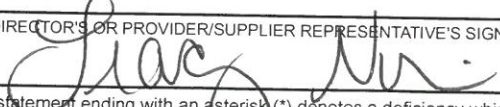


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G271	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ Lic. & Cert. Section B. WING _____	(X3) DATE SURVEY COMPLETED C 09/14/2020
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NAME OF PROVIDER OR SUPPLIER VOCA-ROLLINS GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 297 BOB ROLLINS ROAD FOREST CITY, NC 28043
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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 000	INITIAL COMMENTS	W 000	<p>① Home Supervisor and Clinical Supervisor will Monitor Direct Support Professionals staff to ensure implementation of Behavior Support Plan's and will redirect staff as necessary</p> <p>② Behaviorist will re-in-service all staff on Behavior Support Plans,</p> <p>③ Clinical Supervisor will implement and monitor any team meetings recommendations</p>	ongoing
W 249	<p>PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by: Based on facility record/document review and interview, the facility failed to ensure sufficient interventions were implemented as prescribed relative to behavior management for 1 of 3 sampled clients (#3). The finding is:</p> <p>Observations on 9/14/20 at 11:15 AM revealed client #3 to be hospitalized. Observation of client #3 at the hospital revealed right side facial bruising, the client to appear sedated and to refuse her lunch meal. Interview with client #3's nurse on 9/14/20 at 11:45 AM revealed the client to currently be sedated and hospitalized for antibiotics with leg wounds and safety concerns due to recently pulling out stitches in her leg.</p> <p>Review of internal facility documentation on 9/14/20 revealed an incident report dated 8/20/20. Review of the 8/20/20 incident for client #3 revealed while on an outing, client #3 began</p>	W 249		10/15/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Program Manager	(X6) DATE 9/28/2020
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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.

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

PRINTED: 09/24/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G271	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/14/2020
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NAME OF PROVIDER OR SUPPLIER VOCA-ROLLINS GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 297 BOB ROLLINS ROAD FOREST CITY, NC 28043
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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 000	INITIAL COMMENTS	W 000	<p>① Home Supervisor and Clinical Supervisor will Monitor Direct Support Professionals Staff to ensure implementation of Behavior Support Plans and will redirect staff as necessary.</p> <p>② Behaviorist will re-in-service all staff on Behavior Support Plans to include target behaviors and redirection techniques.</p>	<p>Immediately + ongoing</p> <p>10/6/2020</p>
W 249	<p>PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by: Based on facility record/document review and interview, the facility failed to ensure sufficient interventions were implemented as prescribed relative to behavior management for 1 of 3 sampled clients (#3). The finding is:</p> <p>Observations on 9/14/20 at 11:15 AM revealed client #3 to be hospitalized. Observation of client #3 at the hospital revealed right side facial bruising, the client to appear sedated and to refuse her lunch meal. Interview with client #3's nurse on 9/14/20 at 11:45 AM revealed the client to currently be sedated and hospitalized for antibiotics with leg wounds and safety concerns due to recently pulling out stitches in her leg.</p> <p>Review of internal facility documentation on 9/14/20 revealed an incident report dated 8/20/20. Review of the 8/20/20 incident for client #3 revealed while on an outing, client #3 began</p>	W 249		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Program Manager 9/28/2020

(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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NAME OF PROVIDER OR SUPPLIER VOCA-ROLLINS GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 297 BOB ROLLINS ROAD FOREST CITY, NC 28043		
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W 249	<p>Continued From page 1</p> <p>yelling and screaming. Further review revealed, while getting on the van to leave, client #3 fell off the step rail of the van, hitting the right side of her head causing a small dime size bruise on the corner of her right eye. Continued review revealed staff conducted a guided fall to assist and a post head injury assessment was started.</p> <p>Subsequent review of the 8/20/20 incident report revealed during a behavior on the van client #3 began hitting her ankle and foot on the metal frame of the seat in front of her causing a large three inch cut on the ankle of her right foot. Further review revealed staff used intervention model, "Your safe, I'm safe" (YSIS) to redirect behavior and client #3 continued behavior until they arrived at the group home. Continued review revealed client #3 got off the van and sat down on the ground and began rubbing her foot against the concrete driveway and picking wounds on both feet while staff used YSIS to redirect behavior. Ongoing review revealed client #3 began kicking at staff while staff tried to prevent client #3 from continuing self injurious behavior (SIB) and the nurse was called who directed staff to call 911. Additional review of internal documentation revealed client #3 to be transported to the local emergency room and was documented to have received 16 stitches on the ankle of the right foot and 6 stitches on the left leg.</p> <p>Review of an internal incident report dated 8/29/20 revealed client #3 was having a behavior sitting at the kitchen table while staff was preparing breakfast. Further review of the 8/29/20 incident report revealed client #3 informed staff she had pulled out her stitches and staff attempted to stop the client's leg from</p>	W 249	<p>③ Clinical Supervisor will implement and monitor any special team meeting recommendations</p> <p>④ Standing Agenda item will be added to monthly staff meetings to review target behaviors & redirection techniques</p>	<p>Immediately ongoing</p> <p>immediately + ongoing</p>	

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W 249	<p>Continued From page 2</p> <p>bleeding while client #3 continued to fight staff. Subsequent review revealed staff used intervention model, YSIS and called the nurse. Additional review revealed staff was instructed to call 911 and client #3 was transported to the emergency room to close the open wound.</p> <p>Review of client #3's individual support plan (ISP) dated 3/19/20 revealed a diagnosis of mood disorder, obsessive compulsive disorder, personality disorder and severe intellectual developmental disability. Further review of client #3's ISP revealed a behavior support plan (BSP) updated 5/18/20 for target behaviors of habilitation activity refusal, verbal disruption, physical aggression towards staff and other clients, property destruction, tantrum behavior, untrue statements, nudity and excessive bathroom use. Continued review of client #3's BSP revealed prevention strategies to include: Client #3 is a 1:1 when she has extreme attention seeking behaviors or during extreme aggression. If client #3 displays aggressive behaviors, staff will follow the 1:1 process of staff must always be within an arms length of client #3 until she is calm.</p> <p>Continued review of records for client #3 revealed documentation of a team meeting on 8/21/20 and 8/31/20. Review of meeting minutes from the 8/21/20 team meeting revealed increased prevention measures to support safety to include: medication (Xanax 1mg) to assist with reducing anxiety and SIB, increased supervision to 1:1 during awake hours to reduce SIB behavior (Staff are to be within arms reach of client #3 and to redirect SIB behavior and respond more quickly), staff will be in-serviced on use of intervention model, "Your Safe, I'm Safe" and how to</p>	W 249	<p>⑤ Behaviorist will reinservice Direct Support staff immediately of any changes to a Behavior Support Plan prior to staff working with the client</p> <p>⑥ Home Supervisor, Clinical Supervisor, Behaviourist, Program Manager will complete observations of Direct Support staff to ensure</p>	<p>Immediate + ongoing</p> <p>Immediate + ongoing</p>	

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W 249	<p>Continued From page 3</p> <p>properly redirect behavior as it relates to client #3's SIB behavior, client #3 would have a audio/visual monitor in her room to better monitor times she is in her room or during sleep hours, a bed rail would be used to assist with reducing behavior of throwing herself in the floor and the use of a gait belt to assist with lifting, walking and preventing falls when getting in/out of the facility van or moving around the home. Subsequent review of meeting minutes from the 8/21/20 team meeting revealed attendance to include the program manager, facility nurse, group home supervisor and clinical supervisor. Continued review of minutes revealed client #3's mother to have given written permission for new prevention measures to be put in place to support client safety relative to SIB.</p> <p>Review of meeting minutes from the 8/31/20 team meeting revealed increased prevention measures to support safety to include: client #3 would be a arms-length 1:1 supervision, client #3's wheelchair will be padded to assist with the inability to kick or hit the chair while in it to prevent SIB, the use of gloves and soft boots with guardian consent to reduce incidents of SIB behavior and further injury and client #3 would have a follow-up appointment with psychiatrist on 9/2/20 to evaluate any need for medication adjustments to further assist with behavior management.</p> <p>Interview with the clinical supervisor on 9/14/20 verified verbal guardian consent for interventions developed during the 8/21/20 and 8/31/20 team meetings. Further interview with the clinical supervisor and program manager verified if supervision of arms length 1:1 had been implemented by staff on 8/29/20, client #3 would</p>	W 249	<p>that the Behavior Support Plans are being implemented in the home with clients who are exhibiting behaviors.</p>		

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W 249	Continued From page 4 not have been able to pull out her stitches, opening leg wounds.	W 249			

Community Alternatives of NC

301 10th Street NW, Suite B101

Conover NC 28163

Phone: 828/466-6023 Fax: 828/466-6025

September 28, 2020

Shyluer Holder-Hanson
Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh NC 27699-2718

DHSR - Mental Health

OCT 2 2020

Lic. & Cert. Section

Dear Ms. Holder-Hansen

Please find the enclosed Plan of Correction for the deficiencies cited during the complaint survey at Rollins Road in Forest City NC. Hopefully our corrections will be acceptable. Please accept our invitation to return to our facility on November 14, 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. Thank you

Sincerely,



Tracey Norris, QIDP
Operations Manager



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

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

September 28, 2020

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

Re: Complaint Investigation Completed September 14, 2020
VOCA-Rollins Group Home
Provider Number #34G271
MHL# 081-018
E-mail Address: mpenland@rescare.com
Complaint Intakes: #NC00168834
#NC00169270
#NC00169031

DHSR - Mental Health

OCT 2 2020

Lic. & Cert. Section

Dear Mr. Penland:

Thank you for the cooperation and courtesy extended during the complaint investigation survey completed September 14, 2020.

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 practice that does 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 deficiency was cited.

Time Frames for Compliance

- Standard level deficiency must be **corrected** within 60 days from the exit of the survey, which is November 14, 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.

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 • TEL: 919-855-3795 • FAX: 919-715-8078

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

- 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 my supervisor Kaila Mitchell at (828) 750-2664.

Sincerely,



Shyluer Holder-Hansen
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Enclosure

Cc: QM@partnersbhm.org