STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G220	A. BUILDING _____ B. WING _____	C 11/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-WILSON AVENUE GROUP HOME	2103 WILSON AVENUE 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 review of records and interviews, the facility failed to provide 5 of 5 clients (#1,#2, #3, #4 and #5) residing in the group home with nursing services according to their needs. The findings are: A. Nursing services failed to ensure infection control relative to client #4. For example: Review of internal records on 11/17/20 revealed a medical consult for client #4 dated 6/26/20. Review of the 6/26/20 medical consult revealed client #4 was treated at urgent care for shingles. A review of records for client #4 on 11/16/20 and 11/17/20 revealed a diagnosis history to include moderate intellectual disability, attention deficit hyperactivity disorder (ADHD) and Autism. Continued review of client #4's records revealed a behavior support plan dated 2/14/20 with target behaviors of physical aggression, non-compliance, self-injurious behavior and agitation. Further record review revealed clinical notes dated 3/11/20, 3/18/20 and 5/6/20 to reflect client #4 does not understand boundaries, likes to touch and likes attention. Interview with the facility behaviorist on 11/17/20 verified client #4 has a behavior history of getting close to others, touching others and difficulty understanding the personal space of others. Interview with the facility nurse on 11/17/20 verified shingles can be contagious as it is a	W 331		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (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 331	Continued From page 1	W 331		

virus. Continued interview with the facility nurse verified she did not implement any documented protocols to address infection control after client #4 was diagnosed with shingles. Further interview with the facility nurse verified she had not provided any training to staff relative to shingles and infection control after client #4's diagnosis of shingles.

B. Nursing services failed to provide timely client assessments after a confirmed case of bed bugs was identified in the group home. For example:

Review of internal facility records revealed a confirmed case of bed bugs in the group home on 6/26/20. Review of internal records revealed staff informed the facility program manager on 6/26/20 of bugs on the wall. Further documentation review revealed a treatment service was sent to the group home on 6/26/20 for a full home assessment that confirmed bed bugs were in one bedroom of the group home only. Review of an administration inquiry relative to the 6/26/20 bed bug outbreak at the group home revealed staff sent an email to the program manager on 6/29/20 that revealed on 6/26/20 staff observed a insect drop off client #3's bed. Staff flipped the sheet of the client's bed and saw bugs.

Interview with administration confirmed a case of bed bugs had been discovered in the group home on 6/26/20 and an extermination service assessed the home on 6/26/20 to determine treatment needs. Continued interview with administration confirmed all clients were relocated on 7/1/20 so the group home could be treated. Further interview with administration revealed clients were able to remain in the group home from 6/26-7/1/20 due to confirmation from

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W 331	Continued From page 2 the extermination service that bed bugs were only in one room of the group home and the client that resided in the bedroom with the identified bed bugs was moved to another room. Interview with the facility nurse on 11/17/20 revealed she was informed on 6/26/20 that the group home had a confirmed case of bed bugs. Continued interview with the facility nurse revealed she did not conduct an assessment on any client in the group home on 6/26/20 for any marks or bites related to bed bugs. Continued interview with the facility nurse revealed she had instructed staff to assess each client and staff had reported no marks on any client. Subsequent interview with the facility nurse verified she had not conducted a training with staff relative to the appearance of bed bug bite marks. Additional interview with the facility nurse verified clients in the group home were not assessed by a nursing staff until 7/2/20.	W 331		