STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G158	A. BUILDING _____ B. WING _____	03/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-MALLARD DRIVE	6119 MALLARD DRIVE CHARLOTTE, NC 28227

(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 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, record review and interview, the facility failed to assure that clients use and make informed choices relative to adaptive equipment as recommended for 1 sampled client (#4) and 1 non sampled client (#6). The findings are: A. The facility failed to ensure the gait belt for client #4 was used as prescribed. For example: Observations in the group home on 3/30/21 at 6:50 AM revealed client #4 to ambulate from her room to the hallway bathroom without shoes or a gait belt. Continued observations revealed staff C to open the bathroom door for client #4 as the client walked inside closing the door. Further observation revealed staff C to then exit the bathroom and walk down the hallway leaving client #4 inside the bathroom. Subsequent observation revealed staff C to enter the bathroom and assist client #4 to her room. Staff C was observed telling client #4 that she should wear her gait belt next time she goes to the bathroom. Additional observation at 7:05 AM revealed client #4 to exit from her room wearing a gait belt.	W 436		

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

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W 436	Continued From page 1 Subsequent observation in the group home on 3/30/21 from 7:05 AM to 8:10 AM revealed client #4 to ambulate with staff assistance throughout the group home with a loosely fitted gait belt around her waist that hung below her waistline. At no point during the observation period did staff attempt to tighten the gait belt around client #4's waist during ambulation. Review of records for client #4 on 3/30/21 revealed an individual support plan (ISP) dated 1/28/21. Review of the 1/2021 ISP revealed client #4 continues to have falls and must wear a gait belt continuously to prevent falls from occurring. Continued review of records for client #4 revealed the client had an unsteady gait and a history of falls. Further record review for client #4 revealed a physical therapy (PT) consult dated 1/7/20. Review of the 1/7/20 PT consult revealed the gait belt for client #4 should be used with close supervision while transferring. Continued review of the 1/2020 PT consult revealed the gait belt should also be used when client #4 is up and staff should be with her. Subsequent review of the record revealed a medical consult dated 12/2020 that indicated client #4 required medical treatment at a local hospital due to a fall which resulted in an injury. Additional record review revealed an in-service training dated 12/29/20 that reflected staff must accompany client #4 at all times with a gait a belt when walking throughout the group home due to recent falls. Interview with the home manager on 3/30/21 verified that client #4 should have her gait belt on and secured around her waist when ambulating	W 436		

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W 436	Continued From page 2	W 436		

throughout the group home and in the community. Continued interview with the HM confirmed that client #4 should wear her gait belt secured around her waist as prescribed.

Interview with the qualified intellectual disabilities professional (QIDP) on 3/30/21 verified client #4 should have on her gait belt as soon as she is up and out of her room in order to prevent falls. Continued interview with the QIDP on 3/30/21 verified that client #4 does not like to wear her gait belt. The QIDP further confirmed that client #4 should have her gait belt secured around her waist during ambulation. Additional interview with the QIDP revealed that client #4 would benefit from gait belt guidelines and should wear her gait belt as prescribed.

B. The facility failed to ensure eyeglasses were used as prescribed for client #6.

Observations in the group home on 3/29/21 revealed client #6 to participate in various activities to include: coloring, preparing food items and kitchen chores. Continued observation at 6:00 PM revealed client #6 to participate in the dinner meal. Further observation at 6:28 PM revealed the client to obtain a toothbrush and toothpaste from her bedroom and enter the bathroom.

Observation of client #6 on 3/30/21 at 7:33 AM revealed client #6 to exit her bedroom and walk into kitchen to prepare her breakfast. Subsequent observation of client #6 at 7:51 AM

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W 436	Continued From page 3	W 436		

revealed staff to prompt client #6 to the medication room for morning medication administration. It should be noted at no time during survey observations on 3/29-3/30/21 was client #6 observed to wear glasses or for any staff to prompt the client to put on eyeglasses.

Review of records for client #6 on 3/30/21 revealed an ISP dated 1/21/21. Review of the 1/2021 ISP revealed client #6 is to use glasses continuously. Further review of records for client #6 revealed an undated internal document that reflected an eyeglass prescription for the client. Further review of records for client #6 revealed a community/home life assessment dated 1/21/21 that reflected client #6 can independently wear her glasses as prescribed.

Interview with the QIDP on 3/30/21 verified client #6 has prescribed eyeglasses and is able to independently maintain her glasses in her bedroom. Continued interview with QIDP revealed client #6 is supposed to wear her glasses at all times and will often refuse to wear them. Further interview with the QIDP confirmed that client # 6 would benefit from a program to address the need to wear her eyeglasses as prescribed.