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| V 000 | INITIAL COMMENTS<br><br>An annual and complaint survey was completed on 5/28/21. The complaint (# NC177174) was substantiated. Deficiencies were cited.<br><br>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Intellectual and Developmental Disabilities. | V 000 | | |
| V 105 | 27G .0201 (A) (1-7) Governing Body Policies<br><br>10A NCAC 27G .0201 GOVERNING BODY POLICIES<br>(a) The governing body responsible for each facility or service shall develop and implement written policies for the following:<br>(1) delegation of management authority for the operation of the facility and services;<br>(2) criteria for admission;<br>(3) criteria for discharge;<br>(4) admission assessments, including:<br>(A) who will perform the assessment; and<br>(B) time frames for completing assessment.<br>(5) client record management, including:<br>(A) persons authorized to document;<br>(B) transporting records;<br>(C) safeguard of records against loss, tampering, defacement or use by unauthorized persons;<br>(D) assurance of record accessibility to authorized users at all times; and<br>(E) assurance of confidentiality of records.<br>(6) screenings, which shall include:<br>(A) an assessment of the individual's presenting problem or need;<br>(B) an assessment of whether or not the facility can provide services to address the individual's needs; and<br>(C) the disposition, including referrals and recommendations; | V 105 | DHSR - Mental Health<br>AUG 02 2021<br>Lic. & Cert. Section | |

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| V 105 | Continued From page 1<br>(7) quality assurance and quality improvement activities, including:<br>(A) composition and activities of a quality assurance and quality improvement committee;<br>(B) written quality assurance and quality improvement plan;<br>(C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services;<br>(D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service;<br>(E) strategies for improving client care;<br>(F) review of staff qualifications and a determination made to grant treatment/habilitation privileges:<br>(G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death;<br>(H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;<br><br>This Rule is not met as evidenced by: | V 105 | | |

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| V 105 | Continued From page 2<br><br>Based on record reviews and interviews, the facility failed to implement standards of practice that assured compliance with the licensee's policy on abuse, neglect and exploitation for 1 of 2 clients (Client #1). The findings are:<br><br>Review on 5/27/21 of Licensee's Policy on Abuse, Neglect and Exploitation revealed:<br>-" ...Internal reporting-All employees will immediately report any allegation or suspicion of abuse, neglect or exploitation or any bruising or injury of unknown source to the first supervisor in the chain of command that is not involved in the incident. After reporting internally, proceed with external reporting. An incident report form will be completed and submitted according to operation incident reporting policy ..."<br><br>Review on 5/27/21 of Abuse and Neglect power point presentation by Program Manager at facility staff meetings revealed:<br>"..types of abuse-VERBAL- the act of insulting or profane language or gestures directed toward an individual that subject him or her to humiliation or degradation. Course, loud tone or with language that is perceived by an individual as offending or threatening ...STAFF RESPONISIBLITY IN THE REPORT OF ALLEGED ABUSE, NEGLECT OR EXPLOITATION. All staff are responsible for:<br>-ensuring safety of the individuals<br>-immediately reporting suspected abuse, neglect, exploitation to supervisor<br>-completing incident report ..."<br><br>Review on 5/27/21 of corrective action form to FS #2 on 3/11/21 revealed:<br>-" ...Specifically on 3/4/21 you documented giving one of the clients you serve a shower, however upon further investigation after receiving a report, it was discovered that he had not received a | V 105 | At new hire orientation, human resource manager will review company abuse and neglect policy to include reporting procedure, incident report completion requirement as well as follow-up once reported to ensure follow through of initial report.<br><br>Monthly, QP and/or Residential Manager will review abuse and neglect policy with all current staff at scheduled monthly staff meeting. This review of policy will include reporting procedure, incident report completion requirement, as well as follow-up once reported to ensure follow through of initial report.<br><br>In regard to Corrective Action and Counseling Statements, once submitted by Residential Manager or QP to Program Manager and HRS, follow-up will be made within 3 days and then daily thereafter until Corrective Action has been approved and signed by Executive Director and HRS to be presented. Corrective Actions will be presented and signed by staff then returned to HRS within 7 days of initial submission. | 6/1/2021<br>HRS<br>QP<br>RM<br><br>6/1/2021<br>HRS<br>QP<br>RM |

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| V 105 | Continued From page 3<br>shower on the date/time you had documented. Also on 3/8/21 your supervisor observed you screaming at a consumer from the office as you walked towards him. You were observed screaming "STOP SCREAMING *****" as you were walking towards him as well as when you were standing over him ...you are hearby issued a Counseling Statement. Any additional failure to complete assigned tasks will result in further corrective action, up to and including release from employment ...<br>-this corrective action was not signed.<br>-No internal incident report was completed regarding the alleged verbal abuse.<br><br>Review on 5/27/21 of an email from the Qualified Professional to Human Resources (HR) Representative on 3/15/21 revealed:<br>-Subject: [FS #2] CA (corrective action) attached. "I wasn't sure what level this would be so I left that part blank. Please let me know if you need me to do anything additional."<br><br>Review on 5/27/21 of corrective action form to FS #2 on 5/5/21 revealed:<br>-" ...Specifically on 3/4/21 you documented giving one of the clients you serve a shower, however upon further investigation after receiving a report, it was discovered that he had not received a shower on the date/time you had documented. Also on 3/8/21 your supervisor observed you screaming at a consumer from the office as you walked towards him. On 4/29/21, you Residential Manager [House Manager] had a verbal discussion with you about the inappropriateness (and non-allowable) volume towards clients. Immediately after this discussion, it was reported that you were using inappropriate volume again. Lastly on 5/4/21 during monthly staff meeting, an in-service was done on Abuse and Neglect, | V 105 | | |

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| V 105 | Continued From page 4<br>specifically verbal abuse and the different examples. That same afternoon, you were heard using inappropriate volume with a consumer during a behavior ....you are herby issued a Final Written Warning ..." signed by the House Manager, FS #2, HR Representative and the Executive Director.<br>-No internal incident report was completed regarding the alleged verbal abuse.<br><br>Interview on 5/26/21 and 5/27/21 with the Program Manager revealed:<br>-"I just did a training on abuse/neglect at our monthly staff meeting this morning. We talk about abuse and neglect at every staff meeting."<br>-Incident reports were completed if there was actually an injury to a person.<br>-"We haven't been doing incident reports for verbal but physical injury only.<br>-"No incident reports were completed prior to 5/10/21- we typically don't do report for verbal abuse."<br>-"The QP completes a CA (corrective action) sends to Human Resources and copy's Program manager. If the QP hasn't heard back from HR they should follow up."<br>-"A CA was completed for [FS #2] but no incident report.<br>-He trained on completing incident reports for physical abuse and marks of unknown origin. | V 105 | | |
| V 117 | 27G .0209 (B) Medication Requirements<br><br>10A NCAC 27G .0209 MEDICATION REQUIREMENTS<br>(b) Medication packaging and labeling:<br>(1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly | V 117 | | |

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| V 117 | Continued From page 5<br>visible;<br>(2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate;<br>(3) The packaging label of each prescription drug dispensed must include the following:<br>(A) the client's name;<br>(B) the prescriber's name;<br>(C) the current dispensing date;<br>(D) clear directions for self-administration;<br>(E) the name, strength, quantity, and expiration date of the prescribed drug; and<br>(F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record review, the facility failed to ensure all prescription medications available for administration were not expired and contained a current dispensing date for 2 of 2 clients (Client #1 and Client #2). The findings are:<br><br>Record review on 5/26/21 of March- May 2021 MARs for Client #1 revealed:<br>-received Ketoconazole cream daily. | V 117 | | |

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| V 117 | Continued From page 6<br><br>Record review on 5/26/21 of March-May 2021 MARs for Client #2 revealed:<br>-received Eucerin Cream and Fluticasone spray daily.<br><br>Observation at 12:30pm on 5/26/21 of medication container for Client #1 revealed:<br>-Ketoconazole Cream 2% with dispense date of 3/27/20 expiring on 3/27/21.<br>-Caldyphen lotion with dispense date of 1/7/19 expiring on 1/7/20.<br>-Nystatin powder with dispense date of 1/7/19 expiring on 1/7/20.<br>-Anti diarrheal tab unopened box 12 tabs 2mg with dispense date of 4/15/20 expiring on 4/15/21.<br><br>Observation at 12:45pm on 5/26/21 of medication container for Client #2 revealed:<br>-Eucerin cream with dispense date of 3/29/20 expiring on 3/29/21.<br>-Fluticasone spray with dispense date of 5/3/20 expiring on 5/3/21.<br>-Terbinafine cream 1% with dispense date of 1/7/19 expiring on 1/7/20.<br>-Nystatin Powder with dispense date of 1/7/19 expiring on 1/7/20.<br><br>Interview on 5/26/21 with the House Manager revealed:<br>-had just completed her medication review in a sister facility and this facility was next.<br>-Staff were supposed to also monitor expiration dates when they administered medications. | V 117 | Weekly, 3rd shift staff will complete company provided medication closet checklist - which includes checking of expiration dates of all routine and PRN medication present. All expired meds will be pulled out of the medication closet and destroyed of properly.<br><br>Residential Manger will review these checklist each week onces completed and double check to ensure all expired PRN and Routine Meds are no longer in the medication closet and are being destroyed.<br><br>Monthly, QP will complete a thorough visual check of the medication closet as a follow-up to ensure all expired mediations have been promptly removed and disposed of. | 6/1/2021 DSP RM QP |
| V 118 | 27G .0209 (C) Medication Requirements<br><br>10A NCAC 27G .0209 MEDICATION REQUIREMENTS<br>(c) Medication administration: | V 118 | | |

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| V 118 | Continued From page 7<br>(1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs.<br>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.<br>(3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications.<br>(4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following:<br>(A) client's name;<br>(B) name, strength, and quantity of the drug;<br>(C) instructions for administering the drug;<br>(D) date and time the drug is administered; and<br>(E) name or initials of person administering the drug.<br>(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to keep MAR current affecting 2 of 2 clients (Client #1 and Client #2). The findings are: | V 118 | | |

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| V 118 | Continued From page 8<br><br>Record review on 5/26/21 for Client #1 revealed:<br>-Date of admission -9/8/15<br>-Diagnosis - moderate intellectual/developmental disability, Hypertension, potassium deficiency, diabetes, hyperlipidemia, Bipolar Disorder, recurrent depressive episode<br>-Physician ordered medication included:<br>-Ketoconazole Cream 2%-apply to affected area topically once daily.<br><br>Review on 5/26/21 of MARs for 3/1/21-5/25/21 revealed:<br>-Ketoconazole had no initials on 3/6/21 or 5/6/21.<br><br>Record review on 5/26/21 for Client #2 revealed:<br>-Date of admission -10/31/91<br>-Diagnosis - moderate intellectual/developmental disability, Schizoaffective Disorder, Obsessive Compulsive Disorder, Hypertension, borderline hypercholesterolemia, Hypothyroidism, unspecified Dementia with behavioral disturbances, neuroleptic induced Parkinson's<br>-Physician ordered medication included:<br>-Eucerin Cream-apply to affected area of dry skin on face twice daily.<br>-Fluticasone Spray 50mcg-instill 2 sprays in each nostril once daily.<br>Review on 5/26/21 of MARs for 3/1/21-5/25/21 revealed:<br>-Eucerin Cream had no initials on 3/6/21.<br>-Fluticasone had no initials on 3/6/21.<br><br>Interview on 5/26/21 with the House Manager revealed:<br>-all of these missed medications were on the TAR (Treatment Administration Record). Staff sometimes forgot to click over to the TAR after administering medications from the MAR. She had even missed review of the TAR before. | V 118 | Daily, residential manager is to check QuickMar for any administration holes in the MAR and TAR and accurately correct immediately upon recognition of any holes.<br><br>Weekly, QP will review QuickMar and notify Residential Manager of any holes in MAR and TAR found. If holes are not corrected within 3 days, corrective action will be presented. | 6/1/2021<br>RM<br>QP |

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| V 118 | Continued From page 9<br><br>Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician. | V 118 | | |
| V 536 | 27E .0107 Client Rights - Training on Alt to Rest. Int.<br><br>10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS<br>(a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions.<br>(b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented.<br>(c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered.<br>(d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.<br>(e) Formal refresher training must be completed by each service provider periodically (minimum annually).<br>(f) Content of the training that the service provider wishes to employ must be approved by | V 536 | | |

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| V 536 | Continued From page 10<br>the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.<br>(g) Staff shall demonstrate competence in the following core areas:<br>(1) knowledge and understanding of the people being served;<br>(2) recognizing and interpreting human behavior;<br>(3) recognizing the effect of internal and external stressors that may affect people with disabilities;<br>(4) strategies for building positive relationships with persons with disabilities;<br>(5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;<br>(6) recognizing the importance of and assisting in the person's involvement in making decisions about their life;<br>(7) skills in assessing individual risk for escalating behavior;<br>(8) communication strategies for defusing and de-escalating potentially dangerous behavior; and<br>(9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).<br>(h) Service providers shall maintain documentation of initial and refresher training for at least three years.<br>(1) Documentation shall include:<br>(A) who participated in the training and the outcomes (pass/fail);<br>(B) when and where they attended; and<br>(C) instructor's name;<br>(2) The Division of MH/DD/SAS may review/request this documentation at any time.<br>(i) Instructor Qualifications and Training | V 536 | | |

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| V 536 | Continued From page 11<br>Requirements:<br>(1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.<br>(2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.<br>(3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.<br>(4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule.<br>(5) Acceptable instructor training programs shall include but are not limited to presentation of:<br>(A) understanding the adult learner;<br>(B) methods for teaching content of the course;<br>(C) methods for evaluating trainee performance; and<br>(D) documentation procedures.<br>(6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach.<br>(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.<br>(8) Trainers shall complete a refresher instructor training at least every two years.<br>(j) Service providers shall maintain documentation of initial and refresher instructor | V 536 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VOCA-8TH AVENUE | 212 8TH AVENUE N W HICKORY, NC 28601 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| V 536 | Continued From page 12<br>training for at least three years.<br>(1) Documentation shall include:<br>(A) who participated in the training and the outcomes (pass/fail);<br>(B) when and where attended; and<br>(C) instructor's name.<br>(2) The Division of MH/DD/SAS may request and review this documentation any time.<br>(k) Qualifications of Coaches:<br>(1) Coaches shall meet all preparation requirements as a trainer.<br>(2) Coaches shall teach at least three times the course which is being coached.<br>(3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.<br>(l) Documentation shall be the same preparation as for trainers.<br><br>This Rule is not met as evidenced by:<br>Based on personnel record review and staff interviews, the facility failed to ensure that all staff completed training in alternatives to restrictive intervention annually for 1 of 1 former staff (FS #2). The findings are:<br><br>Record review on 5/26/21 for FS #2 revealed:<br>-date of hire- 2/17/20 as direct support staff.<br>-date of separation- 5/13/21<br>-You're Safe I'm Safe, alternative to restrictive intervention training was completed on 3/10/20<br>-no annual or updated training was completed. | V 536 | At the beginning of each month, together, HRS, Program Manager, QP and Residential Manager will track employee trainings and ensure any employee working in the home remains up-to-date on trianings and that their training dates have not expired.<br><br>In the event an employees training has expired, they will be pulled from the active schedule until training is complete and back in date. | 7/1/2021<br>HRS<br>PM<br>QP<br>RM |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | mhl018-050 | A. BUILDING: _____ B. WING _____ | 05/28/2021 |

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|---|---|---|---|---|
| V 536 | Continued From page 13<br>Interview on 5/27/21 with the Qualified Professional revealed:<br>-she was responsible for making sure trainings were kept current.<br>-she was not aware FS #3's training had expired in March 2021. | V 536 | | |

# Community Alternatives - North Carolina

10th Street NW Suite B-101
Conover, NC 28613

phone: 828.466.6023
fax: 828.466.6025


July 23, 2021

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

Re: Plan of Correction
VOCA-8th Avenue
212 8th Avenue NW
Hickory, NC 28601
MHL # 018-050

On May 5, 2021 an Annual & Complaint Survey were conducted at 212 8th Avenue NW, Hickory, NC 28601 by the Mental Health Licensure and Certification Section of the NC Division of Health Service Regulation. Attached you will find a copy of the deficiencies along with the Plan of Correction. Please note that according to the letter received, a Plan of Correction should have been returned within ten days of receipt of the letter. Unfortunately, the e-mail with the attached letter was overlooked and therefore the Plan of Correction is late being submitted.

Please do not hesitate to contact me should you have any questions at 828-466-6023 ext. 225 or adolph.gordon@rescare.com or Mike Penland, Executive Director at 828-466-6023 ext. 221 or mpenland@rescare.com

Sincerely,

Adolph Gordon
Program Manager, CANC-West