STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G139	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-NORWICH ROAD GROUP HOME	1006 NORWICH ROAD 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 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observation and interview, nursing services failed to ensure staff were adequately trained to perform appropriate health and hygiene methods for 1 of 6 clients (#1) related to glove use. The finding is: Observation in the group home on 11/2/21 from 8:20 AM to 8:30 AM revealed staff C to wash dishes, load and unload the dishwasher, throw away trash, and wipe the kitchen table while wearing a single pair of vinyl gloves. Further observation at 8:31 AM revealed staff C to ask client #1 if they needed assistance finishing their breakfast. Continued observation revealed staff C to stop cleaning, wipe their hands with a paper towel, and spoon feed client #1 the remainder of their oatmeal while continuing to wear the same pair of vinyl gloves. Interview with the facility nurse on 11/2/21 revealed staff should change their gloves and wash their hands before and after any client care or chore related task. Further interview with the facility nurse confirmed staff #3 did not follow proper hygiene methods.	W 340		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are	W 369		

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

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W 369	Continued From page 1	W 369		

self-administered, are administered without error. This STANDARD is not met as evidenced by:
Based on observation, record review and interview, the facility failed to assure all drugs were administered without error for 2 of 3 clients observed (#2 and #3). The findings are:

A. The facility failed to assure all drugs were administered without error for client #2. For example:

Observation in the group home on 11/2/21 at 6:59 AM revealed staff B to prepare morning medications for client #2. Continued observation revealed staff B to crush calcium w/vit D3 600MG-200IU and pour into apple sauce. Further observation revealed client #2 to be administered calcium w/vit D3 600MG-200IU and vitamin D 1000IU drop by mouth.

Review of records for client #2 on 11/2/21 revealed physician orders dated 11/2/21. Review of the 11/2/21 physician orders revealed medications to administer at 7:00 AM to be calcium w/vit D3 600MG-200IU, Vitamin D 1000IU drops, and one-daily tab multi-vitamin. During survey observation staff B was not observed to administer one-daily tab multi-vitamin.

B. The facility failed to assure all drugs were administered without error for client #3. For example:

Observation in the group home on 11/2/21 at 7:26 AM revealed staff B to prepare morning medications for client #3. Continued observation revealed staff B to administer nasal spray as prescribed. Further observation revealed client

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W 369	Continued From page 2 #3 to be administered multivitamin and sertraline tab 50 MG. Review of records for client #3 on 11/2/21 revealed physician orders dated 11/2/21. Review of the 11/2/21 physician orders revealed medications to administer at 7:00 AM to be Fluticasone spray 50MCG, multivitamin, sertraline tab 50MG, polyeth glyc powder 3350 NF, chlorhexidine gluc-0.12%-soln. During observation staff B was not observed to administer polyeth glyc powder 3350 NF and chlorhexidine gluc-0.12%-soln. Interview with facility nurse on 11/2/21 verified the physician orders dated 11/2/21 to be current. Continued interview with the facility nurse verified that staff B did not administer prescribed medications. Further interview with the facility nurse confirmed staff will receive training.	W 369		
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the system for drug administration failed to assure 3 of 3 clients (#1, #2, and #3) observed during medication administration were provided the opportunity to participate in medication self-administration or provided teaching related to name, purpose and side effects of medication administered. The findings	W 371		

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are:

A. The system for drug administration failed to assure client #1 was provided the opportunity to participate in medication self-administration. For example:

Observation in the group home 11/2/21 at 6:59 AM revealed staff B to roll medication cart to the bedroom door of client #1 and staff B to prepare medication by crushing pill and pouring into apple sauce. Continued observation revealed staff B to enter the bedroom of client #1 and give medication in applesauce to client #1. Further observation revealed staff B to exit client #1's bedroom to obtain vitamin D-3 drops from medication closet. Subsequent observation revealed staff B to ask client #1 to sit up in her bed and staff B to place vitamin D-3 drop on tongue. Client #1 was not observed to receive any training during medication pass or to participate beyond taking medications from staff B.

Review of records for client #1 revealed a community/home life assessment dated 9/10/21. Review of community/home life assessment revealed client #1 can participate in medication administration with the ability to identify current medication basket and to punch current medications into medicine cup with physical assistance.

B. The system for drug administration failed to assure client #2 was provided the opportunity to participate in medication self-administration. For example:

Observation in the group home 11/2/21 at 7:16

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W 371	Continued From page 4 AM revealed staff B to roll medication cart to the bedroom door of client #2 and staff B to prepare medications by crushing pills and pouring into apple sauce. Continued observation revealed staff B to enter the bedroom of client #2 and give medications in apple sauce to client #2 while she was lying in bed. Further observation revealed staff to exit the bedroom of client #2. Client #2 was not observed to receive any training during medication pass or to participate beyond taking medications from staff B. Review of records for client #2 revealed a community/home life assessment dated 2/26/21. Review of community/home life assessment revealed client #2 can participate in medication administration with the ability to identify current medication basket and punch medications into medicine cup with gestural. C. The system for drug administration failed to assure client #3 was provided the opportunity to participate in medication self-administration. For example: Observation in the group home 11/2/21 at 7:26 AM revealed staff B to roll medication cart to the bedroom door of client #3 and staff B to enter the bedroom of client #3 to spray Fluticasone 50 MCG, 2 times in each nostril. Continued observation revealed staff to exit bedroom and return to medication cart and prepare medications by punching his medications into a medicine cup. Further observation revealed staff B to leave cart and walk to medication closet to obtain water for client #3. Subsequent observation revealed staff B to enter the bedroom of client #3 and administer medications whole with water. Client #3 was not observed to receive	W 371		

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W 371	Continued From page 5 any training during medication pass or to participate beyond taking medications from staff B given whole with water. Review of records for client #3 revealed a community/home life assessment dated 2/14/21. Review of community/home life assessment revealed client #3 can participate in medication administration with the ability to identify correct medication basket and to punch medications into medicine cup with verbal cue. Continued review revealed client #3 can take medications with water independently. Interview with staff B on 11/2/21 revealed she administered morning medications to each client in their bedrooms. Continued interview with staff B revealed she prepared and administered medications to each client. Interview with the facility nurse revealed staff should provide education and the opportunity for client participation with administering medications.	W 371		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure all drugs and biologicals were kept lock except when being prepared for administration. The finding is: Observation on 11/2/21 in the group home at 6:59 AM revealed staff B to access medications for client #1 from the medicine cart. Continued observation revealed staff B to enter the bedroom	W 382		

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W 382	Continued From page 6 of client #1 leaving the medication bin on the corner of the medication cart. Further observation revealed staff B to leave medication bin on the corner of the medication cart during various times while administering medications and staff B to walk away from the medication cart. Various times during observations the qualified intellectual disability professional (QIDP) indicated to staff B to take the medications with her as she walked away from medication cart. Interview with staff B verified medications should always be kept locked except when being administered. Continued interview with staff B revealed she was nervous and was aware she had not locked the medications when the QIDP indicated to her to take the medications and not leave them on the medication cart. Interview with facility nurse verified medications should be locked up except when being prepared.	W 382		
W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure 2 of 6 clients (#5 and #6) received food consistent with their developmental level. The findings are: A. The facility failed to ensure client #5's diet consistency was provided as prescribed. For example: Observation in the group home on 11/1/21 at 5:15	W 474		

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W 474	Continued From page 7 PM revealed the dinner menu to be two Salisbury steak patties, mashed potatoes, mixed vegetables, and milk/juice. Further observation revealed client #5 to be provided with a regular plate and a full place setting. Continued observation revealed client #5 to serve themselves two whole Salisbury steak patties and cut the patties with a fork as they ate. Review of client #5's record revealed an individual support plan (ISP) dated 2/18/21. Review of client #5's ISP revealed a nutritional assessment dated 5/10/21. Review of the nutritional assessment indicated "current diet order: ADA, mechanical soft; adaptive devices: plate guard." Continued review of client #5's record revealed a nursing note dated October 2021. Review of the nursing note indicated "current diet ADA, mech soft." Interview with the qualified intellectual disabilities professional (QIDP) and facility nurse on 11/2/21 verified that "mechanical soft" means food grounded in a blender or food processor that is soft enough to eat for clients with no teeth. Further interview with the QIDP and the facility nurse confirmed staff should use the food processor at all times when mechanical soft is indicated in a client's diet program. B. The facility failed to ensure client #6's diet consistency was provided as prescribed. For example: Observation in the group home on 11/1/21 at 5:15 PM revealed the dinner menu to be two Salisbury steak patties, mashed potatoes, mixed vegetables, and milk/juice. Further observation revealed client #6 to serve themselves two whole	W 474		

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W 474	Continued From page 8 Salisbury steak patties. Continued observation revealed the client to cut the first patty with a fork and then rely on staff D to cut the second patty into pieces. Review of client #6's record revealed an individual support plan (ISP) dated 8/20/21. Further review of client #6's record revealed a nutritional assessment dated 5/10/21. Review of the nutritional assessment indicated "current diet order: mechanical soft, chopped (1/4"), prune juice 4 oz bid." Interview with the qualified intellectual disabilities professional (QIDP) and facility nurse on 11/2/21 verified that "mechanical soft" means food grounded in a blender or food processor that is soft enough to eat for clients with no teeth. Further interview with the QIDP and the facility nurse confirmed staff should use the food processor at all times when mechanical soft is indicated in a client's diet program.	W 474		