DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					MAPPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	<u> 0938-0391</u>
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED	
34G139		B. WING			11	/02/2021	
NAME OF PI	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-NO	RWICH ROAD GROUP H	IOME			1006 NORWICH ROAD		
VOOA-NO					CHARLOTTE, NC 28227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			(X5) COMPLETION DATE
W 340	 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: 		Ŵ	34(D		
	services failed to ensite trained to perform application of the service of the se	n and interview, nursing ure staff were adequately propriate health and hygiene					
	use. The finding is:	ents (#1) related to glove					
	8:20 AM to 8:30 AM r	oup home on 11/2/21 from revealed staff C to wash					
	away trash, and wipe wearing a single pair	ad the dishwasher, throw the kitchen table while of vinyl gloves. Further					
	client #1 if they neede	M revealed staff C to ask ed assistance finishing their observation revealed staff C					
	to stop cleaning, wipe towel, and spoon feed their oatmeal while co	e their hands with a paper d client #1 the remainder of ontinuing to wear the same					
	pair of vinyl gloves.	-					
	wash their hands before or chore related task.	change their gloves and ore and after any client care Further interview with the					
	proper hygiene metho	ed staff #3 did not follow					
W 369	DRUG ADMINISTRA CFR(s): 483.460(k)(2	TION	W	369	9		
	The system for drug a that all drugs, includir	administration must assure ng those that are					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E		TITLE		(X6) DATE

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

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G139	B. WING			11/	02/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
VOCA-NO	RWICH ROAD GROUP H	OME			006 NORWICH ROAD HARLOTTE, NC 28227		
(X4) ID PREFIX TAG				х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 369	 This STANDARD is r Based on observatio interview, the facility f were administered wi observed (#2 and #3) A. The facility failed t administered without example: Observation in the gra AM revealed staff B to cru 600MG-200IU and por Further observation ra administered calcium vitamin D 1000IU dro Review of records for revealed physician or of the 11/2/21 physici medications to admin calcium w/vit D3 6001 1000IU drops, and or During survey observed observed to administered multi-vitamin. B. The facility failed to administered without example: Observation in the gra AM revealed staff B to administered revealed staff B to administered 	e administered without error. not met as evidenced by: n, record review and failed to assure all drugs thout error for 2 of 3 clients . The findings are: to assure all drugs were error for client #2. For to phome on 11/2/21 at 6:59 to prepare morning #2. Continued observation ush calcium w/vit D3 our into apple sauce. evealed client #2 to be w/vit D3 600MG-200IU and p by mouth. client #2 on 11/2/21 ders dated 11/2/21. Review an orders revealed ister at 7:00 AM to be MG-200IU, Vitamin D ne-daily tab multi-vitamin. ation staff B was not er one-daily tab	W	369			

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	S FOR MEDICARE &				OMB NO. 0938-0
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,		(X3) DATE SURVEY COMPLETED	
		34G139	B. WING		11/02/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
VOCA-NO	RWICH ROAD GROUP H	IOME		1006 NORWICH ROAD CHARLOTTE, NC 28227	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLET
W 369	· · · · · · · · · · · · · · · · ·	e 2 I multivitamin and sertraline	W 36	9	
	of the 11/2/21 physici medications to admin Fluticasone spray 501 tab 50MG, polyeth gly chlorhexidine gluc-0. observation staff B wa	ders dated 11/2/21. Review an orders revealed ister at 7:00 AM to be MCG, multivitamin, sertraline yc powder 3350 NF, 12%-soln. During as not observed to yc powder 3350 NF and			
W 371	physician orders date Continued interview v that staff B did not ad	interview with the facility will receive training. TION	W 37	1	
	that clients are taught medications if the inte determines that self-a is an appropriate obje does not specify othe This STANDARD is r Based on observatio interviews, the system failed to assure 3 of 3	administration of medications active, and if the physician rwise. not met as evidenced by: n, record review and n for drug administration a clients (#1, #2, and #3) ication administration were nity to participate in nistration or provided			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 11/15/2021 APPROVED . 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G139	B. WING		_	11/0	02/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
VOCA-NO	RWICH ROAD GROUP H	OME		1006 NORWICH ROAD CHARLOTTE, NC 28227	7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 371	Continued From page are:	3	W 371				
	assure client #1 was	ug administration failed to provided the opportunity to ion self-administration. For					
	AM revealed staff B to bedroom door of clien medication by crushin sauce. Continued ob enter the bedroom of medication in applesa observation revealed bedroom to obtain vita medication closet. Su revealed staff B to as bed and staff B to pla tongue. Client #1 was any training during me participate beyond tal B.	auce to client $#1$. Further staff B to exit client $#1$'s amin D-3 drops from ubsequent observation k client $#1$ to sit up in her ce vitamin D-3 drop on s not observed to receive edication pass or to king medications from staff					
	Review of community revealed client #1 car administration with the medication basket an medications into med assistance.	assessment dated 9/10/21. /home life assessment n participate in medication e ability to identify current d to punch current icine cup with physical					
	assure client #2 was participate in medicat example:	ug administration failed to provided the opportunity to ion self-administration. For					
	Observation in the gro	oup home 11/2/21 at 7:16					

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	-	D HUMAN SERVICES				FORM): 11/15/2021 I APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	. ,	CONSTRUCTION		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
		34G139	B. WING		_	11/0	02/2021	
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE	-		
		ONE	1	006 NORWICH ROAD				
VUCA-NU	RWICH ROAD GROUP H	OME	C	HARLOTTE, NC 2822	7			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
W 371	AM revealed staff B to bedroom door of clien medications by crushi apple sauce. Continu- staff B to enter the be medications in apple was lying in bed. Fur staff to exit the bedroo was not observed to n medication pass or to medication pass or to medication from staff Review of records for community/home life Review of community revealed client #2 car administration with the medication basket an medicine cup with ges C. The system for dra assure client #3 was p participate in medicat example: Observation in the gra AM revealed staff B to bedroom door of client bedroom of client #3 to medications by punch medications by punch medications by punch medication revealed of client #3 and admir	 b roll medication cart to the tit #2 and staff B to prepare ing pills and pouring into led observation revealed droom of client #2 and give sauce to client #2 while she ther observation revealed or of client #2. Client #2 eceive any training during participate beyond taking f B. client #2 revealed a assessment dated 2/26/21. //home life assessment at 2/26/21. //home life assessment at a participate in medication e ability to identify current d punch medications into stural. ug administration failed to provided the opportunity to ion self-administration. For bup home 11/2/21 at 7:26 or not stural to provide the opportunity to ion self-administration failed to provide the opportunity to ion self-administration failed to a staff to exit bedroom and the staff to exit bedroo	W 371					

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/ FORM APPI OMB NO. 093	ROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				PLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		34G139	B. WING _		11/02/202	21
	ROVIDER OR SUPPLIER	НОМЕ		STREET ADDRESS, CITY, STATE, ZIP CO 1006 NORWICH ROAD CHARLOTTE, NC 28227	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C	DN SHOULD BE COMP IE APPROPRIATE D	X5) PLETIO ATE
W 371	participate beyond ta B given whole with v Review of records for community/home life Review of communit revealed client #3 ca administration with t medication basket a medicine cup with vor revealed client #3 ca water independently Interview with staff E administered mornin in their bedrooms. (C B revealed she prep medications to each facility nurse reveale education and the op participation with ad DRUG STORAGE A CFR(s): 483.460(I)(2 The facility must kee locked except when administration. This STANDARD is Based on observati review, the facility fa biologicals were kep prepared for administ Observation on 11/2 AM revealed staff B client #1 from the more	nedication pass or to aking medications from staff vater. or client #3 revealed a e assessment dated 2/14/21. cy/home life assessment an participate in medication he ability to identify correct and to punch medications into erbal cue. Continued review an take medications with 8 on 11/2/21 revealed she ig medications to each client Continued interview with staff ared and administered client. Interview with the ed staff should provide oportunity for client ministering medications. ND RECORDKEEPING 2) ep all drugs and biologicals	W 3			

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ATCACLUZ -				CONCEPTION	(NO) 5 4	
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	· · ·	TE SURVEY MPLETED	
		34G139	B. WING		1	1/02/2021
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-NORWICH ROAD GROUP HOME				006 NORWICH ROAD HARLOTTE, NC 28227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
W 382	Continued From pag of client #1 leaving th corner of the medica	ne medication bin on the	W 382			
	medication bin on the cart during various tii medications and staf medication cart. Var observations the qua professional (QIDP)	lified intellectual disability indicated to staff B to take her as she walked away				
W 474	always be kept locke administered. Contin revealed she was ne had not locked the m indicated to her to ta leave them on the m		W 474			
	developmental level This STANDARD is Based on observation interview, the facility (#5 and #6) received developmental level. A. The facility failed to	not met as evidenced by: ons, record review and failed to ensure 2 of 6 clients food consistent with their				

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		ND HUMAN SERVICES MEDICAID SERVICES					RINTED: 11/15/202 FORM APPROVE /IB NO. 0938-039	
STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		· ,		IPLE CC		(X3) DATE SURVEY COMPLETED		
		34G139	B. WING _				11/02/2021	
	ROVIDER OR SUPPLIER	НОМЕ		1006	EET ADDRESS, CITY, STATE, ZIP CODI 5 NORWICH ROAD ARLOTTE, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
W 474	PM revealed the dim steak patties, mashe vegetables, and milk revealed client #5 to plate and a full place observation revealed themselves two whol cut the patties with a Review of client #5's individual support pla Review of client #5's assessment dated 5/ nutritional assessme order: ADA, mechani plate guard." Continu- record revealed a nu 2021. Review of the "current diet ADA, me Interview with the qu professional (QIDP) verified that "mechar grounded in a blende soft enough to eat fo Further interview with nurse confirmed staff processor at all times indicated in a client's B. The facility failed to consistency was pro- example: Observation in the gr PM revealed the dim steak patties, mashevegetables, and milk	her menu to be two Salisbury d potatoes, mixed /juice. Further observation be provided with a regular setting. Continued I client #5 to serve le Salisbury steak patties and fork as they ate. record revealed an an (ISP) dated 2/18/21. ISP revealed a nutritional (10/21. Review of the nt indicated "current diet ical soft; adaptive devices: ued review of client #5's rsing note dated October nursing note indicated ech soft." alified intellectual disabilities and facility nurse on 11/2/21 nical soft" means food er or food processor that is r clients with no teeth. In the QIDP and the facility f should use the food s when mechanical soft is a diet program. to ensure client #6's diet vided as prescribed. For	W 4	74				

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/15/2021 APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		34G139	B. WING				11/	02/2021
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE	, ZIP CODE		
VOCA-NO	RWICH ROAD GROUP H	ОМЕ			006 NORWICH ROAD CHARLOTTE, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION 'E ACTION SHOULD BE D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
W 474	revealed the client to and then rely on staff into pieces. Review of client #6's individual support pla Further review of clien nutritional assessment the nutritional assess order: mechanical sof juice 4 oz bid." Interview with the qua professional (QIDP) a verified that "mechan grounded in a blende soft enough to eat for Further interview with nurse confirmed staff	s. Continued observation cut the first patty with a fork D to cut the second patty record revealed an n (ISP) dated 8/20/21. nt #6's record revealed a tt dated 5/10/21. Review of ment indicated "current diet ft, chopped (1/4"), prune alified intellectual disabilities and facility nurse on 11/2/21 tical soft" means food r or food processor that is clients with no teeth. the QIDP and the facility should use the food when mechanical soft is	W	474				

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