STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G194	A. BUILDING _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-FREEDOM GROUP HOME	5911 FREEDOM DR 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 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are 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 3 of 6 clients (#3, #5, and #6). The findings are: A. Medications were not administered as prescribed for client #3. For example: Observations in the group home on 2/1/22 at 6:57 AM revealed clients to participate in the breakfast meal and for client #3 to be in their bed. Continued observation revealed staff A to inform surveyors that all medications were given at 6:00 AM except for client #4. Review of the record for client #3 revealed an individual support plan (ISP) dated 2/4/21. Review of medication administration record (MAR) dated 2/2022 revealed the medications Clonidine tab 0.1MG, Lamotrigine tab 200MG ER, Loratadine tab 10MG, and Vimpat tab 200MG to be administered at 8:00 AM. Interview with the director of nursing (DON) on 2/1/22 revealed medication can be administered up to one hour before and one hour after the time prescribed. Continued interview with the DON verified she was not contacted by the group home staff to indicate medications were administered prior to 7:00 AM on 2/1/22. Further interview with the DON confirmed that medications administered prior to 7:00 AM was considered a medication error and staff will be in-serviced	W 369		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G194	A. BUILDING _____ B. WING _____	02/01/2022

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W 369	Continued From page 1 trained on the importance of timely administering medication. B. Medications were not administered as prescribed for client #5. For example: Observations in the group home on 2/1/22 at 6:57 AM revealed client #5 to participate in breakfast meal. Continued observation revealed staff A to inform surveyors that all medications were given at 6:00 AM except for client #4. Review of the record for client #5 revealed an ISP dated 2/19/21. Review of MAR dated 2/2022 revealed medications Docusate Sodium 100MG caps, Loratadine tab 10MG, Polyethylene Glycol Powder 3350 NF, and Vitamin D cap 1000 unit to be administered at 8:00 AM. Interview with the DON on 2/1/22 revealed medication can be administered up to one hour before and one hour after the time prescribed. Continued interview with the DON verified she was not contacted by the group home staff to indicate medications were administered prior to 7:00 AM on 2/1/22. Further interview with the DON confirmed that medications administered prior to 7:00 AM was considered a medication error and staff will be in-serviced trained on the importance of timely administering medication. C. Medications were not administered as prescribed for client #6. For example: Observations in the group home on 2/1/22 at 6:57 AM revealed client #6 to participate in the breakfast meal. Continued observation revealed staff A to inform surveyors that all medications were given at 6:00 AM except for client #4.	W 369		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G194	A. BUILDING _____ B. WING _____	02/01/2022

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VOCA-FREEDOM GROUP HOME	5911 FREEDOM DR CHARLOTTE, NC 28208

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W 369	Continued From page 2 Review of the record for client #6 revealed an ISP dated 1/7/22. Review of MAR dated 2/2022 revealed medications Benztropine tab 1MG, Divalproex tab 500 MG ER, Lactulose Sol 10GM/15, Linzess cap 145MCG, Metformin tab 500MG, Polyethylene Glycol Powder 3350 NF, Topiramate tab 100MG, and Vitamin D cap 1000 unit to be administered at 8:00 AM. Interview with the DON on 2/1/22 revealed medication can be administered up to one hour before and one hour after the time prescribed. Continued interview with the DON verified she was not contacted by the group home staff to indicate medications were administered prior to 7:00 AM on 2/1/22. Further interview with the DON confirmed that medications administered prior to 7:00 AM was considered a medication error and staff will be in-serviced trained on the importance of timely administering medication.	W 369		
W 448	EVACUATION DRILLS CFR(s): 483.470(i)(2)(iv) The facility must investigate all problems with evacuation drills, including accidents. This STANDARD is not met as evidenced by: Based on review of records and interview, the facility failed to investigate fire drills specific to the reason for extended time needed for home evacuation and missing evacuation times. The finding is: Review of the facility fire drills reports from 2/8/21 through 1/18/22 revealed staff had documented extended times to evacuate in the home on various shifts with no identified reasons or issues with evacuation. Continued review of the facility	W 448		

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W 448	Continued From page 3	W 448		

fire drill reports from 10/3/21 through 1/18/22 revealed that staff did not document evacuation times on 10/3/21, 11/2/21 and 1/18/22. Further review revealed the following drills during the 2/8/21 through 1/18/22 time period.

2/8/21- 4:00 - 2nd Shift - 2 Staff - 6 Clients
3/11/21 - 45:00 - 3rd Shift - 3 Staff - 6 Clients
4/1/21 - 35:00 - 1st Shift - 2 Staff - 6 Clients
5/7/21 - 15:00 - 1st Shift - 3 Staff -6 Clients
6/23/21 - 3:00 - 2nd Shift - n/a Staff - 6 Clients
7/28/21 - 3:00 - 1st Shift - n/a Staff - 6 Clients
8/24/21 - 3:29 - 2nd Shift - 2 Staff - 6 Clients
9/2/21 - 3:00 - 1st Shift - n/a Staff - 6 Clients
10/3/21 - n/a - 1st Shift - n/a Staff - 6 Clients
11/2/21 - n/a - 2nd Shift - n/a Staff - 6 Clients
12/10/21 - 20:00 - 3rd Shift - 2 Staff - 6 Clients
1/18/22 - n/a - 1st Shift - 2 Staff - 6 Clients

Interview with the qualified intellectual disabilities professional (QIDP) verified all fire drills should be conducted in 5 minutes or less. Continued interview with the QIDP revealed that he had not identified the extended times noted and no inquiry or investigation had been conducted regarding evacuation times. Further interview with the QIDP confirmed that the fire drill report should be documented thoroughly following a drill. The facility will inservice train staff to document the fire drill report thoroughly and to investigate any identified issues on the report.