STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G195	A. BUILDING _____ B. WING _____	06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-HARRISBURG ROAD GROUP HOME	6620 HARRISBURG ROAD CHARLOTTE, NC 28277

(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 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to provide 6 out of 6 clients with the opportunity for choice and self-management relative to access to kitchen knives. The finding is: Observation in the group home on 6/8/22 at 7:09 AM revealed staff D to ask staff E to unlock the medication room closet to access a knife to slice oranges for the breakfast meal. Continued observation revealed staff E located the knives in an upper cabinet in the kitchen inaccessible to all clients but accessible to staff with the use of a small utility ladder. Staff D retrieved the knife and cut the oranges into slices for the breakfast meal. Interview with the qualified intellectual disabilities professional (QIDP) on 6/8/22 verified that the knives were locked due to a prior clients' behavior support plans (BSP) guidelines. The QIDP verified that the knives should not be locked due to the current clients not having guidelines restricting access to knives identified in any of their BSP's.	W 247	W247 The facility will ensure individual program plan must include opportunities for client choice and self-management when warranted. QIDP will in-service staff that knives should not be locked without individuals having guidelines or restricting access to knives unless identified in any of the individuals BSP's. To prevent further occurrence: QIDP and Site Supervisor will complete observation in the home monthly and document on site review form. Person(s) Responsible: QIDP and Site Supervisor	
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide nursing services in accordance with the needs of 2 of 3 sampled clients (#1 and	W 331	RECEIVED JUL 01 2022 DHSR-MH Licensure Sect	

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

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.

Cinthia Dunkins 6/24/22

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W 331	Continued From page 1 #6) and 1 unsampled client # 5 relative to offering privacy during medication administration. The finding is: Observation in the group home on 6/8/22 at 6:51 AM revealed staff E to administer medications to client # 5 with the medication room door open. Continued observation at 6:58 AM revealed staff E to administer medications to client #6 with the medication room door open. Further observation at 7:08 AM reveal staff D to stand at the open medication room door while client #5 was participating in medication administration requesting a kitchen knife from staff E that was locked in the closet area. Staff E was observed to stop medication administration with client #5 and obtain a step ladder to look for kitchen knives in closet area. Subsequent observation at 7:13 AM revealed staff E to administer medications to client #5 on a spoon dropping 4 pills to the floor. Staff E was observed to call out the open door for the site supervisor (SS) to assist her with calling nurse for medication replacements. Interview with staff E revealed that staff have not been told to close the medication room door. Continued interview with staff E revealed that the medication room door should remain open rather than closed during medication administration. Interview with the facility nurse on 6/8/21 confirmed that staff should be administering medications with the door closed for privacy. Continued interview with the facility nurse verified that further training will be provided for staff regarding privacy during medication administration.	W 331	W331 The facility will ensure all clients with nursing services needs in relation to privacy are met in accordance with their needs. Nurse will in-service staff on medication administration process in relation to privacy. To prevent further occurrence: Nurse, QIDP and Site Supervisor will complete medication passes in the home weekly and document on medication pass form. Person(s) Responsible: Nurse, QIDP and Site Supervisor	

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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 1 of 3 clients sampled (#1) observed during medication administration. The finding is: Observation in the group home on 6/8/22 at 8:11 AM revealed staff E to prepare morning medications for client #1. Continued observation at 8:15 AM revealed staff E to punch all tablets or pills into medicine cup for client #1. Further observation revealed staff E to drop 2 pills and to call nurse for approval to administer replacement pills. Subsequent observation revealed client #1 to take all medications with water. During the survey observation staff E was observed to administer an additional dose of carbamazepin tab 200mg ER (3) tablets to client #1. Review of records for client #1 on 6/8/22 revealed physician orders dated 6/8/22. Review of the 6/8/22 physician orders revealed medications to administer at 8:00 AM to be amlodipine besylate 5 mg tabs, asa ec tablet delayed release 81 mg, calcium 500 +D3 500-600 mg-unit tabs, carbamazepin tab 200mg ER (3) tablets, clobazam tab 20 mg, glycopyrrolate 1 mg tabs, lisinopril 20 mg tabs, multivitamin tabs, pantoprazole sodium 40mg-tb, polyethylene glycol powder-3350 NF 17 GM/scoop powder, propranolol HCL 10 mg tabs, and sodium chloride 1 gm tabs (2) tablets.	W 369	W369 The facility will ensure clients have their medications administered as ordered by the prescribing Physician. Nurse will in-service staff on medication administration process. Staff will attend medication administration class as required. Staff will pass the class with a minimum score of 80 and above. Staff will be observed at three medication passes before staff can officially start administering medication. To prevent further occurrence: Nurse, Site Supervisor and QIDP will complete medication observation in the home weekly and document on medication observation form. Person(s) Responsible: Nurse, QIDP and Site Supervisor	

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W 369	Continued From page 3 Interview with qualified intellectual disabilities professional (QIDP) on 6/8/22 verified the physician orders dated 6/8/22 to be current. Interview with the facility nurse on 6/8/22 verified that the QIDP notified the nurse by phone that staff E had administered a wrong dose to client #1. Continued interview with the facility nurse confirmed that client #1 should not have received an additional dose of carbamazepine tab 200mg ER (3) tablets.	W 369		
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 observation, record review and interview the facility failed to ensure proper use of adaptive equipment for 1 non-sampled client (#5) relative to the prescribed use of helmet and gait belt. The finding is: Observation in the group home on 6/7/22 from 4:45 PM to 6:45 PM revealed client #5 to wear his seizure helmet on his head with the chin strap fastened/snapped but not adequately secured to his head to prevent excessive movement and to not wear gait belt. Continued observation at 5:20 PM revealed the client to ambulate to the living room, sit to watch tv and randomly lift his helmet on and off his head. Further observation at 5:30 PM revealed client #5 to follow a prompt given to wash hands, come to the dining room table for super and randomly lift helmet on and off his	W 436	W436 The facility will ensure clients number #5 needs are met in relation to helmet and gait belt needs. QIDP will trained staff on client number #5 gait belt and helmet needs. To ensure these needs are met. Staff will document daily on check list develop by QIDP. To prevent further occurrence: Staff will document daily on daily check list and review by QIDP monthly. Person(s) Responsible: QIDP and Site Supervisor	

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W 436	Continued From page 4 head. Subsequent observation did not reveal staff assisting client #5 in tightening his helmet. At no time during the observation did staff prompt client #5 to wear prescribed gait belt. Observation in the group home on 6/8/22 from 6:30 AM - 7:25 AM revealed client #5 to wear his seizure helmet throughout the morning with the chin strap not fastened/snapped. Continued observation revealed staff C to provide a prompt at 7:26 AM for client #5 to snap his strap to secure the helmet. Review of records for client #5 on 6/8/22 revealed an individual support plan (ISP) dated 4/22/22. Review of the ISP for client #5 revealed objectives to address cultural participation/involvement, range of motion exercise, bathing thoroughly, wash hands before meals, increase safety awareness and speaking full name & address. Continued review of records for client #5 revealed a behavior support plan (BSP) dated 5/28/21 to reflect the client has a visual monitor due to falls that will be used while the client is in his room during 3rd shift to alert staff when he gets out of his bed. Further review of records revealed a PT consult dated 12/20/21 stating client #5 must have helmet and gait belt on when he is walking. Interview with qualified intellectual disabilities professional (QIDP) on 6/8/22 verified that the ISP and BSP are current for client #5. Continued interview with the QIDP verified that client #5 wears a helmet and a gait belt due to a history of seizures and multiple falls. Further interview with the QIDP confirms that client #5 should have on his gait belt and does not have guidelines for the helmet or gait belt.	W 436		

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W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to provide training to staff relative to eliminating opportunities for cross-contamination. The finding is: Observation in the group home on 6/7/22 from 4:45 PM to 5:30 PM revealed staff B to don on a pair of gloves to prepare the dinner meal. Continued observation revealed staff to wear the same pair of gloves continuously throughout the meal prep while handling a trash can lid to throw food items away, providing meal prep instructions to clients #2, #4 and #5 and while placing dinner meal on the dinner table. Further observation revealed clients #2, #4, and #5 to participate in setting the dining room table for dinner with prompts by staff B to do so without washing hands. Subsequent observation during the dinner meal at 5:50 PM revealed client #1 to drop his bread on the floor and to pick it up placing it back on his plate and staff B to remove the soiled bread off client #1's plate and replace it with a new piece of bread to the exact location. Observation in the group home on 6/8/22 revealed client #6 to complete the medication administration and sit at the table without washing his hands nor did client #6 receive a hand washing prompt from staff prior to his 6:50 AM medication pass. Continued observation at 7:13 AM revealed clients #1, #2, #3, #4, and #5 to receive a prompt from staff D to sit down at the table to participate in the breakfast meal without	W 455	W455 The facility will ensure all client needs are met in relation to hand washing. The facility will ensure all staff trained on infection control in relation to hand washing. Nurse will in-service all staff on infection control to include proper had washing. QIDP will develop and implement training program for all client in relation to hand washing. To ensure these needs are met. QIDP will train all staff on said programs. To prevent further occurrence: Training programs will be documented on daily and review monthly by QIDP. Person(s) Responsible: Nurse, QIDP and Site Supervisor To be completed by: 07/20/2022	

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W 455	Continued From page 6 washing their hands. Interview with the qualified intellectual disabilities professional (QIDP) and facility nurse on 6/8/22 verified that staff have had training on hand washing. Continued intervew with QIDP and facility nurse verified that staff should have prompted all clients to wash their hands prior to medication administration and mealtimes.	W 455		

ResCare

Community Alternatives
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June 24, 2022
Ms. Lisa Jones
Mental Health Licensure & Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Dear Ms. Lisa Jones,

Please find the enclosed plan of correction for deficiencies cited during the recent Recertification and Completed June VOCA Harrisburg Group Home Survey on 6/8/2022. Deficiencies will be corrected as indicated in plan of correction.

We would like to request an invitation for your return visit on or after August 8, 2022.

Thank you for all your assistance that you provide us in helping meet the needs of the people we serve.

Sincerely

Evita Dinkins
Program Manager