STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G208	A. BUILDING _____ B. WING _____	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-PURSER GROUP HOME	1615 PURSER DRIVE CHARLOTTE, NC 28215

(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 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to implement the individual support plan (ISP) for 1 of 6 clients (#2) relative to using prescribed AFOs. The finding is: Observation in the group home on 9/29/22 at 6:30 AM revealed client #2 to sit in a recliner located in the activity room and to not be wearing shoes and prescribed AFOs. Continued observation at 6:57 AM revealed client #2 to ambulate with walker to the dining room table with staff assisting the client into a chair. Further observation revealed client #2 to exit the dining room and ambulate with a walker to the kitchen and medication area. Subsequent observation at 8:00 AM revealed staff A to assist client #2 to the bathroom and return to activity room with the client wearing shoes and prescribed AFOs. Review of record on 9/29/22 for client #2 revealed an ISP dated 8/9/22. Review of the ISP revealed client #2 to have a diagnosis of severe intellectual disabilities, cerebral palsy, contractures, and early stage cataract. Continued review of client #2's ISP revealed the client to be prescribed AFOs	W 249		

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

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W 249	Continued From page 1 and a walker to assist with ambulation whenever ambulating. Further review of ISP revealed a physical therapy evaluation dated 9/16/22 that states client should continue to wear AFOs with shoes. Interview with the qualified intellectual disabilities professional (QIDP) verified the PCP dated 8/9/22 for client #2 was current. Continued interview with the QIDP confirmed that staff should be using client #2's adaptive equipment as prescribed.	W 249		
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 observations, record review and interview, the system for drug administration failed to ensure 2 of 2 clients (#1 and #4) observed during medication administration were provided the opportunity to participate in medication self-administration. The findings 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 on 9/29/22 at 6:35 AM revealed client #1 to enter the medication room and to sit in a chair while staff E prepared and administered medications to the client.	W 371		

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W 371	Continued From page 2	W 371		

Continued observation revealed staff E to reconcile medications from a bubble pack with the medication record and punch all medications for client #1 into a medication cup. Further observation revealed client #1 to then take all medications whole followed by water that was poured by the staff. Staff E was further observed to provide no identification of any medication or education regarding purpose or side effects to the client.

Review of records for client #1 on 9/29/22 revealed an individual support plan (ISP) dated 7/19/22. Continued review of records for client #1 revealed a community home/life assessment dated 7/15/22. Review of the assessment revealed client #1 to have the ability to punch medications into cup with physical assistance and take medication with water with verbal cue.

Interview with the facility nurse on 9/29/22 verified staff should provide education and allow participation to all clients capable of participation.

B. The system for drug administration failed to assure client #4 was provided the opportunity to participate in medication self-administration. For example:

Observation in the group home on 9/29/22 at 7:02 AM revealed client #4 to enter the medication room and to sit in a chair while staff E prepared and administered medications to the client. Continued observation revealed staff E to reconcile medications from a bubble pack with the medication record and assist client #4 with punching their medications into a medication cup. Further observation revealed client #4 to then take all medications whole followed by water that

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W 371	Continued From page 3 was poured by the staff. Subsequent observation revealed staff to administer Fluticasone 50mcg to client #4. Staff E was further observed to provide no identification of any medication or education regarding purpose or side effects to the client. Review of records for client #4 on 9/29/22 revealed an ISP dated 10/8/21. Continued review of records for client #4 revealed a community home/life assessment dated 9/19/20. Review of the assessment revealed client #4 to have the ability to punch medications into cup with physical assistance and take medication with water with verbal cue. Interview with the facility nurse on 9/29/22 verified staff should provide education and allow participation to all clients capable of participation.	W 371		
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 observation, record review and interview, the facility failed to ensure 2 of 6 clients (#2 and #4) received a specially prescribed diet. The findings are: A. The facility failed to ensure client #2 received a specially prescribed diet diet consistent with their developmental level. For example: Observation on 9/28/22 at 5:11 PM revealed staff B to give client #2 a snack "Cheetos". Continued observation revealed client #2 to maneuver the snack around mouth to soften and consume. Further observation revealed client #2 to have	W 474		

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difficulty eating and to drop a piece from their mouth. At no time was staff B observed to mince client #2's snack as prescribed.

Observation on 9/29/22 at 7:00 AM revealed client #2 to receive a breakfast meal consisting of Ensure, muffin, and whole wheat toast. Continued observation revealed staff to cut up client #2's food into quarter size pieces. Further observation at 7:36 AM revealed client #2 to eat the breakfast meal with their fingers. At no time was staff observed to provide client #2 with prescribed minced diet.

Review of client #2's record on 9/29/22 revealed an individual support plan (ISP) dated 8/9/22. Continued review of client #2's ISP revealed a nutritional assessment dated 7/4/22. Review of the nutritional assessment revealed client #2's diet to be regular heart healthy (ADA), minced, offer 2nd helping and Boost/Ensure if client does not eat meal.

Interview on 9/29/22 with the qualified intellectual developmental professional (QIDP) revealed that the ISP dated 8/9/22 is current. Continue interview on 9/29/22 with the facility nurse confirmed that staff should be following prescribed diet.

B. The facility failed to ensure client #4 received a specially prescribed diet consistent with their developmental level. For example:

Observation during a community outing on 9/28/22 revealed the dinner meal to consist of pizza, salad, birthday cake and sugar free beverage. Continued observation revealed client #4 to be served and consume the dinner meal in

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whole form.

Observation in the group home on 9/29/22 revealed the breakfast meal to consist of muffins, toast with margarine and orange juice. Continued observation revealed client #4 to be served and consume the breakfast meal in whole form.

Review of records for client #4 on 9/29/22 revealed an individual support plan (ISP) dated 10/8/21. Review of the ISP revealed client's diet is currently regular heart healthy with no adaptive equipment. Continued review of client #4's record revealed a nutritional assessment dated 7/4/22 and physician orders dated 9/27/22. Review of both documents revealed client's current diet is ADA, chopped with no adaptive equipment.

Interview with the qualified intellectual disabilities professional (QIDP) on 9/29/22 revealed they were unaware of the diet order discrepancy in client #4's record. Continued interview with the QIDP confirmed client's diet should be followed as recommended by the clinical team.