

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/13/2023  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34G194</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                            |                      | (X3) DATE SURVEY COMPLETED<br><br><b>02/07/2023</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>VOCA-FREEDOM GROUP HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5911 FREEDOM DR<br/>CHARLOTTE, NC 28208</b>                         |                      |                                                     |
| (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 189                                                              | <p><b>STAFF TRAINING PROGRAM</b><br/>CFR(s): 483.430(e)(1)</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>This STANDARD is not met as evidenced by:<br/>Based on observations and interview the facility failed to ensure that staff were sufficiently trained in hygiene methods specific to ensuring hand soap was accessible in the bathrooms for 5 of 6 clients (#1, #3, #4, #5, and #6). The finding is:</p> <p>Observations in the group home on 2/6/23 and 2/7/23 revealed clients #1, #3, #4, #5, and #6 at various times to enter the bathrooms with no soap, wash hands, and exit the bathroom. Continued observations on 2/7/23 revealed both bathrooms to remain with no soap throughout the observation period. Further observations at 8:30 AM revealed the surveyor to ask the site supervisor if the home had hand soap. Subsequent observations revealed the site supervisor to direct staff D to the laundry room to obtain soap and for staff D to respond that there was no soap.</p> <p>Interview with the site supervisor on 2/7/23 confirmed that the group home did not have hand soap and that staff would go purchase soap. Interview with the qualified intellectual disabilities professional (QIDP) on 2/7/23 confirmed that there is an issue with the home not having soap and the site supervisor is responsible for ensuring hygiene products are purchased and accessible to the clients.</p> | W 189                                                                   |                                                                                                                 |                      |                                                     |
| W 249                                                              | <p><b>PROGRAM IMPLEMENTATION</b><br/>CFR(s): 483.440(d)(1)</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | W 249                                                                   |                                                                                                                 |                      |                                                     |

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34G194</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                            |                      | (X3) DATE SURVEY COMPLETED<br><br><b>02/07/2023</b> |
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| W 249                                                              | <p>Continued From page 1</p> <p>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.</p> <p>This STANDARD is not met as evidenced by:<br/>Based on observations, record reviews and interviews, the facility failed to ensure 4 of 6 clients (#1, #2, #3 and #6) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Service Plan (ISP). The findings are:</p> <p>A. The facility failed to provide continuous active treatment for client #1 relative to communication, preparing one meal item and to set place at table. For example:</p> <p>During observations throughout the 2/6-7/23 survey client #1 was observed to participate in a coloring activity, spray Lysol on the dining table, dinner and breakfast meals, take dishes to the kitchen, and medication administration. Continued observations revealed staff to verbally prompt client to transition from one area to the other. At no time during observations throughout the 2/6-7/23 survey was client #1 prompted to utilize his communication program, assist with preparing one meal item or setting his place at the table.</p> <p>Review of client #1's record on 2/7/23 revealed an ISP dated 9/21/22. Continued review of the</p> | W 249                                                                   |                                                                                                                 |                      |                                                     |

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| W 249                                                              | <p>Continued From page 2</p> <p>ISP revealed training objectives in the areas of communicating a choice of activity, hygiene, staying on task, preparing one item on the menu, clean bedroom, set place at table, and community/home participation.</p> <p>B. The facility failed to provide continuous active treatment for client #2 relative to meal preparation. For example:</p> <p>During observations throughout the 2/6-7/23 survey client #2 was observed to participate in a coloring activity, dinner/breakfast meals and medication administration. At no time during observations throughout the 2/6-7/23 survey was client #2 prompted to prepare one item on the menu for dinner or breakfast.</p> <p>Review of client #2's record on 2/7/23 revealed an ISP dated 5/26/22. Continued review of the ISP revealed training objectives in the areas of walking exercise, floss teeth, brush teeth, stretching exercise, bathing/drying, clean bedroom and preparing one item on the menu for breakfast, lunch and dinner.</p> <p>C. The facility failed to provide continuous active treatment for client #3 relative to communication and privacy. For example:</p> <p>During observations throughout the 2/6-7/23 survey client #3 was observed to pace the hallways, go for a van ride to the store, participate in dinner and breakfast meals, take dishes to the kitchen and medication administration. Continued observations on 2/7/23 at 7:10 AM revealed client #3 to enter and use the bathroom and while the door remained open. Further observation revealed client #3 to get into others' personal</p> | W 249                                                                   |                                                                                                                 |                      |                                                     |

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| W 249                                                              | <p>Continued From page 3</p> <p>space as staff to verbally prompt client to transition from one area to the other. At no time during observations throughout the 2/6-7/23 survey was client #3 prompted to utilize his communication program and close the door while using the bathroom.</p> <p>Review of client #3's record on 2/7/23 revealed an ISP dated 2/1/23. Continued review of the ISP revealed training objectives in the areas of communicating his wants and needs, tolerate medical appointments, privacy of others, close bathroom door behind him, empty trash, understand his environment and transition successfully and participate in community/home events.</p> <p>D. The facility failed to provide continuous active treatment for client #6 relative to meal preparation. For example:</p> <p>During observations throughout the 2/6-7/23 survey client #6 was observed to participate in a coloring activity, dinner/breakfast meals and medication administration. Continued observations on 2/7/23 at 7:55 AM revealed client #6 to walk from his bedroom to the bathroom unclothed. Further observations revealed client #6 to take a shower with the door open while staff was in the bathroom assisting. Subsequent observations at 8:02 AM revealed client #6 to exit the bathroom and enter his bedroom with no clothes on as staff walked behind him. At no time during observations throughout the 2/6-7/23 survey was client #2 prompt to utilize his communication program, close the door for privacy while taking a shower or to put on robe while transition from his bedroom to the bathroom.</p> | W 249                                                                   |                                                                                                                 |                      |                                                     |

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| W 249                                                              | Continued From page 4<br><br>Review of client #6's record on 2/7/23 revealed an ISP 1/5/23. Continued review of the ISP revealed training objectives in the areas of walking exercise, floss teeth, brush teeth, stretching exercise, bathing/drying, clean bedroom and preparing one item on the menu for breakfast, lunch and dinner.<br><br>Interview with the qualified intellectual developmental professional (QIDP) on 2/7/23 revealed clients #1, #2, #3 and 6's training objectives are current. Continued interview with the QIDP revealed all clients' program goals should be followed as prescribed.                                                                                                                                                                                                                                                                                                | W 249                                                                   |                                                                                                                 |                      |                                                     |
| W 448                                                              | <b>EVACUATION DRILLS</b><br>CFR(s): 483.470(i)(2)(iv)<br><br>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. The finding is:<br><br>Review of the facility fire drills reports on 2/7/23 revealed from 2/3/23 through 3/8/22 staff had documented extended times to evacuate in the home on various shifts with no identified reasons or issues with evacuation.<br><br>2/3/23 - 2nd shift - Duration 10:00 minutes<br>1/1/23 - 1st shift - Duration 20:00 minutes<br>12/1/22 - 1st shift - Duration 15:00 minutes<br>11/1/22 - 2nd shift - Duration 15:00 minutes<br>10/1/22- 1st shift - Duration 20:00 minutes<br>9/3/22 - 3rd shift - Duration 30:00 minutes | W 448                                                                   |                                                                                                                 |                      |                                                     |

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| W 448                                                              | Continued From page 5<br>8/2/22 - 1st shift - Duration 35:00 minutes<br>7/3/22 - 2nd shift - Duration 10:00 minutes<br>6/4/22 - 2nd shift- Duration 10:00 minutes<br>5/3/22 - 1st shift - Duration 3:45 minutes<br>4/3/22 - 3rd shift - Duration 5:00 minutes<br>3/8/22- 2nd shift - Duration 4:00 minutes<br>3/3/22 - 3rd shift - Duration 6:00 minutes<br><br>Interview with the site supervisor on 2/7/23 revealed he conducted drills from the time the drill begins until staff and clients returns back to the group home in which the times are then documented. Continued interview with the site supervisor revealed he was unaware that the time of the fire drill ends when all clients evacuate the home.<br><br>Interview with the qualified intellectual disabilities professional (QIDP) on 2/7/23 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. | W 448                                                                   |                                                                                                                 |                      |                                                     |
| W 455                                                              | INFECTION CONTROL<br>CFR(s): 483.470(l)(1)<br><br>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.<br>This STANDARD is not met as evidenced by:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | W 455                                                                   |                                                                                                                 |                      |                                                     |

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| W 455                                                              | Continued From page 6<br>Based on observations and interviews, the facility failed to implement an active program for the prevention and control of infection and communicable diseases. The finding is:<br><br>Observation in the group home on 2/7/23 at 7:00 AM revealed the site supervisor to meet the surveyors at the door and screen both surveyors. Continued observations revealed both the site supervisor and staff D to wear a face mask not covering nose and to not wear mask appropriately as the mask is a current requirement by the Centers for Medicare and Medicaid Services (CMS) to limit the spread of the COVID-19 virus. Further observations revealed both the site supervisor and staff D wore the face mask throughout the observation below their nose.<br><br>Interview on 2/7/23 with the qualified intellectual disabilities professional (QIDP) confirmed that staff working in the group home should be wearing a face mask. Continued interview with the QIDP confirmed that both the site supervisor and staff D should have been wearing mask correctly by covering their nose throughout the surveyors observation. | W 455                                                                   |                                                                                                                 |                      |                                                     |
| W 463                                                              | FOOD AND NUTRITION SERVICES<br>CFR(s): 483.480(a)(4)<br><br>The client's interdisciplinary team, including a qualified dietitian and physician must prescribe all modified and special diets.<br>This STANDARD is not met as evidenced by:<br>Based on observations, record reviews and interviews, the facility failed to ensure 1 of 6 client (#6) received their specially prescribed diet as ordered by the interdisciplinary team. The finding                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | W 463                                                                   |                                                                                                                 |                      |                                                     |

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| W 463                                                              | <p>Continued From page 7</p> <p>is:</p> <p>Afternoon observations on 2/6/23 at the group home revealed the dinner menu to include; honey glazed boneless pork, buttered rice, steamed vegetables, mandarin oranges, milk and juice. Continued observation at 5:00 PM revealed client #6 to particiapte in the dinner meal independently and consume the entire meal. At no point during observation did staff prompt or offer to chop client's boneless pork into 1/2 inch pieces nor did the client recieve prescribed 4 oz prune juice.</p> <p>Morning observations on 2/7/23 revealed the breakfast menu include; toasted oats cereal, milk, whole wheat toast, margarine and orange juice. Continued observation at 7:35 AM revealed client #6 to participate in the breakfast meal independently and consume the entire meal. At no point during observation did staff prompt or offer to chop client's toast into 1/2 inch pieces nor did the client recieve prescribed 4 oz prune juice.</p> <p>Review of client #6's record on 2/7/23 revealed an individual support plan dated 1/5/23. Further review of the ISP revealed a diagnosis of autism, profound IDD, chronic constipation, profound sensorineural hearing loss, bilateral deafness and edentulous (without teeth). Continued review revealed a nutritional evaluation dated 1/9/23 which indicated client's current diet order includes ADA, high fiber 1/2" chopped pieces, and prune juice 4 oz BID. Further review revealed a physician order dated 1/23 revealed to promote bowel regularity with 4 oz prune juice daily at 7:00 AM and 8:00 PM.</p> <p>Interview with the facility nurse on 2/7/23 revealed client #6 diet is current and should be followed as</p> | W 463                                                                   |                                                                                                                 |                      |                                                     |

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FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                   |                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34G194</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                            |                      | (X3) DATE SURVEY COMPLETED<br><br><b>02/07/2023</b> |
|--------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|----------------------|-----------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>VOCA-FREEDOM GROUP HOME</b> |                                                                                                                        |                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5911 FREEDOM DR<br/>CHARLOTTE, NC 28208</b>                         |                      |                                                     |
| (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 463                                                              | Continued From page 8 prescribed.                                                                                      | W 463                                                                   |                                                                                                                 |                      |                                                     |