Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING mhl018-050 02/23/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 212 8TH AVENUE N W VOCA-8TH AVENUE HICKORY, NC 28601 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 000 INITIAL COMMENTS V 000 An annual and follow up survey was completed on 2/23/23. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 3 beds and currently has a census of 3 clients. The survey sample consisted of audits of 3 current clients. V 114 27G .0207 Emergency Plans and Supplies V 114 10A NCAC 27G .0207 EMERGENCY PLANS V114 Emergency Plans and Supplies AND SUPPLIES (a) A written fire plan for each facility and Fire and disaster drills will be scheduled area-wide disaster plan shall be developed and by the home manager and will be conducted monthly. The Program Manager will follow up shall be approved by the appropriate local monthly to ensure that they are being authority. conducted. Also, disaster drills are being (b) The plan shall be made available to all staff reviewed at monthly safety meetings. Inservice and evacuation procedures and routes shall be will be completed with staff to review posted in the facility. requirements of drills as well as schedule (c) Fire and disaster drills in a 24-hour facility of drills. shall be held at least quarterly and shall be Inservice will be completed 03/20/2023 repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. DHSR - Mental Health MAR 1 6 2023 This Rule is not met as evidenced by: Lic. & Cert. Section Based on record review and interview, the facility failed to conduct fire and disaster drills quarterly for each shift. The findings are: Review on 2/23/23 of the facility's fire and disaster drill logs revealed no documentation of

Division of Health Service Regulation

LABORA

SIGNATURE

FOS (am Manager 3/13/28)

STATE F

STATE F

SIGNATURE

IXCC11

II Continuation Sheet 1 of a

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
	mhl018-050	B. WING		02/22/2022			
NAME OF PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE	02/23/2023	\dashv		
VOCA-8TH AVENUE 212 8TH AVENUE N W							
		, NC 28601					
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE			
shift. Disaster drills: -April-June 2022 (Seccion-October-December 20 shift. Interview on 2/23/23 wherevealed: -She could not speak to because she wasn't the quarter was done because she with the district of the computer and lost, but book. V 118 27G .0209 (C) Medication 10A NCAC 27G .0209 INTEQUIREMENTS (C) Medication administ (1) Prescription or nononly be administered to order of a person authordrugs. (2) Medications shall be clients only when authordient's physician. (3) Medications, including administered only by licunlicensed persons train pharmacist or other legal privileged to prepare and (4) A Medication Administered only minimals.	ond Quarter): 2nd shift. O22 (Fourth Quarter) - 1st ith the Program Manager o 1st and 2nd quarters ere, but she knew 4th huse she was there. was documented on the it should have been in the ion Requirements MEDICATION ration: prescription drugs shall of a client on the written wized by law to prescribe e self-administered by rized in writing by the ng injections, shall be ensed persons, or by ned by a registered nurse, ally qualified person and d administer medications. istration Record (MAR) of o each client must be kept ministered shall be	V 114	V118 Medication Requirem Home manager will review documentation weekly to er are documented correctly a medications are given as re physicans orders. Staff will administration. Home Supervisior will be in-serviced as to the corr of quickmar and medication. This in-service will accure of the persons respondsible a Supervisior and Program Management.	medication insure that they and that the equired by re trained on me rect monitoring is. in 3/17/2023	∌d		

Division of Health Service Regulation

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER:	A. BUILDING:		COV		
		mhl018-050	B. WING		0	2/23/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE			
VOCA ST	H AVENUE	212 8TH	AVENUE N W				
VOCA-611	HAVENUE	HICKOR	RY, NC 28601				
(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 (EACH CORRECTIVE / CROSS-REFERENCED T DEFICII	ACTION SHOULD BE TO THE APPROPRIATE	D BE COMPLETE	
	212 8TH AVENUE SUMMARY STATEMENT OF DEFICIENCIES X (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		V 118				
	Observation on 2/23/23	3 at 10:30 a.m. of Client					

Division of Health Service Regulation

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		COMP	LETED
		mhl018-050	B. WING		02/	23/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
VOCA-8T	H AVENUE		AVENUE N W			
			Y, NC 28601			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	Continued From page	3	V 118			
	#2's medications reversity and process of the control of the contr	aled: 19, 1 tablet 3 times a day. 25 mg, 1 capsule twice a 10 capsule once a day. 11 tablet at bedtime. 12 tablet at trevealed: 13, 1 tablet 3 times a day, 14 tablet 3 times a day, 15 tablet 3 times a day, 16 to 4:00 p.m. and 8:00 17 a.m. 18 25 mg, 1 capsule twice a 18 blank for 8:00 p.m.; 19 capsule once a day, 19 for 8:00 a.m. 19 ablet at bedtime, 12/26/22 19 p.m. 10 tablet at bedtime, 12/26/22 19 p.m. 11 tablet at bedtime, 12/26/22 19 p.m. 12 tablet at bedtime, 12/26/22 19 p.m. 19 tablet at bedtime, 12/26/22 19 p.m. 10 tablet at bedtime, 12/26/22 10 p.m. 11 tablet 3 times a day, 12 tablet 3 times a day, 13 tablet 3 times a day, 14 tablet 3 times a day, 15 tablet 3 times a day, 16 tablet 4 to 4:00 p.m.; 17 tablet 3 times a day, 18 tablet 3 times a day, 19 tablet 4 to 4:00 p.m.; 10 tablet 4 to 4:00 p.m.; 10 tablet 5 mg, 1 capsule twice a 10 tablet 6 times a day, 10 tablet 7 times a day, 10 tablet 7 times a day, 10 tablet 8 times a day, 10 tablet 9 t	V 118			