

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

PRINTED: 10/06/2022  
FORM APPROVED  
OMB NO. 0938-0391

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

**VOCA-PURSER GROUP HOME**

STREET ADDRESS, CITY, STATE, ZIP CODE

**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	<p><b>PROGRAM IMPLEMENTATION</b> CFR(s): 483.440(d)(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: 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:</p> <p>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.</p> <p>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</p>	W 249	<p>W249 The facility will assure the ISP is implemented for all the consumers relative to needed adaptive equipment including Client #2 to utilize AFOs as prescribed. The QP will inservice staff on when to utilize the prescribed adaptive for all consumers including AFOs for Client#2.</p> <p>To prevent further occurrences: QP and site supervisor will complete monitoring tool weekly which include the use of adaptive equipment as prescribed. In addition Program Manager or designee will monitor the use of adaptive equipment during monthly site review.</p> <p><b>DHSR - Mental Health</b>  <b>OCT 18 2022</b>  <b>Lic. &amp; Cert. Section</b></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Kamphae Belin*

TITLE

*Program Manager*

(X6) DATE

*10/13/22*

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.

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NAME OF PROVIDER OR SUPPLIER  <b>VOCA-PURSER GROUP HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1615 PURSER DRIVE CHARLOTTE, NC 28215</b>		
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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.	W 249			
W 371	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.  <b>DRUG ADMINISTRATION</b> 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	W371 The facility will assure the consumers are provided the opportunity to participate in medication self- administration. QP will inservice staff to give opportunities to the consumers to participate in medication self-administration based on the consumers' strengths indicated in the Community Home /Life Assessment. Nursing will also in- service staff to identify medication, give purpose of medication and give side effects of medication.  A. Specific to Client#1: QP will inservice staff to give opportunities to Client: #1 to participate in medication self-administration based on the consumers' strengths indicated in the Community Home /Life Assessment including punching medication into cup with physical assistance and take medication with water with a verbal cue. Nursing will also in- service staff to identify medication, give purpose of medication and give side effects of medication.  B. Specific to Client#2: QP will in-service staff to give opportunities to Client: #1 to participate in medication self-administration based on the consumers' strengths indicated in the Community Home /Life Assessment including punching medication into cup with physical assistance and take medication with water with a verbal cue. Nursing will also in- service staff to identify medication, give purpose of medication and give side effects of medication.  To prevent further occurrences: Nursing, QP and/or site supervisor will complete monitoring tool weekly which include the opportunity to participate in self- administration. In addition Program Manager or designee will monitor the opportunity to participate in medication self-administration during monthly site review.		

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W 371	<p>Continued From page 2</p> <p>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.</p> <p>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.</p> <p>Interview with the facility nurse on 9/29/22 verified staff should provide education and allow participation to all clients capable of participation.</p> <p>B. The system for drug administration failed to assure client #4 was provided the opportunity to participate in medication self-administration. For example:</p> <p>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</p>	W 371			

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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	<b>MEAL SERVICES</b> 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	W474 The facility will assure all consumers will receive prescribed diet. QP will inservice staff on the prescribed diets for each consumer.  A. Specific to Client #2 QP will in-service staff on current diet order of a regular heart healthy ADA, minced, offer 2nd helping and Boost/Ensure if she does not eat meal.  B. Specific to Client #4 Nutritionist has re-evaluated Client #4. Diet has been changed from ADA, chopped with no apaptive equipment to ADA, regular with no adaptive equipment. QP will in-service staff on current diet order.  To prevent further occurences: QP and site supervisor will complete monitoring tool weekly which includes diet orders. Program Manager or designee will monitor diets during monthly site review		



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W 474	<p>Continued From page 4</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>B. The facility failed to ensure client #4 received a specially prescribed diet consistent with their developmental level. For example:</p> <p>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</p>	W 474			

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W 474	<p>Continued From page 5 whole form.</p> <p>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.</p> <p>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.</p> <p>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.</p>	W 474			