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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-SECOND AVENUE GROUP HOME	**49 SECOND AVENUE SE TAYLORSVILLE, NC 28681**

(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 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure privacy during personal care and medication administration for 2 of 6 clients (#4 and #5). The findings are: A. The facility failed to provide privacy for client #5 while receiving personal care. For example: Observations in the group home on 5/8/24 at 4:30 PM revealed a visual monitor to sit on top of a desk in the livingroom. Continued observation revealed client #5 could be seen on the visual monitor receiving personal care from staff A. Further observation revealed other clients and staff standing and sitting in the livingroom area while the visual monitor remained on. Subsequent observations revealed the area supervisor (AS) to enter client #5's room and asked staff A to reset the bed monitor, then exit the room while the visual monitor remained on. Interview with the facility quality assurance personnel (QA) on 5/8/24 revealed the visual monitor should be left on only at nights to monitor client #5's safety relative to risks of falling. Continued interview with QA revealed the visual monitor should be off during the day to maintain privacy especially while receiving personal care. B. The facility failed to provide privacy for client #4 during medication administration. For example:	W 130		

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.

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(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 130	Continued From page 1 Observations in the group home on 5/8/24 at 7:15 AM revealed client #4 to sit at the dining table participating in the breakfast meal. Continued observation revealed staff D to ask client #4 if she was ready to take her medications and promised to bring client #4 right back to finish her meal. Further observations revealed staff to request additional three times and client #4 to respond "I'm eating", "no" and "bring it to me". Subsequent observations at 7:30 AM revealed staff to bring client #4's medication to the dining table and administer two medications while client #4 and others were participating in the breakfast meal. Interview with staff D on 5/8/24 revealed that her supervisor had given her permission to administer client #4's medications while sitting at the dining table participating in the breakfast meal. Interview with the director of nursing (DON) on 5/8/24 revealed designated areas to administer medications are in the med room, bedroom, or any area where privacy is provided and staff can focus on administering medications. Continued interview with the DON revealed privacy should be provided for all clients while medications are being administered.	W 130		
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	W 249		

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plan.

This STANDARD is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to ensure 5 of 6 clients (#2, #3, #4, #5 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:

A. The facility failed to ensure a continuous active treatment program in the areas of leisure and opportunities for choices for client #2. For example:

During observations at the group home on 5/7/24 from 4:30 PM until 6:30 PM client #2 was observed to stand outside, walk and pace the hallways, dining room and living room unengaged. At no point during the observations was client #1 prompted to do anything other than wash her hands and participate in dinner meal.

During observations on 5/8/24 from 7:00 AM - 8:30 AM client #2 was observed to participate in medication administration and the breakfast meal.

Review on 5/8/24 of client #2's record revealed an ISP dated 3/21/24. Continued review revealed training objectives in the areas of cleaning her dining room table area after meals, putting away laundry, taking her medications, dust bedroom furniture and choosing preferred snacks.

Interview on 5/8/24 with the quality assurance

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(QA) Manager confirmed that client #2's training objectives are current.

B. The facility failed to ensure a continuous active treatment program in the areas of leisure and opportunities for choices for client #3. For example:

During observations at the group home on 5/7/24 from 4:30 PM until 6:30 PM client # 3 was observed to sit in the living room and watch movies or music videos. At no point during the observations was client #4 prompted to do anything other than pick out her night clothes, wash her hands and participate in dinner meal.

During observations on 5/8/24 from 7:00 AM - 8:30 AM client #3 was observed to sit in the livingroom, participate in medication administration and the breakfast meal.

Review on 5/8/24 of client #3's record revealed an ISP dated 3/11/24. Continued review revealed training objectives in the areas of pouring her own beverage into a cup, wearing her eyeglasses, dressing appropriately, laundry, learn medications, and change bed linens.

Interview on 5/8/24 with the QA Manager confirmed that client #3's training objectives are current.

C. The facility failed to ensure a continuous active treatment program in the areas of leisure and opportunities for choices for client #4. For example:

During observations at the group home on 5/7/24 from 4:30 PM until 6:30 PM client #4 was

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observed to sit on the front porch outside and sit in the living room engaged in a brief writing activity. At no point during the observations was client #4 prompted to do anything other than wash her hands and participate in dinner meal.

During observations on 5/8/24 from 7:00 AM - 8:30 AM client #4 was observed to sit in the livingroom, participate in medication administration and the breakfast meal.

Review on 5/8/24 of client #4's record revealed an ISP dated 3/18/24. Continued review revealed training objectives in the areas of participation in medication administration, cleaning her bedroom, cooking and meal prep, laundry, and changing bed linens.

Interview with the QA Manager on 5/8/24 confirmed that client #4's training objectives are current.

D. The facility failed to ensure a continuous active treatment program in the areas of leisure and opportunities for choices for client #5. For example:

During observations at the group home on 5/7/24 from 4:30 PM until 6:30 PM client #5 was observed to sit on the porch outside and sit in the living room unengaged. At no point during the observations was client #5 prompted to do anything other than finish eating his snack and participate in dinner meal.

During observations on 5/8/24 from 7:00 AM - 8:30 AM client #5 was observed to participate in the breakfast meal and medication administration.

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Review on 5/8/24 of client #5's record revealed an ISP dated 3/1/24. Continued review revealed training objectives in the areas of medication administration, feeding the birds, cleaning his dining room chair, exercise, observing others privacy and making choices.

Interview with the QA Manager on 5/8/24 confirmed that client #5's training objectives are current.

E. The facility failed to ensure a continuous active treatment program in the areas of leisure and opportunities for choices for client #6. For example:

During observations at the group home on 5/7/24 from 4:30 PM until 6:30 PM client #6 was observed to sit on the porch outside, sit in the living room and participate in medication administration. At no point during the observations was client #6 prompted to do anything other than participate in medication administration and dinner meal.

During observations on 5/8/24 from 7:00 AM - 8:30 AM client #6 was observed to participate in the breakfast meal and medication administration.

Review on 5/8/24 of client #6's record revealed an ISP dated 3/1/24. Continued review revealed training objectives in the areas of cleaning her dining room table after meals, showering/bathing, learning her medications, dusting her bedroom, and observe the privacy of others.

Interview with the QA Manager on 5/8/24

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W 249	Continued From page 6 confirmed that client #6's training objectives are current. Continued interview revealed all clients should have been prompted and engaged in training objectives as written.	W 249		
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure that restrictive techniques were monitored and reviewed annually by the human rights committee (HRC) for 1 of 6 clients (#5). The finding is: Observations throughout the recertification survey period from 5/7/24 - 5/8/24 revealed exterior door alarms to chime as staff, clients and surveyors entered and exited the group home. Continued observations revealed client #5's bedroom closet door to be locked. Review of client #5's records on 5/8/24 revealed a signed consent dated 1/27/23 for an audio/visual monitor and bed pads with alarm. Continued observations did not reveal consents for exit door alarms or a locked bedroom closet. Interview with the area supervisor (AS) on 5/8/24 revealed that updated signed consent forms could not be located during the survey. Continued interview revealed HRC limitation consent forms for all clients should be updated and signed by the HRC annually.	W 262		

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W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure restrictive techniques were reviewed and approved by the legal guardians for 1of 6 clients (#5). The finding is: Observations throughout the recertification survey period from 5/7/24 - 5/8/24 revealed exterior door alarms to chime as staff, clients and surveyors entered and exited the group home. Continued observations revealed client #5's bedroom closet door to be locked. Review of client #5's records on 5/8/24 revealed a signed consent dated 1/27/23 for an audio/visual monitor and bed pads with alarm. Continued observations did not reveal consents for exit door alarms or a locked bedroom closet. Interview with the area supervisor (AS) on 5/8/24 revealed that updated signed consent forms could not be located during the survey. Continued interview revealed HRC limitation consent forms for all clients should be updated and signed by the legal guardian annually.	W 263		
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,	W 436		

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W 436	Continued From page 8 and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to assure that adaptive equipment was furnished as prescribed for 1 of 6 clients (#4). The finding is: Observation in the group home during recertification survey 5/7/24-5/8/24 revealed client #4 to participate in various activities to include writing/drawing, watching television, dinner and breakfast meal, and medication administration. At no point during the survey period was client #4 observed to wear prescribed eyeglasses nor did any staff prompt the client to obtain eyeglasses. Review of records for client #4 on 5/8/24 revealed an individual service plan (ISP) dated 3/18/24. Continued review of IHP revealed client #4 wears prescribed eyeglasses. Further review of records revealed an eye exam on 1/25/23 which revealed client #4 to be prescribed new eyeglasses. Interview with the quality assurance (QA) on 5/8/24 confirmed client #4 has prescribed eyeglasses. Continued interview with the QA confirmed client #4 should be wearing her prescribed eyeglasses.	W 436		
W 463	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(4) The client's interdisciplinary team, including a qualified dietitian and physician must prescribe all modified and special diets. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure 2 of 6 clients	W 463		

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(#5 and #6) received their specialty diets as prescribed. The findings are:

A. The facility failed to ensure that client #5 received specialty diet as prescribed. For example:

Observation in the group home on 5/8/24 at 7:00 AM revealed client #5 to participate in the breakfast meal which included dry cereal, biscuits with jelly, ham, and juice. Continued observations at 7:14 AM revealed client #5 was given ham and poured an additional bowl of cereal. Further observation revealed client #5 consumed his breakfast meal with his hands and staff poured a third bowl of cereal.

Review of records on 5/8/24 for client #5 revealed a nutritional evaluation dated 3/5/23. Continued review of the nutritional evaluation revealed that client #5 is prescribed a low fat, low cholesterol chopped diet, no concentrated sweets, no seconds, no grapefruit, no caffeine, and thickened liquids.

Interview on 5/8/24 with the director of nursing (DON) confirmed client #5's diet as prescribed. Continued interview with the DON confirmed that staff should have provided client #5 with the client's prescribed diet and seconds should not have been provided to the client.

B. The facility failed to ensure that client #6 received specialty diet as prescribed. For example:

Observation in the group home on 5/7/24 at 6:15 PM revealed client #6 to participate in the dinner meal which included vegetables and beef, lettuce

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W 463	Continued From page 10 with dressing, banana, croissant roll, and sprite soda. Continued observations at 6:23 PM revealed staff to feed client #6 lettuce with dressing. Further observations revealed client #6 consumed her dinner meal with assistance from staff. Review of records on 5/8/24 for client #6 revealed a nutritional evaluation dated 3/6/23. Continued review of the nutritional evaluation revealed that client #6 is prescribed a 1500 calorie, chopped diet, low cholesterol, low fat, no seconds except free foods, no leafy greens or broccoli. Interview on 5/8/24 with DON confirmed client 6's diet as prescribed. Continued interview with the DON confirmed that staff should have provided client #6 with the client's prescribed diet and lettuce should not have been provided to the client.	W 463		
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 observations, record review and interview, the facility failed to ensure food was served in a form consistent with the developmental level for 3 of 6 clients (#2, #5, and #6). The findings are: A. The facility failed to ensure prescribed diet consistency for client #2. For example: Observation in the group home on 5/7/24 at 6:00 PM revealed client #2 to participate in the dinner meal which included vegetables and beef, lettuce	W 474		

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with dressing, strawberries, croissant roll, and sprite soda. Continued observations revealed staff to cut up client #2's food with kitchen shears into sizes larger than bite size. Further observations revealed client #2 consumed her dinner meal with no further assistance from staff to ensure modified diet.

Review of records for client #2 on 5/8/24 revealed a nutritional evaluation dated 3/6/23. Review of the nutritional evaluation for client #2 indicates that the client is prescribed a regular chopped diet, offer seconds and high calorie snacks, encourage 2000cc fluids plus per day, and Ensure QID.

Interview with the director of nursing (DON) on 5/8/24 confirmed client #2's diet as current. Continued interview with the DON confirmed that staff should have a food processor to assist with modified diet and/or mechanically ensure clients receive prescribed diets.

B. The facility failed to ensure prescribed diet consistency for client #5. For example:

Observation in the group home on 5/7/24 at 6:03 PM revealed client #5 to participate in the dinner meal which included vegetables and beef, lettuce with dressing, grapes, croissant roll, and juice. Continued observations revealed staff to cut up client #5's food with kitchen shears into sizes larger than bite size. Further observations revealed client #5 consumed his dinner meal with no further assistance from staff to ensure modified diet.

Review of records for client #5 on 5/8/24 revealed a nutritional evaluation dated 3/15/23. Review of

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the nutritional evaluation for client #5 indicates that the client is prescribed a no concentrated sweets, low fat, low cholesterol, chopped diet, no seconds, no grapefruit, and thickened liquids.

Interview with the director of nursing (DON) on 5/8/24 confirmed client #5's diet as current. Continued interview with the DON confirmed that staff should have a food processor to assist with modified diets and/or mechanically ensure clients receive prescribed diets.

C. The facility failed to ensure prescribed diet consistency for client #6. For example:

Observation in the group home on 5/7/24 at 6:15 PM revealed client #6 to participate in the dinner meal which included vegetables and beef, lettuce with dressing, banana, croissant roll, and sprite soda. Continued observations revealed staff to cut up client #6's food with kitchen shears into sizes larger than bite size. Further observations revealed client #6 consumed her dinner meal with no further assistance from staff to ensure modified diet.

Review of records on 5/8/24 for client #6 revealed a nutritional evaluation dated 3/6/23. Continued review of the nutritional evaluation revealed that client #6 is prescribed a 1500 calorie, chopped diet, low cholesterol, low fat, no seconds except free foods, no leafy greens or broccoli.

Interview with the director of nursing (DON) on 5/8/24 confirmed client #6's diet as current. Continued interview with the DON confirmed that staff should have a food processor to assist with modified diets and/or mechanically ensure clients receive prescribed diets.

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