| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G290 | A. BUILDING _____ B. WING _____ | 08/28/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VOCA-OAKHAVEN DRIVE GROUP HOME | 12516 OAKHAVEN DRIVE CHARLOTTE, NC 28273 |

| (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 |
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| E 015 | Subsistence Needs for Staff and Patients<br>CFR(s): 483.475(b)(1)<br><br>[(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:<br><br>(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:<br>(i) Food, water, medical and pharmaceutical supplies<br>(ii) Alternate sources of energy to maintain the following:<br>(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.<br>(B) Emergency lighting.<br>(C) Fire detection, extinguishing, and alarm systems.<br>(D) Sewage and waste disposal.<br><br>*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.<br>(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:<br>(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:<br>(A) Food, water, medical, and pharmaceutical | E 015 | Please see Attached Plan of Correction.<br><br>DHSR NHL & C Black Mountain WRO Received SEP 25 2018 by: SAH | 10/26/18 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Angie Hughes | TITLE: Program Manager | (X6) DATE: 09.24.18

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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| E 015 | Continued From page 1<br>supplies.<br>(B) Alternate sources of energy to maintain the following:<br>(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.<br>(2) Emergency lighting.<br>(3) Fire detection, extinguishing, and alarm systems.<br>(C) Sewage and waste disposal.<br>This STANDARD is not met as evidenced by:<br>Based on observations, verified by interviews and review of facility policy the team failed to ensure sufficient water was on site for emergency situations as required in the facility emergency plan (EP). The finding is:<br><br>Review of the facility's EP, verified by interview with the operations manager, revealed the facility should have 1 gallon of water for each person per day for 3 days. Interviews with the home manager revealed 6 residents reside in the group home with 3 staff scheduled for first and second shifts for a total of 9 people. Therefore, per facility's EP the facility should have 27 gallons of water on hand.<br><br>Observations in the group home on 8/27/18 revealed the facility had 10 gallons of water on hand in case of an emergency. Continued interview with the group home manager substantiated only 10 gallons of water were present in the home on 8/27/18. Further interviews with the operations manager verified the facility should have 27 gallons of water per facility EP. | E 015 | | |
| E 037 | EP Training Program<br>CFR(s): 483.475(d)(1) | E 037 | Please see attached Plan of Correction | 10/28/18 |

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| E 037 | Continued From page 2<br><br>(1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following:<br><br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.<br>(ii) Provide emergency preparedness training at least annually.<br>(iii) Maintain documentation of the training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br>*[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least annually.<br>(iii) Maintain documentation of the training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br><br>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.<br>(ii) Demonstrate staff knowledge of emergency procedures. | E 037 | | |

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| E 037 | Continued From page 3<br>(iii) Provide emergency preparedness training at least annually.<br>(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.<br><br>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) After initial training, provide emergency preparedness training at least annually.<br>(iii) Demonstrate staff knowledge of emergency procedures.<br>(iv) Maintain documentation of all emergency preparedness training.<br><br>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least annually.<br>(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.<br>(iv) Maintain documentation of all training. | E 037 | | |

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| E 037 | Continued From page 4<br>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:<br>(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least annually.<br>(iii) Maintain documentation of the training.<br>(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.<br><br>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least annually.<br>(iii) Maintain documentation of the training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br><br>*[For CMHCs at §485.920(d):] (1) Training. The | E 037 | | |

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| E 037 | Continued From page 5<br>CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually.<br><br>This STANDARD is not met as evidenced by:<br>The facility failed to ensure staff were sufficiently trained to implement the emergency plan (EP) as evidenced by observations, interviews and review of records. The finding is:<br><br>Review of the facility's EP training records, verified by interview with the group home manager and staff, revealed training of the facility EP had been conducted. However, interviews on 8/27/18 revealed direct care staff and the group home manager were unable to locate the client information books developed for each individual client. The book for client #6 could be located but not for the other residents of the group home.<br><br>Interviews with the operations manager and the qualified intellectual disabilities professional revealed the client information books were in the client's individual book bag. Continued interviews with the operations manager verified staff should have known where the individual books were and additional training will need to be done. | E 037 | | |
| W 249 | PROGRAM IMPLEMENTATION<br>CFR(s): 483.440(d)(1)<br><br>As soon as the interdisciplinary team has | W 249 | Please see attached Plan of Correction | 10/29/18 |

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| W 249 | Continued From page 6<br>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.<br><br>This STANDARD is not met as evidenced by:<br>The team failed to ensure objectives listed on the individual support plans (ISPs) relative to communication and behavior plans for 2 of 3 sampled clients (#5 and #6) were implemented with sufficient frequency and as prescribed to support the achievement of the objectives as evidenced by observations, interview and review of records. The findings are:<br><br>A. Review of the record for client #5 revealed an ISP dated 12/5/17. Review of the 12/5/17 ISP, verified by interview with the qualified intellectual disabilities professional (QIDP), revealed objective training to increase skills in washing hair thoroughly and washing upper body.<br><br>Observations on 8/28/18 at 6:23 AM in the group home revealed staff A to verbally and gesturally prompt client #5 to go to the bathroom and take his shower. Continued observations revealed the client to go in to the bathroom with his clothes. Staff A was noted to hand the client his hygiene caddy. Further observations revealed staff A to stand outside of the bathroom and wait for the client to come out at 6:40 AM. Staff was noted to call to the client to see if he was OK. At 6:40 AM the client was observed to exit the bathroom with his hair wet. | W 249 | | |

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| W 249 | Continued From page 7<br><br>Interview with the staff A revealed the client had gone in to the bathroom to take a shower and get dressed. Continued interview with staff A, verified by interview with staff B, revealed client #5 is fairly independent with bathing and washing his hair and likes to do things for himself.<br><br>Additional interview with the QIDP substantiated the client does like to be independent and do things for himself. However, he does need prompts and some assistance to do a thorough job of bathing and washing his hair. Continued interviews with the QIDP, verified staff should have given the client sometime alone in the bathroom but then to go in and provide assistance to do a thorough job of bathing and washing his hair.<br><br>Therefore, staff failed to implement the objectives to wash upper body and to wash hair thoroughly with sufficient frequency to support the achievement of these objectives.<br><br>B. Review of the records for client #6 revealed an ISP dated 6/20/18. Review of the 6/20/18 ISP revealed a behavior support plan (BSP) to reduce target behaviors to 10 or less per month for 6 consecutive months. Continued review of the BSP revealed staff are to use a notebook containing pictures representing activities of his daily schedule to assist in transitioning from one activity to another.<br><br>Observations on 8/27/18 in the group home revealed the client to participate in leisure activities including playing monopoly and playing basketball outside, going to the bathroom, washing hands and eating diner. Continued | W 249 | | |

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| W 249 | Continued From page 8<br>observations revealed staff to use verbal and gestural prompts to transition client #6 to various activities during the survey. However, at no time was staff observed to prompt the client to his . notebook to check his schedule.<br><br>Interview with the behaviorist substantiated client #6's has a notebook including pictures representing his schedule and also exercises on deep breathing to assist in dealing with his feelings. Continued interview with the behaviorist, who was also present in the group home on 8/27/18, also stated staff were not observed to prompt the client to use his notebook to check schedule to transition to activities. Further interview with the behaviorist revealed staff should have prompted the client to his notebook in transition to wash hands, leisure activity and to eat dinner.<br><br>Therefore, staff failed to implement the BSP as prescribed in the ISP. | W 249 | | |
| W 440 | EVACUATION DRILLS<br>CFR(s): 483.470(i)(1)<br><br>The facility must hold evacuation drills at least quarterly for each shift of personnel.<br><br>This STANDARD is not met as evidenced by:<br>The facility failed to show evidence quarterly fire drills were conducted for each shift of personnel as evidenced by interview and review of records. The finding is:<br><br>Review of the facility fire drill reports revealed for the quarter beginning 9/17 through 11/17 no second shift fire drill report was available for | W 440 | Please see attached Plan of Correction. | 10/20/18 |

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| W 440 | Continued From page 9<br>review. Continued review of the fire drill reports revealed for the quarter beginning 12/17 through 2/18 revealed no second shift fire drill report was available for review. Further review of the fire drill reports revealed for the quarter beginning 3/18 through 5/18 no third shift fire drill report was available for review.<br><br>Interview with the home manager verified the missing fire drill reports were not available for review. Therefore, the facility failed to show evidence quarterly fire drills were conducted for each shift of personnel. | W 440 | | |

12516 Oakhaven Drive
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Plan of Correction
Date of Annual On-Site Visit: August 27- 28, 2018
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E 015 483.475(b)(1) Subsistence Needs for Staff and Patients

The Oakhaven team failed to ensure that sufficient water was on site for emergency situations as required in the facility emergency plan.

CANC, specifically the Oakhaven team, will follow the implemented Emergency Plan. The Oakhaven facility will ensure to have 1 gallon of water for each staff and consumer per day for 3 days, totaling 27 gallons of water.

The Oakhaven team will ensure the Emergency plan is followed. The Residential Manager will check the emergency supply to ensure sufficient amounts of water is available 2x weekly. The Clinical Supervisor will check the emergency supply to ensure sufficient amounts of water is available 2x weekly. The Program Manager will check the emergency supply to ensure sufficient amount of water during monthly site reviews.

Person Responsible: Residential Manager, Clinical Supervisor, Program Manager
Date to Be Completed: 10.28.2018

E037 483.475(d)(1) Training Program

The Oakhaven team failed to ensure staff was sufficiently trained to implement the emergency plan (EP).

CANC, specifically the Oakhaven team will ensure all staff is trained on the location of the consumer specific information related to the emergency plan and has knowledge on how to implement the emergency plan (EP).

The Oakhaven team, specifically the Clinical Supervisor, will ensure all staff is re-trained on the location of the client specific books for all consumers, which is located inside of each client's bookbag in front zipper pouch. The Clinical Supervisor will train the Residential Manager, Direct Support staff and clients on the emergency preparedness policy and procedures and annually thereafter. Training will also include demonstration of staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.

CANC, specifically the Oakhaven group home will maintain documentation of all training. The Program Manager will request staff knowledge of emergency plan (EP) during monthly site reviews.

Person Responsible: Residential Manager, Clinical Supervisor, Program Manager
Date to Be Completed: 10.28.2018

W249 483.440(d)(1) Program Implementation

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.

The Oakhaven team, especially the Clinical Supervisor, will ensure objectives listed on the individual support plan (ISP's) relative to communication and behavior plans for 2 of 3 sampled clients (#5 and #6) are implemented with sufficient frequency and as prescribed to support the achievement of the objectives as evidenced by observations.

A. The Clinical Supervisor will train and re-train staff on client #5's program implementation for washing his hair thoroughly and washing his upper body. Training will include frequency of documentation. The Residential Manager will ensure the program is implemented as written 3x weekly. The Clinical Supervisor will ensure the program is implemented as written 2x weekly. The Program Manager will ensure program implementation during monthly site reviews.

B. The behaviorist will re-train staff on client #6's behavior support plan to include using his notebook that represents activities of his daily schedule to assist in transitioning from one activity to another. The Behaviorist will provide weekly observations to ensure client #6's BSP is implemented as written. The Residential Manager will provide observations 2 x weekly to ensure BSP is implemented as written. The Clinical Supervisor will provide observations 2 x weekly to ensure the BSP is implemented as written. The Program Manager will ensure BSP is implemented as written during monthly site reviews.

Person Responsible: Behaviorist, Residential Manager, Clinical Supervisor, and Program Manager
Date to Be Completed: 10.28.2018

W440 483.470 (i)(1) Evacuation Drills

The facility must hold evacuation drills at least quarterly for each shift of personnel.

CANC, specifically the Oakhaven Group Home, failed to provide evidence that quarterly fire drills were conducted for each shift of personnel.

The Oakhaven team, specifically the Clinical Supervisor, will retrain the Residential Manager and Direct Support Staff on conducting one fire drill per shift, per quarter and maintaining documentation of all drills conducted. The Residential Manager will schedule all monthly fire drills and delegate the shift required to conduct the fires drill. The Residential Manager will ensure the fire drill is conducted per the schedule and records are being maintained. The Clinical Supervisor will review and ensure the fire drill was conducted and a copy is filed in the drill book. The Program will ensure the fire drill was completed and filed during monthly site reviews.

Person Responsible: Residential Manager, Clinical Supervisor, and Program Manager
Date to Be Completed: 10.28.2018