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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G220 | A. BUILDING ______ B. WING ______ | C 01/09/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VOCA-WILSON AVENUE GROUP HOME | 2103 WILSON AVENUE CHARLOTTE, NC 28208 |

| (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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| W 122 | CLIENT PROTECTIONS<br>CFR(s): 483.420<br><br>The facility must ensure that specific client protections requirements are met.<br><br>This CONDITION is not met as evidenced by:<br>This CONDITION is not met as evidenced by:<br>The facility failed to ensure implementation of written policies and procedures that prohibit mistreatment, neglect or abuse of clients (W149); failed to ensure that all allegations of neglect were reported immediately to the administrator and to other officials in accordance with State law (W153); and failed to provide evidence that all alleged violations were thoroughly investigated (W154).<br><br>The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated client protections. | W 122 | Please see attached Plan of Correction<br><br>RECEIVED<br>JAN 24 2019<br>DHSR NH L & C<br>Black Mountain / WRO | 02/23/19 |
| W 149 | STAFF TREATMENT OF CLIENTS<br>CFR(s): 483.420(d)(1)<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.<br><br>This STANDARD is not met as evidenced by:<br>Based on review of facility records and staff interviews, the facility failed to assure its policies and procedures that prohibit neglect were implemented to prevent neglect for 1 of 6 clients residing in the group home (#4). The findings are:<br><br>A. The facility was neglectful by not training staff | W 149 | Please attached Plan of Correction | 02/23/19 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Program Manager (X6) DATE: 01.19.19

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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| W 149 | Continued From page 1<br>in a thorough and timely manner related to appropriate monitoring of client #4 following an episode of elopement on 12/8/18 in order to prevent subsequent episodes of elopement on 12/9/18 and 12/29/18, and by not training staff on the procedure for reporting to law enforcement and administration immediately when client #4 was discovered to be missing from the facility on 12/29/18.<br><br>Review of a facility investigation dated 12/11/18 - 12/16/18 revealed client #4 eloped from the facility on 12/8/18 between 4:00 PM and 5:00 PM, then eloped again between 7:00 AM and 7:30 AM on 12/9/18. Further review of the 12/11/18-12/16/18 investigation revealed on both occasions client #4 was found and returned to the facility by the police after having been missing for several hours on each occasion. Review of an incident report dated 12/29/18 for client #4 revealed client #4 eloped from the facility between 7:00 AM and 7:08 AM unobserved by staff. Continued review of the 12/29/18 incident report revealed staff noted client #4 was noted to be missing from the home at 7:08 AM and the 3 staff present in the home took turns searching the neighborhood until 7:38 AM at which time the on-call manager and police were notified. Therefore, there was a delay of 30 minutes in reporting client #4's whereabouts was unknown.<br><br>Review of the record for client #4, conducted on 1/9/19, revealed an individual support plan (ISP) dated 10/1/18 which included a behavior support plan (BSP) dated 8/30/18 with a BSP addendum dated 12/12/18. Review of the BSP addendum dated 12/12/18 revealed the addendum was initiated in order to maintain client #4's safety due to increasing episodes of elopement and property | W 149 | | |

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| W 149 | Continued From page 2<br>destruction. Added restrictions documented on the 12/12/18 BSP addendum included: bedroom and window alarms, group home exit door alarms, visual monitor set up in bedroom with assigned staff watching the monitor, GPS wrist or ankle bracelet set up by appropriate agency, and 1:1 staff monitoring during waking hours.<br><br>Continued review of the 12/12/18 BSP addendum revealed the 1:1 monitoring procedure included instructions for staff to visually monitor client #4 at all times while in the home and check on him every 10 minutes while he is in his room. This procedure further documented staff should be close enough to intervene but give client #4 privacy while he was in the bathroom or his bedroom, but must remain outside the door. No evidence staff were trained in appropriate monitoring methods to prevent further episodes of elopement prior to 12/29/18 was available.<br><br>Further review of facility records revealed a staff inservice dated 12/29/18 following client #4's third episode of elopement from the group home providing instruction for staff related to 1:1 staff supervision. This staff training documented staff should remain within arms-length of client #4 at all times, and should assure another staff took over supervision duties if assigned staff needed to take a break.<br><br>Interviews conducted on 1/9/19 with the executive director, program manager and qualified intellectual disabilities professional (QIDP) revealed no record of staff training was available related to interventions put in place on 12/8/18 following client #4's first episode of elopement, no record of staff training on the restrictions and interventions documented on the 12/12/18 BSP | W 149 | | |

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| W 149 | Continued From page 3<br>addendum prior to the third episode of elopement on 12/29/18, and no record of staff training related to reporting missing persons immediately following the third episode of elopement on 12/29/18. These interviews further revealed the GPS tracking belt recommended in the 12/12/18 BSP addendum had been ordered, however, it had not arrived or been implemented currently.<br><br>B. The facility was neglectful by not assuring it's policies and procedures for reporting missing persons were implemented as written, and not assuring all episodes of neglect were reported to other officials in accordance with State law.<br><br>Review of a facility investigation dated 12/11/18 - 12/16/18 revealed client #4 eloped from the facility on 12/8/18 between 4:00 PM and 5:00 PM, then eloped again between 7:00 AM and 7:30 AM on 12/9/18. Further review of the 12/11/18-12/16/18 investigation revealed on both occasions client #4 was found and returned to the facility by the police after having been out of supervision for several hours each time. While this investigation did indicate facility administration as well as law enforcement were contacted immediately on both occasions, this investigation did not include documentation indicating the department of social services (DSS) was notified of client #4's elopement incidents on 12/8/18 and 12/9/18, and further did not indicate a 24 hour or 5-day report was filed with the Health Care Personnel Registry (HCPR) as required by State law.<br><br>Continued review of facility reports revealed an incident report dated 12/29/18 for client #4 documenting he eloped from the facility between 7:00 AM and 7:08 AM unobserved by staff. | W 149 | | |

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| W 149 | Continued From page 4<br>Continued review of the 12/29/18 incident report revealed staff noted client #4 was missing from the home at 7:08 AM and the 3 staff present in the home took turns searching the neighborhood until 7:38 AM at which time the on-call manager and police were notified. Therefore, there was a delay of 30 minutes in reporting client #4's whereabouts was unknown. No facility investigation was available regarding client #4's elopement on 12/29/18. Review of a facility policy relating procedure to be followed for a missing person documents a supervisor should be notified immediately and law enforcement should be involved immediately if there is reason to believe the person's safety was in jeopardy.<br><br>Interview with the facility's executive director, program manager and QIDP, conducted on 1/9/18, revealed staff should have notified the law enforcement and the supervisor immediately upon becoming aware client #4 was not present in the facility. These interviews further revealed law enforcement officers located client #4 on 12/29/18 when responding to a 911 call related to client #4 attempting to enter an unknown house in the area seeking food.<br><br>C. The facility was neglectful by failing to thoroughly investigate episodes of elopement for client #4.<br><br>Review of a facility investigation dated 12/11/18 - 12/16/18, conducted on 1/9/19, revealed client #4 eloped from the facility on 12/8/18 between 4:00 PM and 5:00 PM, then eloped again between 7:00 AM and 7:30 AM on 12/9/18. Continued review of this investigation revealed documentation stating the investigation was focused on ruling out abuse/neglect and | W 149 | | |

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| W 149 | Continued From page 5<br>determining if the elopements were reported in a timely manner. Review of the record for client #4, conducted on 1/9/19, revealed an individual support plan (ISP)dated 10/1/18 which included a behavior support plan (BSP) dated 8/30/18. Continued review of the 8/30/18 BSP indicated targeted behaviors included elopement, physical aggression, property destruction and disruptive behavior. Continued review of the record for client #4 revealed a consent for the BSP dated 8/30/18 and signed by the guardian on 9/7/18 documenting door chimes on the front and back doors were being utilized to ensure safety.<br><br>Interviews conducted on 1/9/19 with the executive director, program manager and qualified intellectual disabilities professional (QIDP) indicated 1:1 staffing for client #4 had been put into place on 12/8/18 following client #4's first elopement episode. These interviews further indicated client #4 was known to disable monitors and alarms in the home on a frequent basis. On-going review of the investigation verified by interviews, revealed it did not address the issue of which staff was assigned to 1:1 supervision with client #4 when he was able to leave the home undetected on 12/29/18, what the expectations of staff related to 1:1 supervision of client #4 were, if staff had been trained and understood what the expectations were related to 1:1 supervision of client #4, or whether or not the door chimes were functioning or heard by staff during client #4's elopement episodes.<br><br>Further review of facility reports, conducted on 1/9/19, revealed an incident report dated 12/29/18 documenting client #4 eloped from the facility between 7:00 AM and 7:08 AM while staff assigned to supervision of client #4 was in the | W 149 | | |

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| W 149 | Continued From page 6<br>bathroom and the two other staff present in the home were assisting other clients behind closed doors. Continued review of the 12/29/18 incident report revealed the 3 staff present in the home took turns searching the neighborhood until 7:38 AM at which time the on-call manager and police were notified. Written statements from the 3 staff present in the home when client #4 eloped on 12/29/18 were available, however, no facility investigation was available related to client #4's elopement on 12/29/18.<br><br>Interview conducted on 1/9/19 with the executive director, program manager and QIDP revealed 1:1 staffing, a visual monitor and door and window alarms should have been in place prior to 12/29/18, however, no investigation had been initiated by the facility to evaluate the circumstances surrounding client #4's ability to leave the facility undetected by staff on that date.<br><br>Therefore, the facility was neglectful because it failed to assure staff were thoroughly and appropriately trained in a timely manner related to the implementation of interventions, appropriate staff monitoring and reporting of missing persons for client #4; failed to report to the administrator and law enforcement immediately when client #4 was discovered to be missing from the home on 12/29/18: failed to report allegations of neglect to other officials according to state law;and failed to investigate episodes of elopement for client #4 in a thorough and timely manner in order to assess if interventions and restrictions were appropriate and effective. | W 149 | Please see attached Plan of Correction | 02/23/19 |
| W 153 | STAFF TREATMENT OF CLIENTS<br>CFR(s): 483.420(d)(2) | W 153 | | |

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| W 153 | Continued From page 7<br>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.<br><br>This STANDARD is not met as evidenced by:<br>Based on review of records and interviews, the facility failed to assure that all allegations of neglect were reported immediately to the administrator and to other officials in accordance with State law for 1 of 6 clients residing in the group home (#4). The findings are:<br><br>A. Review of a facility investigation dated 12/11/18 - 12/16/18 revealed client #4 eloped from the facility on 12/8/18 between 4:00 PM and 5:00 PM, then eloped again between 7:00 AM and 7:30 AM on 12/9/18. Further review of the 12/11/18-12/16/18 investigation revealed on both occasions client #4 was found and returned to the facility by the police. While this investigation did indicate facility administration as well as law enforcement were contacted immediately on both occasions, this investigation did not include documentation indicating the department of social services (DSS) was notified of client #4's elopement incidents on 12/8/18 and 12/9/18, and further did not indicate a 24 hour or 5-day report was filed with the Health Care Personnel Registry (HCPR) as required by State law.<br><br>Interview with the facility's executive director, program manager and qualified intellectual disabilities professional, conducted on 1/9/18, verified the HCPR and DSS had not been notified of the allegation of neglect investigated by the | W 153 | | |

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| W 153 | Continued From page 8<br>facility related to client #4's incidents of elopement on 12/8/18 and 12/9/18.<br><br>B. Review of an incident report dated 12/29/18 for client #4 revealed client #4 eloped from the facility between 7:00 AM and 7:08 AM unobserved by staff. Continued review of the 12/29/18 incident report revealed staff noted client #4 was missing from the home at 7:08 AM and the 3 staff present in the home took turns searching the neighborhood until 7:38 AM at which time the on-call manager and police were notified. Therefore, there was a delay of 30 minutes in reporting client #4's whereabouts was unknown. No facility investigation was available regarding client #4's elopement on 12/29/18. Review of a facility policy relating procedure to be followed for a missing person documents a supervisor should be notified immediately and law enforcement should be involved immediately if there is reason to believe the person's safety was in jeopardy.<br><br>Interview with the facility's executive director, program manager and qualified intellectual disabilities professional, conducted on 1/9/18, revealed staff should have notified the law enforcement and the supervisor immediately upon becoming aware client #4 was not present in the facility. | W 153 | | |
| W 154 | STAFF TREATMENT OF CLIENTS<br>CFR(s): 483.420(d)(3)<br><br>The facility must have evidence that all alleged violations are thoroughly investigated.<br><br>This STANDARD is not met as evidenced by: | W 154 | Please see attached Plan of Correction | 02/23/19 |

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| W 154 | Continued From page 9<br>Based on record review and interviews, the facility failed to provide evidence a thorough investigation was conducted relative to allegations of neglect for 1 of 6 clients residing in the home (client #4). The findings are:<br><br>A. Review of a facility investigation dated 12/11/18 - 12/16/18, conducted on 1/9/19, revealed client #4 eloped from the facility on 12/8/18 between 4:00 PM and 5:00 PM, then eloped again between 7:00 AM and 7:30 AM on 12/9/18. Continued review of this investigation revealed documentation stating the investigation was focused on ruling out abuse/neglect and determining if the elopements were reported in a timely manner. Review of the record for client #4, conducted on 1/9/19, revealed an individual support plan (ISP) dated 10/1/18 which included a behavior support plan (BSP) dated 8/30/18. Continued review of the 8/30/18 BSP indicated targeted behaviors included elopement, physical aggression, property destruction and disruptive behavior. Continued review of the record for client #4 revealed a consent for the BSP dated 8/30/18 and signed by the guardian on 9/7/18 documenting door chimes on the front and back doors were being utilized to ensure safety. Interviews conducted on 1/9/19 with the executive director, program manager and qualified intellectual disabilities professional (QIDP) indicated 1:1 staffing for client #4 had been put into place on 12/8/18 following client #4's first elopement episode. These interviews further indicated client #4 was known to disable monitors and alarms in the home on a frequent basis. On-going review of the investigation verified by interviews, revealed it did not address the issue of which staff was assigned to 1:1 supervision with client #4 when he was able to leave the | W 154 | | |

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| W 154 | Continued From page 10<br>home undetected on 12/29/18, what the expectations of staff related to 1:1 supervision of client #4 were, if staff had been trained and understood what the expectations were related to 1:1 supervision of client #4, or whether or not the door chimes were functioning or heard by staff during client #4's elopement episodes.<br><br>B. Review of an incident report dated 12/29/18 revealed client #4 eloped from the facility between 7:00 AM and 7:08 AM while staff assigned to supervision of client #4 was in the bathroom and the two other staff present in the home were assisting other clients behind closed doors. Continued review of the 12/29/18 incident report revealed the 3 staff present in the home took turns searching the neighborhood until 7:38 AM at which time the on-call manager and police were notified. Written statements from the 3 staff present in the home when client #4 eloped on 12/29/18 were available, however, no facility investigation was available related to client #4's elopement on 12/29/18.<br><br>Interview conducted on 1/9/19 with the executive director, program manager and QIDP revealed 1:1 staffing, a visual monitor and door and window alarms should have been in place prior to 12/29/18, however, no investigation had been initiated by the facility to evaluate the circumstances surrounding client #4's ability to leave the facility undetected by staff on that date. | W 154 | | |

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W122 483.420 CLIENT PROTECTIONS

The facility must ensure that specific client protections requirements are met.

Community Alternatives of NC, specifically the Wilson Avenue Group Home, will ensure that specific client protections requirements are met.

Please see plan of correction for W149, W153, and W154.

Person Responsible: Residential Manager, QIDP, Behaviorist, Program Manager
Date to Be Completed: 02.23.19

W149 483.420(d)(1) STAFF TREATMENT OF CLIENTS

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, or abuse of the client.

Community Alternatives of NC, specifically the Wilson Avenue Group Home, will ensure developed written policies and procedures that prohibit mistreatment, neglect, or abuse of the client are implemented.

A. The Program Manager will retrain the Clinical Supervisor on CANC's Missing Person Policy to ensure staff immediately inform the supervisor or supervisor on call as soon as an individual is discovered missing. The Clinical Supervisor will retrain the Residential Manager and all Direct Support Professionals on CANC's Missing Person Policy to ensure staff immediately inform the supervisor or supervisor on call as soon as an individual is discovered missing. The Behaviorist will retrain all staff on client #4's Behavior Support Plan. Training will include, but not be limited to, 1:1 monitoring, proactive interventions, restrictive interventions, reporting, and documentation. The Clinical Supervisor will train all staff on client #4's individual activity schedule and utilization of the GSP belt. The Residential Manager will train all staff on the purpose and use of the audible chimes and video monitor. The Residential Manager will provide observations 3 x weekly to ensure staff are following client #4's individual activity schedule as well as monitoring, reporting, and documenting per his BSP. The Residential Manager will train all staff on the purpose and use of the audible chimes and video monitor. The Clinical Supervisor will provide observations 2 x weekly to ensure staff are following client #4's individual activity schedule as well as monitoring, reporting, and documenting per his BSP. The Behaviorist will provide observations weekly to ensure staff are following client #4's individual activity schedule as well as monitoring, reporting, and documenting per his BSP. The Program Manager will provide observations during monthly site reviews to ensure staff are following client #4's individual activity schedule as well as monitoring, reporting, and documenting per his BSP.

B. The Program Manager will retrain the Clinical Supervisor on CANC's Missing Person Policy to ensure staff immediately inform the police and supervisor or supervisor on call as soon as an individual is discovered missing. The Clinical Supervisor will retrain the Residential Manager and all Direct Support Professionals on CANC's Missing Person Policy to ensure staff immediately inform the supervisor or supervisor on call as soon as an individual is discovered missing. The Clinical Supervisor and/or Residential Manager will immediately notify the Program Manager. The Program Manager will immediately notify the Executive Director as soon as an individual is discovered missing. An investigation will immediately be initiated. The Program Manager will submit an IRIS and ensure all authorities are notified in accordance with State Law. The Program Manager will submit a 24 hour and 5-day report to the NCHCPR. The Executive Director will review all investigations to ensure all authorities are notified in a timely manner. The Safety Committee will review all investigations on a quarterly basis to ensure all notifications are made in a timely manner.

C. The Program Manager will review the Missing Persons Policy with the Clinical Supervisor to ensure all episodes of elopement are immediately reported and thoroughly investigated. Upon notification of a missing person/client elopement, the Program Manager will immediately notify the Executive Director. An investigation will immediately be initiated to rule out neglect. The Program Manager will review the completed investigation to ensure it is thorough and determine if neglect can be substantiated. The Executive Director will review all completed investigations to ensure they are thorough and completed in a timely manner.

Person Responsible: Residential Manager, QIDP, Behaviorist, Program Manager
Date to Be Completed: 02.23.19

W153 483.420(d)(2) STAFF TREATMENT OF CLIENTS

The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.

Community Alternatives of NC, specifically the Wilson Avenue Group Home, will ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.

A. The Program Manager will immediately notify the Executive Director as soon as an individual is discovered missing. An investigation will immediately be initiated. The Program Manager will submit an IRIS and ensure all authorities are notified in accordance with State

Law. The Program Manager will notify DSS and submit a 24 hour and 5-day report to the NCHCPR. The Executive Director will review all investigations to ensure all authorities are notified in a timely manner. The Safety Committee will review all investigations on a quarterly basis to ensure all notifications are made in a timely manner.

B. The Clinical Supervisor will retrain all staff relative to the Missing Persons Policy to ensure the police are immediately notified when a person is discovered missing. Staff will immediately call 911 and then notify a supervisor. The Residential Manager will provide monitoring and review the documentation 3 x weekly to ensure staff are following protocol. The Clinical Supervisor will provide monitoring and review the documentation 2 x weekly to ensure staff are following protocol. The Program Manager will provide monitoring and review the documentation during monthly site reviews to ensure staff are following protocol.

Person Responsible: Residential Manager, QIDP, Program Manager
Date to Be Completed: 02.23.19

W154 483.420(d)(3) STAFF TREATMENT OF CLIENTS
The facility must have evidence that all alleged violations are thoroughly investigated.

Community Alternatives of NC, specifically the Wilson Avenue Group Home, will ensure that all alleged violations are thoroughly investigated.

A. Upon notification that an investigation is initiated, the Program Manager will meet with the assigned investigator to review the incident and develop a list of questions for the investigator to ask during interviews. The Investigator will request training records to review to ensure staff have been trained on the protocol outlined in the individual's ISP and BSP. The investigator will include training of 1:1 monitoring if applicable. The Program Manager will review the completed investigation to ensure it is thorough and all questions have been answered. After a review of the investigation summary, the Program Manager will submit the final investigation report and recommendations to the Executive Director for review. The Executive Director will review the investigation report and recommendations to ensure the investigation is thorough.

B. The Program Manager will retrain the Clinical Supervisor in CANC's Missing Person Policy. The Clinical Supervisor will retrain the Residential Manager and all Direct Support Professionals on CANC's Missing Person Policy to include immediately reporting a missing person to a supervisor. The supervisor will immediately notify the Program Manager. The Program Manager will immediately notify the Executive Director. An investigation will be

immediately initiated to ensure protocol was followed and rule out neglect. The Executive Director will review all investigations to ensure they are thorough and all notifications are made in a timely manner. The Safety Committee will review all investigations on a quarterly basis to ensure they are thorough and all notifications are made in a timely manner.

Person Responsible: Residential Manager, Clinical supervisor, Program Manager
Date to Be Completed: 02.23.19