STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G201	A. BUILDING _____ B. WING _____	C 03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-OAK DRIVE GROUP HOME	5416 OAK DRIVE CHARLOTTE, NC 28216

(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 000	INITIAL COMMENTS Complaint intakes NC00149165 and NC001149490.	W 000		
W 152	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1)(iii) The facility must prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect or mistreatment. This STANDARD is not met as evidenced by: The facility failed to assure a criminal background check was completed for staff to ensure employment of individuals with a conviction or prior employment history of child or client abuse, neglect or mistreatment did not occur as evidenced by observation, interview and record verification. The findings are: A. Review of a facility investigation, substantiated by interviews with the facility program manager and administrator, revealed staff A was noted to take client #1 on a the van to the main office to pick up staff A's check on 2/25/19 at 3:45 PM. Staff A then reported he was going to take client #1 for ice cream. The home manager reported to her supervisors at 7:30 PM on 2/25/19 that staff A and client #1 had not returned to the group home. Further review of the facility investigation and interviews revealed the police were called and they issued a silver alert and were actively looking for the group home van that staff A was driving. Staff A and client #1 did not return that night but staff A did finally call the next morning to report he and client #1 were at his house and someone	W 152		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W 152	Continued From page 1	W 152		

could come pick up the van and client #1. The police arrived and transported client #1 to the hospital to be checked out and the client was found to be unharmed.

Continued review of the facility's investigation and interviews revealed part of the facility investigation included a review of staff A's training and personnel file. During that review it was found that staff A's criminal background check had not been completed. It should be noted a check was completed at this point and was found to be free of any convictions that would have precluded staff A from being employed at the group home. However, the facility failed to assure a check was completed prior to staff A working with the clients at the group home.

B. Interview with the facility administrator revealed that the finding of a missing criminal background check from the group home resulted in a thorough review of all personnel files of staff working at the group home to assure all that criminal background checks had been completed. Further interview with the facility administrator, substantiated by review of the background checks, revealed no other checks were missed for staff assigned to the group home.

Afternoon observations in the group home on 3/14/19 revealed 3 staff working in the group home on second shift along with the qualified intellectual disabilities professional (QIDP). Interviews with staff B, staff C, and staff D revealed none of them regularly work in the group home. Further interviews, substantiated by interview with the QIDP, revealed staff B is a new staff, staff C was hired as a PRN staff and staff D is the home manager at a sister facility but used

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W 152	Continued From page 2 to work in the group home. Interview with the facility administrator revealed background checks were completed for staff C and staff D as required. Further interview with the facility administrator revealed staff B was a rehire but no background check could be found. Continued interview revealed staff B was removed from the group home work schedule until a background check could be completed but facility failed to assure all staff working with the clients in the group home had a completed background check.	W 152		