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	34G290	A. BUILDING _____ B. WING _____	C 08/13/2019

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
E 009	Local, State, Tribal Collaboration Process CFR(s): 483.475(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This STANDARD is not met as evidenced by: The facility failed to develop an Emergency Preparedness Plan (EP) which included a process for cooperation and collaboration with local, state and federal emergency preparedness officials' efforts of an integrated emergency response or documentation of the facility's efforts to contact such officials as evidenced by interview	E 009	Please see Attached Plan of Correction RECEIVED SEP - 6 2019 DHSR NH L & C Black Mountain / WRO	10/7/19

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

[signature] Program Manager 09.05.19

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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E 009	Continued From page 1 and record verification. The finding is: Review on 8/12/19 of the facility's EP revealed no documentation of an ongoing, integrated emergency collaborative process with local EP officials relative to available resources for emergency evacuations. Interview on 8/13/19 with the facility program manager revealed the facility's EP does not include documentation of efforts on their process for ensuring cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials for an integrated response during a disaster or emergency situation.	E 009		
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the	E 039	Please see attached Plan of Correction	10/11/19

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E 039	Continued From page 2 [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to assure exercises were conducted	E 039		

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E 039	Continued From page 3 annually to test the facility's emergency preparedness plan (EP), as required. The finding is: Review of the facility's EP, conducted on 8/12/19, revealed staff were provided with instruction related to the facility's EP during a staff meeting on 1/16/18, however, no documentation was provided to indicate any testing or table-top exercises were conducted during the past year. Interview with the facility program manager confirmed no system was in place to assure testing of the facility's EP, and she further verified no EP drill had been conducted during the past year to test the facility's emergency plan, as required.	E 039		
W 000	INITIAL COMMENTS Intake #NC 00154442 and #NC 00154310 allegations were unsubstantiated; however, an unrelated non-compliance, W155, was cited on 8/13/19.	W 000		
W 129	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy. This STANDARD is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to assure the privacy rights of 1 of 3 sampled clients (#5) related to the use of a video camera in his bedroom. The finding is:	W 129		

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W 129	Continued From page 4 Observations in the group home on 8/13/19 at 7:00 AM revealed a video camera mounted on the wall in the bedroom of client #5. Continued observations revealed a maintenance staff member came into the group home and removed the video camera from client #5's bedroom wall. Further observations revealed a visual monitor in the staff office which was connected to the video camera in client #5's bedroom. Interview with the facility qualified intellectual disabilities professional (QIDP) revealed she was new to the facility and was not aware if the video camera was functional or not functional, nor if the video camera was being utilized or being monitored to evaluate client #5's behaviors while in his bedroom. Record review on 8/13/19 for client #5 revealed an individual support plan (ISP) dated 6/20/19. Further review of client #5's ISP revealed a behavioral support plan (BSP) dated 6/30/19 which stated "restrictions of door chimes, window and exit doors along with restrictions of shoe laces and belts. He has a monitor in his bedroom for safety issues." Continued review of the client #5's BSP revealed "restrictions will be reviewed monthly and criteria to remove the restrictions will be considered when there are zero (0) reports of aggression toward self, others and property." Interview with the facility QIDP and the facility program manager confirmed the use of a video camera in the bedroom for client #5 was utilized more than a year ago to guard against suicidal threats and ideation expressed by client #5. Continued interview revealed no suicidal threats or ideations have been made in the last year and the video camera should have been removed	W 129		

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W 129	Continued From page 5 several months ago to protect the privacy rights of client #5. Further interview with the program manager revealed there has been no documentation of the use of the video camera in the past 6 months as staff have been unclear about whether to utilize the bedroom video camera and monitor for client #5, whether the video camera was functional or not, and whether there was written informed consent for the use of the video camera. Subsequent interview with the facility psychologist and the behaviorist confirmed client #5 did not require video surveillance in his bedroom to address suicidal threats or ideations over the past year. Continued interview confirmed the video camera should have been removed from client #5's bedroom several months ago.	W 129		
W 155	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on review of facility internal documents and interviews, the facility failed to implement sufficient client protection measures after an investigation was in progress. The finding is: Review of facility internal documents on 8/12/19 for a complaint investigation revealed an investigation started on 7/29/19 and ended on 8/1/19. The original scope of the investigation was to determine neglect or abuse for an incident noted to have occurred on 7/28/19 between clients #1 and #4 regarding inappropriate oral sexual activity. Continued review of facility	W 155		

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W 155	Continued From page 6 internal documents revealed initially 3 staff (C, J, and K) on duty during the 7/28/19 incident were reported to be placed on administrative leave, during the investigation. Subsequent review revealed 2 staff (C and J) were placed on administrative leave, during the investigation, and not staff K. Ongoing reviews on 8/12/19 of facility internal documents revealed, during the investigation, a revision occurred to place staff specifically assigned to clients #1 and #4 during the 7/28/19 incident on administrative leave. Continued review revealed staff J and K were assigned separately to clients #1 and #4 and these 2 staff members, per the administrative leave revision, should have been placed on administrative leave. Further review revealed staff C should not have been placed on administrative leave, per the administrative leave revision, as she was assigned to client #5 on 7/28/19. Subsequent review revealed the administrative leave oversight stemmed from initial reports of all 3 staff on duty 7/28/19 being placed on administrative leave and the decision to later revise, during the investigation, which staff should be placed on administrative leave. Consequently, and despite the administrative leave revision to include specific staff assigned/responsible for clients #1 and #4 during the 7/28/19 incident, staff K continued to work during the facility investigation. Continued review of the facility internal documents, confirmed by interview with the program manager and the administrator, on 8/13/18, revealed the investigation did not substantiate neglect or abuse. Further interview confirmed the oversight in allowing staff K to work throughout the facility's investigation did not	W 155		

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W 155	Continued From page 7 protect clients from potential abuse and neglect during the internal investigation. In addition, the program manager revealed the facility investigator may need more training.	W 155		
W 285	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(2) Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected. This STANDARD is not met as evidenced by: Based on observations, interview and record review the facility failed to assure interventions to manage the behavior of 1 of 3 sampled clients (#5) was employed with sufficient safeguards to assure the rights of the client. The finding is: Observations in the group home on 8/13/19 revealed a video camera being removed by a maintenance staff member from client #5's bedroom wall. Interview with the qualified intellectual disabilities professional (QIDP) on 8/13/19 revealed she was unaware a video camera was in client #5's bedroom. Continued interview with the home manager revealed the video camera had been implemented and utilized to safeguard client #5 when he was suicidal over a year ago. Review of client #5's individual support plan (ISP) dated 6/20/19 contained a behavior support plan (BSP) dated 6/30/19 for the client to "decrease inappropriate behaviors of self harm or suicidal	W 285		

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W 285	Continued From page 8	W 285		

ideation, of placing cords or shoestrings around his neck, or consuming toxic non-edible perishable substances." Interview with the acting QIDP and the facility behaviorist revealed client #5's suicidal/self harm behaviors subsided over a year ago, after medication changes and the implementation of 1:1 staff for client #5. Continued interview with the program manager on 8/13/19 confirmed although there was a legitimate reason for use of a bedroom video camera on client #5's admission in 2017, client #5 had not exhibited suicidal ideations or suicidal attempts in over one year. Further record review on 8/13/19 revealed there had not been interdisciplinary team meetings, for over 6 months, to fully discuss the progress and needs of client #5 or the use/removal of the bedroom video camera. Subsequent record review for client #5 revealed no written informed consent from client #5's legal guardian for a video camera in client #5's bedroom other than the use of a monitor. In addition, there was no current written tool in place for staff to document usage of the bedroom video camera or the monitor to enable the facility to track the usage of the bedroom video camera and the monitor.

Interview with the facility QIDP and the program manager confirmed the video camera in client #5's bedroom had not been managed correctly by the team to assure the rights of client #5. Further interview with the program manager confirmed a team meeting would take place today on 8/13/19 to reassess client #5's BSP in regards to providing a safe environment, the use of a video camera, and the use of a monitor. Subsequent interview with the QIDP and the program manager confirmed written informed consents would be obtained from client #5's legal guardian

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W 285	Continued From page 9 and the human rights committee if a video camera or monitor was utilized to provide safety for client #5.	W 285		

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E 009 Local, State, Tribal Collaboration Process
CFR(s): 483.475(a)(4)

CANC, specifically the Oakhaven team, will ensure there is ongoing Local, State, Federal, and Tribal Collaboration with Mecklenburg County regarding the EP.

The Program Manager and Clinical Supervisor will document their efforts to have ongoing, integrated emergency collaboration with local EP officials relative to available resources for emergency evacuations. The Clinical Supervisor will reach out to FEMA to establish an EP on the federal level. The Program Manager will reach out to county officials to create an integrated response during a disaster or emergency situation The Program Manager and Clinical Supervisor will document all collaboration efforts and file in the Oakhaven Disaster Preparedness Manual. The Clinical Supervisor will discuss collaborative efforts with the team at monthly staff meetings.

Person Responsible: Clinical Supervisor, Program Manager
Date to Be Completed: 10.07.19

E039 EP Testing Requirements
CFR(s): 483.475(d)(2)

CANC, specifically the Oakhaven team will ensure that an Emergency Preparedness drill is conducted at least annually to test the facility's Disaster Preparedness Plan.

The Residential Manager and Clinical Supervisor will conduct a mock emergency evacuation drill at least annually. Ongoing training will be conducted at monthly staff meetings to ensure all staff are prepared. The drill will be documented on a Disaster Drill form. The Residential Manager and Clinical Supervisor will review the document and submit to the Program Manager for Safety Committee review. Any issues or concerns will be communicated to the Oakhaven team. The Program Manager will review staff meeting discussions and drills during monthly site reviews.

Person Responsible: Residential Manager, Clinical Supervisor, Program Manager
Date to Be Completed: 10.07.19

W129 PROTECTION OF CLIENTS RIGHTS
CFR(s): 483.440(a)(7)

The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy.

CANC, specifically the Oakhaven team, will the rights of all clients, including the opportunity for personal privacy.

The video camera was removed from the consumer's bedroom on 08.13.19. The Core Team met to review client #5's Behavior Support Plan including any restrictions. The team agreed not to reinstate the video camera due to lack of documentation. The behaviorist will continue to monitor and review the data submitted to determine if the video camera is needed. If needed, the Behaviorist will obtain consent from his parent and Human Rights Committee. The Core Team will review data during monthly meetings. The Program Manager will review the behavior data during monthly site reviews.

Person Responsible: Behaviorist, Clinical Supervisor, and Program Manager
Date to Be Completed: 10.07.19

W155 STAFF TREATMENT OF CLIENTS
CFR(s): 483.420 (d)(3)

The facility must prevent further potential abuse while the investigation is in progress.

CANC, specifically the Oakhaven Group Home, will prevent further abuse while any investigation is in progress.

The Executive Director retrained the Program Manager and the investigator to ensure all clients are protected from further potential abuse and neglect during internal investigations. They will ensure all involved employees are placed on administrative leave during the investigation. If substantiated, formal corrective action will be presented up to and including termination. The Program Manager will review the allegation with the assigned investigator prior to the investigation to include staff placed on administrative leave. During the investigation, the investigator will inform the Program Manager if additional staff need to be placed on administrative leave.

Person Responsible: Program Manager and assigned investigator
Date to Be Completed: 10.07.19

W285 MANAGEMENT OF INAPPROPRIATE CLIENT BEHAVIOR
CFR(s): 483.450 (b)(2)

Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected.

CANC, specifically the Oakhaven group home, will ensure Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and

supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected.

The video camera was removed from the consumer's bedroom on 08.13.19. The Core Team met to review client #5's Behavior Support Plan including any restrictions. The team agreed not to reinstate the video camera due to lack of documentation. The Core Team will meet monthly to review behavioral data and the need for restrictive interventions or the need to discontinue restrictive interventions. All restrictive intervention will require consent from the guardian/parent and Human Rights Committee prior to implementation. The Behaviorist will document rates of behaviors and the use of restrictive interventions in the monthly progress notes. The Program Manager will review the behavior data and the use of restrictive interventions during monthly site reviews and ensure there is written consent for any restrictive intervention. The Clinical Supervisor and/or Behaviorist will review all restrictive interventions at monthly staff meetings.

Person Responsible: Behaviorist, Clinical Supervisor, and Program Manager
Date to Be Completed: 10.07.19