STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G263	A. BUILDING _____ B. WING _____	02/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-YOUNG GROUP HOME	211 YOUNG STREET SHELBY, NC 28150

(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 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide opportunities for choice and self management for 1 of 5 sampled clients (#6). The finding is: Observations in the group home on 2/12/20 at 7:00 AM revealed staff A assisting client #6 with preparing cereal as a part of the breakfast meal. Staff A was observed in the kitchen assisting client #6 with pouring cereal and pouring milk into the cereal. Continued observations revealed the facility home manager to enter the kitchen and prompt the client for medications. Client #6 then went to the medication room and staff A covered the cereal bowl and put it in the refrigerator. It should be noted that client #6 was administered a pre-meal medication during medication administration. Further observations at 7:30 AM revealed staff A taking the cereal bowl from the refrigerator and assist the client with taking it to the table along with other breakfast items. Client #6 was not offered the opportunity to prepare a new bowl of cereal and milk. Interview with the facility qualified intellectual disabilities professional (QIDP) and the facility program manager (PM) on 2/12/20 confirmed client #6 should have been offered the opportunity to assist with preparing a new bowl of cereal. The QIDP and the PM confirmed the bowl of cereal prepared at approximately 7:00 AM would be soggy after sitting in the refrigerator until 7:30 AM. Therefore, the facility failed to assure	W 247		

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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W 247	Continued From page 1 client choice and self management.	W 247		
W 289	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(4) The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure interventions used to manage inappropriate client behaviors were incorporated into the individual service plans (ISP) for 1 of 5 sampled clients (#1). The finding is: Observations in the group home on 2/11/20 at 5:15 PM revealed client #1 exiting the home through the front door. The qualified intellectual disabilities professional (QIDP) was observed to immediately follow the client and attempt to redirect client #1 back in to the home verbally and with physical prompting. The client was observed to resist redirection and attempt to stand by the door of the facility transportation van. Further observations on 2/12/20 at 7:25 AM and 7:40 AM revealed client #1 to exit the front door of the home with the QIDP following the client and attempting to re-direct the client back into the home with the client being resistant. Continued observations at 8:00 AM revealed client #1 to again exit the front door followed by Staff C who followed the client around the group home	W 289		

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W 289	Continued From page 2	W 289		

parking lot and attempted to re-direct the client back into the home to change his shirt.

Review of the record for client #1 on 2/12/20 revealed an individual support plan (ISP) dated 8/7/19. Further review of the ISP revealed a team meeting occurred on 12/17/19 related to increased client behaviors. The documentation indicated 1:1 supervision had been initiated on 10/17/19 due to increased aggressive behavior and attempts to run out the front door of the group home and the day program. The recommendations included continuing the 1:1 supervision at arms length due to continued aggression and AWOL attempts. Further review of the record revealed a team meeting on 1/15/20 which indicated a decrease in client #1's behaviors and a recommendation to end the 1:1 supervision.

Continued review of the ISP revealed a behavior support plan (BSP) dated 2/12/10 which included target behaviors of verbal disruption, physical aggression, self injurious behavior and non-compliance. The BSP did not contain AWOL as a target behavior. Further review of the BSP revealed interventions for target behaviors to include 1:1 staff supervision if significantly agitated or aggressive behavior continued for 10 minutes. The BSP did not contain specific interventions for AWOL behavior.

Interview with the qualified intellectual disabilities professional (QIDP) on 2/12/10 revealed client #1 had undergone medication changes in August or September of 2019 and this had changed client #1's behavior. The QIDP indicated that overall the behaviors had decreased, but the client continued to have occasions of attempting AWOL

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W 289	Continued From page 3 at the group home and at the day program. The QIDP indicated there had been no occasions of AWOL that were not witnessed by staff and immediately followed up with. Interview with the QIDP and the facility behaviorist on 2/12/20 confirmed that AWOL was not included as a target behavior in the BSP and confirmed interventions for staff to prevent and intervene relative to the management of AWOL behavior also were not included in client #1's BSP.	W 289		