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 03/04/2020

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
W 000	INITIAL COMMENTS	W 000		
W 157	Intake #NC00161045, NC00161563 STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(4) If the alleged violation is verified, appropriate corrective action must be taken. This STANDARD is not met as evidenced by: Based on record review and verified by interviews, the facility failed to show evidence of timely corrective action related to a verified allegation of neglect. The finding is: Review of internal records on 3/3/20 revealed an internal investigation dated 2/10-2/19/20. Review of the internal investigation revealed on 2/8/20 client #6 was transported by emergency services to a local emergency room due to behaviors of threatening elopement, exhibiting physical aggression and property destruction. Continued review of the internal investigation revealed client #6 was not accompanied by staff to the hospital for emergency evaluation or care. A review of factual findings relative to the 2/10/20 internal investigation revealed medics transported client #6 to the hospital around 6:30 PM on 2/8/20 and no staff accompanied the client to the hospital or while at the hospital. Continued review of findings revealed client #6 returned to the group home around 2:54 AM on 2/9/20. Subsequent review revealed the home manager (HM) of the group home was on call during the incident and did not answer telephone calls in a timely manner and responded to missed phone calls through text messages with staff.	W 157		

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

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W 157	Continued From page 1 Additional review revealed staff assigned to client #6 on 2/8/20 did not accompany client #6 to the hospital as the group home would have been out of ratio with other client's still at home. Ongoing review of findings revealed the group home had an outdated on-call list, the BSP for client #6 included target behaviors exhibited on 2/8/20 and the home manager submitted a resignation during the investigation. Findings relative to the investigation also noted on 1/4/20 the facility submitted a 60 day discharge notice to the LME for client #6 due to incidents of property destruction and elopement. A review of conclusions relative to the 2/10/20 internal investigation revealed a substantiated finding of neglect for the HM. Neglect was substantiated as phone calls were not answered timely, client #6 was not accompanied by a staff to the hospital and a current on-call schedule was not posted in the group home. A review of recommended corrective actions relative to the 2/10/20 internal investigation of substantiated neglect revealed the termination of the HM, who resigned 2/19/20 and trainings to be conducted by the qualified intellectual disabilities professional (QIDP) and director of nursing (DON). Continued review of the recommended corrective actions revealed the QIDP was to in-service staff on the on-call protocols of the facility and in-service staff on protocols regarding individuals transported to the hospital. The DON was to in-service nursing staff to answer calls when on-call and ensure voicemail is not full when on-call. Interview with the QIDP on 3/3/20 revealed she	W 157		

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W 157	Continued From page 2 had not conducted in-services relative to the 2/10/20 internal investigation of client #6 as she had not been informed of recommended actions. Interview with administration staff on 3/4/20 revealed in-services relative to the 2/10/20 investigation had not been completed as of the current survey date of 3/4/20. Further interview with administration staff verified the recommended actions had not been conducted timely after an internal investigation that resulted in a substantiated finding of neglect.	W 157		