STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G193	A. BUILDING ______ B. WING ______	03/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-SIMPSON GROUP HOME	**3017 SIMPSON DRIVE CHARLOTTE, NC 28205**

(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 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, record review and interviews the facility failed to assure each employee receives sufficient training regarding behavior support plans (BSPs), documentation and incident reporting for 1 of 3 sampled clients (#6). The finding is: Observations on 3/10/20 of the group home's exterior revealed 2 windows with alterations located at the front, far-right of the house and the window adjacent at the end of the house. The front window had two 2" x 4" boards approximately 18" in length fastened with screws vertically at each side and an alarm could be seen on the inside of the window. Further observation revealed the adjacent exterior window at the right end of the house appeared to have an alarm and a board covering the window from inside. Continued observation inside the group home revealed client #6's bedroom at the end of the hallway to have a large piece of plywood fastened with screws that fully covered the window. Interview on 3/10/20 at 6:00 pm with the home manager (HM) revealed the room to be client #6's bedroom. Further interview with the HM revealed on 2/24/20 client #6 had a behavior and tore the window frame off and pushed out the window. Continued interview on 3/11/20 with the HM	W 189		

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 189	Continued From page 1 revealed she notified the maintenance company on 2/24/20 to fix the window and notified the qualified individual disabilities professional (QIDP), program manager and behaviorist by email of the incident on 2/24/20. Subsequent interview with the HM revealed client #6 had damaged the same window on 3 other occasions during a behavioral episode since his admission 12/18/19. The HM was unable to give dates of the prior incidents. Subsequent interview with the HM revealed staff found out the window was damaged when they checked on client #6 and verified staff did not hear the window alarm at the time of damage. Review on 3/11/20 of facility incident reports for the last 6 months did not reveal documentation of property destruction or behavioral incidents involving client #6. Record review for client #6 revealed a BSP written 11/19/19 which indicated the client has a history of running and prying locks related to target behaviors including property destruction and elopement. Further review of the BSP revealed staff are to always monitor client #6 closely and all target behaviors including other behaviors will be documented on the behavior data log every time they occur. Review of client #6's behavior log for the last 3 months did not reveal documentation of behaviors involving property destruction of windows. Interview on 3/11/20 with the QIDP and program director revealed they had not been informed of client #6's behaviors or the destruction of his bedroom window and were unaware the windows to his room were blocked. Further interview with the program manager revealed all staff working with client #6 have been trained to document all	W 189		

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W 189	Continued From page 2 behaviors and should have filled out an incident report for the damaged window.	W 189		
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the individual support plan (ISP) failed to include sufficient training objectives or interventions relative to behavior management for 1 of 3 sampled clients (#6). The finding is: Observations throughout the 3/10/20 to 3/11/20 survey revealed client #6 to participate in various activities with staff supervision. Continued observations revealed client #6 to have a staff accompany and/or monitor him at meal times, visits to the bathroom, various activities and time spent in his room. Further observations revealed one window being intact and fully covered by a wooden board from inside the window in client #6's bedroom. Additional observations revealed a second window in client #6's bedroom having two 2" x 4" pieces of plywood approximately 18" long and fixated with nails along the outer sides of the window frame. It is important to mention that during the observation period the window panes in client #6's bedroom were not broken or cracked. Review of records for client #6 revealed an	W 227		

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W 227	Continued From page 3 individual support plan (ISP) dated 12/17/19 which included the following programs: hygiene (e.g. toothbrushing, handwashing, bathing), privacy, communication, and making his bed. Continued review of records for client #6 included a behavioral support plan (BSP) dated 11/19/19 which listed the following target behaviors: masturbation, anxiety/disruptions, verbal and physical aggression, non-compliance, elopement, property destruction of his clothing, and inappropriate toileting. Further review of the ISP revealed no programming or training objectives relative to property destruction of windows or the need for 1:1 staff supervision. Interview with the home manager (HM) on 3/10/20 revealed that client #6 has had a total of four incidents since his admission on 11/18/19 which included attempts to break or push out a window in his bedroom. Further interview with the HM revealed that a work order was placed on 2/24/20 due to client #6 pushing out his window with his hand, which led to the wooden board being placed over the window in his room. The HM confirmed via interview that client #6 should not have wooden boards or plywood to block egress or combat property destruction. Further interview with the HM verified that client #6 does not have any programming or training objectives relative to property destruction. Interview with the qualified intellectual disabilities professional (QIDP) on 3/11/20 verified that client #6 should not have boards on his windows to block egress or prevent property destruction. The QIDP confirmed that client #6 does not have any programming or training objectives relative to property destruction of windows. The QIDP additionally confirmed during the interview that	W 227		

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W 227	Continued From page 4 client #6 could benefit from programming and/or training objectives relative to property destruction of his environment such as windows.	W 227		
W 287	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used for the convenience of staff. This STANDARD is not met as evidenced by: Based on observations and staff interviews, the facility failed to assure techniques used to manage inappropriate behavior for client #6 were not used for the convenience of staff for 1 of 3 sampled clients (#6). The finding is: Observations on 3/10/20 of the group home's exterior revealed 2 windows with alterations at the front, far-right of the house and the window adjacent at the end of the house. The front window had two 2" x 4" boards approximately 18" inches in length fastened with screws vertically over the front far-right window at each side and an alarm could be seen on the inside of the window. Further observation revealed the adjacent window at the right end of the group home appeared to have an alarm and a board covering the window from inside. Continued observation inside the group home revealed client #6's bedroom at the end of the hallway to have a large piece of plywood fastened with screws that fully covered the window. Interview on 3/10/20 with the home manager (HM) revealed on 2/24/20 client #6 was having a	W 287		

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W 287	Continued From page 5	W 287		

behavior, tore the window frame off and pushed out the window. Further interview on 3/11/20 with the HM revealed she notified the maintenance company on 2/24/20 to fix the window and notified the qualified intellectual disabilities professional (QIDP), program manager and behaviorist by email of the incident and the request to have the window repaired. Continued interview with the HM revealed client #6 had damaged the same window during a behavior episode on 3 other occasions since his admission on 12/18/19. The HM was unable to give dates of the prior incidents and did not make out an incident report for the property destruction. Subsequent interview with the HM revealed on 2/24/20 a staff person found out the window was damaged when they checked on client #6 and verified staff did not hear the window alarm sound at the time of destruction.

Review of records on 3/11/20 for client #6 revealed a behavior support plan (BSP) dated 11/19/19 listing restrictions that included medications, alarms and sensors on the bedroom door and windows due to elopement and a shadow box to protect his TV from property destruction. Further review of client #6's BSP revealed staff are to always monitor him closely and all target behaviors including other behaviors will be documented on the behavior data log every time they occur. Review of group home incident reports for the last 6 months and client #6's behavior log for the last 3 months revealed no documentation of behaviors and the destruction of his bedroom window.

Interview on 3/11/20 with the QIDP and program director revealed they had not been informed of client #6's behaviors or the destruction of his

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W 287	Continued From page 6 bedroom window. Continued interview revealed the QIDP and program director were unaware the windows to client #6's room were blocked to prevent opening. Further interview with the program director revealed staff should have documented all behaviors for client #6 and completed incident reports for damage to the window. Additional interview with the QIDP revealed all staff have been trained on client #6's BSP and incident reporting.	W 287		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation and interviews, the team failed to assure all medications and biologicals remain locked except when being prepared for medication administration for 1 of 3 sampled clients (#1). The finding is: Afternoon observations in the group home on 3/10/20 at 4:40 PM revealed client #1 to sit in the medication room and prepare for medication administration. Continued observation revealed staff D to state "I need to get some applesauce" and was observed to leave the medication room and enter the hallway. Client #1 was observed to be left unattended in the medication room with the medication basket on the counter and medication cabinet left open. It is important to mention that this surveyor stepped into the hallway and continued to monitor client #1 and the medication basket from the hallway.	W 382		

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W 382	Continued From page 7 Subsequent observation revealed staff D was observed to return to the medication room with applesauce and proceed to administer medications to client #1. Interview with staff D on 3/10/20 revealed that there is always a staff member on the outside of the closed door to the medication room during medication administration to assist as necessary. Interview with the home manager (HM) on 3/11/20 confirmed that client #1 should not have been left in the medication room unsupervised with open access to the medication cabinet and medication basket. Interview with the HM also verified that if staff need assistance during medication administration they are to remain in the room with clients and call into the hallway for assistance until a staff member or management is available to assist. Interview with the qualified intellectual disabilities professional (QIDP) on 3/11/20 confirmed that all clients should remain supervised while in the medication room during medication administration times. The QIDP also confirmed during the interview that all medications should be locked at all times prior to medication administration.	W 382		