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 _____	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 157	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. 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	W 157		

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

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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 Ongoing review of findings revealed the group home had an outdated on-call list, the BSP for client #6 included target behaviors exhibited on 2/8/20 and the home manager submitted a resignation during the investigation.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 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

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W 157	Continued From page 2 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		
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 observations, review of records, and staff interview, the individual support plan (ISP) failed to include sufficient objectives to address identified needs relative to rate of eating and drinking for 1 of 3 sampled clients (#1). The finding is: Afternoon observations in the group home on 3/3/20 at 5:45 PM revealed client #1 to sit at the dining table and to participate in the dinner meal. Client #1 was observed to eat a pureed meal that included zucchini chicken stew, couscous, cornbread, applesauce, and a sugar free drink. Further observation revealed client #1 used the following adaptive equipment during the dinner meal: angled spoon, high sided dish, spout cup and a shirt protector. Continued observations revealed staff to redirect client #1 several times to slow his rate of eating and drinking in between bites throughout the dinner meal.	W 227		

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W 227	Continued From page 3 Morning observations in the group home on 3/4/20 at 7:10 AM revealed client #1 to sit at the dining table and to participate in the breakfast meal. The breakfast meal consisted of cereal, cut up banana pieces, water and juice. Client #1 was observed to eat a bowl of cereal placed on top of a shirt protector which was fastened around his neck. During the breakfast meal, staff were observed continuously redirecting client #1 to slow his rate of eating and drinking. Review of records for client #1 on 3/4/20 revealed an individual support plan (ISP) dated 6/18/19. Review of the ISP for client #1 revealed adaptive equipment to include: a gait belt, wheelchair, scoop/divided plate, spout cup, teaspoon for meals, adult briefs, thick-it and a puree diet due to history of choking. Further review of records for client #1 revealed an Adaptive Behavior Inventory (ABI) dated 5/14/19 that indicated client #1 can chew food and use a napkin neatly and independently. Subsequent review of the client record revealed a choking assessment dated 2/18/19 that indicated client #1 has a fast rate of drinking and requires supervision. Review of records for client #1 revealed no programming or guidelines relative to rate of eating or drinking during meals. Interview with the qualified intellectual disabilities professional (QIDP) on 3/4/20 revealed client #1 had no current programming or guidelines to prevent choking and slow his rate of eating and drinking during meals. Continued interview with the QIDP confirmed that client #1 could benefit from programming relative to rate of eating and drinking during meals to prevent choking.	W 227		

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W 247	Continued From page 4	W 247		
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 4 clients (#4) residing in the home relative to bathroom choice. The finding is: Observation in the group home on 3/3/20 at 4:35 PM revealed client #4 to walk to a hallway bathroom of the group home and attempt to enter the bathroom. Staff B was observed to immediately intervene with the client by stating "No, client #1 is in there, you will have to wait" and redirected client #4 to her bedroom. Client #4 was observed to verbalize "I have to go to the bathroom" before entering her bedroom. Subsequent observation revealed client #4 to go to the bathroom after client #1 exited. Interview with the interim home manager (HM) on 3/3/20 revealed there were two bathrooms in the home that client's utilize. Continued interview with the HM revealed the alternate bathroom on 3/3/20 was inaccessible due to a maintenance issue. Interview with the qualified intellectual disabilities professional (QIDP) on 3/3/20 at 6:40 PM verified the group home had three bathrooms with only two bathrooms having a shower/bathtub. Further interview with the QIDP verified client #4 should have been offered the choice to use an alternate bathroom in the group home at 4:45 PM as an additional bathroom was accessible for toileting at that time. Additional	W 247		

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W 247	Continued From page 5 interview with the QIDP verified the bathroom in the group home without a shower/bathtub is often thought of as the "staff bathroom" although client's should be able to use any bathroom in the group home.	W 247		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observation and staff interview, the interdisciplinary team failed to provide staff training of appropriate hygiene practices relative to meal preparation and client care. The finding is: Observation in the group home on 3/3-3/4/20 revealed the dinner and breakfast meals to be prepared in the kitchen of the group home. Continued observation on 3/3-3/4/20 revealed various clients to be involved with dinner and breakfast meal preparation at various times and to throw items in the trash during meal preparation activities. Observation of the kitchen trash can revealed residue from multiple meals and a flip top lid that required touching the trash can lid to throw away trash during meal preparation. Observation on 3/4/20 at 7:35 AM revealed the facility qualified intellectual disabilities professional (QIDP) to reach her hand into the trash can to push trash deeper into the	W 340		

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W 340	Continued From page 6 trash can so trash would not over flow into the floor, touching trash and the top of the trash can without gloves. Interview with the QIDP on 3/4/20 verified the kitchen trash can in the group home was dirty and had residue from various past meals indicating the trash can had not been cleaned for an undetermined amount of time. Continued interview with the QIDP on 3/4/20 confirmed staff should have washed their hands, and prompted clients to wash their hands, each time after touching the trash can. Additional interview with the QIDP confirmed the condition of the kitchen trash can was not acceptable and created hygiene concerns for the group home.	W 340		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to assure wheelchairs were clean and in good repair for 1 of 3 sampled clients (#1). The finding is: Afternoon observations in the group home on 3/3/20 at 5:45 PM revealed client #1 to be seated at the dining table and to participate in the dinner meal. Continued observation revealed client #1	W 436		

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had a tear in his wheelchair headrest cover of approximately 2" inches wide. Further observation revealed client #1 had dried food particles and spillage around his wheelchair lap belt, seat, and alongside the wheelchair frame.

Morning observations in the group home on 3/4/20 from 6:45 AM to 8:00 AM revealed client #1 to sit at the dining table and to participate in various activities such as a game activity with staff. Continued observation revealed client #1 to also participate in the breakfast meal. Further observation revealed client #1 to have dried food particles around the wheelchair frame and lap belt of his wheelchair as noted in previous observations.

Interview with the home manager (HM) on 3/4/20 revealed client #1 did not have a current wheelchair cleaning schedule. The qualified intellectual disabilities professional (QIDP) on 3/4/20 further verified a wheelchair cleaning schedule for client #1 was not available. Subsequent interview with the QIDP revealed the previous HM was responsible for a cleaning schedule of client #1's wheelchair and the wheelchair had not been thoroughly cleaned since the previous HM's departure, approximately three weeks ago.

Interview with the QIDP further verified that she was aware of the tear in client #1's headrest cover. Additional interview with the QIDP confirmed that a replacement headrest cover was needed for the wheelchair. Subsequent interview with the QIDP verified a wheelchair cleaning schedule for client #1's wheelchair was needed to ensure consistent cleaning.