STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G139	A. BUILDING _____ B. WING _____	C 04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-NORWICH ROAD GROUP HOME	1006 NORWICH ROAD CHARLOTTE, NC 28227

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W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record review and verified by interviews, the facility failed to complete a thorough investigation with the inability to show evidence of complete interviews or appropriate corrective measures related to a substantiated finding of neglect with a client injury. The finding is: Review of internal records on 4/6/21 revealed an internal investigation dated 2/12/21. Review of the internal investigation revealed on 2/12/21 an internal investigation was initiated due to an injury of a fractured collar bone of client #2. Continued review of the internal investigation revealed Staff A was working in the group home at 9:30 AM on 2/12/21 when she saw client #2 fall after client #6 ran out of her room and knocked client #2 down. Further review of the internal investigation revealed staff A to report in interview that she attempted to call nursing at the time of the fall and nursing did not answer. Subsequent review of the 2/12/21 internal investigation revealed the site manager spoke with the nurse and client #2 was transported to Urgent Care for medical evaluation. There was no time noted as to when nursing was reached regarding client #2's injury in the internal investigation. Additional review of the internal investigation revealed on 2/12/21 client #2 was treated for a fracture of the right collarbone.	W 154		

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

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Review on 4/6/21 of the internal incident report from the 2/12/21 incident revealed at 9:30 AM on 2/12/21 client #2 was coming down the hallway, was bumped by another client and hit her shoulder on the floor. Review of notifications on the 2/12/21 incident report revealed the home supervisor and clinical supervisor were contacted, nursing was unable to be reached and the nurse's cell phone voicemail box was full.

A review on 4/6/21 of the conclusion and recommendations of the 2/12/21 internal investigation revealed a substantiated finding of neglect due to staff ratio. Recommendations revealed the need to ensure staff ratio was met according to the individual support plans of clients in the home, the need to ensure management is supporting coverage, ensure staff report to management any ratio issues, ensure staff are able to reach the nurse and the team will evaluate support for client #6 to decrease targeting behavior.

Review of records on 4/6/21 for client #2 revealed an individual support plan (ISP) dated 3/26/20 with a diagnosis history of Autism and Profound intellectual disability. Review of medical records for client #6 revealed an annual physical exam on 8/18/20 with a diagnosis of osteoporosis. Review of a med consult dated 2/12/21 verified client #2 was medically treated for a right clavicle fracture and referred to a orthopedic provider for follow-up. Subsequent review on 4/6/21 of medical consults for client #2 revealed a consult dated 2/16/21 for a follow-up from urgent care; right clavicle fracture, sling 3 weeks with return appointment scheduled 3/9/21.

Review of records for client #6 on 4/6/21 revealed

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a behavior support plan dated 8/21/20. Review of the current behavior plan revealed target behaviors of: aggression (biting, hitting, slapping, kicking, or other actions towards others which may cause injury), self-injurious behavior and depression.

Interview on 4/6/21 with the facility administrator and staff conducting the internal investigation verified the investigation had resulted in a substantiated finding of neglect due to staff ratio issues at the time of the incident. Continued interview with the facility administrator revealed additional efforts that had been implemented to support proper staff ratio since the 2/12/21 injury of client #2. Further interview with the facility administrator revealed the group home had been staffed with proper ratio since the 2/12/21 incident.

Interview with the facility site manager on 4/6/21 revealed the nurse was contacted at approximately 3:00 PM on 2/12/21. Continued interview with the site manager revealed she sent pictures to the nurse regarding the bruising of client #2 and the nurse directed staff to take the client to Urgent Care. Further interview with the site manager revealed she arrived with client #2 at Urgent Care on 2/12/21 about 4:00 PM. Subsequent interview with the site manager verified client #2 had been to (2) follow-up appointments with the orthopedic doctor since the 2/12/21 incident and the client was out of a sling and had no further pending appointments relative to the injury. Additional interview with the site manager verified staffing support had improved since the 2/12/21 injury of client #2 and an in-service with staff was conducted 3/11/21 to ensure staff report properly if ratio was not met

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W 154	Continued From page 3 when reporting for a shift. Interview with the facility nurse on 4/6/21 verified she remembered getting a call about an injury to client #2 on 2/12/21 although she could not remember what time she was contacted. Interview on 4/6/21 with the internal investigator of the 2/12/21 incident verified she had not interviewed the facility nurse during the investigation. Subsequent interview with the internal investigator revealed she was unsure of the time lapse of when client #2 was injured and when the client received medical care after the injury. Interview with administrative staff on 4/6/21 verified the facility nurse should have been interviewed during the internal investigation to ensure a thorough investigation. Continued interview with administration staff verified recommendations to address a more timely response from nursing after an injury should have been included with formal recommendations of the internal investigation.	W 154		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide timely nursing services in accordance with the needs of 1 of 6 sampled clients (#2) relative to a injury of a fractured collar bone. The finding is:	W 331		

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Review of internal records on 4/6/21 revealed an internal investigation dated 2/12/21. Review of the internal investigation revealed on 2/12/21 an internal investigation was initiated due to an injury of a fractured collar bone of client #2. Continued review of the internal investigation revealed Staff A was working in the group home at 9:30 AM on 2/12/21 when she saw client #2 fall after client #6 ran out of her room and knocked client #2 down. Further review of the internal investigation revealed staff A to report in interview that she attempted to call nursing at the time of the fall and nursing did not answer.

Subsequent review of the 2/12/21 internal investigation revealed the site manager spoke with the nurse and client #2 was transported to Urgent Care for medical evaluation. There was no time noted as to when nursing was reached regarding client #2's injury in the internal investigation. Additional review of the internal investigation revealed on 2/12/21 client #2 was treated for a fracture of the right collarbone.

Review on 4/6/21 of the internal incident report from the 2/12/21 incident revealed at 9:30 AM on 2/12/21 client #2 was coming down the hallway, was bumped by another client and hit her shoulder on the floor. A review of notifications on the 2/12/21 incident report revealed the home supervisor and clinical supervisor were contacted, nursing was unable to be reached and the mailbox was full.

Interview with the facility site manager on 4/6/21 revealed the nurse was contacted at approximately 3:00 PM on 2/12/21. Continued interview with the site manager revealed she sent pictures to the nurse regarding the bruising of

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W 331	Continued From page 5 client #2 and the nurse directed staff to take the client to Urgent Care. Further interview with the site manager revealed she arrived with client #2 at Urgent Care on 2/12/21 about 4:00 PM. Subsequent interview with the site manager verified client #2 had a delay of over 5 hours in receiving medical care for a fractured collar bone due to the inability to reach the facility nurse on 2/12/21. Interview with the facility nurse on 4/6/21 verified she was on-call and remembered getting a call about an injury to client #2 on 2/12/21 although she could not remember what time she was contacted. Continued interview with the facility nurse verified client #2 required medical attention outside the facility due to bruising that resulted in a diagnosis of a fractured collar bone. Further interview with nursing revealed she could not remember the reason for the difficulty in staff reaching her on 2/12/21. Interview with administration staff on 4/6/21 verified a delay in over 5 hours for medical treatment of a fractured collar bone is untimely.	W 331		