STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G096	A. BUILDING _____ B. WING _____	04/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-DENBUR DRIVE GROUP HOME	8324 DENBUR DRIVE CHARLOTTE, NC 28215

(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 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure privacy was maintained for 1 of 4 sampled clients (#2) during shower preparation. The finding is: Observation in the group home on 4/13/21 at 5:15 PM revealed staff A to exit the bedroom of client #1, enter the bathroom next to client #1's bedroom and stand in the doorway of the bathroom with the door open. Continued observation at 5:18 PM revealed staff A to verbally prompt client #1 to the bathroom from his bedroom and for client #1 to exit his bedroom wearing no clothing. Client #1 was observed to walk to the bathroom and staff A to close the bathroom door. The residential manager was observed to prompt staff A to "make sure client #1 has on a robe next time." Review of records for client #1 on 4/14/21 revealed an individual support plan (ISP) dated 10/22/20. Review of the 10/2020 ISP revealed training objectives relative to: cleaning eyeglasses, community integration, participation in habilitation programs, exercise, hand washing, oral hygiene, chores and coin identification. Further record review revealed a community home life assessment dated 1/18/20 to reflect client #1 shows awareness of a need for privacy with verbal cues.	W 130		

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

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W 130	Continued From page 1 Interview with the group home site supervisor verified staff should have redirected client #1 to his room for a robe when the client exited his room wearing no clothing. Interview with the facility qualified intellectual disabilities professional (QIDP) revealed she was unaware of privacy issues with client #1 such as exiting his room with no clothing. Continued interview with the QIDP verified client #1's right to privacy should be protected and staff should have provided redirection to prevent the client from exiting his room without wearing any clothing.	W 130		
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, review of records and interview, the individual support plan (ISP) failed to have sufficient training objectives to meet identified client needs for 2 of 4 sampled clients (#1 and #6). The findings are: A. The ISP for client #1 failed to have programming to address needs relative to maladaptive behaviors. For example: Observation at the group home on 4/14/21 at 8:25 AM revealed client #1, #2, #3 and #5 to load the facility van for an outing. Continued observation revealed client #1 to sit in the front passenger seat. Further observation revealed	W 227		

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W 227	Continued From page 2	W 227		

clients #2, #3 and #5 to converse with each other from the back seat of the van and client #2 to call client #1's name. Subsequent observation revealed client #1 to say to client #2 "What, What do you want?" "I said What do you want?" "You just keep calling my name, What do you want?" Observation additionally revealed staff C to intervene with client #1 and ask the client to calm down.

Review of records for client #1 on 4/14/21 revealed an admit date of 10/22/20. Continued review of records for client #1 revealed a diagnosis history to include: severe intellectual disability and autism. A review of training objectives and programming for client #1 revealed no program or guidelines relative to targeted behavioral needs.

A review of monthly summary notes relative to client #1 revealed behavioral incidents in 12/2021, 1/2021 and 2/2021. A review of the 12/2021 behavioral note for client #1 revealed episodes of behavioral agitation at another resident; staff documented clt would tell resident to shut up, put his fist up to the resident and tell the resident to go to his room. During one incident, staff noted client #1 was at the table mocking another resident calling him a dummy and getting on his nerves.

Review of the 1/2021 behavioral note revealed: staff reported client #1 would get agitated with another resident and make a fist as if client #1 was going towards the resident and yell at staff. Client #1 was documented to tell staff to "shut up", to ask a staff if she wanted to fight and went towards the staff. Continued review of the 1/2021 monthly note revealed the guardian had been

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W 227	Continued From page 3 used as an intervention to calm client #1 down. Review of the 2/2021 behavioral note revealed: verbal aggression towards another resident telling them to "shut up". Continued review of the 2/2021 behavioral note revealed: the site supervisor expressed client #1 agitates other residents, this will be discussed at core team. Interview with the facility behaviorist on 4/14/21 confirmed client #1 had demonstrated episodes of verbal aggression in 12/2020, 1/2021 and 2/2021. Continued interview with the facility behaviorist revealed client #1's behavior continues to be monitored to determine needs of the client. Subsequent interview with the facility behaviorist verified no current program or guidelines to address verbal aggression behaviors of client #1 had been implemented after 3 consistent months of behavioral incidents. B. The PCP for client #6 failed to have programming to address dietary support with weight gain. For example: Observation in the group home on 4/13/21 at 5:00 PM revealed client #6 to sit at the table with other residents to participate in the dinner meal. Continued observation at 5:05 PM revealed client #6 to take his plate consisting of Teriyaki Asian salad and green beans to the trashcan and throw food items away. Subsequent observation revealed the site supervisor to ask client #6 if he wanted something else and for client #6 to go to the kitchen cabinet to point out ravioli. Additional observation revealed the site supervisor to heat a can of ravioli for client #6 and to provide the client with the meal substitution. Client #6 was observed to eat several bites of ravioli and take	W 227		

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his dish again to the trash.

Observation in the group home on 4/14/21 revealed the breakfast menu to include hot cereal, whole wheat bread, milk and orange juice. Observation of the breakfast meal for client #6 revealed the client to be served cold cereal and an ensure meal supplement. Continued observation revealed client #6 to drink the milk from the cereal and to walk to the trashcan to throw away the rest of his cereal.

Review of records for client #6 on 4/14/21 revealed an ISP dated 4/6/21. Review of the current ISP revealed training goals relative to hygiene, community integration, dental desensitization, habilitation activity participation, getting dressed and group participation. Further review of the ISP for client #6 revealed a diagnosis history of severe intellectual disability, autism and psychotic disorder.

Continued review of records for client #6 revealed a nutritional evaluation dated 3/8/21. Review of the 3/2021 nutritional evaluation revealed a prescribed unrestricted diet with the need to continue supplements to support weight management. Continued review of the current nutritional assessment revealed client #6 to weigh 115 lbs with a desired body weight of 140-160 lbs and a ideal body weight of 150-170 lbs.

Interview with the site manager on 4/13/21 revealed client #6 is a very picky eater and often refuses meal items. Continued interview with the site manager verified staff do not track the amount client #6 eats at meals, if substitutions are offered or what the client was offered as a substitution. Further interview with the site

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W 227	Continued From page 5 manager verified client #6 should always be offered a meal substitution if he does not eat or does not want the offered menu items. Interview with the QIDP verified client #6 should be provided meal substitutions when he refuses menu items and that the client tends to like tomato based items. Continued interview with the facility QIDP verified client #6 is a picky eater and has no meal guidelines to support the need for weight gain.	W 227		