STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G158	A. BUILDING ______ B. WING ______	C 02/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-MALLARD DRIVE	6119 MALLARD DRIVE CHARLOTTE, NC 28227

(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 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 interview, the facility failed to complete a thorough investigation for 1 of 1 sampled clients (#1) to investigate injuries sustained by unknown origin. The finding is: Review of internal records on 2/3/22 revealed an incident report (IRIS) dated 11/29/21 which revealed client #1 returned home from therapeutic leave with an injured left foot. Continued review of the IRIS report revealed that at 12:00 PM staff heard a thump on the floor and found client #1 on the floor trying to stand up. Further review of the IRIS report revealed that the nurse assessed the client and client #1's left ankle was swollen and red. Review of the IRIS report revealed that at 6:00 PM staff and client #1 were transported to the local emergency department (ED) for evaluation. Review of IRIS report revealed that client #1 was evaluated and the attending physician found a sewing needle lodged in the client's left foot along with a 5th toe fracture. Review of the internal investigative summary dated 11/29/21 revealed that client #1 returned from therapeutic leave with her guardian with a limp and swollen left ankle. Continued review of the internal investigative summary revealed the guardian told the nurse that the guardian transported client #1 to the hospital on 11/26/21 due to the client injuring her left foot. Further review of the investigative summary revealed that the guardian reported to the nurse that no	W 154		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G158	A. BUILDING ______ B. WING ______	C 02/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-MALLARD DRIVE	6119 MALLARD DRIVE CHARLOTTE, NC 28227

(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 154	Continued From page 1 additional treatment was needed for client #1. Review of the internal investigative summary revealed that on the afternoon of 11/29/21 client #1 was having difficulty standing, was assessed by the nurse and had a swollen left ankle that was warm to the touch. The investigative summary revealed that the staff accompanied the client and was transported by EMS to the ED for further evaluation of the left foot. The facility unsubstantiated the internal investigation based on allegations of neglect and injury of unknown origin. Further review of the record was not completed as client #1's record was not made available during the survey upon request. The following documentation was not available for review as requested: client diagnosis and medical history, facility communication log, medical consults, discharge instructions, follow up care and appointments, nurses notes and body checks. Interview with the facility nurse on 2/3/22 revealed that client #1's guardian called her on 11/29/21 to discuss the client's injury to her left foot. The nurse revealed that the guardian reported she took client #1 to the ED and no additional treatment was needed. The nurse also revealed during the interview that the discharge and follow up instructions were not available as the guardian kept a copy. Continued interview with the nurse revealed that staff called her on 11/29/21 at 12:00 PM to report that client #1 could not stand up. Interview with the nurse revealed that staff did not tell her that client #1's left ankle was swollen or that the client had fallen. Further interview with the nurse revealed that she traveled to the group home and assessed client #1's foot and left ankle was swollen and red. The nurse instructed staff to transport client #1 to the ED for an evaluation.	W 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G158	A. BUILDING ______ B. WING ______	C 02/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-MALLARD DRIVE	6119 MALLARD DRIVE CHARLOTTE, NC 28227

(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 154	Continued From page 2	W 154		

The nurse also revealed during the interview that she was not sure why client #1 was not taken to the hospital until 6:00 PM.

Subsequent interview with the nurse revealed that staff called on 2/2/22 to report that client #1 had a change in health status and was having some mobility issues. Continued interview with the nurse revealed that staff called her again on 2/3/22 to report that client #1 had additional mobility changes and was having difficulty standing. Additional interview with the nurse revealed client #1 was scheduled for a follow up appointment on 2/3/22 to remove the needle from the left foot however the client missed the appointment due to staff not being able to get the client in the car. The nurse also revealed during the interview that the staff reported on 2/3/22 client #1 was having difficulty standing and they called EMS to transport the client to the hospital at 2:00 PM. Interview with the nurse revealed she instructed staff to transport client #1 to the ED to check for sepsis symptoms. The nurse verified during the interview that she did not complete nurses notes for client #1 relative to the swollen ankle, sewing needle embedded in the foot and the assessments of the client's foot.

Interview with the Program Manager (PM) on 2/3/22 revealed she was not sure why an internal investigation was not initiated due to client #1's fall on 11/29/21 at the group home. Continued interview with the PM revealed that on 11/29/21 client #1 receive a medical boot and wheelchair for her left foot and the sewing needle remains in her foot. The PM revealed during the interview that client #1 had a follow up appointment on 1/31/22, the fracture is healing, and the medical boot was removed. The PM verified that client #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G158	A. BUILDING ______ B. WING ______	C 02/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-MALLARD DRIVE	6119 MALLARD DRIVE CHARLOTTE, NC 28227

(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 154	Continued From page 3 had a scheduled appointment on 2/3/22 to remove the sewing needle however the client missed her appointment. The PM revealed that sewing needle remains in client #1's left foot. Further interview with the PM revealed that there were no team meetings to discuss client #1's changes in health status. The PM revealed during the interview that she was unsure why there was a delay in seeking medical treatment for client #1 on 2/2/22 due to a change in medical status.	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 nursing services in accordance with the needs of 1 of 6 clients (#1) relative to not responding timely to medical concerns with a change in client health status. The finding is: Review of internal investigation 2/3/22 revealed provider was investigating an injury of unknown origin due to report from mother/guardian stating no treatment was given while at hospital on 11/26/21. Continued review of internal investigation revealed client #1 returned to group home on 11/29/21 and staff reported to the facility nurse swelling in foot and client #1 having difficulty walking. Further review of internal investigation revealed client #1 returned to the group home at approximately 10:00 AM on 11/29/21. Subsequent review of internal investigation revealed staff A to hear a thump outside the office	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G158	A. BUILDING ______ B. WING ______	C 02/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-MALLARD DRIVE	**6119 MALLARD DRIVE CHARLOTTE, NC 28227**

(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 331	Continued From page 4 at approximately 12:00 PM on 11/29/21 and the facility nurse to be notified of client #1 refusing to stand with left ankle and foot swollen. The facility nurse arrived at the group home and instructed client #1 to be taken to the emergency department (ED) and client #1 was transported by medic to the hospital at approximately 6:00 PM. Client #1 had a fractured left toe and a sewing needle embedded in foot. Review of additional documentation could not be completed as the record for client #1 was unavailable during the survey. The following documentation was not available during the survey after numerous requests: facility incident report, nursing notes, assessments, hospital discharge papers, and physician consults. Interview with the facility nurse on 2/3/22 confirmed that client #1 was sent to the ED on 11/29/22 due to not being able to stand. The nurse also revealed during the interview that staff didn't tell her that client #1 had fallen and had a swollen ankle. Continue interview with the facility nurse verified that she arranged for client #1 to go out to ED on 11/29/22 for further evaluation. Further interview on 2/3/22 with the facility nurse confirmed that she did not document nursing notes regarding report of unknown injury and she did not document her assessments, nursing notes, and follow-up care for client #1. Subsequent interview with facility nurse revealed client #1 was placed in a medical boot and wheelchair for fracture to left toe. Additional interview with the facility nurse revealed that she received a call on 2/2/22 from staff that client #1 was experiencing mobility changes. The nurse also revealed that she received a second call on 2/3/22 from staff that client #1's mobility was	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G158	A. BUILDING ______ B. WING ______	C 02/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-MALLARD DRIVE	**6119 MALLARD DRIVE CHARLOTTE, NC 28227**

(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 331	Continued From page 5 continuing to decline. The nurse also revealed during the interview that she was not sure why she did not send staff to transport client #1 to the ED for medical evaluation on 2/2/22. The nurse was told of missed appointment for client #1 which was to occur at 11:00 AM on 2/3/22 while coordinating ED visit.	W 331		