STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G128	A. BUILDING _____ B. WING _____	C 12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-KIMSEY	1305 OLD HWY 60 WILKESBORO, NC 28697

(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 000	INITIAL COMMENTS Complaint Survey #NC00182198	W 000		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on facility record/document review and interviews, the facility failed to ensure an injury was reported to external officials in accordance with state law for 1 of 1 incident reviewed. The finding is: Review of facility incident reports dated 8/21-11/21/21 revealed an incident dated 9/18/21. Review of the 9/18/21 incident revealed at 7:50 PM while staff were conducting bed checks, staff found client #1 on his bedroom floor unresponsive. Further review of the incident revealed 911 was immediately called and client #1 was transported and admitted to the local hospital. A review of incident notifications revealed the facility nurse, on call personnel, qualified intellectual developmental professional (QIDP) and client #1's guardian were notified on 9/18/21. Continued review revealed no evidence of a report completed within the Incident Response Improvement System (IRIS). Review of client #1's record on 12/1/21 revealed an appointment for a CT scan dated 9/17/21.	W 153	The facility admits it failed to report an injury through the IRIS system for the incident dated 9/18/2021. The QIDP will be inserviced by the Program Manager on completing IRIS reports for all incidents of abuse, neglect, exploitation, or injuries of unknown source within the appropriate time frame. In the future, all incident reports will be reviewed during the facility's monthly safety meeting. The team will discuss and ensure that necessary IRIS reports have been completed for all required incidents.	12/31/2021

DHSR - Mental Health
DEC 30 2021
Lic. & Cert. Section

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jenny Chappell, BA/QP, Clinical Supervisor		12/21/2021

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
	34G128	A. BUILDING _____ B. WING _____	C 12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-KIMSEY	1305 OLD HWY 60 WILKESBORO, NC 28697

(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 153	Continued From page 1 Further review revealed a QIDP note to indicate CT results revealed a hematoma on client #1's brain had increased in size. Continued review of the 9/17/21 note revealed the neuro office had advised that client #1 be admitted to the hospital on 9/22/21 for observation. Interview with the QIDP and home manager (HM) on 12/1/21 verified client #1 had been admitted to the hospital on 9/18/21 after staff found the client unresponsive in his room. Continued interview revealed client #1 was to undergo surgery in the attempt to drain fluid from his brain because the hematoma had increased in size. Further interview with the QIDP revealed the client was later released to a rehabilitation facility for further evaluation and services. ~~Interview with the facility program manager (PM)~~ revealed conversations with the client's guardian, the internal interdisciplinary team and hospital staff relative to the client's level of care was initiated following his release to the rehabilitation facility. Continued interview with the PM confirmed a discharge decision was made due to the medical attention required on a daily basis for client #1 with a change in health status resulting from the brain hematoma. Additional interview with the QIDP revealed client #1 had not returned to the group home following the 9/18/21 incident. Continued interview with the QIDP revealed a letter of discharge dated 10/4/21. Continued interview with the QIDP revealed an IRIS report had not been completed with client #1's incident on 9/18/21 and a report should have been completed.	W 153		