STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G165	A. BUILDING _____ B. WING _____	C 06/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-WOODBRIDGE ROAD GROUP HOME	5901 WOODBRIDGE ROAD 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 000	INITIAL COMMENTS Intake #NC00190343	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, documentation review and interviews, the facility failed to ensure an injury was reported to external officials in accordance with state law for 2 of 2 incidents reviewed. The finding is: Review of facility incident reports dated 5/2022-6/2022 revealed an incident dated 6/10/22 and 6/11/22. Review of the 6/11/22 incident revealed at 9:35PM client #3 was outside and suffered a seizure that lasted for a minute. Continued review revealed the client fell to the ground, hitting her head causing a small bump on the head. Further review of the incident revealed 911 was immediately called and client #3 was transported and admitted to the hospital. A review of incident notifications revealed the facility area supervisor, on-call triage nurse, qualified intellectual developmental professional (QIDP) and client #3's guardian were notified on 6/11/22. Continued review revealed no evidence of an incident report completed within the Incident Response Improvement System (IRIS).	W 153		

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

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W 153	Continued From page 1 Review of client #3's record on 6/27/22 revealed hospital discharge summaries dated 6/10/22 and 6/13/22. Review of the 6/10/22 hospital discharge summary revealed client #3 was treated for heat exhaustion and released to the group home the same day with follow up instructions. Continued review of the 6/11/22 hospital summary included an admitting diagnosis of dehydration, seizure disorder, heat exhaustion, initial encounter and nontraumatic rhabdomyolysis. Further review revealed a CT Head without injected contrast technique was completed on 6/11/22 with no evidence of acute brain injury along with other laboratory tests. Subsequent review of the discharge summary dated 6/13/22 revealed medication prescribed: Ativan 0.5 mg tablet to be given one time a day at 4PM for five days and follow up with client #3's primary care provider in one to two weeks. Future appointment scheduled on 6/14/22 with a medical doctor. Medical consult dated 6/16/22 revealed the medical appointment was completed with no further recommendations. Futher review revealed a Neurologist appointment scheduled for 7/8/22. Interview with the facility nurse on 6/27/22 revealed she was made aware of the incident involving client #3 on 6/10/22, however she was not aware of the incident on 6/11/22 which led to the client being hospitalized for three days. Interview with the QIDP and home manager (HM) on 6/27/22 verified client #3 left the premises on 6/10/22 and walked around the neighborhood for several hours, which led to the client being lethargic and transported to the hospital. The hospital determined the client had heat	W 153		

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W 153	Continued From page 2 exhaustion and was treated and released. Continued interview with the QIDP confirmed client #3 left the premises again on 6/11/22, remained outdoors for several hours, became weak, fell and bumped her head. Staff was with the client the entire time during both incidents on 6/10/22 and 6/11/22, however the client remained outdoors for several hours according to the QIDP's report. Further interview with the QIDP revealed staff called 911 and the client was transported to the hospital on 6/11/22. The hospital determined the client had heat exhaustion, a seizure and the client remained in the hospital for two days. Subsequent interview with the QIDP confirmed an incident report was not completed for the 6/10/22 incident. Additional interview with the QIDP verified an IRIS report had not been completed with client #3's incidents on 6/10/22 and 6/11/22.	W 153		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure 1 sampled client (#3) received a continuous active treatment	W 249		

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W 249	Continued From page 3	W 249		

program consisting of needed interventions as identified in their individual support plan (ISPs). The finding is:

Observations during the complaint investigation on 6/27/22 at 11:15 AM revealed client #3 to lay in the bed. Continued observations revealed the door chime to not alarm as the staff opened the door. Further observations revealed this surveyor to discover numerous door chimes and door alarms not in working order in the facility. The following door chimes were not in working order: front door, sliding glass door, side entry door and client #3's bedroom door. Observations revealed the sliding glass door chime to lay on the ground in pieces outside the door. Further observations at 11:45 AM revealed client #3 to share she had not had any food or drink all day. This surveyor encouraged the client to tell her staff that she was hungry. Observations at 11:50 AM revealed client #3 to sit at the dining table and eat cereal, toast and water. Additional observations from 12:00 PM to 3:30 PM revealed staff to keep clients engaged and not encourage client #3 to come out of her room and join the group.

Review of documentation during the complaint investigation on 6/27/22 revealed the following documentation: individual support plans (ISPs), behavior support plans (BSPs), medical consults, guardianship documentation, incident reporting, staff schedules and consents. Review of incident reports dated 5/20/22, 5/22/22, 6/11/22 and 6/17/22 revealed the client has refused several medications previously.

Review of the ISP dated 2/9/22 for client #3 revealed the following diagnosis: I/DD, mild; Intermittent Explosive Disorder; Dementia, mild;

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obstructive sleep apnea; Stevenson Johnson Syndrome; scoliosis; Unspecified Congentital Cystic Disorder; left kidney removed and deaf in right ear. Review of the BSP for client #3 dated 1/4/22 revealed the following target behaviors: agitation, verbal outbursts, physical aggression towards others, self-injurious behaviors (SIBs) and elopement. Review of the documentation did not reveal the following documentation for client #3: IRIS reports dated 6/10/22 and 6/11/22, treatment team minutes, updated interventions to address dementia concerns, nutritional assessment, interventions relative to dementia diagnosis and food intake concerns, and nurses' notes relative to incidents on 6/10/22 and 6/11/22.

Interview with staff A on 6/27/22 revealed the client refuses food and water often. Staff A also revealed the client has left out the door without permission on numerous occasions however staff are able to quickly get the client to return inside the group home. Continued interview with staff A revealed the client also does not sleep well at night. Further interview with staff A revealed the client has to be prompted to eat throughout the day. Interview with staff B on 6/27/22 revealed the client did not sleep on the night of 6/9/22 and was pacing and talking to herself all night. Staff B also revealed the client was packing her clothes and stating that her family was getting ready to pick her up and take her home. Further interview with staff B revealed the client did not eat or drink on the morning of 6/10/22.

Interview with the site supervisor (SS) on 6/27/22 revealed two incidents involving client #3 on 6/10/22 and 6/11/22. The SS revealed during the interview client #3 left the premises on 6/10/22 and walked around the neighborhood for several

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W 249	Continued From page 5	W 249		

hours, became lightheaded and lethargic which led to the client being transported to the hospital. The hospital determined the client had heat exhaustion and was treated and released to the group home on the same day.

Interview with the qualified intellectual disabilities professional (QIDP) on 6/27/22 revealed client #3 exhibited dementia symptoms such as disorientation, delusions, short term memory loss and leaving the area without permission. The QIDP also revealed the client has shown an increase in dementia symptoms over the past few months. Continued interview with the QIDP revealed the client refuses to eat and drink often. The QIDP also revealed the client does not have interventions relative to dementia and food intake concerns.

Subsequent interview with the QIDP on 6/27/22 revealed the client left the premises on 6/11/22, remained outdoors for several hours, became weak, fell, bumped her head and had a seizure. The QIDP revealed staff was with the client the entire time, however the client remained outdoors for several hours. Continued interview with the QIDP revealed staff called 911 and the client was transported to the hospital on 6/11/22. The hospital determined the client had heat exhaustion and a seizure and the client remained in the hospital for two days. The QIDP verified the client was released on 6/13/22 and returned to the group home with a follow up neurological appointment. Further interview with the QIDP revealed the client has not made any further attempts to leave the premises since the incident on 6/11/22. The QIDP verified there have been no treatment team discussions relative to the client's dementia and food intake concerns.

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W 249	Continued From page 6 Additional interview with the QIDP revealed there have been no changes to the client's ISP, BSP or interventions since the incidents occurred.	W 249		