DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G290	A. BUILDING ______ B. WING ______	C 07/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-OAKHAVEN DRIVE GROUP HOME	12516 OAKHAVEN DRIVE CHARLOTTE, NC 28273

(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 A complaint survey was completed on July 25, 2022 for Intake #NC00190133. Deficiencies were cited.	W 000		
W 201	ADMISSIONS, TRANSFERS, DISCHARGE CFR(s): 483.440(b)(4)(i) If a client is to be either transferred or discharged, the facility must have documentation in the client's record that the client was transferred or discharged for good cause. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the interdisciplinary team failed to demonstrate good cause for the discharge 1 of 1 client (#6) from the facility. The finding is: Review of records on 7/25/22 for client #6 revealed an admission date of 3/19/20 and a discharge date of 6/15/22. Continued review of records for client #6 revealed a behavior support plan (BSP) dated 3/19/22 with target behaviors of physical aggression, property destruction, non-compliance, disruptive behavior (i.e. yelling, loud vocalizations, stomping feet and hitting on tables) and agitation/tantrums (i.e. hollering, crying, kicking, screaming at the top of his voice, cursing, throwing a tantrum, not able to control his anger or emotions, etc.) Subsequent review of records for client #6 on 7/25/22 revealed a facility discharge plan. Continued review of the discharge plan revealed facility concerns with the recent change in behaviors the client had been exhibiting over the last 6 months which led to recent hospitalization visits on 5/23/22, 5/24/22 and 6/4/22. Review of a medical consult dated 5/19/22 revealed the	W 201		

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.

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W 201	Continued From page 1 client was in need of a higher level of care due to an increase in daily physical aggression, impulsivity and the inability to de-escalate the client. Continued review of the 5/19/22 medical consult revealed the client received multiple medication changes in attempts to minimize the client's behaviors and did not work out for the long term. Review of the record did not reveal a facility discharge letter addressed to the guardian and the LME/MCO. Review of behaviorist's notes dated 3/23/22, 4/20/22, 5/19/22, and 6/6/22 indicated the client has had two medication changes in March and April 2022 which did not work out well in the long term. Continued review of behaviorist's note (3/23/22) indicated the client was in need of a 1:1 worker and ABA services, which was not completed. Review of the behaviorist's note dated 5/19/22 indicated the client needed a higher level of care to address his increasing explosive behaviors. Review of the documentation during the survey did not reveal core team meeting minutes discussing treatment recommendations, discharge or placement options for the client, no QP notes indicating communication with the LME/MCO, hospital, or LRP and no written discharge notification to the LME/MCO or LRP. Interview with the Program Manager (PM) on 7/25/22 revealed the team did not follow through with the recommendations for ABA services and a 1:1 worker for the client due to not receiving financial assistance from the LME/MCO. Continued interview with the PM revealed she did not know the facility needed to contact the LME/MCO relative to the client's increasing behaviors and pending discharge. The PM also	W 201		

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W 201	Continued From page 2 verified the facility did not send written notification of discharge to the LME/MCO and LRP. Interview with the qualified intellectual disabilities professional (QIDP) revealed the client was still in the hospital since 6/4/22 and awaiting a bed at BHC Randolph (psychiatric hospitalization). Continued interview with the QIDP also revealed the client was officially discharged from the facility on 6/14/22 and a new client would be admitted to the facility on 6/15/22. The QIDP also revealed she was uncertain why the client did not have an updated BSP to include the increasing behaviors such as disrobing and running in the street unclothed. The QIDP also revealed she was uncertain why the recommended services (i.e. ABA services, 1:1 worker) were not implemented as recommended by the psychologist and the IDT. Further interview with the QIDP revealed she did not submit notification to the LRP and LME/MCO confirming the client's discharge from the facility on 6/14/22. Subsequent interview with the QIDP revealed she visited the client at the hospital on 5/31/22 and did not communicate with any medical professionals relative to the client's care or discharge notification. The QIDP also revealed she did not communicate with LME/MCO to discuss the client's increasing behaviors and seek assistance relative to treatment and placement options. Continued interview with the QIDP revealed she communicated with the LRP on 6/10/22 via phone contact to report that the facility would discharge the client on 6/14/22.	W 201		
W 202	ADMISSIONS, TRANSFERS, DISCHARGE CFR(s): 483.440(b)(4)(ii)	W 202		

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W 202	Continued From page 3	W 202		

If a client is to be either transferred or discharged, the facility must provide a reasonable time to prepare the client and his or her parents or guardian for the transfer or discharge (except in emergencies).
This STANDARD is not met as evidenced by:
Based on interviews and record review, the facility failed to provide client #6 and the guardian with the level of assistance necessary to prepare for a successful transfer from the current group home to an alternative placement. The finding is:

Review of documentation during the complaint survey on 7/25/22 revealed behaviorist notes, psychological evaluation dated 3/19/22, QP notes and medical consults. Review of the behaviorist's notes dated 3/23/22, 4/20/22, 5/19/22, and 6/6/22 indicated the client has had two medication changes in March and April 2022 which did not work out well in the long term. Continued review of behaviorist's note (3/23/22) indicated the client was in need of a 1:1 worker and ABA services, which was not completed. Review of the behaviorist's note dated 5/19/22 indicated the client needed a higher level of care to address his increasing explosive behaviors. Review of the documentation during the survey did not reveal any attempts to secure alternative treatment for the client, no documented attempts to securing funding for 1:1 worker, no core team meeting minutes discussing treatment or placement options for the client, no QP notes indicating communication with the LME/MCO, hospital, or LRP.

Subsequent review of documentation revealed a medical consult dated 5/19/22 stating the client was in need of a higher level of care due to an increase in daily physical aggression, impulsivity

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W 202	Continued From page 4 and the inability to de-escalate the client. Continued review of the 5/19/22 medical consult revealed the client received multiple medication changes in attempts to minimize the client's behaviors and did not work out in the long term. Review of internal records did not reveal attempts to secure alternative placement options in coordination with the LME/MCO, guardian and/or hospital prior to the client's discharge from the facility on 6/14/22. Interview with the facility nurse on 7/25/22 revealed that client #6 has had significant behavior changes over the last six months. The facility nurse also revealed client #6 has had several medication changes in March and April 2022 to address the increasing behavior concerns. Continued interview with the nurse revealed the client went to the hospital for a mental health evaluation on 5/23/22 and 5/24/22. Further interview with the nurse revealed she was not aware the client entered into the hospital on 6/4/22 and has been there through his discharge on 6/14/22. The nurse verified that the recommended services for the client (i.e. ABA services, 1:1 worker) were not secured prior to the discharge. Interview with the behaviorist on 7/25/22 revealed client #6's increasing behaviors led to an increased number of emergency department (ED) visits over the last two months. Continued interview with the behaviorist revealed that client #6 was last transported to the hospital on 6/4/22 and remained there through his discharge from the facility on 6/14/22. Further interview with the behaviorist revealed the IDT did not secure recommended services prior to the client's discharge. The qualified intellectual disabilities	W 202		

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W 202	Continued From page 5 professional (QIDP) and Program Manager (PM) revealed the team did not follow through with treatment recommendations for ABA services and a 1:1 worker for the client due to not receiving financial assistance from the LME/MCO. The PM verified during the interview the facility did not exhaust all treatment options for the client prior to the client's hospitalization on 6/4/22. Subsequent interview with the QIDP on 7/25/22 revealed that the facility had not been working with the MCO, guardian or hospital to secure an alternative placement or support transition planning for client #6 once he was discharged from the hospital. Continued interview with the QIDP verified the client should have received ABA services and a 1:1 worker prior to discharging the client to the guardian's care on 6/14/22.	W 202		