STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G201	A. BUILDING ______ B. WING ______	C 08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-OAK DRIVE GROUP HOME	5416 OAK DRIVE CHARLOTTE, NC 28216

(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 8/9/22 for Intake #NC00191792. Deficiencies were cited.	W 000		
W 122	CLIENT PROTECTIONS CFR(s): 483.420(a) The facility must ensure the rights of all clients. Therefore the facility must This CONDITION is not met as evidenced by: The facility failed to: implement written policies and procedures that prohibit mistreatment, neglect and abuse of clients (W149). The cumulative effect of this systemic practices resulted in the facility's failure to provide statutorily mandated services of Client Protection for it's clients.	W 122		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure the policies and procedures that prohibit abuse and neglect were implemented to assure client safety of 2 of 6 clients (#1 and #6). The finding is: Review of an incident report during a complaint investigation on 8/9/22 revealed on 8/6/22 at 3:00 PM client #1 ran out the door and when the staff (staff B) tried running behind him, he ran across the road. The other staff (staff A) had to go after client #1 in the van with the other clients. Client #1 was redirected onto the van. Once back at the group home, client #1 began destroying items in	W 149		

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 149	Continued From page 1	W 149		

his room. Continued review of the 8/6/22 incident report revealed the home manager (HM), qualified intellectual disabilities professional (QIDP) and program manager were all contacted.

Record review for client #1 revealed an individual support plan (ISP) dated 6/2/22. Continued review of the record revealed a behavior support plan (BSP) dated 5/26/22 with the following targeted behaviors; physical aggression, property destruction, dropping to the floor, non-compliance, mouthing body parts, elopement and meltdown. Further review of interventions relative to elopement revealed that staff should not chase but follow closely and ensure client's safety. Block client from entering dangerous roadways or other areas where serious injury could occur, verbally prompt the client to return to the designated area and find out what he wants.

Interviews with the HM verified she was made aware of the incident and was contacted by staff. Continued interview with staff A revealed client #1 had been having behavior challenges on 8/6/22 throughout the day. Around 3:00 PM client #1 exited the home through the back door, staff B immediately went after him, she later loaded the van with the other clients and went to pick up client #1 and staff B.

Further interview with staff B revealed when client #1 exited the home through the back door, by the time he exited the door, client #1 was already out of the yard. Staff B then stated he and client #6 began following client #1. Client #1 then laid in the grass, staff B attempted to get client up but he refused. Staff B further stated he contacted staff A to come and pick them up with the van in which staff A complied.

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W 149	Continued From page 2	W 149		

Further interview with the HM and QIDP revealed the incident was reported properly and client #1's behaviors and the incident were documented and handled appropriately according to the client's BSP.

However, interview with a neighbor of the facility later in the 8/9/22 complaint investigation revealed he was driving in the neighborhood on 8/6/22 when he saw client #1 walking around. The neighbor revealed he then drove to the group home, blew his horn but no one responded. The neighbor then went and knocked on the door and client #6 answered. The neighbor believed that client #6 was a staff person and told him client #1 was walking down the road. Further interview with the neighbor revealed client #6 came out of the group home and got into the neighbor's vehicle with him to go find client #1. Continued interview revealed once they located client #1, client #6 jumped out of the car and began hitting client #1 in the head repeatedly. Subsequent interview with the neighbor, verified by photos and video taken by the neighbor because he thought a staff person was abusing client #1, revealed client #6 was hitting, choking and pulling client #1 by the shirt while lying in the grass.

Additional interview with the neighbor revealed staff B walked over to where client #1 was and stood over client #1 redirecting client #6 to back up and not to hit client #1. The neighbor also revealed that he left once he noticed staff B to have things under control.

Interview with the facility administrator, QM Director, QIDP, HM and program manager revealed they were unaware of these findings

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	34G201	A. BUILDING ______ B. WING ______	C 08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-OAK DRIVE GROUP HOME	5416 OAK DRIVE CHARLOTTE, NC 28216

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W 149	Continued From page 3	W 149		

based on the interview with the neighbor until shared by the survey team. Further interviews with this management team revealed they were also unaware of the physical altercation between client #6 towards client #1. Continued interviews revealed the facility was going to start an investigation immediately and staff A and staff B were to be suspended immediately and while the investigation was ongoing.

Although the facility was taking the proper steps once this new information was found, the facilities policy regarding neglect defines neglect as "failure to provide care of services necessary to maintain the mental health, physical health and well being of the client". In that staff were not aware that client #1 or client #6 had left the group home and failed to monitor them appropriately, the facility was neglectful in the care of the clients.

W 186 DIRECT CARE STAFF (W 186)
CFR(s): 483.430(d)(1-2)

The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.

Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.
This STANDARD is not met as evidenced by:
Based on interviews and record verification the facility failed to provide sufficient direct care staff to manage and supervise clients appropriately.
The finding is:

Interviews with the facility group home manager (HM) on 8/9/22 revealed she was made aware of

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W 186	Continued From page 4	W 186		

an incident that occurred on 8/6/22 which involved client #1 exiting the home and staff along with client #6 following behind him. Continued interview with staff A revealed client #1 had been having behavior challenges on 8/6/22 throughout the day. Further interview with staff A revealed client #1 and client #6 got into an argument about a pair of glasses. Then around 3:00 PM client #1 exited the home through the back door and staff B immediately went after him. Staff A later loaded the van with the other clients and went to pick up client #1 and staff B was able to get client #1 into the van and they returned home.

Interview with staff B revealed when client #1 exited the home through the back door, by the time he exited the door, client #1 was already out of the yard. Staff B then stated him and client #6 began following client #1 across the street. Continued interview with staff B revealed client #1 then laid in the grass and staff B attempted to get client up but he refused. Staff B further stated he contacted staff A to come and pick them up with the van in which staff A complied. Staff B also revealed he had not witnessed any physical altercations between client #6 and client #1.

Interview with the neighbor revealed he was riding in the neighborhood when he saw client #1 walking around. The neighbor then revealed he then drove to the group home, blew the horn and no one responded. Continued interview revealed client #6 came out of the home and entered the complainant's vehicle after informing client #6 that client #1 was walking around the neighborhood. Further interview revealed once they located client #1, client #6 jumped out of the complainant's car and began hitting client #1 in

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W 186	Continued From page 5	W 186		

the head repeatedly. Subsequent interview verified by photos revealed client #6 hitting, choking and pulling client #1 by the shirt while lying on the grass.

Additional interview with the neighbor revealed after 10 minutes staff B walked over towards where client #1 was and stood over client #1 redirecting client #6 to back up and not to hit client #1. The neighbor also revealed that he left once he noticed staff B to have things under control. Let it be noted that the complainant was under the impression that client #6 was actually a staff and not a client.

Review of records for client #1 revealed an individual support plan (ISP) dated 6/2/22. Continued review of the record revealed a behavior support plan (BSP) dated 5/26/22 with the following targeted behaviors; physical aggression, property destruction, dropping to the floor, non-compliance, mouthing body parts, elopement and meltdown. Further review of interventions relative to elopement revealed that staff should not chase but follow closely and ensure client's safety. Block client from entering dangerous roadways or other areas where serious injury could occur, verbally prompt the client to return to the designated area and find out what he wants.

Review of records for client #6 revealed an ISP dated 7/25/22 with an admit date of 6/27/22. Continued review of the ISP did not reveal a behavior plan or guidelines.

Interview with the facility administrator, QM Director, QIDP, HM and PM revealed there were unaware of the findings based on the interview

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W 186	Continued From page 6 with the neighbor who verbally agreed to share photos and videos with the facility. Continued interview revealed there were also unaware of any physical altercation between client #6 towards client #1. Further interview confirmed the facility had failed to provide appropriate supervision on 8/6/22 during a time period that a substantiated incident of physical abuse had occurred between client #6 and client #1 outside of the home.	W 186		