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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 9/5/24 for intake #NC00221426 (unsubstantiated), #NC00221556 (substantiated), #NC00221507 (substantiated), #NC00221547 (substantiated) and #NC00221553 (substantiated). An immediate jeopardy in client protections, facility staffing, and active treatment was called. The facility provided an immediate plan of protection which reduced the immediate jeopardy to conditions of participation in client protections, facility staffing and active treatment. In addition, standard level 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: ensure clients were not subjected to abuse or neglect (W127); and ensure all alleged violations are thoroughly investigated (W154). The cumulative effect of these systemic practices resulted in the facility's failures to provide statutorily mandated services of client protections to its clients.	W 122		
W 127	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(5) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility	W 127		

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

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W 127	Continued From page 1 failed to ensure 4 of 6 audit clients (#3, #4, #5 and #6) residing in the home were not subject to potential abuse or neglect. The finding is: Observations in the home on 9/5/24 at 7:10am revealed clients #3, #4, #5 and #6 get on the facility van to prepare for transport to school. Staff B was observed to sit in the passenger seat in the front of the van, and Staff C was observed to drive. Further observations revealed the van to back out of the parking spot, pull forward, back up some more, drive down the driveway and turn onto the road. Clients #3, #4, #5 and #6 were not wearing seatbelts while the van was in motion. Interview on 9/5/24 with the site supervisor (SS) revealed when transporting clients to school, one staff should drive and a client should be seated in the front passenger seat. The remaining clients and staff should be staggered in the back of the van, alternating seating placement. The SS confirmed staff should ensure all clients have their seatbelts on and buckled prior to leaving. Interview on 9/5/24 with the qualified intellectual disabilities professional (QIDP) confirmed clients should have their seatbelts on and buckled prior to leaving in the van. The QIDP stated the facility had completed immediate training on the day of the survey regarding the safety issue; however, no documentation of the training could be produced by the end of the survey.	W 127		
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:	W 154		

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W 154	Continued From page 2	W 154		

Based on record reviews and interviews, the facility failed to thoroughly investigate allegations of abuse and investigate injuries of unknown origin for 2 of 6 audit clients (#2 and #5). The findings are:

A. The facility failed to thoroughly investigate allegations of potential abuse for client #5.

Review on 9/5/24 of the facility's internal investigation dated 8/30/24 - 9/5/24 revealed an interview on 9/3/24 with Client #2's guardian. The guardian reported she overheard on the telephone screaming and cursing from Staff D towards client #5. Client #5 was heard to say, "I can't breathe" and Staff D was heard to say "Calm the f**k down." In addition, Staff D was heard to call 911 for assistance but was unable to tell emergency personnel on the phone the address to the home. However, once emergency personnel did arrive at the home, Staff D was unable to tell them about any information regarding client #5 such as medications, diagnosis, etc.

Staff in the home were interviewed as part of the investigation. Only one staff that was interviewed had knowledge of the incident, as the other two staff had already left work for the day.

The conclusion of the investigation revealed that client #4 was the person who was heard cursing in the background of the telephone call. In addition, the investigation concluded that there were critical shortcomings in staff training and emergency preparedness, as well as staff not being able to manage a crisis situation and behaviors appropriately. The investigation concluded that although these issues were found,

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the allegations were deemed "unfounded."

Interview on 9/5/24 with the program manager (PM) and qualified intellectual disabilities professional (QIDP) revealed that although the investigation concluded that the cursing that was heard came from client #4, there were no interviews done with the clients to support this finding. Further interview revealed that the investigation did find some issues that needed to be addressed, but no recommendations were made at the time of the survey.

B. The facility failed to report and investigate an injury of unknown origin.

Review on 9/5/24 of client #2's body checks revealed on 8/17/24, a scratch that was approximately 3-4 inches in size, red and enflamed, was noted by staff on client #2's right shoulder blade area. Continued review of the facility's accident/injury reports and facility investigations revealed no report or investigation into the scratch, nor was there any documentation to show the injury was treated medically.

Review on 9/5/24 of the facility's policy "Abuse, Neglect & Exploitation" revealed all employees will immediately report any injury of unknown source, to the first supervisor not involved in the incident. An incident report will be completed. The supervisor receiving the report will immediately initiate an investigation.

Interview on 9/5/24 with client #2's guardian revealed on 8/18/24, while client #2 was on a home visit, the scratch was observed on his right shoulder. The guardians questioned the staff via

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W 154	Continued From page 4 text message and picture about the injury, the staff reported not knowing anything regarding the injury. In addition, the staff reported client #2 would be taken to urgent care the following day for care and treatment. Interview on 9/5/24 with the facility's RN and licensed practical nurse (LPN) revealed that when injuries are noted during body checks, staff are expected to complete an accident/injury report and notify nursing, who will then assess and determine if treatment is required. Further interview with the RN and LPN revealed they review body checks, but confirmed they did not know client #2's injury, as nothing had been reported to them by staff. The RN and LPN, after seeing the picture of the injury, confirmed the scratch appeared to be infected, and should have been assessed and treated by nursing. Interview on 9/5/24 with the PM and QIDP revealed no investigation into client #2's injury of unknown origin was completed as the policy states.	W 154		
W 158	FACILITY STAFFING CFR(s): 483.430 The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: The facility failed to: provide adequate staff to manage and supervise clients (W186); and ensure staff training was provided (W189). The cumulative effect of these systemic practices resulted in the facility's failures to provide statutorily mandated services of facility staffing requirements.	W 158		

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W 186	DIRECT CARE STAFF 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 observations, record reviews and interviews, the facility failed to provide sufficient direct care staff to manage and supervise 6 of 6 clients (#1, #2, #3, #4, #5 and #6). The finding is: During observations in the home on 9/5/24 at 6:00am, Staff A and Staff B were observed to be on duty with 6 clients in the home. Staff C was observed to enter the home and Staff A left for the day. At 8:00am, the site supervisor (SS) entered the home and Staff B left for the day. During the observations, Staff B and Staff C were asked to identify the clients for the surveyors. Staff B was unable to name the clients or state anything specific to the clients, and Staff C was unable to correctly identify the clients by name or state anything specific about the clients. Review on 9/5/24 of the facility's staff schedules for the period of July 2024 - September 2024 revealed 2 staff being on shift in the home. Further review of the schedules revealed days where no staff names were listed beside available times, or staff names hand written beside available times. Review on 9/5/24 of the staff's time sheets revealed there are only 2 staff on duty per shift. Further review of the staff time sheets revealed	W 186		

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W 186	Continued From page 6 numerous days where only 1 staff was on duty, particularly occurring on days when third shift had left the home, leaving one first shift staff on duty alone until the clients left for school or when they would transport the clients to school. Interview on 9/5/24 with Staff B revealed her first night in the home was on 9/4/24 so she is not familiar with the clients or the home. Interview on 9/5/24 with Staff C revealed she started working in the home on 9/3/24. Staff C stated there are 2 staff on each shift (1st, 2nd and 3rd) but the SS needed 3 people on each shift because client #3 is 1:1 with his supervision. Interview on 9/5/24 with the SS revealed the minimum number of staff on each shift is 3, because client #3 is 1:1. The SS confirmed there should be three staff on each shift. Interview on 9/5/24 with the qualified intellectual disabilities professional (QIDP) confirmed there are supposed to be three staff on each shift, and by operating with only 1-2 staff on each shift left the home out of compliance with their staffing guidelines.	W 186		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure staff were sufficiently trained to perform his or her duties for	W 189		

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W 189	Continued From page 7 6 of 6 audit clients (#1, #2, #3, #4, #5 and #6). The finding is: During observations in the home on 9/5/24 at 6:00am, there were six clients and two staff on duty (A and B). Staff A was observed to leave for the day and Staff C came on duty. Staff B was asked by the surveyors to identify the clients for them. However, Staff B was unable to name the clients. When Staff C came on duty, she was able to name the clients, but not by their correct names. Interview on 9/5/24 with Staff B revealed she started working in the home on the previous night, 9/4/24, for her first shift. Further interview with Staff B revealed she had received some initial training prior to working in the home, but had not received any client specific training. Staff B stated she had not learned the clients names yet so did not have any information she could share with the surveyors. Additional interview with Staff B, when asked what information she would share with emergency personnel if their assistance was needed for anything, revealed she would not be able to tell emergency personnel any information about the clients, and she could not tell the surveyors the address to the home if it was needed. Interview on 9/5/24 with Staff C revealed she has worked in the facility since 9/3/24. Staff C stated she had some initial training, but has not received any client specific training, such as active treatment programming or clients' needs and supports. In addition, Staff C stated she was not trained on the Emergency Preparedness Plan	W 189		

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W 189	Continued From page 8 (EPP) and did not know what she would need to do in the event of an emergency situation. Interview on 9/5/24 with the qualified intellectual disabilities professional (QIDP) confirmed staff should receive adequate training to work with the clients in the home prior to entering the home to work directly with the clients, and should be training on the emergency preparedness plan to be able to assist in the event of an emergency situation.	W 189		
W 195	ACTIVE TREATMENT SERVICES CFR(s): 483.440 The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: The facility failed to: ensure an active treatment program was provided to each client (W196); ensure individual support plans (ISP's) were prepared within 30 days of admission (W226); ensure ISP's included specific objectives and formal interventions to manage inappropriate behaviors (W227); ensure that data was collected and documented (W252); and ensure the ISP was revised, updated and available on an annual basis as required (W260). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated active treatment services to the clients.	W 195		
W 196	ACTIVE TREATMENT CFR(s): 483.440(a)(1)	W 196		

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Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward:
(i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and
(ii) The prevention or deceleration of regression or loss of current optimal functional status.

This STANDARD is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to assure that 6 of 6 clients (#1, #2, #3, #4, #5 and #6) received an aggressive and continuous active treatment program directed towards acquisition of skills identified in their individual support plans (ISP's). The findings are:

A. Cross reference W226. The facility failed to ensure the ISP is prepared within 30 days of admission for 1 of 6 audit clients (#5).

B. Cross reference W227. The facility failed to ensure 5 of 6 audit client's (#1, #2, #3, #4 and #5) ISP's included specific objectives and formal interventions to manage inappropriate behaviors.

C. Cross-reference W252. The facility failed to ensure that data was collected and documented for 6 of 6 clients (#1, #2, #3, #4, #5 and #6).

D. Cross-reference W260. The facility failed to ensure the ISP for 1 of 6 clients (#2) was revised, updated and available on an annual basis as required.

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W 226	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to implement an individual support plan (ISP) within 30 days of admission for 1 of 6 audit clients (#5). The finding is: Review on 9/5/24 of client #5's record revealed an admission date of 7/30/24. Continued review of client #5's record revealed no ISP had been developed and implemented for client #5. Interview with the qualified intellectual disabilities professional (QIDP) on 9/5/24 verified that there is no formal ISP for client #5. Continued interview with the QIDP confirmed client #5's ISP should have been completed within thirty days of the client's admission.	W 226		
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 5 of 6 audit clients (#1, #2, #3, #4 and #5) individual support plans (ISP's) included specific objectives and formal interventions to manage inappropriate behaviors. The findings are: A. Review on 9/5/24 of client #2's record revealed a BSP dated 8/3/23 with a target date of	W 227		

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W 227	Continued From page 11 8/1/24. Further review of the BSP revealed the client is currently taking behavior medications which includes Ariprazole 5mg (twice daily) and Clonidine 0.1mg (three times a day). Interview on 9/5/24 with the qualified intellectual disabilities professional (QIDP) confirmed an updated BSP was not completed at the time of the survey. B. Review on 9/5/24 of client #4's record revealed an admission date of 7/8/24. Continued review of record revealed the client to receive the following psychotropic medications: Amitriptyline 10mg, Divalproex 250 mg and Hydroxyz Pam Cap 25 mg. Further review did not reveal a BSP for surveyor to review. Interview with the QIDP on 9/5/24 confirmed an initial BSP was not completed for client #4. C. Review on 9/5/24 of client #5's record revealed an admission date of 7/30/24. Continued review of record revealed the client to receive the following psychotropic medications: Vyvanse 40 mg every morning and Adderal 10mg daily. Further review did not reveal a BSP for surveyor to review. Interview with the QIDP on 9/5/24 confirmed an initial BSP was not completed for client #5. D. Review on 9/5/24 of client #3's record revealed an admission date of 5/24/24. Continued review of record revealed the client to receive the following psychotropic medications: Risperidone, Levetiracetam and Guanfacine; as well as the use of a soft helmet for head banging. Further review did not reveal a BSP for surveyor to	W 227		

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W 227	Continued From page 12 review. Interview with the QIDP on 9/5/24 confirmed an initial BSP was not completed for client #3.	W 227		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that body checks and sleep data were documented for 6 of 6 audit clients (#1, #2, #3, #4, #5 and #6). The findings are: A. The facility failed to ensure body checks were completed and documented as required. Review on 9/5/24 of the facility's body check data from 8/1/24 through 9/5/24 for all clients residing in the home revealed numerous days of body checks being completed only one to two times, numerous days of body checks not being completed at all, and numerous body checks being documented at times clients were not in the home. Interview on 9/5/24 with Staff C revealed body checks are done three times a day, once on each shift, and should be documented on the body check sheets located in the binder for each client.	W 252		

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W 252	Continued From page 13 Interview on 9/5/24 with the site supervisor (SS) revealed body checks are done three times a day, once on each shift, and should be documented on the body check sheet with the time documented when the body check was completed. Further interview with the SS confirmed that some of the times documented on the completed body checks would have been at times when the clients were not in the home but in school. Interview on 9/5/24 with the qualified intellectual disabilities professional (QIDP) confirmed body checks should be done three times a day, once on each shift, and documented on the body check form at the time of the check. B. The facility failed to ensure sleep data was completed and documented as required. Review on 9/5/24 of the facility's sleep data from 8/1/24 through 9/5/24 for all clients residing in the home revealed numerous nights when sleep checks were not documented in 30-minute increments, or not documented at all. Interview on 9/5/24 with Staff B revealed sleep checks are completed and documented one time per night at 11:30pm for each client. Interview on 9/5/24 with the SS revealed sleep checks are done every night, starting at the time when the client goes to sleep and stops when the client wakes up. Sleep checks are done utilizing the facility's sleep data forms, which starts at 8:00pm and goes through 8:00am. The SS confirmed the sleep checks should be completed on each client every night.	W 252		

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 09/05/2024

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W 252	Continued From page 14 Interview on 9/5/24 with the QIDP confirmed sleep checks should be done on each client every night and should be documented on the sleep data form.	W 252		
W 260	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to update the individual support plan (ISP) annually for 1 of 6 audit clients (#2). The finding is: Review on 9/5/24 of client #2's record revealed an ISP dated 9/6/22. Interview on 9/5/24 with the qualified intellectual disabilities professional (QIDP) revealed an ISP was developed in 2023; however, it could not be located at the time of the survey.	W 260		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure client were taught to use and make informed choices about the use of eyeglasses. This affected 3 of 6 audit clients (#2, #3 and #6). The findings are:	W 436		

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 09/05/2024

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W 436	Continued From page 15 A. During observations in the home on 9/5/24 from 6:00am until 6:30am, client #2 was observed to make a bowl of cereal and eat breakfast, gather his belongings for school, and stand and wait for the school bus. At 6:30am, client #2 got on the school bus and left his home. At no time during the observations was client #2 wearing his eyeglasses, and at no time did staff prompt him to wear his eyeglasses. Review on 9/5/24 of client #2's individual support plan (ISP) dated 9/6/22 revealed client #2 wears eyeglasses full time for Myopic Astigmatism. Interview on 9/5/24 with Staff C revealed client #2 should be wearing eyeglasses, and should have had his glasses on when he left for school. When asked where client #2's eyeglasses were, staff were unable to locate them in the home. Interview on 9/5/24 with the qualified intellectual disabilities professional (QIDP) confirmed client #2 should be wearing glasses and staff should prompt him to wear them. B. Observations in the facility on 9/5/24 at 6:00AM revealed client #3 to participate in the breakfast meal assisted by staff B. Continued observations revealed client #3 to participate various activities without his eyeglasses. Subsequent observations at 7:15AM revealed client #3 to board the facility van to travel to school without his eyeglasses. Review of the record for client #3 on 9/5/24 revealed an individual support plan (ISP) dated 6/12/24. Continued review of the ISP revealed client #3 has the following adaptive equipment:	W 436		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 436	Continued From page 16 eyeglasses to improve his vision, worn daily and soft helmet for head banging, worn during wake hours. Interview on 9/5/24 with the QIDP confirmed client #3 should be wearing glasses and staff should prompt him to wear them. C. Observations in the facility on 9/5/24 at 6:00AM revealed client #6 to watch a preferred show on the television with peers. Continued observations revealed client #6 to participate various activities without his eyeglasses. Subsequent observations at 7:15AM revealed client #6 to board the facility van to travel to school without his eyeglasses. When asked where client #2's eyeglasses were, Staff C found them in the staff office in a case. Interview on 9/5/24 with the QIDP confirmed client #6 should be wearing glasses and staff should prompt him to wear them.	W 436		