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 _____	R-C 10/21/2024

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 10/21/24 for intake #NC00222121. The allegation was unsubstantiated and no deficiencies were cited. Additionally, a revisit was conducted for all previous deficiencies cited on 09/05/2024. The deficiency was not corrected and documentation was not provided as referenced in the facility's plan of correction (POC). The deficiency will be re-cited along with additional deficiency practices.	{W 000}		
W 248	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(7) A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure current Individual Support Plan (ISP) and Behavioral Support Plans (BSP) were available to all relevant staff. This affected 6 of 6 clients in the home. The finding is: Observations on 10/21/24 from 6:00 AM - 7:45 AM revealed all six clients in the home to be up and getting prepared for the day. Continued observations revealed three staff also in the home to verbally prompts each client to get ready for school. Further observations revealed clients to participate in their morning routine. Subsequent observations and interview with staff when surveyor request to review the clients' ISP's and BSP's revealed, the clients' clinical books were not in the home. Additional interview with staff revealed staff was unsure of how long the	W 248		

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

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W 248	Continued From page 1 books had not been in the home since the home had been recently repainted. Further interview revealed relevant staff did not have access to any of the clients ISP's and BSP's. Interview with the Program Manager (PM) on 10/21/24 revealed all clinical books should be accessible to all relevant staff working in the home. Continued interview with the PM revealed client's clinical books should remain in the home and not in the administrative office.	W 248		
{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	{W 252}		

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{W 252}	Continued From page 2	{W 252}		

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.

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

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{W 252}	Continued From page 3 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. 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. A revisit was conducted on 10/21/24 for all previous deficiencies cited on 09/05/24. Record review on 10/21/24 of the Facility's body check data sheets for clients #2,#3 and #6 revealed numerous days of body check sheets did not identify the times of the checks and numerous body check sheets being documented at times clients were not in the home. The facility failed to continue to ensure all body check sheets were completed accurately for clients #2,#3 and #6. As a result, the deficiency will be re-cited.	{W 252}		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation and interviews, the facility failed to assure all medications and biologicals remained locked except when being prepared for medication administration for 2 of 6 clients (#2, #5). The finding is: Observations on 10/21/24 from 6:00AM-6:35AM revealed staff to leave the medication closet	W 382		

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open, unlocked and unattended while it was not being used. Observations revealed the medication closet to remain open, unlocked, and unattended for a total of 38 minutes. Continued observation at 6:45AMrevealed staff to close and secure the medication cabinet, however a medication basket remained on the table in the living room area.

Subsequent observations at 6:15AM revealed staff to place the medication basket for client #2 on the table in the living room area. Continued observations revealed staff to leave the table with the medication basket unattended on the table. Further observations revealed staff to also leave the laptop on the table with the medication basket. Observations also revealed the laptop to have the client's medication information visible as staff and clients walked through the living room area.

Additional observations at 6:45AM revealed staff to enter into the medication room and bring the medication basket for client #5 to the living room area. Continued observations revealed staff to place the medication basket on the table in the living room. Further observation revealed staff to walk away from the table to leave the medication basket unattended for several minutes while walking down the hallway to check on the clients.

Interview with the Nursing Services on 10/21/24 revealed that staff have been recently trained to secure medications when the medication closet is not being used. Continued interview with Nursing Services verified that all medications should be locked and secured in the medication cabinet when they are not being administered. Further interview with Nursing Services verified that

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W 382	Continued From page 5 medication administration should be completed with all clients in the medication room to ensure their privacy.	W 382		
{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: 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.	{W 436}		

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{W 436}	Continued From page 6 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: 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.	{W 436}		

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{W 436}	Continued From page 7 Interview on 9/5/24 with the QIDP confirmed client #6 should be wearing glasses and staff should prompt him to wear them. A revisit was conducted on 10/21/24 for all previous deficiencies cited on 09/05/24. During a morning observation at the facility on 10/21/24 revealed clients #2 and #6 to participate in getting dressed and medication administration. Continued observations revealed client #2 to exited the facility to catch the school bus without wearing his eyeglasses. Further observation revealed client #6 preparing to get in the van for an appointment without his eyeglasses. Interview with the staff revealed both clients did not have their eyeglasses at the facility and awaiting to receive new glasses from the vision center. Interview with the facility's Nurse confirmed clients #2 and #6 had not received their eyeglasses from the vision center as of 10/21/2024. The facility failed to continue to ensure that clients #2 and #6 are wearing their eyeglasses as prescribed. As a result, the deficiency will be re-cited.	{W 436}		