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 06/25/2024

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 6/24/24 - 6/25/24 for intake #NC00218466. The allegation was substantiated. A Condition of Participation in Clients Rights and a Condition of Participation in Health Care Services was cited; In addition, standard level deficiencies were also cited.	W 000	RECEIVED JUL 17 2024 DHSR-MH Licensure Sect	
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: promptly notify client guardians of significant incidents and injury (W148); implement written policies and procedures that prohibit mistreatment, neglect and abuse of a client (W149); and ensure all alleged violations are thoroughly investigated (W154). The cumulative effect of these systemic practices resulted in the facility's failures to provide statutory mandated services of client protections to its clients.	W 122	The facility will ensure the rights of all clients are protected and encourage individual clients to exercise their rights as client of the facility, and ensure guardians are notified of significant incidents and injury per company policies. To prevent further occurrence: A. PM will educate QIDP on client rights, neglect, and abuse for all clients in the home, notified all client guardians of significant incidents and injury and to ensure all violation is thoroughly investigated. B. QIDP will educate all staff on client rights, neglect, abuse and reporting significant incidents and injury immediately to management.	
W 148	COMMUNICATION WITH CLIENTS, PARENTS & CFR(s): 483.420(c)(6) The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure a client's guardian was informed of a behavior incident with injury. This	W 148	The facility will notify promptly the client's parents or guardian of any significant incidents, orchanges in the client's condition including, but notlimited to, serious illness, accident, death, abuse,or unauthorized absence. To prevent further occurrence: PM will educate QIDP on client rights, neglect, and abuse for all clients in the home, notified all client guardians of significant incidents and injury.	8/9/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Andrew Taylor A Taylor	Program	7/12/2024

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.

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 06/25/2024

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W 148	Continued From page 1 affected 1 of 4 audit clients (#4). The finding is: Review of records on 6/24/24 and 6/25/24 revealed on 4/26/24, client #4 was involved in a peer-to-peer altercation. During the incident, client #4 hit his head on a door knob and sustained two black eyes, and subsequently was sent to the local emergency department (ED). Continued review of client #4's record revealed no contact was made with client #4's guardian to inform them of the injury and ED visit. Interview on 6/25/24 with the quality assurance manager revealed a note from the incident on 4/26/24 where he contacted the guardian. Review of the note indicated his conversation with the guardian was in regards to involuntary commitment paperwork. The quality assurance manager confirmed the guardian was not contacted regarding the peer-to-peer incident resulting in injury to client #4.	W 148		
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 ensure deceased client (dc #1) and client #2 was not subject to unintentional neglect. The findings are: A. Record review on 6/24/24 of the facility's investigative summary dated 5/3/2024 - 5/10/2024 revealed an investigation was conducted following the death of dc #1 to determine if staff followed the prescribed	W 149	The facility will ensure written policies and procedures are implement that that prohibit mistreatment, neglect, or abuse of the client. To prevent further occurrence: PM will educate QIDP's on policies and procedures that prohibited mistreatment, neglect, or abuse of the client.	

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	34G290	A. BUILDING _____ B. WING _____	C 06/25/2024

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W 149	Continued From page 2	W 149		

treatment regimen given by the emergency department (ED) to dispense Tylenol and Ibuprofen with fluids and to return if his condition worsened.

Further review of the investigation revealed that on 4/26/24, the site supervisor (SS) received a call from dc #1's school stating the client was displaying flu like symptoms and needed to be picked up. Client dc #1 was taken to the local ED and was counseled on proper medication management to be performed at the home, symptom control, aggressive hydration and instructions to return to the ED if symptoms worsened. Three days later, on 4/29/24, the SS contacted nursing to inform them of dc #1's condition and was instructed to follow up with the primary care physician (PCP). An appointment was made with the PCP for 5/1/24. The PCP requested labs be completed as soon as possible. DC #1 had labs drawn on 5/2/24 and the SS was called later that afternoon and told to take the client to the hospital immediately. It was reported that upon arrival to the hospital dc #1 coded and later passed away.

Review on 6/24/24 of the facility's internal investigation concluded that based on interviews, witness statements and doctor's consultations, staff followed the prescribed treatment regimen and dc #1 was given Tylenol, Ibuprofen and fluids as ordered. "There were no errors or delays in the support and care for dc #1".

Interview on 6/25/24 with the quality assurance (QA) manager revealed the purpose of his investigation was to determine if dc #1 received the treatments as ordered by the hospital. The QA manager concluded staff did what they were

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 06/25/2024

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

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W 149	Continued From page 3 supposed to do; however, there is no documentation to support that dc #1 received Tylenol or Ibuprofen, or fluids for hydration. B. Interview on 6/24/24 and 6/25/24 revealed that during the month April 2024, client #2 had a consistent runny nose with yellow discharge, and a whistling sound coming from his nose. On 4/28/24, while on a visit with his family, a large piece of rubber was removed from client #2's nose by his mother the size of a quarter. Communication with the mother, site supervisor (SS) and qualified intellectual disabilities professional (QIDP) revealed the SS would make an appointment for client #2 to be seen by his medical provider as it was troubling how this object became lodged in his nose. Interview on 6/25/24 with the QA manager revealed no investigation or follow-up was conducted to determine how the piece of rubber became lodged in client #2's nose. Based on record review and interview, the facility neglected to provide dc #1 preventative medical care and failed to provide nursing services in accordance with client needs, resulting in his status worsening and passing away. In addition, the facility failed to investigate incidents resulting in neglect.	W 149		
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: Based on observations, documentation review and interviews, the facility failed to thoroughly	W 154	The facility must have evidence that all allegedviolations are thoroughly investigated. A. To prevent further occurrence: PM will educate investigators to thoroughly investigate to include interviewing all clients in the home, interview all staff,	

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	34G290	A. BUILDING _____ B. WING _____	C 06/25/2024

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W 154	Continued From page 4 investigate an incident resulting in neglect for deceased client (dc) #1. The finding is: Review of internal documentation and client records on 6/24/24 for dc #1 included the following documentation: internal investigative summaries, written staff statements, behavior support plans, hospital medical consults, individual support plans, facility email correspondence, and incident reporting from 4/1/24 to 5/2/24. Review of a facility internal investigation dated 5/3/24-5/10/24 indicated that on 4/26/24, staff contacted management to report that client dc #1 was being transported to the hospital emergency department (ED) due to shaking and being cold. Continued review of the record for client dc #1 revealed a hospital after visit summary and medical consult dated 4/26/24 at 11:06AM indicating the client was seen and diagnosed with viral syndrome, fever, unspecified fever cause, and Tachycardia. Discharge instructions indicated staff should "encourage oral hydration with fluids. Tylenol and Ibuprofen as needed. Return to ED for worsening or changing symptoms". Review of the internal investigation also indicated the site supervisor (SS) reached out to nursing services on the morning of 4/26/24 to report that client dc #1's school contacted him around 7:45AM to pick the client up and transport him to the hospital. Continued review of the internal investigation also revealed that on 4/26/24, nursing services provided treatment recommendations for staff to transport the client to the hospital and provide follow up. Further review of the internal investigation revealed that upon discharge from the local ED, nursing services recommended staff to "monitor vitals,	W 154	Continue From page 4 review all possible evidence when investigating abuse and neglect concerns or allegations. B. The facility will provide continuous preventative medical care and nursing services in accordance with client needs, as recommended by PCP. C. To prevent further occurrence: DON will educate all nurses, QIDP's and DSP's on the importance of providing continuous preventative medical care and nursing services in accordance with client needs, as recommended by PCP.	

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	34G290	A. BUILDING _____ B. WING _____	C 06/25/2024

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VOCA-OAKHAVEN DRIVE GROUP HOME	12516 OAKHAVEN DRIVE CHARLOTTE, NC 28273

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W 154	Continued From page 5	W 154		

worsening symptoms, and a plan was put in place for a follow up visit to ED if his condition worsens. Staff did not report worsening symptoms and said his vitals were stable."

Subsequent review of the internal investigation revealed several witness statements. Review of a witness statement from staff E indicated that the client "was not feeling well, cough and temp, vomiting. I checked on the client every 30 minutes while he was sleeping and as instructed gave him Tylenol and Gatorade. I observed the client was sluggish and he had very glassy eyes. He wasn't being himself those days".

Review of a witness statement from staff F indicated " I gave him meds for fever to reduce his temp and had him drink water or Gatorade for hydration. In my eyes, I believed he was getting better until I seen him on 5/2/24 when he went to ED. In my opinion, the house needs to be checked for black mold throughout the whole house."

Review of a witness statement from staff A indicated that he informed a previous staff member that the client was sick. "That's ALL I said to her. If she received any other information it did not come from me".

Review of a witness statement from nursing services on 5/3/24 revealed that there were no reports of worsening symptoms noted or reported to nurse or triage. SS advised that consumer seemed to be sluggish, but no fever. Review of the witness statement from nursing services did not reveal the date and/or time that the client received labs or when he arrived at the hospital the second time.

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	34G290	A. BUILDING _____ B. WING _____	C 06/25/2024

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W 154	Continued From page 6	W 154		

Review of the record for dc #1 did not reveal a temperature log, weight log, elimination record, medication administration record, or documentation to verify that the client was receiving medications as prescribed, if vitals were being taken to determine if a fever persisted, or if the client's symptoms were worsening or improving.

Interview with the site SS on 6/24/24 revealed he was contacted by school personnel on 4/26/24 at 7:45AM to pick the client up from school due to excessive shaking and being cold. Continued interview with the SS revealed he was instructed by nursing services to take the client to the hospital for further evaluation. Interview with the SS also revealed that he transported the client to the local ER and the attending physician reported that the client had a virus. The SS also revealed that he was instructed to provide Tylenol, Ibuprofen, fluids, and to return to the hospital should symptoms worsen. Additional interview with the SS revealed that nursing services instructed him to follow the hospital ER recommendations and make an appointment to the primary care physician (PCP) should his condition worsened. The SS also revealed that he made an appointment for 5/1/24 and transported the client to the 12:00PM appointment.

Subsequent interview with the SS revealed that upon arrival at the PCP's office, the client was given a Human Rhinovirus diagnosis, and the SS was instructed to transport the client for lab work. Continued interview with the SS revealed that he transported the client to get labs done and received a call from the PCP later that afternoon.

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	34G290	A. BUILDING _____ B. WING _____	C 06/25/2024

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W 154	Continued From page 7 Further interview with the SS revealed that the PCP stated the client's "labs did not look good and to take him to the hospital". Additional interview revealed that the SS transported the client to the hospital and the client collapsed while exiting the vehicle. Witnesses assisted with a wheelchair and the client was transported into the ER per the SS interview. The SS also revealed client was later placed in ICU, placed on a ventilator, and passed away an hour and a half after the SS left the hospital on 5/2/24. Review of the hospital after visit summary dated 5/2/24 indicated the client had the following diagnosis: acute respiratory distress syndrome, Rhinovirus, lymphedema, Strep A+, cardiac arrest, Hyperkalemia, disseminated intravascular coagulation (DIC), diffuse partial opacification of the paranasal sinuses and left mastoid air cells, mild left frontoparietal scalp edema, septic shock, severe anemia, and acute kidney injury. Interview with the QA Manager on 6/25/24 revealed that client #1's internal investigation findings indicated that the staff acted according to nurses' instructions, hospital recommendations, and PCP treatment recommendations from 4/26/24 - 5/2/24. Continued interview with the QA Manager revealed that the interdisciplinary team had ongoing communication relative to the client's medical needs and the internal investigation was unsubstantiated. Interview with the QA Manager denied knowledge of staff A's written statement relative to telling a former staff that the client was sick. Additional interview with the QA Manager verified that further investigation was not conducted relative to staff witness statements.	W 154		

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	34G290	A. BUILDING _____ B. WING _____	C 06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 154	Continued From page 8 Further interview with the QA Manager revealed that the purpose of the internal investigation was not to look at times/dates of medication (Tylenol or Ibuprofen) relative to treatment recommendations post ER visit on 4/26/24. Additional interview with the QA Manager revealed he was required to "look into" if the treatment recommendations from the attending physician on 4/26/24 were followed as prescribed. QA manager verified during the interview that the client's condition was not documented in the client's record to verify the client's change in condition, and there was no nursing follow-up that occurred during that time. Based on observation, documentation review and interviews, the facility failed to thoroughly investigate nursing following up, and the lack of a thorough investigation could have helped rule out questions of neglect with dc #1. Allegations relative to whether the facility staff followed hospital treatment recommendations and nursing services instructions were investigated and unsubstantiated by the facility investigative team. Review of the internal investigation concluded that "there were no errors or delays in the support and care" for the client. Review of facility documentation did not reveal evidence of an internal investigation due to allegations of neglect.	W 154		
W 318	HEALTH CARE SERVICES CFR(s): 483.460 The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by:	W 318	The facility will ensure that specific health careservices requirements are met. To prevent further occurrence: DON will educate all nurses on the importance of provide nursing services inaccordance with client's needs.	

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 06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 318	Continued From page 9 The facility failed to: provide nursing services in accordance to client's needs (W331); make necessary referrals to address needs (W338); provide guidelines and adequate training for staff regarding healthcare needs (W340); train direct care staff in detecting signs and symptoms of illness (W342); and ensure drugs are administered in compliance with physician's orders (W368). The cumulative effects of these systemic practices resulted in the facility's failure to provide statutory mandated services in health care.	W 318		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure deceased client (dc) #1 was provided nursing services in accordance with his needs regarding monitoring progress following an illness. The finding is: Record review on 6/24/24 of the facility's investigative summary dated 5/3/2024 - 5/10/2024 revealed an investigation was conducted following the death of dc #1 to determine if staff followed the prescribed treatment regimen given by the emergency department (ED) to give Tylenol and Ibuprofen with fluids and to return if his condition worsened. Further review of the internal investigation revealed that on 4/26/24, the site supervisor (SS) received a call from dc #1's school stating the client was displaying flu like symptoms and	W 331	The facility will provide clients with nursing services in accordance with their needs. To prevent further occurrence: A. DON will educate all nurses on the importance of provide nursing services, following doctor's orders as written in accordance with client's needs, regarding monitoring progress and following up with an illness. B. QIDP will educate all staff on the importance of completing body checks daily and accurately as required.	

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 06/25/2024

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 331	Continued From page 10	W 331		

needed to be picked up. Dc #1 was taken to the local ED and was counseled on proper medication management to be performed at the home, symptom control, aggressive hydration and instructions to return to the ED if symptoms worsened. Three days later, on 4/29/24, the SS contacted nursing to inform them of dc #1's condition and was instructed to follow up with the primary care physician (PCP). An appointment was made with the PCP for 5/1/24. The PCP requested labs be completed as soon as possible. DC #1 had labs drawn on 5/2/24 and the SS was called later that afternoon and told to take the client to the hospital immediately. It was reported that upon arrival to the hospital dc #1 coded and later passed away.

Review on 6/24/24 of the facility's internal investigation concluded that based on interviews, witness statements and doctor's consultations staff followed the prescribed treatment regimen as dc #1 was given Tylenol, Ibuprofen and fluids as ordered. "There were no errors or delays in the support and care for dc #1".

Record review on 6/25/24 of the facility's medication administration record revealed that dc #1 had not received Tylenol or Ibuprofen, or increased hydration, between 4/26/24 and 5/2/24. Record review also revealed that no vital signs or temperature checks had been performed on dc #1 since 4/4/24.

Record review of the facility's body checks performed on dc #1 for April 1, 2024 through May 2, 2024 revealed body checks were only performed on 4/4/24; 4/19/24; 4/26/24; 4/27/24; 4/28/24; 4/29/24; 4/30/24; 5/1/24 and 5/2/24. Documentation of body checks revealed on

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 06/25/2024

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 331	Continued From page 11 5/2/24 staff documented body checks were completed at 6am, 4pm and 7:30pm. Record review also revealed the client was at the ED on 5/2/24 at approximately 4pm. Interview on 6/25/24 with the facility's nurse confirmed no Tylenol or Ibuprofen was given to dc #1 from 4/26/24 - 5/2/24. The nurse also confirmed that no temperature checks nor vital signs were taken during that time. The nurse reported that she was unaware that dc #1 did not go for lab work until 5/2/24 and was unaware that there was an approximate 2 hour lapse of time from when the facility was told to get dc #1 to the hospital immediately and when the client was transported. The nurse confirmed she did not go to the home to assess dc #1 during the days prior to his death. However, she instructed the site supervisor to make a follow up appointment with the PCP. Interview on 6/25/24 with the facility's director of nursing (DON) revealed that body checks should be completed three times daily on all clients and confirmed it would be impossible for dc#1 to have had a body check completed on 5/2/24 at 4pm and 7:30pm as he was in the hospital during that timeframe. The DON confirmed that temperature checks, vital signs and fluid intake log should have been initiated for dc #1 when he was identified to be dehydrated and febrile on 4/26/24 and again on 5/1/24. The DON also confirmed that nursing did not assess or monitor medication administration, vital signs or temperature checks on dc #1 during 4/26/24 through 5/1/24. The DON also revealed she was unsure why 911 was not called, and instead staff transported dc #1 himself.	W 331		

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 06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 338	Continued From page 12 NURSING SERVICES CFR(s): 483.460(c)(3)(v) Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must result in any necessary action (including referral to a physician to address client health problems). This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure client #5 received a referral for therapy as recommended by specialists. The finding is: Review on 6/24/24 of client #5's record revealed psychiatric consult records dated 4/28/23, 5/19/23, 2/14/24 and 6/5/24. Further review of the psychiatric consult records for each visit revealed a recommendation for client #5 to be referred for therapy. Continued review on 6/25/24 of client #5's record revealed no evidence of therapy or referral for therapy. Interview on 6/25/24 with the quality assurance (QA) manager and facility nurses confirmed no referral for therapy has been made.	W 338	Facility will ensure client #5 received a referral for therapy as recommended by specialists. To prevent further occurrence: DON will educate the interdisciplinary team to ensure when a referral for therapy is recommended by a specialist the IDT follow up and follow through with recommendations as required (client #5).	
W 342	NURSING SERVICES CFR(s): 483.460(c)(5)(iii) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients. This STANDARD is not met as evidenced by:	W 342	Facility will ensure staff is sufficiently trained in detecting signs and symptoms of illnessand changes in client's health baseline. To prevent further occurrence: DON will educate all staff on the importance of detecting signs and symptoms of illness, changes in client's health baseline, reporting to nursing and following doctor's orders as prescribed.	

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W 342	Continued From page 13	W 342		

Based on record review and interviews, the facility failed to ensure staff were sufficiently trained in detecting signs and symptoms of illness and changes in client's health baseline. This affected 1 of 1 deceased clients (dc) #1. The finding is:

Record review on 6/24/24 of the facility's investigative summary dated 5/3/24 - 5/10/24 revealed an internal investigation was conducted following the death of dc #1 to determine if staff followed the prescribed treatment regimen given by the emergency department (ED) to give Tylenol and Ibuprofen with fluids, and to return if his condition worsened.

Further review of the investigation revealed that on 4/26/24, the site supervisor (SS) received a call from dc #1's school stating the client was displaying flu like symptoms and needed to be picked up. Dc #1 was taken to the local ED and was counseled on proper medication management to be performed at the home, symptom control, aggressive hydration and instructions to return to the ED if symptoms worsened. On 4/29/24, the SS contacted nursing to inform them of dc #1's condition and was instructed to follow up with the primary care physician (PCP). An appointment was made with the PCP for 5/1/24. The PCP requested labs be completed as soon as possible. DC #1 had labs drawn on 5/2/24 and the SS was called later that afternoon and told to take the client to the hospital immediately. It was reported that upon arrival to the hospital, Dc #1 coded and later passed away.

Review on 6/24/24 of the medical records from the ED visit on 4/26/24 revealed that the

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W 342	Continued From page 14	W 342		

caregiver present with dc #1 was counseled on medication management for symptom control as well as aggressive oral hydration with fluids.

Record review on 6/24/24 of the PCP visit on 5/1/2 revealed the client was diagnosed with dehydration and staff present at the visit were educated on the importance of repairing hydration status using pedialyte.

Record review on 6/25/24 of the facility's medication administration record (MAR) revealed that dc #1 had not received Tylenol, Ibuprofen, or increased hydration, between 4/26/24 and 5/2/24. Record review also revealed that no vital signs or temperature checks had been performed on Dc #1 since 4/4/24.

Record review on 6/24/24 of the hospital records from 5/2/24 revealed on admission the client was diagnosed with cardiac arrest, acute respiratory distress syndrome, acute kidney injury, septic shock, hyperkalemia and disseminated intravascular coagulation (DIC).

Interview on 6/25/24 with the facility's nurse confirmed no Tylenol or Ibuprofen was given to dc #1 from 4/26/24 - 5/2/24. The nurse also confirmed that no temperature checks nor vital signs were taken during that time. The nurse reported that she was unaware that dc #1 did not go for lab work until 5/2/24 and was unaware that there was an approximate 2 hour lapse of time from when the facility was told to get dc #1 to the hospital immediately and when the client was transported. The nurse confirms that she did not go to the home to assess dc #1 during the days prior to his death, however, she instructed the site supervisor to make a follow up appointment with

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W 342	Continued From page 15 the PCP. Interview on 6/25/24 with the facility's director of nursing (DON) confirmed that temperature checks, vital signs, and a fluid intake log should have been initiated for dc #1 when he was identified to be dehydrated and febrile on 4/26/24 and again on 5/1/24. The DON also confirmed that nursing did not assess or monitor medication administration, vital signs, or temperature checks on dc #1 from 4/26/24 through 5/1/24. The DON also revealed she was unsure why 911 was not called, and instead staff transported dc #1 himself. The DON confirmed there was no proof staff had been trained on changes in the client's health baseline.	W 342		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure medications were administered in accordance with physician's orders. This affected 2 of 4 audit clients (#2 and #4). The findings are: A. Record review on 6/24/24 of client #2's electronic medication administration record (EMAR) from 5/1/24 through 6/24/24 revealed a total of 44 medications were administered outside the allocated medication administration time frame (1 hour before or 1 hour after scheduled dose). Further record review on 6/24/24 of client #2's EMAR from 5/1/24 through 6/24/24 revealed a	W 368	The facility will ensure medications are administered inaccordance with physician's orders. To prevent further occurrence: DON will educate all staff at the Oakhaven Group Home through the company medication administration process to includes attending the class, passing with 85% or higher, 2 medication observation pass by Site Supervisor and 1 by the nurser.	

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W 368	Continued From page 16 total of 5 medication pass times that had completely been missed and no medications were given at those times. B. Record review on 6/24/24 of client #4's electronic medication administration record (EMAR) from 5/1/24 through 6/24/24 revealed a total of 64 medications were administered outside the allocated med administration time frame. Further record review on 6/24/24 of client #4's EMAR from 5/1/24 through 6/24/24 revealed a total of 15 medication pass times that had completely been missed and no medications were given at those times. Interview on 6/25/24 with the facility's director of nursing (DON) revealed medications can be administered 1 hour before or 1 hour after the time indicated on the physician's orders. The DON confirmed that the EMAR report surveyor reviewed would be accurate.	W 368		
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 review and interview, the facility failed to assure that adaptive equipment was furnished as prescribed for 1 of 4 sampled clients (#3). The finding is: Observations in the facility on 6/24/24 at 8:00AM	W 436	The facility will ensure that adaptive equipment is furnished as prescribed, available to client. To prevent further occurrence: A. QIDP will educate all staff on client #3 adaptive equipment needs. B. QIDP will implement program for client #3 to wear and care for his adaptive equipment (eyeglasses). C. QIDP will educate all staff on client #3 programs for adaptive equipment (eyeglasses).	

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W 436	Continued From page 17 revealed client #3 to participate in the breakfast meal. Continued observations revealed client #3 to participate in various activities without his eyeglasses. Subsequent observations at 2:30PM revealed client #3 to continue participating in various activities without his eyeglasses. Review of the record for client #3 on 6/24/24 revealed an individual support plan (ISP) dated 2/1/24. Continued review of the ISP revealed client #3 has the following adaptive equipment: eyeglasses to improve his vision, worn daily. Further interview with client #3 verified he does not have access to his eyeglasses. Interview with staff D on 6/24/24 revealed that client #3 has broken his eyeglasses and they are kept in the medication room. Interview with nursing services on 6/25/24 revealed that client #3 often breaks his eyeglasses and they need to be replaced often. Interview with the QA Manager on 6/25/24 revealed that the facility and the legal guardian share the responsibility of purchasing eyeglasses for client #3.	W 436	Continued From page 17 D. QIDP will submit monthly program goal update for client #3 on QIDP monthly form. Person(s) Responsible: PM, DON and QIDP	8/9/2024