STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G197	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-ST. JOHN'S CHURCH ROAD GROUP HOME	2220 ST. JOHN'S CHURCH ROAD CHARLOTTE, NC 28215

(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 3/6/25 for intake #NC00228024. The complaint was substantiated. A condition of participation in Client Protections and a standard level deficiency was 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 policies and procedures that prohibit mistreatment, neglect or abuse of a client (W149); ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures (W153). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated services in Client Protections.	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 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 observations, record reviews and interviews, the facility failed to implement written policies and procedures to prevent the neglect of mental health needs for 1 of 1 clients (#1). The findings is:	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, Area Supervisor's and Site Supervisor on policies and procedures that prohibited mistreatment, neglect, or abuse of the client.	04/01/2025

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Andrew Taylor	Program Manager	3/18/2025

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		

Review of facility records on 3/6/25 revealed an incident report dated 3/5/25. Review of the incident report completed by Staff A revealed client #1's behaviors included "physical aggression, hitting/slapping, kicking, pointing a knife and trying to stab me." Continued review of the incident report revealed client #1 hit Staff A "four times on the back of the neck, grabbed a knife and tried to stab me, my manager was on the phone and was telling him to put the knife down, that's when the other staff came in and tried to calm him down but he kept going and saying I deserve to die."

Interview with Staff A on 3/6/25 revealed that on 3/5/25 at approximately 6:30 AM, client #1 asked for a Mountain Dew soda and became upset when directed to wait until breakfast. Continued interview with Staff A revealed she redirected client #1 to complete his morning hygiene, but he continued to escalate, becoming verbally aggressive and throwing his toothbrush, then went into the kitchen and began stabbing the counter with a kitchen knife. Further interview with Staff A revealed client #1 then attacked her by punching her in the neck, kicking her in the head and then threatened to kill her with the kitchen knife, "jabbing the knife at me, he said I deserved to die." Additional interview with Staff A revealed they called the Home Manager (HM) during the incident and client #1 began to deescalate by following redirections from the HM over the phone, as well as redirections from Staff B, who was assisting another client with a shower when the incident began.

Interview with Staff B on 3/6/25 revealed they arrived to the group home at 6:05 AM on 3/5/25 and began assisting clients with their morning

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W 149	Continued From page 2	W 149		

showers. Continued interview with Staff B revealed while assisting another client with their shower she heard Staff A say, "put the knife down." Staff B came out of the bathroom and saw client #1 with a knife and hitting it on the counter. "I told him to put the knife down and get a drink, by then Staff A was on the phone with the HM."

Observations in the group home on 3/6/25, substantiated by interview with Staff B, revealed the knife client #1 used to threatened Staff A was a serrated knife from the kitchen knife block.

Interview with the HM on 3/6/25 revealed he received a phone call from Staff A on 3/5/25 at approximately 6:30 AM to report that client #1 had become physically aggressive after being prompted to complete his morning hygiene. Staff A then reported being hit in the back several times by client #1 before he threatened her with a kitchen knife. Continued interview with the HM revealed he attempted to calm client #1 down over the phone and instructed Staff B, who was giving another client a shower, to also help calm the client down. When he arrived at the group home at 7:00 AM client #1 was calm and he took him into the office to talk about the incident. Further interview with the HM revealed that afterwards he attempted to call and sent a text message to the Qualified Intellectual Disabilities Professional (QIDP) and Area Supervisor (AS) to report the incident. Additional interview with the HM revealed he received a phone call after the incident from the local police (CMPD) offering to send mobile crisis services to the home to access client #1, however he denied the services, telling CMPD their internal team would access client #1 first.

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W 149	Continued From page 3	W 149		

Interview with the QIDP on 3/6/25 revealed she was aware of the incident on 3/5/25, to include that client #1 had refused hygiene, started throwing things, name calling, and hit and kicked Staff A. Continued interview with the QIDP revealed they had no knowledge of client #1 threatening Staff A with a knife, "we would have sought psychiatric help, I would have called mobile crisis." Further interview with the QIDP revealed the HM is misinformed on how to handle a mental health crisis and the severity of the incident should have been reported to management immediately. Continued interview with the QIDP revealed the HM had not disclosed he had spoken directly with the hospital and CMPD Crisis Units or that he told them if they attempted to come to the home they would be denied entry. Additional interview with the QIDP revealed the HM withheld all information as to the severity of the 3/5/25 event.

Continued review of facility records on 3/6/25 revealed Abuse, Neglect, & Exploitation Policy & Procedures dated 11/14/18. Review of the policy and procedures revealed the definition of neglect to be "the failure of an individual to provide the treatment, care, goods or services that are necessary to maintain the health and safety of a person we support." Continued review of the policy and procedures for reporting revealed "all employees will immediately report any allegations or suspicions of abuse, neglect, or exploitation, to include any bruising or injury of unknown source, to the first supervisor, in the chain of command that is not involved in the incident. After reporting internally, proceed with external reporting."

Further review of the policy and procedures revealed their purpose is to "ensure all persons

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W 149	Continued From page 4 served are treated with dignity and respect; ensure that all persons served are free from abuse, neglect and exploitation; establish a protocol for reporting all incidents of abuse, neglect and/or exploitation to the facility's Critical Incident Database; and ensure all incidents of abuse and neglect, and exploitation are reported to the appropriate authority as defined by state and local regulations." Subsequent review of the policy and procedure revealed the facility's HM failed to accurately and timely report the occurrences of the events of 3/5/25, as well as withheld information from management that he spoke with hospital and police who offered crisis intervention for client #1, reporting that "internal staff" would provide crisis services. Additionally, the HM told hospital staff and police if they came to the home they would not be allowed entry thus neglecting timely needed mental health assessment for client #1 for the safety of the client, other clients in the group home and staff.	W 149		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure an incident involving 1 of 1 clients (#1) relative to verbal and physical aggression, assault and homicidal ideation directed towards a direct support staff (Staff A) was reported timely and accurately to the direct supervisor or administrator. The finding is:	W 153	The facility will ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. To prevent further occurrence: PM will educate QIDP's, Area Supervisor's and Site Supervisor on reporting all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, must be reported immediately to the administrator, program manager, DON or to other officials in accordance with State law through established procedures.	04/01/2025

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W 153	Continued From page 5	W 153		

Review of facility records on 3/6/25 revealed an incident report dated 3/5/25. Review of the incident report completed by Staff A revealed client #1's behaviors included "physical aggression, hitting/slapping, kicking, pointing a knife and trying to stab me." Continued review of the incident reported revealed client #1 hit Staff A "four times on the back of the neck, grabbed a knife and tried to stab me, my manager was on the phone and was telling him to put the knife down, that's when the other staff came in and tried to calm him down but he kept going and saying I deserve to die."

Interview with Staff A on 3/6/25 revealed that on 3/5/25 at approximately 6:30 AM, client #1 asked for a Mountain Dew soda and became upset when directed to wait until breakfast. Continued interview with Staff A revealed she redirected client #1 to complete his morning hygiene, but he continued to escalate, becoming verbally aggressive and throwing his toothbrush, then went into the kitchen and began stabbing the counter with a kitchen knife. Further interview with Staff A revealed client #1 then attacked her by punching her in the neck, kicking her in the head and threatened to kill her with the kitchen knife, "jabbing the knife at me, he said I deserved to die." Additional interview with Staff A revealed they called the HM during the incident and client #1 began to deescalate by following redirections from the HM over the phone, as well as redirections from Staff B, who was assisting another client with a shower when the incident began.

Interview with Staff B on 3/6/25 revealed they arrived to the group home at 6:05 AM on 3/5/25

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and began assisting clients with their morning showers. Continued interview with Staff B revealed while assisting another client with their shower she heard Staff A say, "put the knife down." Staff B came out of the bathroom and saw client #1 with a knife and hitting it on the counter. "I told him to put the knife down and get a drink, by then Staff A was on the phone with the HM."

Observation in the group home on 3/6/25 substantiated by interview with Staff B confirmed the knife client #1 used to threatened Staff A was a serrated knife from the kitchen knife block.

Interview with the HM on 3/6/25 revealed he received a phone call from Staff A on 3/5/25 at approximately 6:30 AM to report that client #1 had become physically aggressive after being prompted to complete his morning hygiene. Staff A then reported being hit in the back several times by client #1 before he threatened her with a kitchen knife. Continued interview with the HM revealed he attempted to calm client #1 down over the phone and instructed Staff B, who was giving another client a shower, to also help calm the client down. When he arrived at the group home at 7:00 AM client #1 was calm and he took him into the office to talk about the incident. Further interview with the HM revealed that afterwards he attempted to call and sent a text message to the Qualified Intellectual Disabilities Professional (QIDP) and Area Supervisor (AS) to report the incident. Additional interview with the HM revealed he did not get a response back from the QIDP or AS and no one came to the group home to follow-up regarding the incident.

Interview with the AS on 3/6/25 revealed they received a text message from the HM at 6:43 AM

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W 153	Continued From page 7 reporting client #1 was name calling, throwing stuff and had kicked Staff A after being instructed to complete his hygiene. She then received another text that client #1 had calmed down. Continued interview with the AS revealed she did not read the text messages until 8:30 AM due to working at another home. Further interview with the AS revealed she did not follow-up with the HM due to the report client #1 had calmed down. Additional interview with the AS revealed they have not reviewed the incident report from 3/5/25. Interview with the QIDP on 3/6/25 revealed she was aware of the incident on 3/5/25, to include that client #1 had refused hygiene, started throwing things, name calling, and hit and kicked Staff A. Continued interview with the QIDP revealed they had no knowledge of client #1 threatening Staff A with a knife, "we would have sought psychiatric help, I would have called mobile crisis." Further interview with QIDP revealed the HM is misinformed on how to handle a mental health crisis and the severity of the incident should have been reported to management accurately and immediately so the client's needs could have been quickly assessed.	W 153		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.	W 249		

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W 249	Continued From page 8 This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to update the behavior support plan (BSP) for 1 of 1 clients (#1) relative to increased incidents of physical aggression. The findings is: Review of facility records on 3/6/25 revealed client #1's admission date to be 6/22/24 and an individual support plan (ISP) dated 7/17/24. Review of the facility's incident reports and client behavior logs from June 2024 to present revealed client #1 engaged in physical aggression towards staff on 10/3/24, 10/10/24, and 12/4/24. Further review revealed on 3/5/25 client #1 engaged in physical aggression towards staff and threatened to kill staff with a knife. Review of client #1's record on 3/6/25 revealed a behavior support plan (BSP) dated 9/24/24. Continued review of the BSP revealed the following target behaviors: verbal aggression, non-compliance, elopement, suicidal ideations and self-injurious behavior. Further review of the BSP for client #1 revealed the following behavior medications: Clonazepam 2 MG for anxiety, Fluoxetine 80 MG for anxiety, Risperidone 3 MG for autism, and Trazodone 50 MG for insomnia. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 3/6/25 revealed the team was aware client #1's BSP needed to be updated due to multiple incidents of physical aggression since admission. Continued interview with the QIDP revealed the facility consulted a psychologist but client #1 has not been assessed nor has his BSP been updated to address the	W 249	The facility will ensure when the interdisciplinary team formulated a client's individual program plan, each client will receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. To prevent further occurrence: A. QIDP will ensure client #1 BSP is updated to includes all target behaviors. B. QIDP will trained/in-service all staff on continuous active treatment in relation to client #1 BSP/program to includes (locking all sharps) C. QIDP will obtain consents from each guardian to lock all sharps in the home. D. QIDP will trained/in-service all staff on all individual BSP programs and how to provide continuous active treatment. E. QP will document progress on a Q-note monthly. To be completed by: 04/01/2025. Person(s) Responsible: PM and QIDP	

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W 249	Continued From page 9 increased aggression.	W 249		