CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039: XINTEMM OF DEPICERCUES 101 PROVIDER/UNPLERCUE 121 MULTIPLE CONSTRUCTION 121 MULTIPLE CONSTRUCTION AND FLAN OF CORRECTION 346271 8. WING STREET ADDRESS, CITY, STATE, ZP CODE VOCA-ROLLING GROUP HOME STREET ADDRESS, CITY, NO. 28043 08/28/2018 VOCA-ROLLING GROUP HOME STREET ADDRESS, CITY, NO. 28043 08/28/2018 VPGETX SUMMARY STREET OF DEFICIENCIES PROVIDER STATUS (CORRECTIVE ACTION SOLD DE TEACH DEPICIENCY OR USC DESTIFYING INFORMATION) D PROVIDER UNA OF CORRECTIVE ACTION SOLD DE TEACH DEPICIENCY OR USC DESTIFYING INFORMATION) PROVIDER STATUS (CORRECTIVE ACTION SOLD DE TEACH DEPICIENCY OR USC DESTIFYING INFORMATION) D PROVIDER STATUS (CORRECTIVE ACTION SOLD DE TEACH DEPICIENCY OR USC DESTIFYING INFORMATION) D PROVIDER SOLD THAT SOLD DE TEACH DEPICIENCY OR USC DESTIFYING INFORMATION) D D CORRECTIVE ACTION SOLD DE TEACH DEPICIENCY OR USC DESTIFYING INFORMATION) D D D CORRECTIVE ACTION SOLD DE TEACH DEPICENCY D D CORRECTIVE ACTION SOLD DE TEACH DEPICENCY D D D D CORRECTIVE ACTION SOLD DE TEACH DEPICENCY D	DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00/28/2018 NAME OF PROVIDER OR SUPPLIER 346271 B. WING 00/28/2018 VOCA-ROLLING GROUPPLOME STREET ADDRESS, CITY, STATE, 2P CODE 27 DOB ROLLING ROAD PRETIX SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, NOT AS 20043 COMPLETED VOCA-ROLLING GROUP HOME SUMMARY STATEMENT OF DEFICIENCIES PRETIX CORRECTION SHOULD BE COMPLETED V122 CLIENT PROTECTIONS CERCH DEFICIENCY NUST BE PRECEDED BY FULL PRETIX PRECENCY COMPLETED W 122 CLIENT PROTECTIONS W 122 PRECENCY CERCENCY COMPLETED W 122 CLIENT PROTECTIONS W 122 W 122 CLIENT PROTECTIONS COMPLETED This CONDITION is not met as evidenced by: The facility failed to implement written prolices and procedures that prohbit mistreatment, neglect and abuse of clients (W149), ensure allegations and after an investigation results were reported to the administrator and to other officials in accordance with State law (W153); inplement sufficient client protection the sase allegations of abuse allegations of abuse allegations and after an investigation results were reported to the administrator and to other officials in accordance with State law (W155); inpluse the provide statutority mandated services of Client Protection to 10 is clients; W 149 The cumulative effect of these systemic practices resulted in the facility failure to provide statutority man	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	<u>MB NO.</u>	0938-0391
NMLE OF PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, GTV: STATE, ZP CODE (PAL) TAG SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (PAL) TAG SUMMARY STATEMENT OF DEFICIENCIES PREST CITY, NC 28043 (PAL) TAG SUMMARY STATEMENT OF DEFICIENCIES PREST CITY, NC 28043 (PAL) TAG SUMMARY STATEMENT OF DEFICIENCIES PREST CITY, NC 28043 (PAL) TAG SUMMARY STATEMENT OF DEFICIENCIES PREST CITY, NC 28043 (PAL) TAG SUMMARY STATEMENT OF DEFICIENCIES PREST CITY, NC 28043 (PAL) TAG SUMMARY STATEMENT OF DEFICIENCIES PREST CITY, NC 28043 (PAL) DEFICIENCIES PREST CITY, NC 28043 OWNER (PAL) DEFICIENCIES (PAL) PREST CITY, NC 28043 (PAL) DEFICIENCIES (PAL) OWNER (PAL) DEFICIENCIES (PAL) (PAL) (PAL) DEFICIENCIES </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
VOCA-BULINS GROUP HOME 297 BOB ROLLINS ROAD PORESTURY, NC 28043 CMUID TACK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TACK PROVIDER'S FLAN OF CORRECTION (EACH CORRECTVA CTION SHOULD BE CRUESHEFERNCED TO THE AFFORMATION) DOWNET TACK PROVIDER'S FLAN OF CORRECTION (EACH CORRECTVA CTION SHOULD BE CRUESHEFERNCED TO THE AFFORMATION) OWNET TACK PROVIDER'S FLAN OF CORRECTION (EACH CORRECTVA CTION SHOULD BE CRUESHEFERNCED TO THE AFFORMATION) OWNET TACK PROVIDER'S FLAN OF CORRECTION (EACH CORRECTVA CTIONS CFR(s): 483.420 W 122 W 122 CLIENT PROTECTIONS CFR(s): 483.420 W 122 W 122 This CONDITION is not met as evidenced by: The facility must ensure that specific client protections requirements are met. W 122 This CONDITION is not met as evidenced by: The facility failed to: implement sufficient client protection measures after and procedures that prohibit mistreatment, neglect and abuse of clients (W149): ensure allegations of abuse allegations and after an investigation results were reported to the administrator and to other officials in accordance with State law within 5 days of abuse allegations (W 157). W 149 W 149 STAFE TREATMENT OF CLIENTS CRES: 483.420(1)1 W 149 VI 149 The scality must develop and implement with state and procedures that prohibit mistreatment, neglect or abuse of the client. W 149 VI 149 W 149 STAFE TREATMENT OF CLIENTS CRES: 483.420(1) <td></td> <td></td> <td>34G271</td> <td>B. WING</td> <td></td> <td></td> <td>08/:</td> <td>28/2018</td>			34G271	B. WING			08/:	28/2018
VOCAROLLING GROUP HOME FOREST CITY, NC 28043 (%1)ID PREFIX TAC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES) (EACH DEFICIENCY ON USE BE PROVIDENT FUND RESULTION OF CORRECTION RESULTION OF LSC DENTIFYING INFORMATION) ID PROVIDENS FLAT PROVIDENS FLAT Orgo (EACH DEFICIENCIES) (EACH DEFICIENCIES) (EACH DEFICIENCY ON LSC DENTIFYING INFORMATION) ID PROVIDENS FLAT PROVIDENS FLAT Orgo (EACH DEFICIENCY ON LSC DENTIFYING INFORMATION) IV W 122 CLIENT PROTECTIONS CFR(s): 483.420 W 122 W 122 This CONDITION is not met as evidenced by: The facility failed to: implement written policies and procedures that prohibit mistreatment, neglect and abuse of clients (W149); ensure allegations of abuse allegations and after an investigation results were reported to the administrator and to other officials in accordance with State law (W153); inplement sufficient client protection measures after becoming aware of abuse allegations of abuse (W157). W 149 The cumulative effect of these systemic practices resulted in the facility failure to provide statutority mandated services of Client Protection to it's clients. W 149 W 149 STAFT TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) W 149 The facility failed to assure it's policies and policies and procedures that prohibit mistreatment, neglect or abuse of the client, the facility failed to assure it's policies and W 149	NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CMUID PREFIX TAC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL TAC D PREFIX (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULTORY OR LISC DENTIFYING INFORMATION) D PREFIX TAC D PREFIX TAC D PREFIX TAC D PREFIX TAC OCORRECTION (EACH CORRECTIVE ACTION SHOULD BE CRUSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OCORRECTION (EACH CORRECTIVE TAC OCORECTION (EACH CORRECTIVE TAC OCORECTION (EACH CORRECTIVE TAC OCORECTION (EACH CORRECTIVE TAC OCORECTION (EACH CORRECTIVE TAC O (EACH CORRECTIV	VOCA-RO	OLUNS GROUP HOM	IF					
PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE COMPARING DEFICENCY W 122 CLIENT PROTECTIONS CFR(s): 483.420 W 122 W 122 This CONDITION is not met as evidenced by: The facility failed to: implement written policies and procedures that prohibit mistreatment, neglect and abuse of client (VI49); ensure allegations of abuse were immediately reported to the administrator and to other officials in accordance with State Iaw (W153); implement sufficient client protection measures after becoming aware of abuse allegations (W156); and show evidence of appropriate corrective action for verified allegations of abuse allegations (W157). W 149 W 149 STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) W 149 W 149 STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) W 149 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. W 149			-		F	DREST CITY, NC 28043		
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protections requirements are met. This CONDITION is not met as evidenced by: The facility failed to: implement written policies and procedures that prohibit mistreatment, neglect and abuse of clients (W149); ensure allegations of abuse were immediately reported to the administrator and to other officials in accordance with State law (W153); implement sufficient client protection measures after becoming aware of abuse allegations and after an investigation results were reported to the administrator and to other officials in accordance with State law within 5 days of abuse allegations (W155); ensure investigation results were reported to the administrator and to other officials in accordance with State law within 5 days of abuse allegations (W156); and show evidence of appropriate corrective action for verified allegations of abuse (W157). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated services of Client Protection to it's clients. W 149 W 149 STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) W 149 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. W 149 This STANDARD is not met as evidenced by: Based on record/document review and interview, the facility failed to assure it's policies and W 149	W 122	CFR(s): 483.420		W 1	22			
The facility failed to: implement written policies and procedures that prohibit mistreatment, neglect and abuse of clients (W149); ensure allegations of abuse were immediately reported to the administrator and to other officials in accordance with State law (W153); implement sufficient client protection measures after becoming aware of abuse allegations and after an investigation results were reported to the administrator and to other officials in accordance with State law within 5 days of abuse allegations (W155); and show evidence of appropriate corrective action for verified allegations of abuse (W157).The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated services of Client Protection to it's clients.W 149W 149STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1)W 149The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.W 149								
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policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on record/document review and interview, the facility failed to assure it's policies and	W 149	resulted in the facili statutorily mandate to it's clients. STAFF TREATMEN	ity's failure to provide d services of Client Protection NT OF CLIENTS	W 14	49			
		policies and proced mistreatment, negle This STANDARD is Based on record/d	lures that prohibit ect or abuse of the client. s not met as evidenced by: ocument review and interview,					
		•	•			TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

PRINTED: 08/31/2018

		AND HUMAN SERVICES				FORM	08/31/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G271	B. WING			08/:	28/2018
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-R	OLLINS GROUP HOM	IE			97 BOB ROLLINS ROAD OREST CITY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 149	procedures that pro- implemented to pre- clients residing in th #6). The findings a Review of facility at 8/28/18 revealed or 7/19/18 and ending of the investigation physically or verball home and to asses company cell phone the facility investiga allegations were ad due to statements or result, the total facil abuse/neglect/mistr allegations included and physically abus violating client #2's door open while the Staff B failing to app intervention guidelin a behavior and (C), members "violated client #6 with a wate to wake the client u A. Review of the fa revealed that verba Staff A toward clien respect privacy for company policy" by with a water bottle t Interview with the fa (OM) on 8/28/18 re- from employment e	obibit abuse and neglect were event the abuse of 3 of 6 the group home (#2, #4 and the group home (#2, #4 and the group home (#2,	W 1	49			

Facility ID: 955481

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		AND HUMAN SERVICES				FORM	08/31/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G271	B. WING			08/2	28/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-R	OLLINS GROUP HOM	E			97 BOB ROLLINS ROAD OREST CITY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 149	Review of the facilit A revealed both the Personnel Registry reports were not co of the Incident Resp (IRIS) report reveal 8/9/18 and indicate services and the cli on 8/9/18. Interview with the C guardian was conta written evidence of OM also indicated t completed within 5 investigator and ad reached conclusion B. Review of the fa interview summarie relative of a staff m 7/23/18 about an in 7/23/18 on the facili the clients being tra The interview indica facility driveway, the "No [client #4]" and heard 3 "smacks" th and again heard "N "smacks". The visii client #6 getting off did not visually with was overheard. Review of the interv revealed the staff m #2, #4 and #6 were van while in the par	age 2 ity notifications related to staff 24 hour Health Care (HCPR) and the 5 day HCPR impleted until 8/9/18. Review ponse Improvement System ed it was first entered on d the department of social ent #4's guardian were notified OM on 8/28/18 revealed the acted on 7/19/18, but formal this was not available. The the investigation was not working days because the ministrative staff had not as about all of the allegations. Acility investigation staff es on 8/28/18 revealed a ember was interviewed on cident which occurred on ity van in the morning prior to ansported to the day program. ated that while parked in the e visitor overheard staff B say "give me your hand" and then hen heard someone crying to [client #4]" and heard 2 tor did indicate witnessing the van crying, but otherwise ess anything related to what	W	149			

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		AND HUMAN SERVICES			FORM	08/31/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		34G271	B. WING _		08/:	28/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
VOCA-R	OLLINS GROUP HOM	E		297 BOB ROLLINS ROAD FOREST CITY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 149	client #4. Staff B ind Your Safe, I'm Safe interventions. Furth summary indicated client # 4 on the har way to the day prog gotten out of her se client's clothes. Rev "Factual Findings" r follow Your Safe I'm by hitting client #4 o review of the invest receive corrective a Continued review o reveal staff B was s following the allega indicate staff B com prior to the corrective on 8/9/18. Further verified by interview confirmed no notified HCPR or DSS rega The investigation al the client's guardiar following the allega C. Review of the fa summaries on 8/28 interviewed on 7/19 sprayed client #6 in th The facility's summ completed on 7/19/	dicated she intervened with approved restrictive er review of the interview staff B did admit she "popped" nd while the van was on the gram when the client had eat and was pulling on another view of the investigation revealed staff B "failed to n Safe intervention techniques on the hand one time". Further igation revealed staff B did actions. If the investigation did not suspended immediately tion. Interview with the OM did tinued to work with client's ve actions, which were initiated review of the investigation, with the OM on 8/28/18 cations were made to IRIS, arding this abuse allegation. Iso did not include evidence n was notified immediately	W 14	49		

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		AND HUMAN SERVICES				FORM	08/31/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G271	B. WING			08/;	28/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-R	OLLINS GROUP HOM	E			97 BOB ROLLINS ROAD OREST CITY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 149	was hard to wake u staff C, E, D and B water bottle. The fa staff E on 7/20/18 in client #6 in the face The facility interview 7/23/18 indicated sl face with water to w The facility interview residential manage that on 7/16, staff B sprayed client #6 in the RM told staff B interview summary meeting occurred o staff to not use the client. Interview wit confirmed multiple bottle to wake up at times she became aware client #6 was on 7/1 not made administr time, and indicated this practice on 7/11 meeting. She also knowledge of how I working in the hom on for at least 6 mo documentation on 8 meeting revealed th staff were told to no Continued review o confirmed by intervi did not reveal any in related to this mistr	 ip. The client indicated that had all sprayed her with a icility interview summary with ndicated she had sprayed it to wake her up two times. We summary with staff C on the had sprayed client #6 in the vake her up 3 times. we summary with the facility r (RM) on 7/19/18 revealed as stated to her that she had the face to wake her up and she could not do that. The indicated a house staff on 7/17/18 in which she told all spray bottle to wake up the th the RM on 8/28/18 staff had been using a spray lient #6 because she was hard as the told all staff practice toward 16/18. She indicated the first of this staff aware of this at that she told all staff not to use 7/18 during a house staff indicated that based on her ong some staff had been going onths. Review of the 8/28/18 of the minutes for this his practice was covered and 		149			

Facility ID: 955481

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CENTER STATEMENT AND PLAN C		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G271	. ,	OING		FORM MB NO. (X3) DATE COM	08/31/2018 APPROVED 0938-0391 E SURVEY PLETED 28/2018
VOCA-R	OLLINS GROUP HOM	E			97 BOB ROLLINS ROAD FOREST CITY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 149	investigation did no guardian was notifie the OM on 8/28/18 receive corrective a reporting the staff in administrative staff. corrective action, for redirection of clients 8/28/18 revealed st the facility at the en corrective actions b The facility abuse a procedure titled "Pr Neglect", was revie indicated that any in humiliation or explo supervisor and inve policy described ab mental or physical p accidental means". "demeaning or lowe self-respect or dign that investigations s five business days ensuring notification completed and the reports are complet The facility failed to members immediat abuse and failed to immediately to adm entities as required facility's policy and failed to assure ade failed to increase m	ent mistreatment. The t include evidence the ed immediately. Interview with revealed the RM did not actions for not immediately histreatment of client #6 to . Staff A, B, and E all received or what included "inappropriate s". Interview with the OM on aff C ended employment with d of July, 2018, prior to being initiated.	W	149			

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		AND HUMAN SERVICES				FORM	08/31/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G271	B. WING			08/;	28/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-R	OLLINS GROUP HOM	IE			97 BOB ROLLINS ROAD OREST CITY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 149		ige 6	W 1	49			
W 153	neglectful. STAFF TREATMEN CFR(s): 483.420(d)		W 1	53			
	mistreatment, negle injuries of unknown immediately to the	nsure that all allegations of ect or abuse, as well as a source, are reported administrator or to other nce with State law through ures.					
	Based on facility re interviews, the facili allegations of abuse the administrator ar	s not met as evidenced by: ecord/document review and ity failed to ensure two e were immediately reported to nd to other officials in ate law for 1 of 1 investigation ings are:					
	8/28/18 revealed or 7/19/18 and ending of the investigation physically or verball home and to asses company cell phone the facility investiga allegations were ad due to statements of result, the total facil abuse/neglect/mistr allegations included and physically abus violating client #2's door open while the Staff B failing to app	buse/neglect investigations on the investigation started on on 8/6/18. The original scope was to determine if staff A had ly abused clients in the group s if staff A had violated e policy. Continued review of ation revealed that additional lded during the investigation during staff interviews. As a lity reatment investigation d: (A) Staff A being verbally sive toward clients and privacy by leaving a bathroom e client was showering; (B) propriately perform restrictive nes while client #4 was having					

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		AND HUMAN SERVICES			FORM	08/31/2018 APPROVED 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G271	B. WING		08/2	28/2018
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
VOCA-RO	LLINS GROUP HOM	IE		297 BOB ROLLINS ROAD FOREST CITY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	members "violated client #6 with a wate to wake the client u A. Review of the fa revealed that verba Staff A toward client respect privacy for company policy" by with a water bottle t Interview with the fa (OM) on 8/28/18 rev from employment e work again prior to Review of the facilit A revealed both the Personnel Registry reports were not co of the Incident Resp (IRIS) report reveal 8/9/18 and indicated services (DSS) and notified on 8/9/18. 8/28/18 revealed th 7/19/18, but formal not available. B. Review of the fa interview summarie relative of a staff m 7/23/18 about an in 7/23/18 on the facilit the clients being tra The interview indica facility driveway, the "No [client #4]" and	to determine if any staff company policy" by spraying er bottle in the face in attempt	W 153			

Facility ID: 955481

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/31/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		34G271	B. WING			08/:	28/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-R	OLLINS GROUP HOM	E			97 BOB ROLLINS ROAD OREST CITY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 153	"smacks". The visi client #6 getting off did not visually with was overheard. Review of the intervert revealed the staff m #2, #4 and #6 were van while in the par 7/23/18, which inclu- client #4. Staff B ind Your Safe, I'm Safe interventions. Furth summary indicated client #4 on the ha way to the day prog gotten out of her se client's clothes. Re "Factual Findings" n follow Your Safe I'm by hitting client #4 of Further review of the B did receive correct review of the invest with the OM on 8/20 were made at any t regarding this abus also did not include was notified immed C. Review of the fa- summaries on 8/28 interviewed on 7/19 sprayed client #6 of spray bottle to atter indicated she had b	ge 8 o [client #4]" and heard 2 tor did indicate witnessing the van crying, but otherwise ess anything related to what view summary for staff B nember indicated that client involved in a behavior on the king lot on the morning of ided client's #2 and #6 hitting dicated she intervened with approved restrictive her review of the interview staff B did admit she "popped" ind while the van was on the gram when the client had bat and was pulling on another view of the investigation revealed staff B "failed to in Safe intervention techniques on the hand one time". e investigation revealed staff ctive actions. Continued igation, verified by interview 8/18 confirmed no notifications ime to IRIS, HCPR or DSS e allegation. The investigation evidence the client's guardian iately following the allegation. acility investigation interview /18 revealed staff B was first /18 and indicated she had he time in the face with a inpt to wake the client. Staff B been directed by staff C to do wake her up". Staff B	W 1	153			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES		RINTED: 08/31/2018 FORM APPROVED MB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
34G271	B. WING	08/28/2018
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
VOCA-ROLLINS GROUP HOME	297 BOB ROLLINS ROAD FOREST CITY, NC 28043	
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLTAGREGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
 W 153 Continued From page 9 indicated she had witnessed staff A and and staff D spray client #6 in the face as well, to wake her up. The facility's summary of interview with client #6 completed on 7/19/18 revealed the client did indicate being sprayed in the face because she was hard to wake up. The client indicated that staff C, E, D and B had all sprayed her with a water bottle. The facility interview summary with staff E on 7/20/18 indicated she had sprayed client #6 in the face to wake her up two times. The facility interview summary with staff C on 7/23/18 indicated she had sprayed client #6 in the face with water to wake her up 3 times. The facility interview summary with the facility residential manager (RM) on 7/19/18 revealed that on 7/16/18, staff B stated to her that she had sprayed client #6 in the face to wake her up and the RM told Staff B she could not do that. The interview summary indicated a house staff meeting occurred on 7/17/18 in which she told all staff to not use the spray bottle to wake up the client. Interview with the RM on 8/28/18 confirmed multiple staff had been using a spray bottle to wake up client #6 because she was hard to wake up at times. The RM indicated the first she became aware of this staff practice toward client #6 was on 7/16/18. She indicated she had not made administrative staff aware of this at that time, and indicated she told all staff not to use this practice on 7/17/18 during a house staff meeting. She also indicated that based on her knowledge of how long some staff had been working in the home, this practice had been going on for at least 6 months. Continued review of the facility investigation, confirmed by interview with the OM on 8/28/18, did not reveal that IRIS, HCPR, or DSS were 	W 153	

Facility ID: 955481

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		AND HUMAN SERVICES				FORM	08/31/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G271	B. WING			08/:	28/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-R	OLLINS GROUP HOM	IE			97 BOB ROLLINS ROAD OREST CITY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 153	Continued From pa	ige 10	W 1	53			
W 155	notified at any time, mistreatment. The	, as required for this client investigation did not include lian was notified immediately. NT OF CLIENTS	W 1				
	The facility must pro while the investigati	event further potential abuse ion is in progress.					
	Based on review or and interviews, the sufficient client ptot after becoming awa	s not met as evidenced by: f facility records/documents facility failed to implement tection measures immediately are of abuse allegations and on was in progress for 1 of 1 ved.					
	8/28/18 revealed or 7/19/18 and ending of the investigation physically or verball home and to asses company cell phone the facility investiga allegations were ad due to statements of include: (A) Staff B perform restrictive i client #4 was having determine if any sta company policy" by water bottle in the fa- client up.	buse/neglect investigations on ne investigation started on on 8/6/18. The original scope was to determine if staff A had ly abused clients in the group is if staff A had violated e policy. Continued review of ation revealed that additional ded during the investigation during staff interview to failing to appropriately intervention guidelines while g a behavior and (B) to aff members "violated y spraying client #6 with a face in attempt to wake the					
		acility investigation staff es on 8/28/18 revealed a					

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		AND HUMAN SERVICES				FORM	08/31/2018 APPROVED 0938-0391	
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED	
		34G271	B. WING	;		08/28/2018		
NAME OF	PROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE			
VOCA-R	OLLINS GROUP HOM	IE			297 BOB ROLLINS ROAD FOREST CITY, NC 28043			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
W 155	relative of a staff m 7/23/18 about an in 7/23/18 on the facil the clients being tra The interview indica facility driveway, the "No [client #4]" and heard 3 "smacks" th and again heard "N "smacks". The visit client #6 getting off did not visually with was overheard. Review of the interv revealed the staff m #2, #4 and #6 were van while in the par 7/23/18, which inclu client #4. Staff B ind Your Safe, I'm Safe interventions. Furth summary indicated client # 4 on the hai way to the day prog gotten out of her se client's clothes. Rev "Factual Findings" r follow Your Safe I'm by hitting client #4 o a result, the facility Continued review o reveal staff B was s following the allega Operations Manage staff B continued to corrective actions, w	age 11 ember was interviewed on icident which occurred on ity van in the morning prior to ansported to the day program. ated that while parked in the e visitor overheard staff B say "give me your hand" and then hen heard someone crying lo [client #4]" and heard 2 tor did indicate witnessing the van crying, but otherwise less anything related to what wiew summary for staff B nember indicated that client involved in a behavior on the king lot on the morning of uded client's #2 and #6 hitting dicated she intervened with e approved restrictive her review of the interview staff B did admit she "popped" nd while the van was on the gram when the client had eat and was pulling on another view of the investigation revealed staff B "failed to n Safe intervention techniques on the hand one time", and as substantiated neglect. of the investigation did not suspended immediately tion. Interview with the er (OM) on 8/28/18 indicated o work with client's prior to which were initiated on 8/9/18. licate any protective measures		155				

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		AND HUMAN SERVICES				FORM	08/31/2018 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •				E SURVEY PLETED
		34G271	B. WING			08/	28/2018
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-R	OLLINS GROUP HOM	E			297 BOB ROLLINS ROAD FOREST CITY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 155	were implemented discovery of this all B. Review of the fi- summaries on 8/28 interviewed on 7/19 sprayed client #6 on spray bottle to atter indicated she had w this as the way "to w indicated she had w spray client #6 in th The facility's summ completed on 7/19/ indicate being spray was hard to wake w staff C, E, D and B water bottle. The fa staff E on 7/20/18 client #6 in the face The facility interview 7/23/18 indicated st face with water to w The facility interview residential manage that on 7/16, staff E sprayed client #6 in the RM told Staff B interview summary meeting occurred of staff to not use the client. Interview wit confirmed multiple bottle to wake up cl to wake up at times she became aware client client #6 was	immediately following the	W	155			

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		AND HUMAN SERVICES			FORM	08/31/2018 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G271	B. WING		- 08/28/2018		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP (CODE		
VOCA-R	OLLINS GROUP HOM	E		297 BOB ROLLINS ROAD FOREST CITY, NC 28043			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
W 155	not to use this pract staff meeting. She her knowledge of he working in the home on for at least 6 mo Continued review of confirmed by interve did not reveal any in as a result of this m substantiated by the policy". The OM dia measures were imp following the discow 7/19/18. STAFF TREATMEN CFR(s): 483.420(d) The results of all imp to the administrator or to other officials within five working of This STANDARD is Based on facility re- interviews, the facili investigation results administrator or to of with State law within for 1 of 1 investigat are: Review of facility at 8/28/18 revealed or	d indicated she told all staff tice on 7/17/18 during a house also indicated that based on ow long some staff had been e, this practice had been going inths. If the facility investigation, iew with the OM on 8/28/18, mmediate staff suspensions histreatment which was e facility as "violating company d not indicate any protective blemented immediately very of this allegation on NT OF CLIENTS 0(4) vestigations must be reported or designated representative in accordance with State law days of the incident. s not met as evidenced by: ecord/document review and ity failed to ensure all s were reported to the other officials in accordance in 5 days of abuse allegations ion reviewed. The findings	W 15	5			
	with State law within for 1 of 1 investigat are: Review of facility at 8/28/18 revealed or 7/19/18 and ending	n 5 days of abuse allegations ion reviewed. The findings buse/neglect investigations on					

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES			0	FORM. MB NO.	08/31/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				E SURVEY PLETED
		34G271	B. WING			08/2	28/2018
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-R	OLLINS GROUP HOM	E			97 BOB ROLLINS ROAD OREST CITY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 156	physically or verball home and to asses company cell phone the facility investiga allegations were ad due to statements of result, the total facil abuse/neglect/mistr allegations included and physically abus violating client #2's door open while the Staff B failing to ap intervention guidelin a behavior and (C) members "violated client #6 with a wate to wake the client u A. Review of the far revealed that verba Staff A toward clien respect privacy for company policy" by with a water bottle t Interview with the far (OM) on 8/28/18 ref from employment e work again prior to Review of the facilin A revealed both the Personnel Registry reports were not co of the Incident Resp (IRIS) report reveal 8/9/18 and indicated services and the cli	ly abused clients in the group s if staff A had violated e policy. Continued review of ation revealed that additional lded during the investigation during staff interviews. As a lity reatment investigation d: (A) Staff A being verbally sive toward clients and privacy by leaving a bathroom e client was showering; (B) propriately perform restrictive nes while client #4 was having to determine if any staff company policy" by spraying er bottle in the face in attempt	W	156			

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		AND HUMAN SERVICES				FORM	08/31/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY PLETED
		34G271	B. WING			08/	28/2018
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
VOCA-R	OLLINS GROUP HOM	IE			97 BOB ROLLINS ROAD OREST CITY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 156	revealed the guardi but formal written e available. B. Review of the fai interview summarie relative of a staff m 7/23/18 about an in 7/23/18 on the facili the clients being tra The interview indica facility driveway, the "No [client #4]" and heard 3 "smacks" th and again heard "N "smacks". The visit client #6 getting off did not visually with was overheard. Review of the inter revealed the staff m #2, #4 and #6 were van while in the par 7/23/18, which inclu- client #4. Staff B ind Your Safe, I'm Safe interventions. Furth summary indicated client # 4 on the hai way to the day prog gotten out of her se client's clothes. Review of the invest revealed staff B "fai Safe intervention te on the hand one tim	age 15 ian was contacted on 7/19/18, ividence of this was not acility investigation staff es on 8/28/18 revealed a ember was interviewed on icident which occurred on ity van in the morning prior to ansported to the day program. ated that while parked in the e visitor overheard staff B say "give me your hand" and then hen heard someone crying to [client #4]" and heard 2 tor did indicate witnessing the van crying, but otherwise ress anything related to what view summary for staff B nember indicated that client involved in a behavior on the rking lot on the morning of uded client's #2 and #6 hitting dicated she intervened with approved restrictive her review of the interview staff B did admit she "popped" nd while the van was on the gram when the client had eat and was pulling on another stigation "Factual Findings" iled to follow Your Safe I'm echniques by hitting client #4 ne". Further review of the led staff B did receive	W	156			

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		AND HUMAN SERVICES				FORM	08/31/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE	E SURVEY PLETED
		34G271	B. WING	B. WING			28/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				2	97 BOB ROLLINS ROAD		
VUCA-RO	OLLINS GROUP HOM	Ē		F	OREST CITY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 156	Continued From pa corrective actions. F investigation, verifie 8/28/18 confirmed r IRIS, HCPR or DSS abuse allegation. C. Review of the fa summaries on 8/28 interviewed on 7/19 sprayed client #6 or spray bottle to atter indicated she had b this as the way "to v indicated she had w spray client #6 in th The facility's summ completed on 7/19/ indicate being spray was hard to wake u staff C, E, D and B water bottle. The fac staff E on 7/20/18 i client #6 in the face The facility interview 7/23/18 indicated sl face with water to w The facility interview residential managet that on 7/16, staff B sprayed client #6 in the RM told Staff B interview summary meeting occurred o staff to not use the client. Interview wit confirmed multiple s	Ige 16 Further review of the ed by interview with the OM on no notifications were made to S at any time regarding this acility investigation interview /18 revealed staff B was first 0/18 and indicated she had ne time in the face with a mpt to wake the client. Staff B been directed by staff C to do wake her up". Staff B vitnessed staff A and staff D he face as well, to wake her up. ary of interview with client #6 18 revealed the client did yed in the face because she up. The client indicated that had all sprayed her with a acility interview summary with indicated she had sprayed to wake her up two times. W summary with staff C on he had sprayed client #6 in the vake her up 3 times. W summary with the facility r (RM) on 7/19/18 revealed a stated to her that she had he face to wake her up and she could not do that. The indicated a house staff on 7/17/18 in which she told all spray bottle to wake up the th the RM on 8/28/18 staff had been using a spray lient #6 because she was hard	W		DEFICIENCY)		
	bottle to wake up cl						

Facility ID: 955481

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		AND HUMAN SERVICES			FORM	08/31/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		34G271	B. WING		08/	28/2018
NAME OF F	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-ROLLINS GROUP HOME				297 BOB ROLLINS ROAD FOREST CITY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 156 W 157	client client #6 was she had not made a this at that time, an not to use this prace staff meeting. She her knowledge of he working in the home on for at least 6 mo documentation on 8 meeting revealed th staff were told to no Continued review of confirmed by interve did not reveal that 1 notified at any time mistreatment. The evidence the guard Staff A, B, and E all what included "inap clients". Interview of facility at the end of actions being initiat Interview with the fa- the investigation wa working days becau administrative staff about all of the alleg- indicated, administr to combine the investigation, so all same facility investig	of this staff practice toward on 7/16/18. She indicated administrative staff aware of d indicated she told all staff tice on 7/17/18 during a house also indicated that based on ow long some staff had been e, this practice had been going onths. Review of the 3/28/18 of the minutes for this his practice was covered and o longer do it. f the facility investigation, iew with the OM on 8/28/18, RIS, HCPR, or DSS were as required for this client investigation did not include ian was notified immediately. received corrective action, for propriate redirection of with the OM on 8/28/18 ded employment with the 7/18, prior to corrective ed. acility OM on 8/28/18 indicated as not completed within 5 use the investigator and had not reached conclusions gations. The OM also rative staff made the decision estigation of the new red during the original allegations were a part of the igation. NT OF CLIENTS	W 15			
		• •				

		AND HUMAN SERVICES			FORM	08/31/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G271	B. WING		08/2	28/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-R	OLLINS GROUP HOM	IE		297 BOB ROLLINS ROAD FOREST CITY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 157	Continued From pa	ige 18	W 157	,		
	If the alleged violati corrective action m	ion is verified, appropriate ust be taken.				
	Based on facility re interviews, the facil appropriate correct	s not met as evidenced by: ecord/document review and ity failed to show evidence of ive action for 1 of 1 abuse ved, including 1 of 3 verified e. The finding is:				
	8/28/18 revealed or 7/19/18 and ending of the investigation physically or verbal home and to asses company cell phone the facility investiga allegations were ad due to statements of include: Staff B fail restrictive intervent was having a behave staff members "viol	buse/neglect investigations on ne investigation started on g on 8/6/18. The original scope was to determine if staff A had ly abused clients in the group is if staff A had violated e policy. Continued review of ation revealed that additional dded during the investigation during staff interview to ling to appropriately perform ion guidelines while client #4 vior and to determine if any lated company policy" by with a water bottle in the face in e client up.				
	summaries on 8/28 interviewed on 7/19 sprayed client #6 or spray bottle to atter indicated she had b this as the way "to v indicated she had v D spray client #6 in	ity investigation interview 3/18 revealed staff B was first 3/18 and indicated she had ne time in the face with a mpt to wake the client. Staff B been directed by staff C to do wake her up". Staff B witnessed staff A and and staff the face as well, to wake her ummary of interview with client				

Facility ID: 955481

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		AND HUMAN SERVICES				FORM	08/31/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE	E SURVEY IPLETED
		34G271	B. WING	;		08/:	28/2018
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-R	OLLINS GROUP HOM	IE			297 BOB ROLLINS ROAD FOREST CITY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 157	#6 completed on 7/ indicate being spray was hard to wake u staff C, E, D and B water bottle. The fa staff E on 7/20/18 client #6 in the face The facility interview 7/23/18 indicated st face with water to w The facility interview residential manage that on 7/16, staff E sprayed client #6 in the RM told Staff B interview summary meeting occurred o staff to not use the client. Interview wit confirmed multiple bottle to wake up cl to wake up at times she became aware client #6 was on 7/7 not made administr time, and indicated this practice on 7/17 meeting. She also knowledge of how I working in the hom on for at least 6 mo Interview with the C 8/28/18 revealed th corrective actions fa the staff mistreatme administrative staff.	(19/18 revealed the client did yed in the face because she up. The client indicated that had all sprayed her with a acility interview summary with indicated she had sprayed to wake her up two times. We summary with staff C on he had sprayed client #6 in the vake her up 3 times. We summary with the facility r (RM) on 7/19/18 revealed a stated to her that she had the face to wake her up and she could not do that. The indicated a house staff on 7/17/18 in which she told all spray bottle to wake up the th the RM on 8/28/18 staff had been using a spray lient #6 because she was hard a. The RM indicated the first of this staff practice toward 16/18. She indicated she had rative staff aware of this at that she told all staff not to use 7/18 during a house staff indicated that based on her ong some staff had been e, this practice had been going onths.	W -	157			

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		AND HUMAN SERVICES				FORM	08/31/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G271	B. WING			08/:	28/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-RO	OLLINS GROUP HOM	E			97 BOB ROLLINS ROAD OREST CITY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 157	8/28/18 revealed st the facility at the en actions being initiat	s". Interview with the OM on aff C ended employment with d of 7/18, prior to corrective ed.	W 1				
W 249	PROGRAM IMPLE CFR(s): 483.440(d)	-	W 2	249			
	formulated a client's each client must re- treatment program interventions and se and frequency to su	rdisciplinary team has s individual program plan, ceive a continuous active consisting of needed ervices in sufficient number upport the achievement of the d in the individual program					
	Based on observat interview, the facility interventions in suff to support the achie administration object	s not met as evidenced by: tion, record review and y failed to provide ficient number and frequency evement of a medication ctive identified in the individual for 1 of 3 sampled clients (#6).					
	revealed client #6 e administration area retrieved her medic medication closet a including: Proprano mgtwo tablets, On 50 mg two capsula Lamotrigine 25 mg. mg., Colace 100 mg	cted on 8/28/18 at 6:50 AM entered the medication , sanitized her hands, ation bin from a shelf in the and received medications fol 10 mg., Calcium 600 meprazole 20 mg., Naltrexone es, Citalopram 20 mg., , Bentyl 20 mg., Cogentin 1 g., Haldol 10 mg., Vitamin D3 isone cream applied topically.					

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		AND HUMAN SERVICES			FORM	08/31/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G271	B. WING		08/;	28/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-R	OLLINS GROUP HOM	E		297 BOB ROLLINS ROAD FOREST CITY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 249	Continued observa of client #6's medic water and punched medication delivery #6 to participate. S prompt client #6 to effects of the Colac not respond no info #6 regarding the na medications admin Review of the ISP f conducted on 8/22/ objective for client medication with 75° consecutive month 1. Sanitize hands 2 Repeat name of me effect 5. Push med Interview conducted Supervisor (acting of professional) revea #6 with teaching an the names and side medication as well	tion during the administration ations revealed staff poured medications from the cards without prompting client staff was further observed to state the name and side e, however, when client #6 did ormation was provided to client ame, purpose or side effects of istered. For client #6 dated 1/23/18 was 18. The ISP contained an #6 to take the prescribed % independence for 3 s utilizing the following steps: 2. Identify medication bin 3. edication 4. Name one side lication into cup. d on 8/28/18 with the Clinical qualified intellectual disabilities led staff should provide client of verbal prompts to identify e effects of the prescribed as prompts to participate in ations from the delivery card	W 24			

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