STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G281	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-GREENWOOD GROUP HOME	105 GREENWOOD CIRCLE SMITHFIELD, NC 27577

(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 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 record review and interview, the facility failed to ensure an injury of unknown origin and a choking incident were thoroughly investigated. This affected 1 of 1 recently discharged clients (#1). The finding is: 1. An choking incident involving client #1 was not investigated. Review on 11/9/18 of an incident report involving client #1 dated 8/4/18 revealed, "While in the dining room, while feeding [Client #1] we noticed her face turned blue. She was still alert but the discoloration of her face. The nurse was called. She said to stop feeding her and call 911. The EMT arrived and she was transferred to the hospital." Additional review on 11/9/18 of the Emergency Room report involving client #1 dated 8/4/18 noted, "Reason for visit: Choking". During an interview on 11/9/18 with the facility's nurse via telephone, when asked if the incident on 8/4/18 involved client #1 choking during a meal, the nurse responded, "That's the impression I got." Interview on 11/9/18 with the Qualified Intellectual Disabilities Professional (QIDP) and Home Manager revealed the incident involving client #1 on 8/4/18 had not been discussed with the staff	W 154		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G281	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-GREENWOOD GROUP HOME	105 GREENWOOD CIRCLE SMITHFIELD, NC 27577

(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 154	Continued From page 1 involved and was not investigated. The QIDP acknowledged the incident should have been investigated. 2. An injury of unknown origin involving client #1 was not thoroughly investigated. Review of a facility investigation dated 9/13/18 - 9/24/18 (extended due to hurricane) revealed, "On September 12, 2018, the Executive Director...received a call from [Facility's nurse] that Greenwood staff members noticed bruising on [Client #1's] arm and side while removing clothing to give [Client #1] a shower..." Additional review of the investigation indicated group home staff working directly with client #1 over the prior two days and those working with her at the day program had been interviewed. Further review of the report noted client #1 "was not abused" and there was "not enough evidence to substantiate" abuse. The report; however, indicated discrepancies regarding "stories of how the bruise was discovered" had been found between the statements from the two staff who were working directly with client #1 at the time the injury was initially reported. Interview on 11/9/18 with the investigator confirmed inconsistencies had been found with two staff during initial interviews; however, the staff had not been interviewed again or asked for additional information to clarify these discrepancies.	W 154		
W 203	ADMISSIONS, TRANSFERS, DISCHARGE CFR(s): 483.440(b)(5)(i) At the time of the discharge the facility must develop a final summary of the client's	W 203		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G281	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-GREENWOOD GROUP HOME	105 GREENWOOD CIRCLE SMITHFIELD, NC 27577

(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 203	Continued From page 2 developmental, behavioral, social, health and nutritional status. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a final summary of client #1's status at the time of discharge was developed. This affected 1 of 1 discharged clients. The finding is: A discharge summary was not completed for client #1. Review on 11/9/18 of client #1's record revealed on 9/17/18 she had been admitted to the hospital with pneumonia. The record also indicated the client was later discharged from the hospital (date unknown) and admitted to a skilled nursing facility. The record did not indicate client #1 had been readmitted to the home after her admission to the hospital. Interview on 11/9/18 with the facility nurse via telephone indicated client #1 would not be returning to the facility do to a change in her level of care. Interview on 11/9/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #1 had been discharged from the facility. Additional interview indicated no discharge summary had been completed for client #1 as of the date of this survey.	W 203		