STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G270	A. BUILDING _____ B. WING _____	R 09/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-SIXTH STREET GROUP HOME	**201 NORTH SIXTH STREET SANFORD, NC 27330**

(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 revisit was conducted on 9/26/19 for all previous deficiencies cited on 7/1 - 2/19. All deficiencies have been corrected, but new noncompliance was found. The facility is not in compliance with all regulations surveyed.	W 000		
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure privacy for 1 of 2 audit clients (#1) residing in the home. The finding is: Client #1 was not afforded privacy while in her bedroom. During morning observations in the home on 9/26/19 at approximately 7am, client #1 was observed laying on her bed. Further observations revealed client #1 was naked from the waist down. At 7:04am, Staff A walked into client #1's bedroom, turned on the light, turned client #1 on her side; with her buttocks visible, removed a bed pan from underneath her, walked into the bathroom and emptied the bed pan and returned her bedroom and pulled up her pants. During the entire observation client #1's bedroom door remained open. During an immediate interview, Staff A revealed whenever client #1's bedroom door is closed or if	W 130		

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

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W 130	Continued From page 1 a "dignity cloth' is placed over her, she will scream. Further interview revealed "she never wants the door closed." Review on 9/26/19 of client #1's community/home life assessment dated 11/14/18 indicated she requires physical assistance from staff to observe her privacy. During an interview on 9/26/19, the qualified intellectual disabilities professional (QIDP) revealed staff should have shut client #1's bedroom door. Further interview revealed if client #1 begins to scream staff are to follow her behavior support plan.	W 130		
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure 1 of 2 audit clients (#6) was provided the opportunity of choice. The finding is: Client #6 was not afforded choice and freedom of movement in his home environment. During morning observations in the home on 9/26/19 at approximately 7:11am, client #6 followed two staff into the bedroom of another client. Further observations revealed the 2 staff transferring the other client from their bed to their wheelchair. Further observations revealed Staff A telling client #6, "Stand over there [Client #6]."	W 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G270	A. BUILDING _____ B. WING _____	R 09/26/2019

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W 247	Continued From page 2 During an immediate interview, Staff A revealed she had client #6 come into the other client's bedroom to "keep him from wandering." Staff A stated client #6 is allowed freedom of movement in his home. Staff A also stated, "He won't sit down like everyone else" and wander. Additional interview revealed he will have accidents on himself. When asked what happens if client #6 had a accident Staff A reported he would get "cleaned up." Review on 9/26/19 of client #6's community/home life assessment dated 3/28/19 revealed he is independent when it comes to affording others personal space and observing the privacy of others. During an interview on 9/26/19, the home manager (HM) revealed the home has door alarms and if the alarms go off, staff will check who is going out or coming in. Further interview revealed client #6 has never left the home on his own. During an interview on 9/26/19, the qualified intellectual disabilities professional (QIDP) revealed client #6 should not have been required to stand in another client's bedroom and he should have been allowed freedom of movement within his home.	W 247		