

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

RECEIVED

PRINTED: 08/21/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  34G271	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>2019</u>  B. WING <u>DHSP NHT &amp; C</u> <u>Black Mountain / WRO</u>	(X3) DATE SURVEY COMPLETED  08/20/2019
--	--	---	--

NAME OF PROVIDER OR SUPPLIER  VOCA-ROLLINS GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 297 BOB ROLLINS ROAD FOREST CITY, NC 28043
---	--

(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 242	<p>INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(iii)</p> <p>The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</p> <p>This STANDARD is not met as evidenced by: Based on observations, interview, and record review, the team failed to ensure the individual support plan (ISP) for 1 of 3 sampled clients (#5) included objective training to address observed needs relative to privacy. The finding is:</p> <p>Observations in the group home on 8/20/19 at 6:55 AM revealed client #5 to exit her bedroom wearing only an incontinence brief and a t-shirt, and then entering a bathroom directly across the hallway without knocking before entering. Further observations at 7:35 AM revealed client #5 entering the same bathroom without knocking. Staff (D) was behind the client as she entered the bathroom and re-directed the client out of the bathroom and demonstrated knocking on the door for the client. Interview with staff D at that time revealed she had re-directed the client out of the bathroom because she did not know if another client was in the bathroom. Continued observations at 7:39 AM revealed client #5 to enter the same bathroom again without knocking and staff D was observed re-directing the client to knock.</p>	W 242	<p>New Program(s) will be implemented by QIDP for client 5 for privacy goals by September 3, 2019. The QIDP will monitor the program(s) monthly. Any changes or recommendations for program(s) will be reviewed at the monthly core team and implemented. Staff will be trained on new program(s) by September 3, 2019.</p>	
-------	--	-------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Tracey Now</i>	TITLE Program Manager	(X6) DATE 8-27-19
--	--------------------------	----------------------

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/21/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G271</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/20/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>VOCA-ROLLINS GROUP HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>297 BOB ROLLINS ROAD FOREST CITY, NC 28043</b>		
(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 242	Continued From page 1 Review of the record for client #5 on 8/20/19 revealed an ISP dated 1/7/19. Review of the current program objectives revealed objectives for communication, dining, laundry, medication administration, packing lunch, and brushing teeth. Review of the current "Community/Home Life Assessment" revealed the client required verbal cueing for observing privacy and verbal cueing for appropriate dressing and un-dressing.  Interview with the facility program manager on 8/20/19 confirmed client #5 did not have a current objective related to privacy and confirmed the client lacked skills and needed training for observing privacy related to appropriate dress and knocking before entering.	W 242	<i>See page 1</i>		