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

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MAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 201 MORTH SIZH STREET GROUP HOME SAMPORD, No. 27330 SAMPORD, No. 27330 PREFIX TAG	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER'SUPPLIER/CLIA IDENTIFICATION NUMBER:					ATE SURVEY EMPLETED			
VOCA-SIXTH STREET GROUP HOME VOCA-SIXTH STREET GROUP HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR I.S. IDENTIFYING INFORMATION) 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 with all regulations surveyed. W 130 PROTECTION OF CLIENTS RIGHTS 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 taying on her bed. Further observations revealed client #1 was naked from the waist down. At 7:04am, Staff A wasked into client #1's bedroom, turned on the light, turned client #1's bedroom 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		34G270		B. WING			09	and the second second second	
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ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X8) DATE	40000000			I And I am —	11	***			

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: 09/26/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
34G270		B. WING			R 09/26/2019	
NAME OF PROVIDER OR SUPPLIER VOCA-SIXTH STREET GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 201 NORTH SIXTH STREET SANFORD, NC 27330			,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	COMPLETION DATE
W 130	scream. Further in wants the door closs Review on 9/26/19 life assessment data requires physical as her privacy. During an interview intellectual disabilities revealed staff should be	laced over her, she will terview revealed "she never sed." of client #1's community/home ted 11/14/18 indicated she saistance from staff to observe on 9/26/19, the qualified es professional (QIDP) Id have shut client #1's ther interview revealed if client in staff are to follow her an. CRAM PLAN (6)(vi) ram plan must include ent choice and so not met as evidenced by: itions, record review and ity failed to ensure 1 of 2 audit ovided the opportunity of its: Ifforded choice and freedom of	W 24	30		

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

PRINTED: 09/26/2019 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) MULTIPLE CONSTRUCTION (X3) DATE 6 A. BUILDING COMPL		TE SURVEY MPLETED		
					R		
34G270		B. WING			09	09/26/2019	
NAME OF PROVIDER OR SUPPLIER VOCA-SIXTH STREET GROUP HOME				2	TREET ADDRESS, CITY, STATE, ZIP CODE 01 NORTH SIXTH STREET ANFORD, NC 27330		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	ĸ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 247	During an immedial she had client #6 co bedroom to "keep h stated client #6 is a in his home. Staff / down like everyone interview revealed himself. When ask had a accident Staf "cleaned up." Review on 9/26/19 life assessment dat independent when i personal space and others. During an interview manager (HM) revealer client #6 hown. During an interview intellectual disabilitir revealed client #6 s to stand in another s.	ge 2 se interview, Staff A revealed ome into the other client's im from wandering." Staff A salso stated, "He won't sit else" and wander. Additional will have accidents on ed what happens if client #6 f A reported he would get of client #6's community/home ed 3/28/19 revealed he is toomes to affording others to bserving the privacy of on 9/26/19, the home aled the home has door arms go off, staff will check coming in. Further interview as never left the home on his on 9/26/19, the qualified es professional (QIDP) hould not have been required client's bedroom and he showed freedom of movement	W 2		W247 This deficiency will be corrected the following actions: a. All community/ home assessment will be review to look at all current need persons served. b. Team will address all restrictive movement isservice with written training progent HRC and Behavior support guidelines c. All person served will be afforded the opportunity freedom of movement d. Adequate supervision we provided for consumers ensure safety movement their home e. staff will be in-service on ensuring that all consumare being monitored, as and have freedom of movement f. Residential Manager will monitor on time a week g. Qualified Professional we monitor one time a week	wed eds of sues gram, ort fill be to tin mers sess	11.25.2019

Community Alternatives – NC Southeast Region 1001 Navaho Drive Suite 101 Raleigh, NC 27609

Phone: 984-205-2630 **FAX:** 984-205-2643

FAX

1	
To: LUgina Bains	From enmane Teary
Fax: 9/9 7/5-8028	Pages:
Phone: 919 855 3795	Date: 9/30/19
Re: SURVY	CC:
Urgent For Review Please Comm	ent Please Reply Please Recycle
e	
Comments:	



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September 30, 2019

Eugina Barnes, BSW, QIDP
Facility Survey Consultant I
Mental Health Licensure and Certification section
NC Division of Health Services Regulations
2718 Mail Service Center
Raleigh NC 27699-2718
919.855.3795 office
919.715.8078 fax

RE: Plan of Correction for Follow-up Survey conducted: September 26, 2019 VOCA- Sixth Street Group Home 201 N. Sixth Street, Sanford, NC 27330 Provider Number 34G270 MHL# 053-023

Dear Ms. Eugina Barnes

We appreciate the courtesy extended by you while surveying the VOCA-Sixth Street Group Home North Carolina.

As indicated on the Plan of Correction, we will have the Deficiencies corrected for, the Annual survey conducted On September 26, 2019, it will be completed November 25, 2019

We are committed to providing the highest possible care for the people we serve at **VOCA- Sixth Street Group Home**

If you have questions, please contact JerMaine Kearney, Program Manager 984.205.2630 ext 403

Sincerely,

MUIKA Whack /AL Marika Whack, Executive Director

Community Alternatives North Carolina-Southeast Region

1001 Navaho Drive Sutie 101 Raleigh, North Carolina, 27609

919:827.2790 cell

984.205.2630 ext. 405

mawhack@rescare.com