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

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-C 05/12/2022

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 5/12/22 for all previous deficiencies cited on 2/4/22. Several deficiencies have been corrected and there were several deficiencies cited.	{W 000}		
{W 255}	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(i) The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and interviews with staff the facility failed to consider client #5 for additional training after he met criteria for completion. This affected 1 of 3 audit clients (#5). The finding is: Review on 5/12/22 of client #5's individual program plan (IPP) dated 12/15/21 revealed a training objective to brush his teeth after each meal accordingly to task analysis with 70% accuracy and assist with meal preparation with 35% accuracy for 3 consecutive sessions. Review on 5/12/22 of client #5's progress summaries summaries revealed the following: A) Brushing teeth: 8/2021: 100% 9/2021: 100% 10/2021: 100% 11/2021: 100%	{W 255}		

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

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.

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{W 255} | {W 255}

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Review on 5/12/22 of notes by the qualified intellectual disabilities professional (QIDP) dated 3/10/22 revealed client #5 had scored 100% on toothbrushing in February and 100% on toothbrushing in March. No revisions were noted to this objective.

B) Meal Preparation:
8/2021: 100%
9/2021: 100%
10/2021: 100%
11/2021: 100%

Review on 5/12/22 of client #5's record revealed this meal preparation objective was ongoing and no revisions have been implemented.

Interview on 2/3/22 with the QIDP revealed these programs are ongoing and have not been updated or revised despite client #5 having met criteria for completion.

W 340 | W 340

NURSING SERVICES
CFR(s): 483.460(c)(5)(i)

Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.
This STANDARD is not met as evidenced by:
Based on observations, record review and interviews, the facility failed to ensure nursing staff sufficiently trained direct care staff regarding appropriate nursing practices and protocols. This potentially affected 1 of 6 clients (#2). The finding is:

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W 340	Continued From page 2 During observations in the facility on 5/12/22 from 9:30am-12pm staff A worked with client #2 providing leisure choices, assisting her by feeding her lunch and administering medication at 12 noon. At no time during this observation did staff A wear a facial mask in the facility. Interview on 5/12/22 with staff A revealed her understanding was if a direct care staff was vaccinated, they did not have to wear a facial mask in the facility. Interview on 5/12/22 with the residential manager (RM) revealed all staff are required to wear facial masks in the facility. Vaccinated staff wear surgical masks when they working in the facility and unvaccinated staff are requires to wear NIOSH approved N95 masks at all times. Review on 5/12/22 of the facility's policy on COVID-19 Immunization Requirements for Staff in ICF/IDD facilities dated 1/28/22 revealed, "All fully vaccinated employees will be required to wear a surgical masks at all times while providing care and are within an ICF home unless they are eating or drinking-which will be done six feet or greater from clients." Interview on 5/12/22 with the Co-Executive Director and Facility Nurse confirmed staff A had been inserviced on this COVID-19 Immunization Requirements for Staff in ICF/IDD facilities policy on 4/19/22.	W 340		
{W 436}	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed	{W 436}		

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{W 436}	Continued From page 3 choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide client #2 with her adaptive communication device as documented in her individual program plan (IPP). This affected 1 of 3 audit clients (#2). The finding is: A. Throughout observations on 5/12/22 from 9:30am-12:00pm, client #2 was noted to be in her wheelchair either in the living area or in the dining room. Staff A asked her questions and asked client #2 to respond with eye blinks to indicate yes or no. Adaptive communication devices were not observed to be used. Review on 5/12/22 of client #2's IPP dated 12/9/21 that client #2 was non verbal and that she had spastic quadriparesis. Further review of the IPP revealed client #2 has Oral and Verbal Apraxia. Additional review of the IPP revealed, " Understands simple phrases as well as short conversations. Can answer yes or no to questions. Client #2 has a communication device that assists her in making her wants and needs known. Her device should be charged every evening in preparation for the following day" Additional review on 5/12/22 of client #2's communication guidelines indicates when her communication device is out for repairs, staff should promote choices for client #2, Ask yes/no questions and ask her to provide eye blink responses and involve her in all attempts to communicate.	{W 436}		

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{W 436}	Continued From page 4 Interview on 5/12/22 with staff A regarding client #2's communication device revealed she was not certain where it was currently located. Interview on 2/3/22 with the qualified intellectual disabilities professional (QIDP) and Program Director revealed client #2 does not have an augmentative communication device at the current time. Further interview also confirmed there has not been contact with the speech pathologist or vendor to locate an augmentative communication device.	{W 436}		