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 _____	02/27/2024

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

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E 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency	E 006		

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

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E 006	Continued From page 1	E 006		

Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:
(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.
(2) Include strategies for addressing emergency events identified by the risk assessment.

*[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:

(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.
(2) Include strategies for addressing emergency events identified by the risk assessment.
This STANDARD is not met as evidenced by:
Based on policy review and interview, the facility failed to develop an emergency preparedness (EP) plan including and based upon community and facility-based risk assessment utilizing an all-hazards approach. This had the potential to affect all clients (#1, #2, #3, #4, #5 and #6). The findings is:

Review on 2/27/24 of the EP last reviewed on 2/22/23 by the former Site Supervisor revealed a document "Hazards and Vulnerability Assessment Tool Human Related Events" developed for another city. Another document, "Hazard and Vulnerability Assessment was dated for 2020. No other Hazard Assessment Tools materials were

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E 006	Continued From page 2 presented for review. Interview on 2/27/24 with the current Site Supervisor revealed she began her assignment in December 2023 and did not participate in a risk hazards assessment. Interview on 2/27/24 with the Program Manager revealed she started last year and was not directed to to update the risk hazards assessment.	E 006		
W 111	CLIENT RECORDS CFR(s): 483.410(c)(1) The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to maintain a recordkeeping system that accurately reflected 2 of 3 audit clients (#3 and #4) monthly weights. The findings are: A. Record review on 2/26/24 of client #3's Individual Program Plan (IPP) dated 12/2/23 revealed he was prescribed a healthy weight loss diet of 1500 calories with no seconds. An additional record review on 2/27/24 of Core Team Meeting monthly notes revealed the following recorded weights for client #3: 2/7/24 at 223 lbs. 1/10/24 at 221 lbs. 12/6/23 at 220 lbs. 11/9/23 at 112 lbs. 10/11/23 at 212 lbs. 9/2023 AT 215 lbs.	W 111		

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W 111	Continued From page 3 8/11/23 at 216 lbs. 7/5/23 at 119 lbs. 6/12/23 at 119 lbs. 5/10/23 at 219 lbs. 4/12/23 at 243 lbs. 3/9/23 at 243 lbs. B. Record review on 2/26/24 of client #4's IPP dated 7/27/23 revealed he was prescribed a healthy weight loss diet of 1800 calories with no seconds. An additional record review on 2/27/24 of Core Team Meeting monthly notes revealed the following recorded weights for client #4: 2/7/24 at 224 lbs. 1/10/24 at 254 lbs. 12/6/23 at 257 lbs. 11/9/23 a5 236 lbs. 10/11/23 at 238 lbs. 9/7/23 at 250 lbs. 8/11/23 at 254 lbs. 7/5/23 at 249 lbs. 6/11/23 at 220 lbs. 5/10/23 at 253 lbs. 4/12/23 at 252 lbs. 3/9/23 at 252 lbs. Interview with Staff A on 2/27/24 revealed there was a large digital flat scale in the office of the home. Staff A asked client #4 to stand on the scale and revealed his current weight was 235.2 lbs. Interview with the Site Supervisor on 2/27/24 revealed staff weighed clients every Wednesday. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 2/27/24 revealed she had	W 111		

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W 111	Continued From page 4 inquired about client #4's weights last year and was told it fluctuated due to his medicals and labs but could not explain what that meant. Interview with the Program Director (PD) on 2/27/24 revealed that staff should receive on the job training when hired and learn how to weigh the clients. The PD also revealed staff should contact the nurse if they noticed variances with the weights.	W 111		
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observations and record reviews, the facility failed to provide hair care and grooming services to 2 of 3 audit clients (#3 and #4). The findings are: A. During observations on 2/26/24 to 2/27/24, client #3 was observed with a low afro hairstyle with no defined line up at the hair line. Client #3 had an overgrown beard that grew underneath his chin and covered his neck. Record review on 2/27/24 of client #3's Community/Home Life Assessment from 11/20/23 revealed he needed physical assistance to shave and go to the barber. B. During observations on 2/26/24 to 2/27/24, client #4 was observed with a low afro hairstyle	W 125		

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W 125	Continued From page 5 with no defined line up at the hair line. Client #4 had an overgrown beard that grew underneath his chin and covered his neck. Record review on 2/26/24 of client #4's Community/Home Life Assessment from 7/27/23 revealed he was dependent on staff to go to the barber. Interview on 2/27/24 with the Site Supervisor (SS) revealed the former barber was no longer available due to a change in health. The SS revealed she had been trying to find a new barber to cut "black hair" but was challenged to find someone who would accept the type of credit card (P-Card) issued to the facility; she encountered barbers wanting to be paid in cash. The SS was told a disposable razor would irritate the skin of the black male residents and she bought an electric razor but it did not work properly. The SS acknowledged the male clients have not received a hair cut or shave in a month. Interview on 2/27/24 with the Program Manager confirmed Medicaid does pay for monthly hair care services for clients. The PM revealed the Site Supervisors ordinarily have the money put on their P-Cards and charges the haircuts. The PM revealed they are continuing to look for a vendor to take their P-Card.	W 125		
W 348	DENTAL SERVICES CFR(s): 483.460(e)(1) The facility must provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists either through organized dental services in-house	W 348		

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W 348	Continued From page 6 or through arrangement. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to provide dental services as recommended for 1 of 3 audit clients (#4). The finding is: Record review on 2/26/24 of client #4's dental consultation report revealed on 3/24/23 he had a pre-surgery exam for dental surgery that was performed on 3/31/23. Client #4's next dental checkup was performed on 10/30/23. The dentist found he had a small cavity on the upper left. The dentist recommended to complete fillings in a hospital setting. There was no evidence the dental surgery had been completed. Interview on 2/27/24 with the Site Supervisor (SS) revealed she started working in the home in December, 2023 and was not aware that he needed dental treatment. The SS checked the appointment calendar and revealed his next dental checkup was scheduled for May 2024 for routine care. Interview on 2/27/24 with the Program Manager (PM) revealed that dental service recommendations are the responsibility of the SS to coordinate. The PM acknowledged that most of their specialists required a clearance physical by the doctor if the client needed anesthesia.	W 348		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and	W 460		

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W 460	Continued From page 7 specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure that diet orders were followed for 3 of 3 audit clients (#1, #3 and #4). The findings are: A. During dinner observations on 2/26/24 at 6:10pm revealed client #1 received a pureed dinner consisting of cooked carrots, great northern beans and breaded chicken tenders. Upon close observation, the processed chicken tenders had a coarse texture similar to cooked grits and had brown specks throughout the chicken's consistency. On the wall in the kitchen, hung photographs on achieving a pureed consistency diet. Client #1 was fed her meal and did not display any complications. Record review on 2/26/24 of client #1's Individual Program Plan (IPP) dated 1/19/24 revealed a dietary order of pureed diet of pudding consistency. Client #1 was an aspiration risk due to a diagnosis of dysphagia. B. During dinner observations on 2/26/24 at 6:05pm revealed client #3 placed 8 whole chicken tenders and consumed them. Record review on 2/26/24 of client #3's IPP dated 12/2/23 revealed a dietary order of regular 1500 calories diet, with no second servings. An additional review on 2/27/24 of the Cycle II spread sheet for menus revealed the serving size for chicken tenders was 2 ounces for a 1500 calories diet.	W 460		

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W 460	Continued From page 8 C. During dinner observations on 2/26/24 at 6:06pm revealed client #4 placed 6 whole chicken tenders and consumed them. Record review on 2/26/24 of client #4's IPP dated 7/27/23 revealed a dietary order of regular 1800 calories diet, with no seconds servings. An additional review on 2/27/24 of the Cycle II spread sheet for menus revealed the serving size for chicken tenders was 3 ounces for a 1800 calories diet. Interview on 2/27/24 with the Site Supervisor (SS) revealed the former SS came by the home last week and had them remove the dietary orders from the kitchen wall. The SS also acknowledged the portion sizes per meal were not placed in the menu book. Interview on 2/27/24 with the Program Manager revealed there were several new staff working in the home but the expectation was for all staff to get meal preparation training from the SS. The Program Manager revealed she expected the SS to contact the dietary consultant if they needed onsite training to ensure the diets were prepared correctly.	W 460		