

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

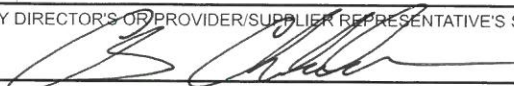
PRINTED: 07/20/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G271	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/18/2023
--	---	--	---

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 227	<p>INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4)</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to assure the person-centered plan (PCP) included interventions to provide behavioral support for 1 non-sampled client (#6).</p> <p>Observations in the group home on 7/18/23 from 6:45 AM-7:45 AM revealed client #6 to remain in her room with the door closed. Continued observations at 7:45 AM revealed the home manager (HM) to knock on client #6's bedroom door and open to find the client's mattress on the floor, bedding on top of the box spring and vomit behind the bedroom door. Further observations revealed the home manager to request assistance from staff to clean up the client and the vomit on the floor. Additional observations revealed staff C to assist client #6 to the bathroom to take a shower.</p> <p>Review of the record for client #6 on 7/18/23 revealed a PCP dated 1/6/23. Continued review of the PCP revealed the following program goals: bathing goal, pick out menu items for dinner, learn medications and punch out meds, respect the privacy of others and herself, rate of eating, toothbrush goal, and choose her clothing. Further review of the record revealed a behavior support plan (BSP) dated 1/6/23 revealed the following target behaviors: property destruction, inappropriate sexual behaviors, verbal aggression, non-compliance, and self-injurious</p>	W 227	<p style="text-align: right; color: blue;">DHSR - Mental Health</p> <p style="text-align: right; color: red;">AUG 9 2023</p> <p style="text-align: right; color: blue;">Lic. & Cert. Section</p>	
-------	--	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Pragya Manjra	(X6) DATE 7/31/23
--	-------------------------------	-----------------------------

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: 07/20/2023
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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/18/2023
--	---	--	---

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 227	<p>Continued From page 1 behaviors (SIBs). Additional review of the record for client #6 did not reveal program goals and objectives relative to vomiting as a target behavior.</p> <p>Interview with staff C on 7/18/23 revealed client #6 consistently sticks her hands in her mouth to cause vomiting. Interview with staff C also revealed client #6 has been known to vomit in her room when she is alone and in the middle of the night. Continued interview with staff C revealed client #6's actions are behavior related especially when she doesn't get her way or seeking attention. Interview with staff C also revealed client #6 exhibits behaviors throughout the day where she will vomit in her mouth or spread feces.</p> <p>Interview with the facility nurse on 7/18/23 revealed client #6 has had previous occasions in which she vomited repeatedly. Continued interview with the facility nurse revealed the repeated vomiting incidents led to medical evaluations for client #6 by the primary care physician on 1/3/23 and 12/14/22 by a psychiatrist. The nurse also revealed client #6 was prescribed medications for GERD on 1/3/23. Further interview with the nurse revealed that the team decided that client #6's vomiting was related to behaviors and not medical concerns.</p> <p>Interview with the HM on 7/18/23 revealed client #6 has vomited on various occasions at the day program and in the group home. Continued interview with the HM and qualified intellectual disabilities professional (QIDP) revealed the client's vomiting was behavior related. Further interview with the HM and QIDP revealed client #6 has not had formal training objectives or</p>	W 227		
-------	---	-------	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G271	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/18/2023
--	---	--	---

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 227	Continued From page 2 programs relative to vomiting as a target behavior. Additional interview with the QIDP and Program Manager revealed client #6 could benefit from training objectives to address vomiting as a target behavior.	W 227	<i>PM, CS will develop training Program to address Vomiting Issue and educate individual on negative effects of Vomiting</i>	
W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observations, record review, and interview the facility failed to assure 1 of 3 sampled clients (#1) and 1 non-sampled client (#6) received diets as medically prescribed. The findings are: Observation in the group home on 7/17/23 at 5:30 PM revealed client #1 and #6 to participate in a dinner meal consisting of a 3 oz hamburger patty, 1 hamburger bun, 12 french fries, ½ cup of slaw, lettuce, tomato, mayo, ketchup, mustard, tea, and 2% milk. Continued observation revealed client #1 and #6 to consume their 3 oz hamburgers in cut up bite size pieces. Review of records for client #1 on 7/18/23 revealed a nutritional assessment dated 5/7/23. Further review of the nutritional assessment revealed a regular, ground meats, no caffeine, limited dairy and gluten diet. Review of records for client #6 on 7/18/23 revealed a nutritional assessment dated 1/6/23. Further review of the nutritional assessment revealed a regular chopped meats diet. Interview with the facilities home manager (HM)	W 474		

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

PRINTED: 07/20/2023
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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/18/2023
--	---	--	---

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 474	Continued From page 3 on 7/18/23 revealed the nutritional assessments to be current for client #1 and #6. Continued interview the HM revealed client #1 should have received his 3 oz hamburger in a ground consistency as his nutritional assessment indicated. Further interview with the HM revealed client #6 should have received her 3 oz hamburger in a chopped consistency as her nutritional assessment stated.	W 474	<i>CS, HS, Nurse will in service all staff a proper diet consistency and properly follow all Doctor orders, nutritional orders and diet and food consistency</i>	
-------	---	-------	--	--