PRINTED: 05/13/2024 FORM APPROVED OMB NO. 0938-0391

VOCA-SECOND AVENUE GROUP HOME STREET ADDRESS, CITY, STATE, ZIP CODE 49 SECOND AVENUE SE TAYLORSVILLE, NC 28681 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 130 PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) 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 and interviews, the facility failed to ensure privacy during personal care and medication administration for 2 of 6 clients (#4 and #5). The findings are: A. The facility failed to provide privacy for client #5 while receiving personal care. For example: Observations in the group home on 5/8/24 at 4:30 Observations in the group home on 5/8/24 at 4:30		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
VOCA-SECOND AVENUE GROUP HOME STREET ADDRESS, CITY, STATE, ZIP CODE			34G280	B. WING		<u> </u>		5/08/2024
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) 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 and interviews, the facility failed to ensure privacy during personal care and medication administration for 2 of 6 clients (#4 and #5). The findings are: A. The facility failed to provide privacy for client #5 while receiving personal care. For example: Observations in the group home on 5/8/24 at 4:30 PM revealed a visual monitor to sit on top of a desk in the livingroom. Continued observation revealed client #5 could be seen on the visual monitor receiving personal care from staff A. Further observation revealed other clients and staff standing and sitting in the livingroom area while the visual monitor remained on. Subsequent observations revealed the area supervisor (AS) to enter client #5's room and asked staff A to reset the bed monitor, then exit			HOME			49 SECOND AVENUE SE	1 0	3/06/2024
CFR(s): 483.420(a)(7) 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 and interviews, the facility failed to ensure privacy during personal care and medication administration for 2 of 6 clients (#4 and #5). The findings are: A. The facility failed to provide privacy for client #5 while receiving personal care. For example: Observations in the group home on 5/8/24 at 4:30 PM revealed a visual monitor to sit on top of a desk in the livingroom. Continued observation revealed client #5 could be seen on the visual monitor receiving personal care from staff A. Further observation revealed other clients and staff standing and sitting in the livingroom area while the visual monitor remained on. Subsequent observations revealed the area supervisor (AS) to enter client #5's room and asked staff A to reset the bed monitor, then exit	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	BE ATE	(X5) COMPLETION DATE
The state of the s		CFR(s): 483.420(a)(7) The facility must ensu Therefore, the facility treatment and care of This STANDARD is n Based on observation failed to ensure privace medication administration and #5). The findings at the facility failed to the failed to	pre the rights of all clients. must ensure privacy during personal needs. not met as evidenced by: ns and interviews, the facility by during personal care and ation for 2 of 6 clients (#4 are: provide privacy for client sonal care. For example: oup home on 5/8/24 at 4:30 monitor to sit on top of a Continued observation do be seen on the visual onal care from staff A. vealed other clients and ng in the livingroom area or remained on. ons revealed the area er client #5's room and ne bed monitor, then exit	W		QP, AM, HS will in-sevice all staff on providing privacindividuals in the home during personal care. Qp, Am	n, Hs will led.	ted by 7/7/2024
Interview with the facility quality assurance personnel (QA) on 5/8/24 revealed the visual monitor should be left on only at nights to monitor client #5's safety relative to risks of falling. Continued interview with QA revealed the visual monitor should be off during the day to maintain	r	personnel (QA) on 5/8/2 monitor should be left o client #5's safety relativ Continued interview wit	24 revealed the visual on only at nights to monitor re to risks of falling. The to Revealed the visual			MANY 2 0 2024		
B. The facility failed to provide privacy for client #4 during medication administration. For Privacy especially while receiving personal care. QP, AM, HS will in-service all staff on providing proper privacy for individuals during medication administration times. QP, AM, HS will monitor medication administration on a weekly basis	p B #	orivacy especially while 3. The facility failed to p 44 during medication ac	receiving personal care. provide privacy for client		f	for individuals during medication administration times	. QP, eekly bas	sis ted by 7 <i>/7/</i> 2024
Chris Childers Program Manager 5/16/2024			PPLIER REPRESENTATIVE'S SIGNATURE					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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WQJ211

Facility ID: 954822

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		34G280	B. WING_			05/08/2024
	PROVIDER OR SUPPLIER COND AVENUE GROUP	НОМЕ		STREET ADDRESS, CITY, STATE, ZIP COD 49 SECOND AVENUE SE TAYLORSVILLE, NC 28681	ÞΕ	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE		ID PREFI) TAG			(X5) COMPLETION DATE
W 130	Observations in the gr AM revealed client #4 participating in the bre observation revealed s was ready to take her to bring client #4 right Further observations r additional three times "I'm eating", "no" and " observations at 7:30 A client #4's medication a administer two medica others were participating Interview with staff D of supervisor had given h	to sit at the dining table to sit at the dining table akfast meal. Continued staff D to ask client #4 if she medications and promised back to finish her meal. evealed staff to request and client #4 to respond bring it to me". Subsequent M revealed staff to bring to the dining table and tions while client #4 and ing in the breakfast meal.	W 1	30		
W 249	5/8/24 revealed design medications are in the any area where privacy focus on administering interview with the DON be provided for all clien being administered. PROGRAM IMPLEMENT CFR(s): 483.440(d)(1) As soon as the interdisc formulated a client's indeach client must receive treatment program consinterventions and service	siplinary team has ividual program plan, e a continuous active sisting of needed es in sufficient number rt the achievement of the	W 24	9		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		34G280	B. WING_		0.5	5/08/2024	
	ROVIDER OR SUPPLIER COND AVENUE GROUP I	НОМЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 49 SECOND AVENUE SE TAYLORSVILLE, NC 28681	1 00	100/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 249	plan. This STANDARD is n Based on observation interviews, the facility clients (#2, #3, #4, #5 continuous active treat of needed intervention	ot met as evidenced by: is, record reviews and failed to ensure 5 of 6	W 2-	49			
	A. The facility failed to treatment program in to opportunities for choice example: During observations at from 4:30 PM until 6:30 observed to stand outs hallways, dining room a unengaged. At no poin was client #1 prompted wash her hands and particularly observations on 8:30 AM client #2 was medication administration meal. Review on 5/8/24 of client ISP dated 3/21/24. Of training objectives in the	the group home on 5/7/24 DPM client #2 was ide, walk and pace the and living room t during the observations I to do anything other than articipate in dinner meal. 15/8/24 from 7:00 AM - observed to participate in on and the breakfast ent #2's record revealed Continued review revealed the areas of cleaning her after meals, putting away dications, dust bedroom oreferred snacks.		QP,AM,HS will in-service all staff on properly provid treatment, providing choices, and properly implementaining programs for each individual in the home. Quill monitor weekly basis on proper active treatment program implementation.	nting P,AM,HS and trainin	g ted by 7/7/2024	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION		E SURVEY MPLETED
		34G280	B. WING			0.	5/08/2024
	ROVIDER OR SUPPLIER COND AVENUE GROUP	HOME		49 SEC	T ADDRESS, CITY, STATE, ZIP CODE COND AVENUE SE DRSVILLE, NC 28681		3/00/2024
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES OF THE	O BE	(X5) COMPLETION DATE
	B. The facility failed to treatment program in to opportunities for choice example: During observations ar from 4:30 PM until 6:3 observed to sit in the limovies or music video observations was client anything other than pict wash her hands and properties of the sit of the	deed that client #2's training deensure a continuous active the areas of leisure and des for client #3. For If the group home on 5/7/24 Deep PM client #3 was diving room and watch so At no point during the did #4 prompted to do do do to the night clothes, darticipate in dinner meal. In 5/8/24 from 7:00 AM - dobserved to sit in the din medication dereakfast meal. Hent #3's record revealed Continued review revealed de areas of pouring her own dearing her eyeglasses, laundry, learn de bed linens. In the QA Manager des training objectives are densure a continuous active de areas of leisure and des for client #4. For	W2	QP,AM,Hs will put that of the training programming pro	M,HS will in-service all staff on properly proment, providing choices, and properly impleing programs for each individual in the home rovide weekly monitoring of active treatmenthoices are provided, and monitoring of train thoices are provided, and monitoring of train thoices are provided, and monitoring of train the service all staff on properly providing active within the service all staff on properly providing active within the service all staff on properly providing programs for each individual in the home. OP,AM, HSwill provide weekly monitoring of a felly monitoring of active treatment, ensuring	menting e. QP,AM,HS t, ensuring ing programs Comple	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION	(X3	3) DATE SURVEY COMPLETED	
		34G280	B. WING_			05/08/2024	
	PROVIDER OR SUPPLIER COND AVENUE GROUP	HOME		STREET ADDRESS, CITY, STATE, ZIP C 49 SECOND AVENUE SE TAYLORSVILLE, NC 28681	ODE		-
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
	observed to sit on the in the living room engal activity. At no point duclient #4 prompted to wash her hands and puring observations on 8:30 AM client #4 was livingroom, participate administration and the Review on 5/8/24 of client ISP dated 3/18/24. training objectives in the medication administration cooking and meal prepared linens. Interview with the QAM confirmed that client #4 current. D. The facility failed to treatment program in the opportunities for choice example: During observations at from 4:30 PM until 6:30 observed to sit on the pliving room unengaged. Observations was client anything other than finis participate in dinner me	front porch outside and sit aged in a brief writing ring the observations was do anything other than articipate in dinner meal. In 5/8/24 from 7:00 AM - observed to sit in the in medication breakfast meal. Ident #4's record revealed Continued review revealed the areas of participation in ion, cleaning her bedroom, or, laundry, and changing Manager on 5/8/24 It's training objectives are Hensure a continuous active the areas of leisure and the sit for client #5. For the group home on 5/7/24 PM client #5 was orch outside and sit in the At no point during the #5 prompted to do sh eating his snack and al. 5/8/24 from 7:00 AM - observed to participate in	W 2	QP.AM.HS will in-service all staff on properly providing active treatment, providing choices, and properly implementing training programs for each individual in the home. QP.AM.HS will provide that choices are provided, and monitoring of training programs will provide weekly monitoring of active treatment, ensuring		era, ensuling	

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G280	B. WING			0.5	/08/2024	
	ROVIDER OR SUPPLIER COND AVENUE GROUP	НОМЕ		4	STREET ADDRESS, CITY, STATE, ZIP CODE 19 SECOND AVENUE SE FAYLORSVILLE, NC 28681	1 03	100/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
	an ISP dated 3/1/24. Of training objectives in the administration, feeding dining room chair, exemprivacy and making chair and making chair and the privacy and making chair and the feeding objectives with the QA I confirmed that client # current. E. The facility failed to treatment program in the opportunities for choice example: During observations at from 4:30 PM until 6:30 observed to sit on the pliving room and participal administration. At no probservations was cliently administration and dinary the program of the preakfast meal and administration. Review on 5/8/24 of cliently administration. Review on 5/8/24 of cliently administration.	lient #5's record revealed Continued review revealed the areas of medication go the birds, cleaning his roise, observing others roices. Manager on 5/8/24 5's training objectives are ensure a continuous active the areas of leisure and the areas	W 2		QP.AM.HS will in-service all staff on properly providing active treatment, providing choices, and properly implementing training programs for each individual in the home QP.AM.HSwill provide weekly monitoring of act that choices are provided, and monitoring of training programs will provide weekly monitoring of active treatment, ensuring	npleted by 7		
1	dining room table after							

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G280	B. WING			0	5/08/2024
	ROVIDER OR SUPPLIER COND AVENUE GROUP	HOME		4	STREET ADDRESS, CITY, STATE, ZIP CODE 49 SECOND AVENUE SE TAYLORSVILLE, NC 28681		010012024
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 249 W 262	confirmed that client # current. Continued into	6's training objectives are erview revealed all clients mpted and engaged in written. RING & CHANGE	W 2				
i f	The committee should monitor individual proginappropriate behavior in the opinion of the colient protection and rithis STANDARD is not Based on observation interviews, the facility frestrictive techniques or reviewed annually by the (HRC) for 1 of 6 clients. Observations throughout period from 5/7/24 - 5/8 alarms to chime as statentered and exited the observations revealed door to be locked. Review of client #5's resigned consent dated 1 monitor and bed pads wobservations did not real alarms or a locked bed interview with the area revealed that updated should not be located dunterview revealed HRC	review, approve, and grams designed to manage and other programs that, ommittee, involve risks to ghts. ot met as evidenced by: s, record review and failed to ensure that ever emonitored and the human rights committee is (#5). The finding is: out the recertification survey 8/24 revealed exterior door ff, clients and surveyors group home. Continued client #5's bedroom closet cords on 5/8/24 revealed a /27/23 for an audio/visual with alarm. Continued eveal consents for exit door room closet.		- 1	QP,AM,HS will ensure that all consents for any rights for individuals will be completed and signed by HRC restriction	for each	ns py 7/7/2024

	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 or 0,000 observation	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G280	B. WING _		0.5	10012024
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 05	5/08/2024
VOCA-SI	ECOND AVENUE GROUP	HOME		49 SECOND AVENUE SE TAYLORSVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE
W 263	CFR(s): 483.440(f)(3)(ii)		W 2	63		
	are conducted only wi consent of the client, p minor) or legal guardia This STANDARD is n Based on observation interviews, the facility techniques were revie	ot met as evidenced by:				,
	period from 5/7/24 - 5/ alarms to chime as sta entered and exited the	out the recertification survey 8/24 revealed exterior door ff, clients and surveyors group home. Continued client #5's bedroom closet				
	signed consent dated a monitor and bed pads	veal consents for exit door		QP,AM,HS will ensure that all consents for any rights for individuals will be completed and signed by HRC rights restriciton	restriction for each mpleted by	ocality con-extra
W 436	revealed that updated so could not be located du	ring the survey. Continued Climitation consent forms updated and signed by ually.	W 436	6		
	and teach clients to use choices about the use of	n, maintain in good repair, and to make informed of dentures, eyeglasses, nunications aids, braces,				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		34G280	B. WING _			E/09/2024
	PROVIDER OR SUPPLIER	номе		STREET ADDRESS, CITY, STATE, ZIP CODE 49 SECOND AVENUE SE TAYLORSVILLE, NC 28681		5/08/2024
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFILE OF THE APPROPROPROFILE OF T) BE	(X5) COMPLETION DATE
W 436	and other devices idea interdisciplinary team This STANDARD is n Based on observation interview, the facility fa equipment was furnish clients (#4). The findin Observation in the gro recertification survey 5 #4 to participate in var writing/drawing, watch breakfast meal, and m At no point during the sobserved to wear pres any staff prompt the client Review of records for an individual service pl Continued review of IH prescribed eyeglasses. revealed an eye exam client #4 to be prescrib Interview with the quali 5/8/24 confirmed client eyeglasses. Continued	ntified by the as needed by the client. of met as evidenced by: as, record review and ailed to assure that adaptive ned as prescribed for 1 of 6 g is: up home during i/7/24-5/8/24 revealed client ious activities to include ing television, dinner and edication administration. survey period was client #4 cribed eyeglasses nor did tent to obtain eyeglasses. client #4 on 5/8/24 revealed an (ISP) dated 3/18/24. P revealed client #4 wears Further review of records on 1/25/23 which revealed ed new eyeglasses. ty assurance (QA) on #4 has prescribed interview with the QA	W 4	QP,AM,HS will ensure that individuals are educate adaptive equipment properly as evidenced by writt brograms as well as ensuring that all adaptive equin the home at all times. QP,AM,Hs will provide we monitoring to ensure adaptive equipment is being and written training programs are being done corre	en training ipment is ekly used properly ctly	by 7/7/2024
W 463	confirmed client #4 sho prescribed eyeglasses. FOOD AND NUTRITIO CFR(s): 483.480(a)(4) The client's interdiscipli	N SERVICES	W 46	33		
	qualified dietitian and p modified and special die This STANDARD is no Based on observation,	hysician must prescribe all ets. t met as evidenced by:				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	79 FACE STATE OF THE STATE OF T		E CONSTRUCTION		TE SURVEY MPLETED
		34G280	B. WING			0,	5/08/2024
	ROVIDER OR SUPPLIER COND AVENUE GROUP	HOME	•	4	STREET ADDRESS, CITY, STATE, ZIP CODE 19 SECOND AVENUE SE TAYLORSVILLE, NC 28681	1 0.	3/06/2024
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	(#5 and #6) received to prescribed. The findin A. The facility failed to received specialty diet example: Observation in the ground AM revealed client #5 breakfast meal which in with jelly, ham, and juinat 7:14 AM revealed clipoured an additional bigobservation revealed clipoured an autritional evaluation review of the nutritional client #5 is prescribed accompanded to the continued interview with the continued interview with staff should have provided to the continued interview with staff s	heir specialty diets as gs are: ensure that client #5 as prescribed. For up home on 5/8/24 at 7:00 to participate in the ncluded dry cereal, biscuits ce. Continued observations ient #5 was given ham and owl of cereal. Further client #5 consumed his s hands and staff poured a 6/8/24 for client #5 revealed dated 3/5/23. Continued I evaluation revealed that a low fat, low cholesterol entrated sweets, no no caffeine, and a the director of nursing #5's diet as prescribed. th the DON confirmed that died client #5 with the and seconds should not the client. ensure that client #6	W	GP.A. speci.	AM.HS, Nurse will in-service all staff on following prescribed itally diets for each individual in the home including proper intency, portions, and exceptions. QP,AM.HS, Nurse will monitoron a weekly basis each individual in proper intency, portions and consistency.	ding prope durse will in prect	er monitor by 7/7/2024

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		TE SURVEY MPLETED	
		34G280	B. WING _		05	/08/2024	
	PROVIDER OR SUPPLIER ECOND AVENUE GROUP	НОМЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 49 SECOND AVENUE SE TAYLORSVILLE, NC 28681	1 03	100/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 463	with dressing, banana soda. Continued obse revealed staff to feed dressing. Further obse	, croissant roll, and sprite rvations at 6:23 PM	W 46	53			
W 474	Review of records on a nutritional evaluation review of the nutritional client #6 is prescribed diet, low cholesterol, lof free foods, no leafy great Interview on 5/8/24 with diet as prescribed. Con	h DON confirmed client 6's attinued interview with the aff should have provided 's prescribed diet and been provided to the	W 47	QP,AM,HS,Nurse will in-service all staff on following prescribed specialty dets for each individual in the home induding proper consistency, portions, and exceptions. QP,AM,HS,Nurse will monitoron a weekly basis each preparation, portions and consistency. On a weekly hasis each individuals right to ensure correct.		sure correct	
	Food must be served in developmental level of This STANDARD is not Based on observations interview, the facility fail served in a form consist developmental level for #6). The findings are: A. The facility failed to consistency for client #2 Observation in the group PM revealed client #2 to	n a form consistent with the the client. t met as evidenced by: s, record review and led to ensure food was tent with the 3 of 6 clients (#2, #5, and		QP,AM,HS,Nurse will in-service all staff on following prescribed diets, consistency of diet, and how to properly prepare food consistency. QP,AM,HS,Nurse will monitoron a weekly basis each individuals preparation, portions and consistency.	diet to ensure corre		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A ME WAS STANDARDS		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G280	B. WING			0:	5/08/2024	
	COND AVENUE GROUP	HOME		4	STREET ADDRESS, CITY, STATE, ZIP CODE 19 SECOND AVENUE SE TAYLORSVILLE, NC 28681	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	-
	sprite soda. Continued staff to cut up client ## into sizes larger than lobservations revealed dinner meal with no fut to ensure modified died. Review of records for a nutritional evaluation the nutritional evaluation the nutritional evaluation that the client is prescudiet, offer seconds and encourage 2000cc fluit Ensure QID. Interview with the direct 5/8/24 confirmed client Continued interview wistaff should have a foo modified diet and/or modified diet #5 to meal which included vewith dressing, grapes, continued observations client #5's food with kitt larger than bite size. For evealed client #5 cons no further assistance from odified diet. Review of records for constant in the group of the size	erries, croissant roll, and d observations revealed 2's food with kitchen shears bite size. Further client #2 consumed her rither assistance from staff st. client #2 on 5/8/24 revealed a dated 3/6/23. Review of on for client #2 indicates ribed a regular chopped d high calorie snacks, ds plus per day, and ctor of nursing (DON) on a #2's diet as current. The DON confirmed that d processor to assist with echanically ensure clients is. ensure prescribed diet 5. For example: up home on 5/7/24 at 6:03 to participate in the dinner egetables and beef, lettuce croissant roll, and juice. Is revealed staff to cut up chen shears into sizes urther observations umed his dinner meal with	W		QP,AM,HS,Nurse will in-service all staff on following diets, consistency of diet, and how to properly prepa QP,AM,HS,Nurse will monitor on a weekly basis earlindividuals diet to ensure correct preparation, portions and consistency.	are food. ch	d by 7/7/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
34		34G280	B. WING			05/08/2024	
NAME OF PROVIDER OR SUPPLIER VOCA-SECOND AVENUE GROUP HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 49 SECOND AVENUE SE TAYLORSVILLE, NC 28681			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 4 Continued From page 12 the nutritional evaluation for client #5 indicates that the client is prescribed a no concentrated sweets, low fat, low cholesterol, chopped diet, no seconds, no grapefruit, and thickened liquids. Interview with the director of nursing (DON) on 5/8/24 confirmed client #5's diet as current. Continued interview with the DON confirmed that staff should have a food processor to assist with modified diets and/or mechanically ensure clients		ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 the nutritional evaluation for client #5 indicates that the client is prescribed a no concentrated sweets, low fat, low cholesterol, chopped diet, no seconds, no grapefruit, and thickened liquids. Interview with the director of nursing (DON) on 5/8/24 confirmed client #5's diet as current. Continued interview with the DON confirmed that staff should have a food processor to assist with		W 4	AP SECOND AVENUE SE TAYLORSVILLE, NC 28681 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IN CROSS-REFERENCED TO THE APPROPR DEFICIENCY) W 474 QP,AM,HS,Nurse will in-service all staff on following diets, consistency of diet, and how to properly prepared QP,AM,HS,Nurse will monitor on a weekly basis ear diet to ensure correct preparation, portions and correct preparation.		e food. individua istency.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DA	(X3) DATE SURVEY COMPLETED	
		34G280	B. WING		0	05/08/2024	
NAME OF PROVIDER OR SUPPLIER VOCA-SECOND AVENUE GROUP HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 49 SECOND AVENUE SE TAYLORSVILLE, NC 28681			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG			(X5) COMPLETION DATE	