PRINTED: 08/22/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		34G271	B. WING		_	C 08/19/2024	
	PROVIDER OR SUPPLIER  OLLINS GROUP HON	1E		STREET ADDRESS, CITY, STA 297 BOB ROLLINS ROAD FOREST CITY, NC 2804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD ) TO THE APPROPR CIENCY)	BE	(X5) COMPLETION DATE
W 000	INITIAL COMMEN	тѕ	w o	00			
W 159	Intake #NC002207 unsubstantiated an related to the allega unrelated to the allega unrelated, coordinated intellectual (allega under allega unrelated under alle	e treatment program must be ated and monitored by a all disability professional whos not met as evidenced by: eviews and interviews the all disabilities professional pordinate and document an am (IDT) meeting or team we to changes in clients' increase in falls for 4 of 6 audit and #6) at the facility. The	W 1	59			
		to meet with the IDT regarding client #1's behaviors and ne facility.					
	revealed a behavio 4/1/24-8/15/24. Col following document was awake all night the bathroom with a was awake all night the bathroom with a threw herself on the she could not hear Client #1 continue to	of client #1's program book or log dated from nitinued review revealed the ted behaviors: 8/7/24 client #1 t staggering around and using assistance. 8/8/24 client #1 t staggering around and using assistance. 8/11/24 client #1 e floor and she was acting as if or comprehend anything. to throw herself on the floor.					
LABORATOR\	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		34G271	B. WING _			C / <b>19/2024</b>
	PROVIDER OR SUPPLIER  OLLINS GROUP HOM	E		STREET ADDRESS, CITY, STATE, ZIP C 297 BOB ROLLINS ROAD FOREST CITY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 159	IDT meeting to revi in client #1's health Review on 8/19/24 Reports revealed the client #1 used the refell down causing health the floor leaving a reprovided medical cawas lethargic and beauthrows herself on the staff. She continue Client #1 was taker low body temperatuctient #1 was transpand was diagnosed the right eye, bruise was black. Continue documentation of a or frequency of falls events or behaviors address fall incident #1 multiple falls and he interview with the pertaining health stafl prevention. Added program manager is supervisor would fin appointment and ID week to discuss inconfirmed that the fishould have had a standard program was a supervisor would fin appointment and ID week to discuss inconfirmed that the fishould have had a standard program was a supervisor would fin appointment and ID week to discuss inconfirmed that the fishould have had a standard program was a supervisor would fin appointment and ID week to discuss inconfirmed that the fishould have had a standard program was a supervisor would fin appointment and ID week to discuss inconfirmed that the fishould have had a standard program was a supervisor would fin appointment and ID week to discuss inconfirmed that the fishould have had a standard program was a supervisor would fin appointment and ID week to discuss inconfirmed that the fishould have had a standard program was a supervisor would find a supervisor would fin	ew status or possible change status.  of the facility's Critical Incident ne following incidents: 4/6/24 estroom lost her balance and er to hit the side of her face on ed bruise. Client #1 was are. 8/15/24 revealed client #1 rody temperature was low; she ne floor and threaten to slap to throw herself on the floor. In to the ER and admitted for are and possible UTI. 8/16/24 ported by EMS to the hospital with subdural hematoma near are on both arms and left eye ed review revealed no in IDT meeting to review status as, injuries related to falling as, or prevention measures to ts.  4 with the program manager has recently experienced pospital visits. Continued rogram manager revealed not team meeting discussions atus, frequency of falls, and itional interview with the revealed that the home ast contact the doctor to get of would usually meet within a cidents. The program manager facility's interdisciplinary team team meeting to ensure ards for client #1's increasing	W 15	59		

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				O DATE SURVEY COMPLETED	
		34G271	B. WING		08	C / <b>19/2024</b>	
	PROVIDER OR SUPPLIER	IE		STREET ADDRESS, CITY, STATE, ZIP 297 BOB ROLLINS ROAD FOREST CITY, NC 28043		710/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
W 159	B. The QIDP failed falls at the facility for Review on 8/19/24 Reports revealed the client #3 was leaving open the back door leaving a scratch or received medical care getting out of the bath the tub chipped his medical care. Control documentation of a or frequency of falls events or behaviors address fall incident Interview on 8/19/2 confirmed client #3 multiple falls. Conting program manager in team meeting discovered to fall event prevention. Addition manager revealed would first contact and IDT would usual discuss incidents. To confirmed that the should have had a appropriate safeguroccurrences.  C. The QIDP failed regarding increase client #4.  Review on 8/19/24	to meet with the IDT regarding or client #3.  of the facility's Critical Incident ne following incidents: 7/28/24 ag for an outing and went to and hit his head on the door in his forehead. Client #3 are. 7/29/24 client #3 was athtub hit teeth on the faucet of front teeth. Client #3 received inued review revealed no in IDT meeting to review status is, injuries related to falling is, or prevention measures to	W 1	59			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTI	COMPLETED
<b>34G271</b> B. WING	C 08/19/2024
VOCA-ROLLINS GROUP HOME	DRESS, CITY, STATE, ZIP CODE OLLINS ROAD CITY, NC 28043
	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE
Continued From page 3 client #4 had a behavior in the living room and bit her right hand. Staff cleaned area and applied a bandage.  Review on 8/19/24 of client #4's program book revealed a behavior log dated for the month of August 2024. Continued review revealed the following documented behaviors: 8/1/24 client #4 was on the van going to workshop; she pulled staff from the back while she was driving and pulled the seat belt so it would choke the staff, clients were scared. 8/2/24 client #4 was getting ready for bath threw her shoes at staff and spit and hit staff on the side. Throwing all her things out of her room. 8/3/24 client #4 hit staff in the face hard, staff cried and went outside to cool off. 8/4/24 client #4 got on the van and smacked three peers, pulled one peers' hair, and tried to bite one peer. 8/8/24 client #4 was sitting in the living room starting yelling, bit her hand until it bled, and wiped blood all over her clothes. 8/9/24 client #4 was in bath, splashed water everywhere out of the tub by kicking and yelling. Client #4 flooded the bathroom floor. 8/11/24 client #4 kicked her shoes off, slung them and hit another peer. Continued review revealed no documentation of an IDT meeting to review status or frequency of behaviors, injuries related to behaviors, or prevention measures to address the increase in behaviors.  Interview on 8/19/24 with the program manager confirmed client #4 has recently experienced an increase in behaviors. Continued interview with the program manager revealed there were no recent team meeting discussions pertaining to the frequency of behaviors, injuries related to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G271	B. WING				C 19/2024
	PROVIDER OR SUPPLIER  OLLINS GROUP HOM			297	REET ADDRESS, CITY, STATE, ZIP CODE 7 BOB ROLLINS ROAD DREST CITY, NC 28043	1 00/	13/2024
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 159	IDT would usually nincidents. The prog the facility's interdishad a team meeting safeguards for clier.  D. The QIDP failed regarding falls at the Review on 8/19/24 Report revealed the client #6 was on the under the bed after and he had bruising the right side of his Non-Emergency to able to stand or wal walker. Continued requency of falls events or behaviors address fall inciden.  Interview on 8/19/24 confirmed client #6 he would get stuck. Continued interview revealed there were discussions pertain events, frequency of Additional interview revealed that the hocontact the doctor the would usually meet incidents. The prog the facility's interdishad a team meeting the safe and the same meeting the safe incidents.	neet within a week to discuss ram manager confirmed that ciplinary team should have go to ensure appropriate at #4's increased behaviors.  Ito meet with the IDT e facility for client #6.  of the facility's Critical Incident e following incident: 5/25/24 e floor of his bedroom stuck a fall. Staff assisted him up go to his head down to hip on body due to fall. Called transport to hospital wasn't k even with assistance of a review revealed no in IDT meeting to review status go, injuries related to falling go, or prevention measures to	W 1	59			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	CON	TE SURVEY MPLETED
		34G271	B. WING _			C / <b>19/2024</b>
	PROVIDER OR SUPPLIER OLLINS GROUP HON	IE		STREET ADDRESS, CITY, STATE, ZIP OF 297 BOB ROLLINS ROAD FOREST CITY, NC 28043	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	are related to the cland assessments. This STANDARD is Based on record refacility failed to door specifically relative reporting forms, aff #3, #4, and #5). The A. Staff did not door on the body check on the body check on the body check of through 8/15/24. For completed on 6/25/25/25/25/25/25/25/25/25/25/25/25/25/	MENTATION (2)  comment significant events that lient's individual program plan is not met as evidenced by: eview and interviews, the ument significant events, to the body check and incident ecting 5 of 6 clients (#1, #2, ne findings are:  ument a completed body audit forms for client #1.  The home on 8/19/24 revealed ecks for client #1 dated 5/1/24 urther review of the body ally one body check was (24, one body check completed e last completed body check (24.)  4 with the home supervisor ger revealed body checks are day by staff and documented form. Further interview is not in the home, it is cumented on the form. The not program manager of documentation shows the ent #1 were not completed.  ument a completed body audit	W 25 W 25			
		of the facility's program chart, ad and Body Check forms				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		34G271	B. WING_		08	C / <b>19/2024</b>	
	PROVIDER OR SUPPLIER OLLINS GROUP HON	IE		STREET ADDRESS, CITY, STATE, ZIP 297 BOB ROLLINS ROAD FOREST CITY, NC 28043			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
W 253	dated 5/1/24-8/19/2 several incomplete document or comp Further review reverselves from 8/12/2 Interview on 8/19/2 and program manaforms are to be corresiding at the facil revealed client bod documented on the in the mornings and program. Further in returns from a hosp a body audit and doform. The home sumanager confirmed staff provided on the #2 that were not concept that were not concept for the body check.  Review on 8/19/24 revealed CANS Hedated 5/1/24-8/19/2 several incomplete document or comp Further review reverselves from 7/23/2 Interview on 8/19/2 and program manaforms are to be corresiding at the facil revealed client bod documented on the several incomplete document or comp Further review reversely from 1/23/2 and program manaforms are to be corresiding at the facil revealed client bod documented on the several incomplete documented on the several forms are to be corresiding at the facil revealed client bod documented on the several incomplete for the several forms are to be corresiding at the facil revealed client bod documented on the several incomplete for the several forms are to be corresiding at the facil revealed client bod documented on the several forms are to be corresiding at the facil revealed client bod documented on the several forms are to be corresiding at the facil revealed client bod documented on the several forms are to be corresiding at the facil revealed client bod documented on the several forms are to be corresiding at the facil revealed client bod documented on the several forms are to be corresided to the several forms ar	24. Continued review revealed dates where staff did not lete a body audit for client #2. Paled no documented body (4-8/19/24.)  4 with the home supervisor ger revealed body check inpleted daily for all residents ity. Continued interview y audits to be completed and a body check form twice a day dafter returning from the day after returning from the day after returning from the day iterview revealed that if a client bital visit, staff are to complete ocument it on the body check pervisor and program dathe lack of documentation is body check forms for client impleted.  Furnment a completed body audit forms for client #3.  Of the facility's program chart, and and Body Check forms (24. Continued review revealed dates where staff did not lete a body audit for client #3. Paled no documented body	W 25	i3			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED C		
		34G271	B. WING _		1	/19/2024
	PROVIDER OR SUPPLIER	IE		STREET ADDRESS, CITY, STATE, ZIP CODE 297 BOB ROLLINS ROAD FOREST CITY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 253	returns from a hosp a body audit and do form. The home su manager confirmed staff provided on the #3 that were not continued on the body check not complete incide client #4's behavior.  Review on 8/19/24 revealed CANS Hedated 5/1/24-8/19/2 several incomplete document or comp Further review revealed several behavior logs dated revealed client #4 got on the peers, pulled one peers, pulled one peer. 8/8/24 client starting yelling, bit I wiped blood all overkicked her shoes of peer. Further revieincident report form.  Interview on 8/19/2 and program managements.	atterview revealed that if a client bital visit, staff are to complete becument it on the body check pervisor and program did the lack of documentation be body check forms for client impleted.  Sument a completed body audit forms for client #4. Staff did ent report forms regarding is.  of the facility's program chart, ad and Body Check forms 24. Continued review revealed dates where staff did not lete a body audit for client #4. ealed no documented body	W 25	3		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  IG	COMPLETED		
		34G271	B. WING _		08	/19/2024
	PROVIDER OR SUPPLIER  OLLINS GROUP HON	/IE		STREET ADDRESS, CITY, STATE, ZIP CODE 297 BOB ROLLINS ROAD FOREST CITY, NC 28043		10/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 253	revealed client bod documented on the in the mornings an program. Further in returns from a hos a body audit and do Subsequent Intervirevealed staff are to form for any behavior a physical injury program manager documentation star and incident report not completed.  E. Staff did not doc on the body check Review on 8/19/24 revealed CANS Heddated 5/1/24-8/19/2 several incompleted document or comp Further review reversed from 7/28/2 Interview on 8/19/2 and program manaforms are to be corresiding at the facili revealed client bod documented on the in the mornings an program. Further in returns from a hos a body audit and do home supervisor and solve and program is a program of a hos a body audit and do home supervisor and solve and supervisor and supervisor and solve and supervisor and supervisor and solve and supervisor and solve and supervisor and solve and supervisor and supervis	ly audits to be completed and be body check form twice a day dafter returning from the day need that if a client pital visit, staff are to complete ocument it on the form.  The with the program manager of complete an incident report it is that include peer to peer and confirmed the lack of from for client #4 that were completed body audit to body audit to body check to the staff provided on the body audit completed body audit to body check completed body audit to body check completed body audit and staff provided on the body audit completed body audit and staff provided on the body audit completed body audit and staff provided on the body audit completed body audit and staff provided that it is a completed body audit and staff provided that it is a completed body audit and staff provided that it is a client with a completed body audit and staff provided that it is a client with a completed body audit and staff provided that it is a client with a client provided that if a client with a client with a client provided that if a client with	W 25	i3		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		34G271	B. WING _		08	C / <b>19/2024</b>
	PROVIDER OR SUPPLIER  OLLINS GROUP HOM	E		STREET ADDRESS, CITY, STATE, ZIP COL 297 BOB ROLLINS ROAD FOREST CITY, NC 28043	•	710/2024
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 253 W 340	•	dy check forms for client #5 leted. ES	W 25			
	other members of tappropriate protection measures that inclutraining clients and health and hygiene This STANDARD is Based on observation failed to ensure statimplement appropri	s not met as evidenced by: ions and interviews, the facility ff were sufficiently trained to ate health methods. This t clients (#1, #2, #3, #4, and				
	and training in comclient #1.	failed to provide oversight pleting daily body checks for e home on 8/19/24 revealed				
	twice daily body che through 8/15/24. For checks revealed on completed on 6/25/ on 6/26/24, and the completed on 7/23/ provided by nursing ensure the body che	ecks for client #1 dated 5/1/24 urther review of the body ly one body check was 24, one body check completed last completed body check 24. There was no oversight or management staff to ecks were being completed to ies or situations that needed				
	and program mana completed twice a	4 with the home supervisor ger revealed body checks are day by staff and documented form. Further interview				

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	A. BUILDING			COMPLETED	
		34G271	B. WING				19/2024
	PROVIDER OR SUPPLIER	IE		297	BOB ROLLINS ROAD REST CITY, NC 28043	1 00/	10/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
W 340	revealed if a client supposed to be dochome supervisor at confirmed the lack body checks for client. B. Nursing services and training in comclient #2.  Review on 8/19/24 revealed CANS Hedated 5/1/24-8/19/2 several incomplete document or comp Further review revechecks from 8/12/2 Interview on 8/19/2 and program manaforms are to be corresiding at the facil revealed client bod documented on the in the mornings and program. Further ir returns from a hosy a body audit and doform. The home sumanager confirmed staff provided on the #2 that were not conclient #3.  Review on 8/19/24	commented on the form. The commented on the commented.  If a failed to provide oversight commented by the commented by	W	340			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` ′	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		34G271	B. WING _		08	C / <b>19/2024</b>
	PROVIDER OR SUPPLIER	1E		STREET ADDRESS, CITY, STATE, ZIP C 297 BOB ROLLINS ROAD FOREST CITY, NC 28043	•	71072024
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
W 340	dated 5/1/24-8/19/2 several incomplete document or comp Further review reversheeks from 7/23/2 Interview on 8/19/2 and program manaforms are to be corresiding at the facil revealed client bod documented on the in the mornings and program. Further in returns from a hosy a body audit and doform. The home sumanager confirmed staff provided on the #3 that were not compart of the sumanager confirmed staff provided on the #3 that were not compared to a several incomplete document or comp Further review revealed Several behavior logs dated revealed several behavior logs dated revealed several document or comp Further review revealed several behavior logs dated revealed revealed revealed several behavior logs dated revealed reve	24. Continued review revealed dates where staff did not lete a body audit for client #3. ealed no documented body 24-8/19/24.  4 with the home supervisor ager revealed body check inpleted daily for all residents ity. Continued interview y audits to be completed and a body check form twice a day dafter returning from the day interview revealed that if a client botal visit, staff are to complete ocument it on the body check inpervisor and program do the lack of documentation in body check forms for client impleted.  5 failed to provide oversight inpleting daily body checks for of the facility's program chart, and and Body Check forms 24. Continued review revealed dates where staff did not lete a body audit for client #4. ealed no documented body	W 34			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		C C	
		34G271	B. WING _		08	/ <b>19/2024</b>
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 CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	HOULD BE COMPLÉTION	
W 340	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		W 34			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G271	B. WING			C / <b>19/2024</b>		
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 PREFI) TAG	X (EACH CORRECTIVE ACCROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
W 340	Interview on 8/19/24 and program mana forms are to be con residing at the facili revealed client body documented on the in the mornings and program. Further in returns from a hosp a body audit and do home supervisor ar confirmed the lack	4 with the home supervisor ger revealed body check inpleted daily for all residents ty. Continued interview y audits to be completed and body check form twice a day dafter returning from the day terview revealed that if a client bital visit, staff are to complete ocument it on the form. The ind program manager of documentation staff dy check forms for client #5	W 3	340				