	-	ID HUMAN SERVICES				FOR	M APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	<u> </u>	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 34G287			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		B. WING			09/25/2024			
NAME OF PR	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	CODE		
VOCA-LAUREL GROUP HOME				ŧ	51 LAUREL STREET			
VOUA-LA	-LAUREL GROUP HOME			GRANITE FALLS, NC 28630				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE			(X5) COMPLETION DATE	
					DEFICIENCY)			
W 472	MEAL SERVICES CFR(s): 483.480(b)(2)(i) Food must be served in appropriate quantity. This STANDARD is not met as evidenced by: Based on observations, record review, and interview, the facility failed to ensure food was served in appropriate quantity for 1 of 5 clients (#4). The finding is: Observation in the group home on 9/25/24 at 6:00 PM revealed client #4 to participate in the breakfast meal which included French toast sticks with syrup, bacon, and orange juice. Continued observations revealed the staff prepared the client's scoop plate with six French toast sticks and two pieces of bacon. Further observations revealed that staff fed client #4 the breakfast meal with no further assistance from staff to ensure the client received double portions.		w.	472	2			
	Review of the nutrition indicates that the client	evaluation dated 8/22/24. nal evaluation for client #4 nt is prescribed a regular high fiber, double portions,						
W 474	professional (QIDP) o #4's diet as current. C		W	474	1			
	developmental level of This STANDARD is r Based on observatio	in a form consistent with the of the client. not met as evidenced by: ns, record review and SUPPLIER REPRESENTATIVE'S SIGNATUR	=		TITLE		(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

PRINTED: 10/01/2024

	-	ID HUMAN SERVICES				FORM	: 10/01/2024 APPROVED
CENTERS FOR MEDICARE & N STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		34G287	B. WING		_	09/25/2024	
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
VOCA-LA	JREL GROUP HOME			1 LAUREL STREET GRANITE FALLS, NC 2	8630		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			(X5) COMPLETION DATE
W 474	Continued From page interview, the facility f served in a form cons developmental level for finding is: Observation in the gro PM revealed client #4 breakfast meal which with syrup, bacon, and observations revealed bacon with kitchen sh size. Further observat client #4 the breakfas assistance from staff Review of records for revealed a nutritional Review of the nutrition indicates that the client diet, chopped meats, Boost liquid 4 times a Interview with the qua professional (QIDP) of #4's diet as current. C QIDP confirmed that s client #4 with his pres MEAL SERVICES CFR(s): 483.480(b)(2)	a 1 ailed to ensure food was istent with the or 1 of 5 clients (#4). The oup home on 9/25/24 at 6:00 to participate in the included French toast sticks d orange juice. Continued d staff to cut up client #4's ears into 1 to 2 inches in tions revealed that staff fed t meal with no further to ensure modified diet. client #4 on 9/25/24 evaluation dated 8/22/24. nal evaluation for client #4 nt is prescribed a regular high fiber, double portions, daily. dified intellectual disabilities on 9/25/24 confirmed client continued interview with the staff should have provided cribed diet.)(iv) with appropriate utensils.	W 474				
	This STANDARD is r Based on observation interview, the facility f	not met as evidenced by: ns, record review and ailed to ensure all vere provided to 2 of 5 he findings are:					

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

Event ID: CR3111

Facility ID: 944838

If continuation sheet Page 2 of 4

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 093 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVE COMPLETED NAME OF PROVIDER OR SUPPLIER B. WING 09/25/200 VOCA-LAUREL GROUP HOME STREET ADDRESS, CITY, STATE, ZIP CODE 51 LAUREL STREET GRANITE FALLS, NC 28630 09/25/200 (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 CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY W 475 Continued From page 2 utensils to client #1. For example: W 475			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE VOCA-LAUREL GROUP HOME 51 LAUREL STREET GRANITE FALLS, NC 28630 51 LAUREL STREET (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) COMP COMP COMP W 475 Continued From page 2 W 475 W 475			
SI LAUREL STREET SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (COMP COMP W 475 Continued From page 2 W 475 W 475 W 475 VW 475	34G287		
VOCA-LAUREL GROUP HOME GRANITE FALLS, NC 28630 (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) (COMP COMP COMP DEFICIENCY) W 475 Continued From page 2 W 475	NAME OF PR		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMP D W 475 Continued From page 2 W 475 W 475	VOCA-LAUREL GROUP HOME		
	PREFIX		
Observation in the group home on 9/25/24 at 6:40 AM revealed client #1 to participate in the breakfast meal with a place setting that consisted of a plate, a cup, and a spoon. Continued observation revealed the breakfast meal to include French toast sticks with syrup and bacon. Further observation revealed client #1 to cut her French toast sticks word spoon and to eat with her fingers. At no time during observation did staff provide a fork and knife for the breakfast meal. Review of record for client #1 on 9/25/23 revealed an individual support plan (ISP) dated 10/13/23. Continued review of the ISP for client #1 revealed a community life assessment for the client to use a regular spoon, fork, and knife at mealtimes independently. Interview with the qualified intellectual disabilities professional (QIDP) on 9/25/24 revealed that client #1's ISP is current. Continued interview with the QIDP confirmed that all meals for client #1 should be provide a full place setting consisting of utensils to client #4. For example: Observation in the group home on 9/25/24 at 6:18 AM revealed client #4 to participate in the breakfast meal with a place setting that consisted	W 475		

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

Facility ID: 944838

If continuation sheet Page 3 of 4

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 10/01/2024 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SU		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	(X3) DATE	(X3) DATE SURVEY COMPLETED	
34G287		B. WING		09	09/25/2024	
NAME OF P	ROVIDER OR SUPPLIER	•		IREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-LA	UREL GROUP HOME			LAUREL STREET RANITE FALLS, NC 28630		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 475	bacon using kitchen s observation did staff p the breakfast meal. Review of record for o an ISP dated 2/19/24 ISP for client #4 revea assessment dated 2/7 regular spoon, fork, a physical assistance. Interview with the QIE client #4's ISP is curre the QIDP confirmed t	shears. At no time during provide a fork and knife for client #4 on 9/25/24 revealed . Continued review of the aled a community life 1/24 for the client to use a ind knife at mealtimes with OP on 9/25/24 revealed that ent. Continued interview with hat all meals for client #4 ull place setting consisting of	W 475			

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

Facility ID: 944838

If continuation sheet Page 4 of 4