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 _____	02/25/2025

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 036	EP Training and Testing CFR(s): 483.475(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.	E 036		

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

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E 036	Continued From page 1 *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This STANDARD is not met as evidenced by: Based on interview and review of the facility's Emergency Preparedness (EP) plan, the facility failed to ensure all staff were trained on the EP plan. The finding is: Review on 2/24/25 of the facility's EP plan and other documentation revealed no staff training for the Emergency Plan. Interview on 2/25/25 with the Qualified Intellectual Disabilities Professional (QIDP) indicated no staff training on the facility's Emergency Preparedness	E 036		

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E 036	Continued From page 2 Plan could be located.	E 036		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure staff were sufficiently trained to properly secure wheelchairs on the facility van. This affected 1 of 4 audit clients (#2). The finding is: During evening and morning observations at the home on 2/24 - 2/25/25, on two separate occasions, staff loaded client #2 onto the facility van to prepare for transport. At each observation, client #2's wheelchair was locked and four tie downs were secured to the frame of the chair, including two on the front and two on the back. Although a wheelchair seat belt was observed at the back of the van, client #2's wheelchair was not secured using the wheelchair seat belt. Interview on 2/24/25 with Staff B revealed what was observed is how they normally secure client #2's wheelchair on the facility van. Review on 2/25/25 of client #2's Guidelines for Wheelchair Use dated 1/11/24 revealed, "Staff should ensure that the wheel locks are engaged...and other means of securement...are utilized." Interview on 2/25/25 with the Physical Therapist (PT) confirmed client #2's wheelchair should be	W 189		

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W 189	Continued From page 3 secure with tie downs as well as a wheelchair seat belt. The PT noted, "It's a part of the safety of individuals." Interview on 2/25/25 with the Program Manager (PM) also confirmed wheelchair seat belts should be used to secure wheelchairs on facility vans and staff are trained regarding this via training videos. The PM acknowledged additional staff training is needed.	W 189		
W 210	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure an audiology examination was completed within 30 days of admission for 1 of 1 newly admitted clients (#1). The finding is: Review on 2/25/25 of client #1's record revealed she was admitted to the facility on 4/22/24. Additional review of the record did not reveal an audiology examination. Interview on 2/25/25 with the Program Manager revealed she thought an audiology examination had been completed for client #1 since his admission; however, no documentation could be located.	W 210		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)	W 249		

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W 249	Continued From page 4 As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 2 of 4 audit clients (#1 and #3) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of dining. The finding is: During 2 of 2 mealtime observations at two local restaurants on 2/24/25, client #1 and client #3 consumed their meals without the use of a plateriser. At the meals, client #1 held his head downward while bringing his utensil to his mouth. During both meals, client #3 consumed her food with verbal and gestural prompts from staff for her to hold her head up and to slow her rate of eating. Interview on 2/25/25 with Staff B revealed both client #1 and client #3 use platerisers at meals. Review on 2/25/25 of client #1's Physical Therapy (PT) update dated 10/24/24 revealed he uses a plateriser at meals. Review of client #3's PT update dated 12/21/24 noted she requires use of a plateriser, along with	W 249		

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W 249	Continued From page 5 other adaptive dining equipment, at meals.	W 249		
W 350	DENTAL SERVICES CFR(s): 483.460(e)(3) The facility must provide education and training in the maintenance of oral health. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure training was provided for the maintenance of client #1's oral hygiene. This affected 1 of 4 audit clients. The finding is: Review on 2/25/25 of client #1's dental examination report dated 10/5/24 revealed heavy plaque and a poor oral hygiene rating. Additional review of the client's Individual Program Plan (IPP) dated 4/10/24 did not reveal any training to address his poor oral hygiene. Interview on 2/25/25 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed no training has been provided to address client #1's poor oral hygiene.	W 350		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure all medications were administered in accordance with physician's orders. This affected 1 of 4 audit clients (#3). The finding is: During observations of medication administration in the home on 2/25/25 at 7:01am, client #3	W 368		

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W 368	Continued From page 6 ingested one Calcium 600mg tablet, along with twelve other medications, with a cup of water. At 8:10am, client #3 left the home to go to McDonalds for breakfast. Review on 2/25/25 of client #3's physician's orders dated 1/4/25 revealed an order for Calcium 600mg, take 1 tablet by mouth twice daily "with meals" at 7am and 5pm. Interview on 2/25/25 with the Program Manager confirmed client #3 should have her Calcium with meals as ordered.	W 368		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations, document review and interviews, the facility failed to ensure all medications remained locked except during administration. The finding is: During afternoon observations at the home on 2/24/25 at 11:17am, four bins containing individual client's medications and a locked box with controlled medications were transported in the trunk of a car to another facility. Once at the facility, the bins and lock box were placed in an office at the other facility. The medications were kept in the unlocked office as various staff walked in and out of the office or left the medications completely unattended. During observations medication administration in the home on 2/25/25 from 7:12am - 7:25am, the	W 382		

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W 382	Continued From page 7 Medication Technician (MT) (Staff A) left the door to the medication closet open and the door leading into the medication area unlocked as he left the room to perform other tasks. Interview on 2/25/24 with the MT indicated he had been trained to lock the medication closet when leaving the area. Review on 2/25/25 of the facility's Medication Safeguards policy (1/03, Rev. 8/12) revealed under the section, "Safety while Transporting Medications" noted, "The medication will be placed in a locked container for transport...The container will remain locked until it is time for the medication to be taken or until it is given to a third party." Additional review of the facility's Medication Storage policy (no date) revealed, "Only authorized persons will have access to the medication storage area...Controlled medications will be kept under double locks." Interview on 2/25/25 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the door to the medication closet should be kept locked when the MT leaves the room and medications should be kept locked.	W 382		
W 383	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) Only authorized persons may have access to the keys to the drug storage area. This STANDARD is not met as evidenced by: Based on observation, document review and interviews, the facility failed to ensure keys to the drug storage area were only accessible to authorized persons. The finding is:	W 383		

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W 383	Continued From page 8 During morning observations of medication administration in the home on 2/25/25 from 7:12am - 7:25am, the keys to the box containing controlled medications was left on a desk in the office while the Medication Technician (MT) left the area on several occasions. Interview on 2/25/25 with the MT revealed keys to the controlled drugs box are normally kept in a combination lock box on the wall in the office. Review on 2/25/25 of the facility's Medication Administration Performance Score Sheet noted staff are tested for their ability to maintain the medication key on their person. Interview on 2/25/25 with the Qualified Intellectual Disabilities Professional (QIDP) indicated keys to the controlled drugs lock box should be kept in the combination lock box in the office. Interview on 2/25/25 with the facility nurse confirmed the key to the medication closet should be kept on the person administering medications or in a lock box in the office of the home.	W 383		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #3 was taught to use and make informed choices	W 436		

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W 436	Continued From page 9 about the use of her eye glasses. This affected 1 of 4 audit clients. The finding is: During observations throughout the survey on 2/24 - 2/25/25, client #3 did not wear eye glasses. The client was not prompted or encouraged to wear eye glasses. Review on 2/25/25 of client #3's Individual Program Plan (IPP) dated 2/17/25 revealed she wears eye glasses as tolerated for correction of her vision. Interview on 2/25/25 with the Site Supervisor and Qualified Intellectual Disabilities Professional (QIDP) confirmed client #3 wears eye glasses but she broke them. Additional interview indicated they don't keep client #3's eye glasses in her room because she breaks them. Further interview revealed the interdisciplinary team has not considered training to teach client #3 to use her eye glasses appropriately and to make informed choices about their use.	W 436		