CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0. 0938-0391
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 / 28/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRE	ESS, CITY, STATE, ZIP CODE		
				297 BOB ROLL	LINS ROAD		
VOCA-RO	LLINS GROUP HOME			FOREST CITY	Y, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EA	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD DSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS		w	W 000			
W 154	A complaint survey was completed on 4/28/25 Intake #NC00229175. The complaint was substantiated and deficiencies were cited. STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3)		W	54			
	violations are thoroug This STANDARD is r Based on documenta the facility failed to sh allegation was thorou	not met as evidenced by: ation review and interviews,					
	Investigative Summar Assurance Manager. included summaries of conducted, factual fin the allegation of negle responsible staff adm and left the clients wit review of the Investig following statement, " the home at 6:00 AM	s on 4/28/25 revealed an ry prepared by the Quality The two-page document of all staff interviews dings, and conclusion that ect was substantiated due to itting that they left the home thout supervision. Further ative Summary revealed the 1st shift staff who arrived at to no staff on the premises ewed for this investigation."					
	4/28/25 revealed that documentation of the the Investigative Sum quality manager, desc confirmed that no time checked, no phone re no efforts outside of r made to attempt to se	alleged incident outside of imary prepared by the cribed above. The PM e clock records were ecords were requested, and equesting an interview were ecure a statement from the					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURI	1		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: 05/02/2025

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TITLE

	S FOR MEDICARE &		0.00 · · · · · · · · · · ·			IO. 0938-039
IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G271 NAME OF PROVIDER OR SUPPLIER		(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED		
		A. BUILDING			с	
		B. WING	0	04/28/2025		
		STR	EET ADDRESS, CITY, STATE, ZIP CODE			
			297	BOB ROLLINS ROAD		
VOCA-RO	OLLINS GROUP HOME		FO	REST CITY, NC 28043		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE J DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
W 154	Continued From page	e 1	W 154			
		the clients unsupervised at				
W 157	STAFF TREATMENT CFR(s): 483.420(d)(4		W 157			
	corrective action must This STANDARD is a Based on record rev facility failed to show determination or com action related to an ir and allegation of neg Review of documents Investigative Summa	not met as evidenced by: iew and interviews, the evidence of the pletion of timely corrective internal investigation involving lect. The finding is: s on 4/28/25 revealed an ry prepared by the Quality				
	included summaries of conducted, factual fin the allegation of negli responsible staff adm and left the clients wi review of the summar	dings, and conclusion that ect was substantiated due to iitting that they left the home thout supervision. Further ry revealed no indication of be taken by the facility in				
	professional (QIDP) a on 4/28/25 revealed t to take any action rel	alified intellectual disabilities and the home manager (HM) hey had never been directed ative to retraining staff or in order to prevent similar				
	4/28/25 confirmed that documentation regard the Investigative Sum	ogram manager (PM) on at there was no additional ding the allegation other than mary referred to above. In the PM revealed that the				

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Facility ID: 955481

If continuation sheet Page 2 of 3

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/02/2025 MAPPROVED D. 0938-0391
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	B. WING			C 04/28/2025	
NAME OF PROVIDER OR SUPPLIER			1		TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-ROLLINS GROUP HOME			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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 157	staff who admitted to unsupervised was ter action was taken to a	leaving the clients minated, but that no further ddress the issues raised, a witness to the neglect	w	157			

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

Event ID: HU1411

Facility ID: 955481

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