STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G271	A. BUILDING _____ B. WING _____	C 04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A complaint survey was completed on 4/28/25 Intake #NC00229175. The complaint was substantiated and deficiencies were cited.	W 000		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on documentation review and interviews, the facility failed to show evidence that the allegation was thoroughly investigated relative to an incident involving 4 of 4 clients in the home. The finding is: Review of documents on 4/28/25 revealed an Investigative Summary prepared by the Quality Assurance Manager. The two-page document included summaries of all staff interviews conducted, factual findings, and conclusion that the allegation of neglect was substantiated due to responsible staff admitting that they left the home and left the clients without supervision. Further review of the Investigative Summary revealed the following statement, "1st shift staff who arrived at the home at 6:00 AM to no staff on the premises declined to be interviewed for this investigation." Interview with the program manager (PM) on 4/28/25 revealed that the provider had no documentation of the alleged incident outside of the Investigative Summary prepared by the quality manager, described above. The PM confirmed that no time clock records were checked, no phone records were requested, and no efforts outside of requesting an interview were made to attempt to secure a statement from the	W 154		

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

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W 154	Continued From page 1 staff who discovered the clients unsupervised at 6:00 AM.	W 154		
W 157	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(4) If the alleged violation is verified, appropriate corrective action must be taken. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to show evidence of the determination or completion of timely corrective action related to an internal investigation involving and allegation of neglect. The finding is: Review of documents on 4/28/25 revealed an Investigative Summary prepared by the Quality Assurance Manager. The two-page document included summaries of all staff interviews conducted, factual findings, and conclusion that the allegation of neglect was substantiated due to responsible staff admitting that they left the home and left the clients without supervision. Further review of the summary revealed no indication of corrective actions to be taken by the facility in light of the substantiated allegation. Interview with the qualified intellectual disabilities professional (QIDP) and the home manager (HM) on 4/28/25 revealed they had never been directed to take any action relative to retraining staff or reviewing procedures in order to prevent similar incidents in the future. Interview with the program manager (PM) on 4/28/25 confirmed that there was no additional documentation regarding the allegation other than the Investigative Summary referred to above. Further interview with the PM revealed that the	W 157		

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W 157	Continued From page 2 staff who admitted to leaving the clients unsupervised was terminated, but that no further action was taken to address the issues raised, including the fact that a witness to the neglect declined to participate in the investigation.	W 157		