		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA           AND PLAN OF CORRECTION         IDENTIFICATION NUMBER:					E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G270	B. WING	-			C 16/2025	
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				2	01 NORTH SIXTH STREET			
VOCA-SI	XTH STREET GROUP	'HOME		SANFORD, NC 27330				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 000	INITIAL COMMENT	S	W 0	000				
W 122	2025 for intake #NC allegation was subs determined by the t jeopardy was prese interdisciplinary tea comprehensive plan immediate jeopardy accepted by the sur from the facility.		W 1	122				
	Therefore the facilit This CONDITION i This CONDITION i The facility failed to subjected to mistrea (W127); implement procedures that pro and abuse of a client investigate allegation and abuse of clients	sure the rights of all clients. y must s not met as evidenced by: s not met as evidenced by: : ensure clients are not atment, neglect and abuse written policies and whibit mistreatment, neglect nt (W149); thoroughly ons of mistreatment, neglect s (W154) and report to State 5 working days (W156).						
W 127	resulted in the facili statutorily mandated to its clients.		W 1	127				
	Therefore, the facili	sure the rights of all clients. ty must ensure that clients are ysical, verbal, sexual or e or punishment.						

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

TITLE

(X6) DATE

PRINTED: 06/20/2025

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.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/20/2025 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED	
		34G270	B. WING	i		C 06/16/2025		
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
VOCA-S	IXTH STREET GROUF	РНОМЕ			201 NORTH SIXTH STREET SANFORD, NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETION DATE	
W 127	This STANDARD is Based on record re facility failed ensure not subjected to ab Review on 6/16/25 incident report reve injury noted to the c aggression directed behavior physical re time end 8:34am w Documented descri client #1 reported th nose felt abnormal. and the visit was co witness to the incide Further review on 6 discharge papers d contusion; general were performed dia bones 3+ views. Continued review o evidence of an IRIS regarding client #1 Interview on 6/16/25 had a behavior and further stated he m then staff A hit him times. Client #1 rev decided he needed and called 911. Clie services came to th the local hospital. Continued interview	s not met as evidenced by: eview and interviews, the e 1 of 1 audit client (#1) was use. The finding is: of the facilities internal aled an incident date 6/5/25 clients' face, physical I toward staff. Response to estraint time started 8:25am hich involved staff A. ption of Incident revealed nat his face was sore and his Client was seen by the ER oncluded with no injuries. One ent. /16/25 of client #1's hospital ated 6/5/25 revealed assault. The following test gnostic Radiology XR Nasal	W.	127				

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		AND HUMAN SERVICES				FORM	06/20/2025 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G270	B. WING	i			C 16/2025
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-S	IXTH STREET GROUP	PHOME			201 NORTH SIXTH STREET SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
W 127	He spoke to the pol charges. Client #1 drove him to the fac Client #1 revealed the home since he retur #1 then asked the se working here, when another staff here. hit me." Interview on 6/16/25 we client #1 had a behas she stumbled a little staff A did hit client times. Staff B intervent client to his bedroot to calm down. Staff write a statement be about the incident up it today. Interview on 6/16/25 revealed an incident client #1. She reveat and was yelling at a herself between him #1 pushed her and bedroom. She also supervisor to report instructed to comple stated client #1 did hospital. She was #1 received. Staff A hands on client #1.	lice and decided not to press confirmed the site supervisor cility from the local hospital. that staff A had worked the irned from the hospital. Client surveyor "why is she still she hit me? There was [Staff B], ask him. He saw her 5 with staff B revealed he with staff A. Staff B revealed avior and pushed staff A and e but didn't fall. Staff B reports #1 in the face a couple of vened and was able to get the m and staff A in another room f B revealed he was asked to ut no one has interviewed him until this surveyor asked about 5 with staff A via phone another client. She placed m and the other client. Client she redirected him to his revealed she called the site t the behavior and was ete the documentation. Staff A call 911 and went to the n't aware of any injuries client A revealed she did not put her	W	127			

If continuation sheet Page 3 of 15

		AND HUMAN SERVICES				FORM	06/20/2025 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		34G270	B. WING				_ 16/2025
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-S	IXTH STREET GROUP	РНОМЕ			01 NORTH SIXTH STREET SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
W 127	site supervisor told and complete the far revealed he transpor- emergency room wi injuries to his nose he notified the area supervisor of the im- revealed staff A cor- received any directi- schedule. There was instructions for Staff Interview on 6/16/29 (AS) revealed he re- site supervisor infor 6/5/25. The area su the qualified intelled (QIDP) and the pro- text message on th- revealed that a foll- team on 6/9/25 and to show the text me they were sent. Record review on 6 timecard revealed so out on the following 6/5/25 11:30am-3: 6/6/25 10:56pm-11 6/7/25 8:22pm-11 6/8/25 8:20pm-8: 6/10/25 11:06pm-7: 6/15/25 8:36am-9: Interview on 6/16/29 was not informed of had not notified the	staff A to write a statement acilities incident report. The SS orted client #1 home from the here he was seen for the from staff A. The SS revealed supervisor which is his cident that occurred. The SS ntinued to work and he had not on to remove staff A from the as no further direction or if A to follow. 5 with the area supervisor eceived a phone call from the rming him of the incident on upervisor revealed he informed ctual disabilities professional gram manager (PM) through a e evening of 6/5/25. The AS ow up email was sent to the 1 on 6/12/25. The AS was able essages and emails and when (16/25 of the employee staff A clocked in and clocked days: 39pm 0:51am :09am 23am 53am 00am	W -	127			

Facility ID: 944946

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		AND HUMAN SERVICES					FORM	06/20/2025 APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATI COM	0938-0391 E SURVEY PLETED
		34G270	B. WING	i				C 16/2025
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP COI	ЭE	-	
VOCA-SI	VOCA-SIXTH STREET GROUP HOME				01 NORTH SIXTH STREET SANFORD, NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD	BE	(X5) COMPLETION DATE
W 127	currently an investig IRIS report had been been placed on adri interview revealed r and the IRIS report completed by anoth was being placed of effective 6/16/25. Review on 6/16/25. Review on 6/16/25. S/12 under Protection under Neglect reveal or services necessathealth, physical heat client" under Physical heat client protecting procedure abuse is the use of posture/gesture, or threatens to inflict presponsibility "staff prevent further abus a person if they with reporting procedure allegation through t System (IRIS) to the Health Services Re Personnel Registry. Manager coordinate ensure the HCPR 2 and submitted on ti made to local DSS Service, the guardia Human Rights Corr	5 the PM revealed there was gation being completed. The en completed and staff A had ministrative leave. Further no investigation had begun was currently being ner program manager. Staff A in administrative leave of the facility's policy revised on from Abuse and Neglect, aled, "failure to provide care ary to maintain the mental alth and well-being of the cal Abuse revealed "physical physical force, body body movement that inflicts or bain on a person. Under staff is required to intervene to se or neglect from occurring to ness such first hand." Under es revealed , " report the he Incident Report Information e LME/MCO and Division of egulation Health Care . The Operations/Program es with the HR manager to 24 Hour Report is completed me. Additional reports are Adult or Child Protective an and Chairperson of the mittee."	W.	127				
	had failed to ensure	it was confirmed the facility e clients were protected from tinued to work in the facility						

If continuation sheet Page 5 of 15

	COF DEFICIENCIES	<u>&amp; MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(¥2) MI II TI	PLE CONSTRUCTION		). 0938-039 TE SURVEY	
	OF DEFICIENCIES	IDENTIFICATION NUMBER:				MPLETED	
					С		
		34G270	B. WING		06/16/2025		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	ZIP CODE		
VOCA-S	IXTH STREET GROUI	PHOME		201 NORTH SIXTH STREET SANFORD, NC 27330			
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
W 127	after it was reported times in the face. (C hospital after the in contusion; general conduct a thorough its policies and pro- mistreatment, negle the incident. Staff A clients in the home The team on site su jeopardy to the clie The facility develop protection to remove the clients in the face "Immediate safety / of suspected of abu immediately remove 6/16/25 and placed ensure the client's 2. Reporting require incidents will be rep authorities and over hours of being iden Response Improve completed and sub Investigation Timeli will begin immediate completed. 5. Exter participate in mand focused on: Unders recognizing early w procedures, Respe boundaries. 6. Daily Monitoring: A struct implemented to pro-	d she hit client #1 multiple Client #1 was seen at the cident and diagnosed with assault. The facility failed to n investigation and implement cedures that prohibit ect and abuse once learning of worked 8 shifts with the after the incident occurred. ubstantiated an immediate	W 12				

If continuation sheet Page 6 of 15

		AND HUMAN SERVICES			FORM	06/20/2025 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		34G270	B. WING _			C 16/2025
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-SIXTH STREET GROUP HOME				201 NORTH SIXTH STREET SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 127	Management staff, , Program manager Professional, Nurse was signed by the F This plan was acce site and the immedi the facility was dete effective 5:30pm or STAFF TREATMEN CFR(s): 483.420(d) The facility must de policies and proced mistreatment, negle This STANDARD is Based on record re neglected to assure that prohibit physica implemented to pro (#1, #2, #3, #4, #5, Review on 6/16/25 discharge papers d diagnoses of contus following test were Radiology XR Nasa Further review of cl Plan (ISP) dated 10 intellectual develop spectrum disorder. highly functional an and needs clearly. Review on 6/16/25	. which includes: Quality Operations Support specialist r, Site Supervisor, Qualified a, Area Supervisor" this plan Program Manager on 6/16/25. Opted by the survey team on iate jeopardy to the clients in ermined to be removed n 6/16/25. NT OF CLIENTS 0(1) evelop and implement written dures that prohibit ect or abuse of the client. s not met as evidenced by: eview and interview, the facility e its policies and procedures al abuse and neglect were otect 6 of 6 clients in the home and #6). The finding is: of client #1's hospital lated 6/5/25 revealed a sion; general assault. The performed diagnostic al bones 3+ views. lient #1's Individual Support 0/19/24 revealed diagnosis of mental disabilities, Autism The ISP revealed client #1 is d can communicate his wants	W 12			
	Plan (ISP) dated 10 intellectual develop spectrum disorder. highly functional an and needs clearly. Review on 6/16/25	0/19/24 revealed diagnosis of mental disabilities, Autism The ISP revealed client #1 is d can communicate his wants				

If continuation sheet Page 7 of 15

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/20/2025 APPROVED 0938-0391	
STATEMENT ( AND PLAN OF	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATI COM	E SURVEY PLETED		
		34G270	B. WING			C 06/16/2025		
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
VOCA-SIXTH STREET GROUP HOME					201 NORTH SIXTH STREET SANFORD, NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
	aggression directed behavior physical re- time end 8:34am will Documented descri client #1 reported the nose felt abnormal. and the visit was con- witness to the incide Interview on 6/16/28 had a behavior and Client #1 revealed for Client #1 revealed for Client #1 revealed for confirmed emergen house and he was to Client #1 revealed for it had been broke regarding the incide site supervisor drow local hospital. Continued interview staff A had worked for from the hospital. Co- surveyor "why is sho hit me? There was ask him. He saw he Interview on 6/16/28 worked on 6/5/25 wi client #1 had a beha she stumbled a little staff A did hit client for times. Staff B interview	Jients' face, physical I toward staff. Response to estraint time started 8:25am hich involved staff A. ption of Incident revealed hat his face was sore and his Client was seen by the ER uncluded with no injuries. One ent. 5 with client #1 revealed, he staff A jumped in his face. he may have pushed staff A. staff A hit him in his face on his Client #1 revealed he went to ed he needed to go the hd called 911. Client #1 cy services came to the aken to the local hospital. his nose was x-rayed to check h. He spoke to the police ent. Client #1 confirmed the re him to the facility from the with client #1 revealed that the home since he returned client #1 then asked the e still working here, when she another staff here. [Staff B],	W 1	149				

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		AND HUMAN SERVICES				FORM	06/20/2025 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G270	B. WING	i		C 06/16/2025		
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
VOCA-S	XTH STREET GROUF	PHOME			201 NORTH SIXTH STREET SANFORD, NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE	
W 149	to calm down. Staff write a statement be about the incident u it today. Interview on 6/16/22 incident did happen revealed client #1 h another client and sh him and the other of pushed her and she bedroom. She also supervisor to report instructed to complet also revealed client the hospital. She w client #1 received. S put her hands on cl Interview on 6/16/22 revealed he was ca reported to him that site supervisor told and complete the fa revealed he notified his supervisor of the SS revealed staff A not received any diff the schedule. Interview on 6/16/25 (AS) revealed he re- site supervisor infor 6/5/25. The area su the qualified intelled (QIDP) and the pro- text message on th revealed that a follow	B revealed he was asked to ut no one has interviewed him until this surveyor asked about 5 with staff A revealed an on 6/5/25 with client #1. She had a behavior yelling at she placed herself between client. Staff A revealed client #1 e redirected him to his revealed she called the site t the behavior and was ete the documentation. Staff A . #1 did call 911 and went to vasn't aware of any injuries Staff A revealed she did not	W	149				

Facility ID: 944946

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		AND HUMAN SERVICES				FORM	): 06/20/2025 // APPROVED ). 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		34G270	B. WING			06	5/16/2025	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD			
VOCA-SI	XTH STREET GROUI	РНОМЕ			201 NORTH SIXTH STREET SANFORD, NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
W 149	Continued From pa	ige 9	<b>W</b> 1	149	)			
	to show the text me they were sent.	essages and emails and when						
	revealed staff A clo following days: 6/5/25 11:30am-3: 6/6/25 10:56pm-1 6/7/25 8:22pm-11 6/8/25 8:20pm-8: 6/9/25 11:07pm-8 6/10/25 11:06pm-7 6/15/25 8:36am-9 Interview on 6/16/2 was not informed o QIDP confirmed sh guardian of an incid The QIDP revealed was informed of the communicates with	0:51am :09am 23am :53am :00am						
	not supervise the s schedule staff to we Interview on 6/16/2 currently an investig IRIS report had bee been placed on add interview revealed and the IRIS report completed by anoth revealed she was n Staff A was being p effective 6/16/25. Review on 6/16/25 5/12 under Protecti	ite supervisor and does not						

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES		F		06/20/2025 APPROVED
		& MEDICAID SERVICES	1			0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	COM	E SURVEY PLETED
		34G270	B. WING			C 16/2025
NAME OF F	PROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-SIXTH STREET GROUP HOME				201 NORTH SIXTH STREET SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 149	Continued From pa	ge 10	W 149			
	or services necessa health, physical hea client" under Physic abuse is the use of posture/gesture, or threatens to inflict p responsibility "staff prevent further abus a person if they witr reporting procedure allegation through t System (IRIS) to the Health Services Re Personnel Registry Manager coordinate ensure the HCPR 2 and submitted on ti made to local DSS Service, the guardia Human Rights Com	ary to maintain the mental alth and well-being of the cal Abuse revealed "physical physical force, body body movement that inflicts or bain on a person. Under staff is required to intervene to se or neglect from occurring to ness such first hand." Under es revealed , " report the he Incident Report Information e LME/MCO and Division of gulation Health Care . The Operations/Program es with the HR manager to 24 Hour Report is completed me. Additional reports are Adult or Child Protective an and Chairperson of the mmittee."				
W 154	the facility was dete effective 5:30pm or	IT OF CLIENTS	W 154	l.		
	violations are thorous This STANDARD is Based on record re facility failed to ensu	s not met as evidenced by: eview and interviews, the ure an allegation of abuse was ated. This affected 1 of 1				
		revealed no documentation of ation regarding an allegation of				

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		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	06/20/2025 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE COM	E SURVEY PLETED
		34G270	B. WING					C 16/2025
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
VOCA-SI	XTH STREET GROUP	PHOME			11 NORTH SIXTH STREET ANFORD, NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD	BE	(X5) COMPLETION DATE
TAG W 154	Continued From parabuse of client #1 c Review on 6/16/25 discharge papers d diagnoses of contus following test were Radiology XR Nasa Interview on 6/16/29 needed to be seen being hit in the nose #1 called 911 and w revealed the site su the hospital and he hitting him in the nose Interview on 6/16/29 revealed he was can reported to him that site supervisor told and complete the far revealed he notified his supervisor of the SS revealed staff A not received any dir the schedule. Interview on 6/16/29 (PM) revealed there investigation being had been complete	ge 11 on 6/5/25. of client #1's hospital ated 6/5/25 revealed a sion; general assault. The performed diagnostic al bones 3+ views. 5 with client #1 revealed, he at the emergency room due to be by a staff at the home. Client vas taken to the ER. Client #1 pervisor drove him home from informed him of the staff ose. 5 with the site supervisor (SS) lled by staff A and she t client #1 had a behavior. The staff A to write a statement acilities incident report. The SS I the area supervisor which is e incident that occurred. The continued to work and had rection to removed staff A from 5 with the program manager e was currently an completed. The IRIS report d and staff A had been placed	W 1	54				
	revealed no investig and the IRIS report completed by anoth 6/16/25. The guard staff of the incident	ave. Further interview gation has begun as of 6/16/25 was currently being her program manager on ian had not been notified by on 6/16/25. Staff A was being rative leave effective 6/16/25.						

Facility ID: 944946

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CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1)         PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         34G270		(X1) PROVIDER/SUPPLIER/CLIA	· ,	PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED C	
		B. WING		06/16/2025		
			STREET ADDRESS, CITY, STATE, ZIP CC	E, ZIP CODE		
VOCA-SI	XTH STREET GROU	РНОМЕ		201 NORTH SIXTH STREET SANFORD, NC 27330		
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
W 154		o conduct a thorough ed in clients being subjected to	W 154	4		
W 156	STAFF TREATMEN CFR(s): 483.420(d		W 156	5		
	to the administrato or to other officials within five working This STANDARD is Based on record re failed to ensure an completed and res	vestigations must be reported r or designated representative in accordance with State law days of the incident. is not met as evidenced by: eview and interview, the facility investigation of abuse was ults reported to state law working days. This affected 1 ). The finding is:				
	discharge papers of diagnoses of contu	of client #1's hospital lated 6/5/25 revealed a sion; general assault. The performed diagnostic al bones 3+ views.				
	A had hit him in the group home. Client	5 with client #1 revealed staff nose on 6/5/25 while at the #1 revealed staff A has since the day the incident				
		ecords on 6/16/25 revealed no an IRIS report or investigation ation of abuse.				
	revealed staff A had client #1's behavior the emergency roo	5 with the Site supervisor (SS) d called him to inform him of r and that client #1 had gone to m. The SS revealed he went to sport client #1 back to the				

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				: 06/20/2025 APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	<del></del>		<u> </u>	. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ,	LE CONSTRUCTION	Сом	(X3) DATE SURVEY COMPLETED	
	34G270		B. WING		C 06/16/2025	
NAME OF F	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-SI	XTH STREET GROUP	, НОМЕ		201 NORTH SIXTH STREET SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETION DATE
W 156	Continued From pa	ge 13	W 156			
	what happen and b The SS revealed he supervisor the area further instructions.					
W 252	(PM) revealed she date or time when s incident. There was being completed. T completed and staf administrative leave No investigation ha IRIS report was cur another program m guardian had not be incident on 6/16/25 administrative leave	MENTATION	W 252			
	specified in client in	complishment of the criteria ndividual program plan documented in measurable				
	Based on record re	s not met as evidenced by: eview and interview, the facility f 1 audit clients (#1) behavior ted. The finding is:				
	Plan (BSP) dated 1 target behaviors, "1	of client #1's Behavior Support 0/24/24 revealed the following . Noncompliance: failure to f requests to perform an				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/20/2025 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
34G270		34G270	B. WING			C 06/16/2025	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
VOCA-SIXTH STREET GROUP HOME			201 NORTH SIXTH STREET SANFORD, NC 27330				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 252	essential activity of Attempts to leave o program unsupervis Verbal Aggression// and nonverbal signs use, anger outburst define as any action the possible effect of another person. 5. I as causing or attem property starts. Review of the facilit revealed incident da physical aggression staff. Response to I time started 8:25an involved staff A. De reported that his fac abnormal. Client wa was concluded with the incident. Review on 6/16/25 sheet revealed: Ma behavior, June 202 Interview on 6/16/25	ge 14 daily living 2. Elopement- r leaving the home or day sed or without permission. 3. Agitation: Defined as verbal s that he is upset (profanity ) 4. Physical Aggression: n that is directed at others with of doing physical harm to Property Destruction: defined opting to cause damage to dehavior directed toward behavior directed toward behavior physical restraint n time end 8:34am which scription of Incident " client ce was sore and his nose felt as seen by the ER and the visit no injuries. One witness to of client #1 behavioral data ay 2025 (1) documented 5 no documented behaviors. 5 with the qualified intellectual onal (QIDP) all behaviors ated on the behavior data rmed there was 1 documented onth and May 2025 and no iors for the month of June	W 2	252			

Facility ID: 944946

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