

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/21/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G271	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/16/2025
NAME OF PROVIDER OR SUPPLIER VOCA-ROLLINS GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 260	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to update the Individual Support Plan (ISP) annually for 1 of 3 audited clients (#3). The finding is: Review of client #3's record on 7/15/25 revealed an ISP dated 4/10/24. Continued review of client #3's record revealed no evidence of a current ISP. Interview with Area Manager on 7/16/25 revealed they have an upcoming ISP meeting scheduled for client #3. Continued interview with the Area Manager confirmed the facility is responsible for ensuring ISPs are updated on an annual basis.	W 260	The QP (Qualified Professional), QA (Quality Assurance), and PM (Program Manager) will review and update all client records to ensure that current Individual Support Plans (ISPs) are completed in a timely manner and properly filed. The QP will be responsible for notifying the appropriate staff of any missing or incomplete ISPs and will ensure that they are completed immediately. During ISP completion, the QP, QA, and PM will conduct a file review and utilize a checklist to ensure accuracy and compliance. Ongoing review of ISPs will occur as follows: • Monthly review by the QP • Quarterly review by the QA and PM This process is in place to maintain compliance and ensure that all client records are up to date and meet regulatory standards. ISP for client was completed in TMP and in the book. QP will ensure all documents are in the book and printed ISP from TMP is present. Resp: QP, PM, QAM		09-10-2025
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure all drugs were administered without error for 2 of 3 audited clients (#3 and #4) observed during medication administration. The findings are: A. The facility failed to administer medications to client #3 without error. For example: Observations in the home on 7/16/25 at 7:00 AM revealed client #3 to enter the medication	W 369	W369 cites improper medication administration, including failure to follow physician orders, MAR (Medication Administration Record) errors, or lack of staff competency in medication procedures. All staff involved in medication administration will be immediately re-trained on proper procedures, including the "Five Rights" (right person, medication, dose, time, and route). The QP, AS, or RN will review all current MARs and compare them to physician orders to ensure accuracy. Any errors found will be corrected immediately, and responsible staff will receive corrective action and additional support as appropriate.		

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

TITLE

(X6) DATE

Michael Penland

Executive Director

07-31-2025

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.

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W 369	Continued From page 1 administration room and the client to sanitize his hands. Continued observations revealed that the staff administered Retaine MGD EMU 0.5-0.5% 2 drops into each of the client's eyes. Further observations revealed the client to use his oral rinse and take medications whole with a cup of water. Review of records for client #3 on 7/16/25 revealed physician's orders (PO) dated 7/3/25. Review of the PO's revealed medications prescribed at 7:00 AM to be Clonidine tab 0.1MG, Lorazepam tab 2MG, Chlorhexidine Gluc-0.12% solution, and Retain MGD EMU 0.5-0.5% instill 1 drop both eyes twice daily. Interview with the facility nurse on 7/16/25 confirmed that client #3's physician's orders to be current. Continued interview with the nurse confirmed that the staff should have administered the client #3's eye drops as prescribed. B. The facility failed to administer medications to client #4 without error. For example: Observations in the home on 7/16/25 at 7:36 AM revealed staff to enter medication room with client #4. Continued observations revealed the staff to obtain the medication bin, educate medications to include side effects, and scan medications. Further observations revealed staff punched all medications into a medicine cup and the client took all medications whole with water. Subsequent observations revealed the staff poured 60 ML of MiraLAX into a measuring cup and mixed it in water. The client consumed the MiraLAX mixed in water. Review of records for client #4 revealed POs	W 369	A competency checklist and observation form will be used for all medication-trained staff, with evaluations conducted at least quarterly by the RN or QP. All new medication orders will be double-verified by two trained staff before being added to the MAR. A standardized MAR audit process will be implemented weekly by the QP or RN to identify and correct potential errors proactively.	09-10-2025	

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W 369	Continued From page 2 dated 6/25/25. Review of the PO's revealed medications prescribed at 7:00 AM to be Acetaminophen tab 325MG, Docusate SOD CAP 1000, Vitamin D3 1,000 IU, Losartan POT tab 100MG, Risperidone 1 MG tab, Tetrabenazine tab 12.5 MG, Vilazodone Tab 40 MG, MiraLAX mix 17 GM (one capful) in 8 ounces of liquid and drink by mouth once daily. The staff administered Clonidine tab 0.1MG which is ordered at bedtime. Amlodipine tab 5MG and Vitamin B-12 500 CG tabs were not available to administer to the client during medication administration. Interview with the facility nurse on 7/16/25 confirmed that client #4's PO's to be current. Continued interview with the nurse revealed that the MiraLAX dosage that was administered to client #4 exceeded the amount of MiraLAX prescribed to the client. Further interview with the nurse revealed that she did not know where the facility stood with medication orders; however, medications should be administered as prescribed.	W 369	Monthly medication audits will be conducted by the QP or RN and reviewed by the QA team. Ensure Physician's orders are correct and all staff is aware. Errors or trends identified will be addressed in monthly staff meetings and individual supervision sessions as needed. Ongoing training will be held semi-annually or more frequently if necessary. Responsible parties: SS, QP, QA, and RN		
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 interview, the facility failed to ensure that prescribed adaptive equipment was maintained for 1 of 3 audited clients (#4) relative to prescribed eyeglasses. The finding is:	W 436	The facility was cited under W436 for failure to provide sufficient space and/or maintain proper use equipment in a safe, clean, and functional condition to meet the needs of individuals served. Ensuring proper adaptive equipment is being used and provided to all individual served.		

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W 436	Continued From page 3 Observation in the group home during recertification survey 7/15-16/25 revealed client #4 to participate in playing an UNO card game, dinner mealtime, breakfast mealtime, and medication administration. Continued observations revealed client #4 to not wear prescribed eyeglasses throughout the survey. Further observations revealed that staff did not at any time provide the client with his prescribed eyeglasses. Review of records for client #4 on 7/16/25 revealed an individual support plan (ISP) dated 12/18/24. Continued review of ISP revealed an eye exam completed on 6/2/25 with a new prescription for eyeglasses. Interview with the facility nurse on 7/16/25 confirmed that the client is prescribed eyeglasses. Continued interview with the facility nurse confirmed that the client had an eye exam completed on 6/2/25 and should have prescribed eyeglasses.	W 436	The QP (Qualified Professional) and SS immediately reviewed the individual's record and contacted the guardian and physician to verify current eyewear needs and prescriptions. Replacement or repair of the individual's prescribed eyewear has been initiated or completed. Staff were notified and re-trained on the importance of ensuring that individuals have access to and are using prescribed adaptive equipment. The QP will review adaptive equipment needs quarterly to ensure all items (including eyewear, hearing aids, mobility devices, etc.) are present, functional, and in use. Any missing or damaged adaptive equipment will be reported immediately to the Program Manager and addressed within 48 hours. QA will conduct quarterly audits to ensure that adaptive equipment is documented, available, and appropriately used. Results of audits and any identified needs will be reviewed in interdisciplinary team meetings for prompt resolution. Training on the proper use and importance of adaptive equipment will be provided to staff semi-annually or as needed. Resp: QP, QAM, SS		09-10-2025
W 448	EVACUATION DRILLS CFR(s): 483.470(i)(2)(iv) The facility must investigate all problems with evacuation drills, including accidents. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to investigate all problems with evacuation drills specific to the timeliness of the evacuation. The finding is: Review of the facility fire drill reports on 7/15/25 revealed three fire drills reports which exceeded three minutes evacuation time (12/6/24 - 13	W 448	To ensure compliance with W448, all evacuation drills will be conducted as required and properly documented. The QP and Program Manager (PM) will review all evacuation drill records to identify any missed, incomplete, or improperly documented drills. Any deficiencies will be addressed immediately. Make-up drills will be scheduled and completed as needed. SS will also hold inservice on drills that go over or any missed drill to make needed corrections for drills. AS- will conduct montly reviews to ensure drills are correct and train all staff on processes to ensure staff and clients understand drill processes. Responsible parties: DSPs, SS, QP, AS, PM		09-10-2025

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W 448	Continued From page 4 minutes; 5/5/25 - 29 minutes; 6/4/25 - 7.45 minutes). Continued review revealed the three fire drill reports to be missing an explanation for the evacuation time. Interview with the Area Manager on 7/15/25 verified the expectation for the fire drill evacuation time is three minutes. Continued interview with the Area Manager confirmed the facility is responsible for reviewing all fire drills to ensure timeliness of evacuations and developing a plan to address any difficulties with fire drills.	W 448			