

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

PRINTED: 01/27/2026
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 C 01/14/2026
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 249	<p>PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure that a continuous active treatment program consisting of needed behavioral interventions were implemented as identified in the individual support plan (ISP) for 1 of 6 clients (#1). The finding is:</p> <p>Review of the record during the complaint investigation survey for client #1 on 1/14/26 revealed an ISP dated 5/12/25 which indicated the client was admitted to the facility on 5/6/25. Further review of the 5/2025 ISP indicated client #1 has exhibited the following target behaviors: self-injurious behaviors, defecating on herself, inappropriate masturbation, rectal digging/fecal smearing, inappropriate disrobing, physical and verbal aggression. Continued review of the record for client #1 did not reveal any formal behavioral interventions or techniques to address the target behaviors.</p> <p>Review of the record for client #1 on 1/14/26 revealed an incident report dated 11/28/25 which indicated the client was hitting herself in the ear, which led to hematoma, significant swelling of left</p>	W 249			

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

TITLE

(X6) DATE

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.

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

PRINTED: 01/27/2026
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 C 01/14/2026
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 249	Continued From page 1 ear and required medical treatment. Review of the record for client #1 on 1/14/26 revealed behavior data from 6/19/25-11/28/25 to include the following behaviors: removing clothes, defecated on herself multiple times, pulling a staff member's hair out, attacking staff, fecal smearing, throwing food, yelling and "beating the side of her head", physically assaulting staff multiple times, hitting her ears and walls, throwing objects, and behaviors on the facility van. Review of the record for client #1 did not reveal a behavior support plan (BSP) to address the behaviors. Interview with the residential manager (RM) on 1/14/26 revealed client #1 has been assaulting staff and causing injuries and bruising. Further interview with the RM revealed client #1 has been attacking staff when they provide personal care to her. Continued interview with RM verified client #1 does not have a BSP for staff to use to address her target behaviors. Interview with the QA Manager on 1/14/26 revealed she has attempted to get client #1 a BSP from the facility psychologist to address her target behaviors. Further interview with the QA Manager verified client #1 does not have formal behavioral interventions or techniques to address target behaviors.	W 249			
W 322	PHYSICIAN SERVICES CFR(s): 483.460(a)(3) The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record review and interview, the facility	W 322			

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

PRINTED: 01/27/2026
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 C 01/14/2026
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 322	<p>Continued From page 2</p> <p>failed to ensure assessments and findings were incorporated into the individual support plan (ISP) for client #1 in a timely manner. The finding is:</p> <p>Review of the record for client #1 during the complaint investigation survey on 1/14/26 revealed an ISP dated 5/12/25 which indicated the client was admitted to the facility on 5/6/25.</p> <p>Review of a nurses' notes dated 12/18/25 and 12/19/25 revealed client #1 was in the hospital after being found on the floor on the morning of 12/17/25. Continued review of the 12/2025 nurse's note revealed the client was slightly shaking and not responding to her name. The nurse's note also indicated the client's "kidneys were not responding to antibiotics and were currently on dialysis. The hospital will be completing a lumbar puncture to determine if the client has an infection to the brain. Further recommendations are for a neurologist". The client was transported to the hospital and remains in the hospital to date. Review of the record for client #1 revealed a nurse's note dated 12/26/25 revealed the client has received a rhabdomyolysis diagnosis. The client was also transferred to second hospital for continued medical care.</p> <p>Subsequent review of the record for client #1 revealed a medical consult dated 6/17/25 which provided the following recommendations: referral to Ear, Nose, and Throat (ENT), dentist, and psychiatrist. Continued review of the 6/2025 medical consult recommended following up with a specialist and fasting labs in 42-72 hours. Review of the record for client #1 also revealed a medical consult dated 6/23/25 indicating the client received lab work however lab results were not found. Additional review of the 6/23/25 medical</p>	W 322			

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

PRINTED: 01/27/2026
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 C 01/14/2026
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 322	<p>Continued From page 3</p> <p>consult revealed "see documents" however no lab work results were available.</p> <p>Review of a nurses' notes dated 10/7/25, 10/28/25, 11/24/25, 11/28/25, 12/3/25 indicated several medication changes including psychotropic medications. Review of the record for client #1 did not reveal lab work results as prescribed.</p> <p>Interview with the resident manager (RM) and QA Manager on 1/14/26 revealed client #1 had lab work completed once, and the lab results have not been located. Interview with the RM and QA Manager agreed that the lab results and assessment findings are necessary to determine further treatment interventions and objectives for clients.</p>	W 322			