

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

PRINTED: 02/18/2026
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G270	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2026
NAME OF PROVIDER OR SUPPLIER VOCA-SIXTH STREET GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 201 NORTH SIXTH STREET SANFORD, NC 27330		
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E 036	<p>EP Training and Testing CFR(s): 483.475(d)</p> <p>§403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d).</p> <p>*[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.</p> <p>*[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.</p>	E 036			

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.

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E 036	<p>Continued From page 1</p> <p>*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).</p> <p>*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.</p> <p>This STANDARD is not met as evidenced by: Based on interview and review of the facility's Emergency Preparedness (EP) plan, the facility failed to ensure all staff were trained on the EP plan. The finding is:</p> <p>Review on 2/17/26 of the facility's EP plan revealed no information regarding training on the EP plan for all staff working in the home.</p> <p>Interview on 2/17/26 with the Qualified Intellectual Disabilities Professional (QIDP) and the Program Manager (PM) confirmed training on the facility's</p>	E 036			

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E 036 W 249	Continued From page 2 Emergency Preparedness Plan was not completed for all new and existing staff. PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) 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. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure each client received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP). This affected 2 of 3 audit clients (#1 and #2). The findings are: A. During morning observations in the home after breakfast on 2/17/26 from 6:34am - 8:30am, staff completed various household chores such as washing/folding laundry, loading/starting the dishwasher, wiping the table, sweeping/mopping the kitchen floors, sweeping the dining room and living room floors. During this time all of the clients remained in their bedrooms, except client #1 who was positioned in front of the television in her wheelchair. At this time, client #2 finished his meal, cleared his items from the table, took a shower and went back to his bedroom. No clients were prompted or encouraged to participate in	E 036 W 249			

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W 249	<p>Continued From page 3 household chores.</p> <p>Review on 2/16/26 of client #2's IPP dated 7/23/25 revealed he is very useful around the house and enjoys doing chores.</p> <p>Additional review of a "Consumer Schedule" posted in the home revealed clients participate with daily chores from 8:00a - 9:00a. Another shift schedule (7am - 3pm) posted in the home noted the primary focus during this time should be morning routines, meal prep, clean up, bathrooms, laundry started, common areas, active treatment and documentation. The shift schedule noted, "promote independence...encourage resident involvement..."</p> <p>Interview on 2/17/26 with the Site Supervisor (SS) and Qualified Intellectual Disabilities Professional (QIDP) the posted schedule was a "general schedule" currently being used in the home.</p> <p>B. During dinner preparation observations in the home on 2/16/26 at 4:54pm, client #1's food was pureed in a blender while she sat nearby in the living room. Client #1 was not prompted or encouraged to participate with this task.</p> <p>Review on 2/17/26 of client #1's IPP dated 1/14/26 revealed she consumes a pureed food consistency. Additional review of the plan identified an objective to blend her food in a blender with 70% completion for 6 months (implemented 8/25/25).</p> <p>Interview on 2/17/26 with the QIDP confirmed client #1's objective was current and could be integrated into her mealtime routine.</p>	W 249			

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W 252	<p>PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1)</p> <p>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure data relative to the accomplishment of objectives identified in the Individual Program Plan (IPP) was documented in measurable terms. This affected 1 of 3 audit clients (#1). The finding is:</p> <p>Review on 2/17/26 of client #1's IPP dated 1/14/26 revealed the following guidelines/recommendations from the Physical Therapist (PT): "...Staff should continue to assist [Client #1] with her exercise program to promote flexibility, mobility and circulation in both lower extremities and to prevent worsening of contractures. Staff should continue to use the monthly exercise log to monitor [Client #1's] participation and response...Staff should continue to assist [Client #1] with her proper positioning and pressure relief program to promote pressure relief and circulation and prevent skin breakdown and worsening of contractures. Staff should continue to use the monitoring log to ensure timely implementation of repositioning schedule..."</p> <p>Additional review of client #1's training records did not include documentation of PT recommendations for the client's consistent participation in an exercise program, pressure</p>	W 252			

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W 252	Continued From page 5 relief and repositioning schedule. Interview with Staff D indicated she was not sure where documentation for client #1's PT recommendations was located. Interview on 2/17/26 with the PT confirmed staff on each shift should be documenting client #1's participation in all recommendations made by the PT.	W 252			
W 257	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(iii) The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Individual Program Plan (IPP) was revised as necessary after 2 of 3 audit clients (#1 and #2) failed to progress toward identified objectives. The findings are: A. Review on 2/17/26 of client #1's IPP dated 1/14/26 revealed objectives implemented on 2/1/25 to participate in medication management with 75% acc for six months, to allow staff to assist during toothbrushing with 70% completion for six months, and to participate in making a purchase with 70% accuracy for six months. Additional review of progress notes for the objectives indicated the following: Medication Management	W 257			

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W 257	<p>Continued From page 6</p> <p>08/25 - 48% 09/25 - 3.3% 10/25 - 0% 11/25 - 5% 12/25 - 10.1% 01/26 - 55.5%</p> <p>Toothbrushing</p> <p>08/25 - 8.06% 09/25 - 3.3% 10/25 - 0% 11/25 - 5% 12/25 - 10.1% 01/26 - 53.3%</p> <p>Make a Purchase</p> <p>08/25 - 25% 09/25 - 0% 10/25 - 0% 11/25 - 0% 12/25 - No note 01/26 - No note</p> <p>Interview on 2/17/26 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed no revisions have been made to the objectives to address the lack of progress.</p> <p>B. Review on 2/16/26 of client #2's IPP dated 7/23/25 revealed objectives implemented on 2/1/25 to identify medication with 70% accuracy for six months, and to shave with 70% completion for six months. Additional review of progress notes for the objectives indicated the following:</p> <p>Identify Medication</p>	W 257			

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W 257	Continued From page 7 08/25 - No note 09/25 - 20% 10/25 - 9.6% 11/25 - 0% 12/25 - 13.7% 01/26 - 61.5% Shaving 08/25 - No note 09/25 - 12.5% 10/25 - 0% 11/25 - 0% 12/25 - No note 01/26 - 71.4%	W 257			
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, document review and interviews, the facility failed to ensure all staff were sufficiently trained to wear latex gloves appropriately. This affected 1 of 3 audit clients (#1). The finding is: During morning observations in the home on 2/17/26 at 6:28am, Staff D was noted wearing latex gloves while assisting clients at the	W 340			

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W 340	Continued From page 8 breakfast table. Afterwards, the staff continued to wear gloves while feeding client #1. At 6:32am, Staff A applied latex gloves and entered the dining area. The staff continued to wear the gloves while standing around the table and briefly assisting clients at the meal. Interview on 2/17/26 with Staff D revealed she had been trained to wear latex gloves when handling food or medications and during hygiene tasks or touching bodily fluids. Review on 2/17/26 of the facility's Infection Control/Infectious Disease policy (Revised 3/2020) noted, "Gloves - wear when touching blood, body fluids, secretions, excretions, mucous membranes, or non-intact skin." Additional review of the policy did not indicate gloves should be worn in the manner previously described.	W 340			
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 document review and interviews, the facility failed to ensure all problems identified during evacuation drills were investigated and a plan to ensure difficulties will not reoccur was developed. This affected 1 of 3 audit clients (#1). The finding is: Review on 2/16 - 2/17/26 of the facility's fire drill reports from January '25 - January '26 revealed	W 448			

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W 448	<p>Continued From page 9</p> <p>three fire drills were conducted on third shift. Additional review of the reports noted on 9/1/25 and 12/19/25, the Qualified Intellectual Disabilities Professional (QIDP) was present during the fire drills along with two other staff.</p> <p>Interview on 2/17/26 with the QIDP revealed third shift generally has two staff assigned to work on the shift; however, she had been coming in to assist with fire drill, specifically helping with client #1 who utilizes a wheelchair.</p> <p>Review on 2/17/26 of client #1's IPP dated 1/14/26 revealed she has a diagnosis of spastic Cerebral Palsy, Quadriparesis and utilizes a wheelchair throughout the day. Additional review of the plan also noted a mechanical lift is required for the client's lifts and transfers.</p> <p>Interview on 2/17/26 with the Program Manager (PM) confirmed the QIDP had been assisting with fire drills due to behavioral issues noted by former clients in the home.</p>	W 448			