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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G262	A. BUILDING ______ B. WING ______	02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-WOODLAND	123 WOODLAND DR RUTHERFORDTON, NC 28139

(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 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure all drugs and biological's were kept lock except when being prepared for administration. The finding is: Observations in the group home on 2/5/20 at 6:55 AM revealed a staff member (A) who was assisting client #6 with medication administration, to ask the program manger (PM) to get an insulin pen out of the kitchen refrigerator. Further observations at that time revealed the PM to retrieve a plastic bag with insulin pens inside it and take it to the medication room. Continued observations at 8:45 AM, revealed the plastic bag to contain two pre-filled Novolog Mix 70/30 insulin pens for client #6. Review of the record for client #6 on 2/5/20 revealed quarterly physician orders dated 11/21/19 which included Novolog Mix 70/30 -Prefill, inject 15 units subcutaneously in the AM, and inject 22 units in the evening before dinner. Interview with the PM on 2/5/20 revealed the Novolog Mix 70/30 insulin pens for client #6 were being kept in the kitchen refrigerator because the refrigerator located in the medication closet in the medication room was not working. The PM indicated staff had recently defrosted the refrigerator and it had stopped working at that time. The PM confirmed, group home staff should not have temporarily stored medication in the kitchen refrigerator without it being kept in a	W 382		

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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W 382	Continued From page 1 locked container.	W 382		
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 observation, interview and record review, the facility failed to ensure 1 of 4 sampled clients (#2) was taught to use and make informed choices about the use of a hearing aid. The finding is: Observations in the group home on 2/5/20 at 7:08 AM, revealed client #2 entering the medication room for morning medication administration. Further observations in the medication room at 7:20 AM revealed staff member A to obtain a hearing aid from the medication closet and then assist client #3 with placing it on his left ear. Interview with staff A at that time revealed she was not sure why the hearing aid was kept locked in the medication closet, but indicated it may be because the client could lose or damage the hearing aid. Review of client #2's individual service plan (ISP) dated 6/17/19 revealed an adaptive equipment section which included a hearing aid for the left ear to improve hearing. Further review of the ISP revealed a audiology follow-up on 9/24/19 which	W 436		

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W 436	Continued From page 2 included recommendation for a left hearing aid to be used daily. Continued review of the ISP did not reveal any training objectives related to the use, care or storage of the hearing aid. Review of the behavior support program did not reveal any restrictions related to the use or storage of the hearing aid. Interview with the program manager (PM) on 2/5/20 confirmed client #2's hearing aid was being stored in the medication room to avoid loss or damage. The PM also confirmed client #2 did not have any current or past program objectives related to training the client on the skills necessary for the use, care and storage of the hearing aid.	W 436		