

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G262	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/16/2023
NAME OF PROVIDER OR SUPPLIER VOCA-WOODLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 000	INITIAL COMMENTS	W 000			
W 186	<p>A complaint survey was completed on 2/16/23 for intakes #NC00197117 and #NC00197894. No deficiencies were cited as a result of the complaint survey, however, a deficiency was cited.</p> <p>DIRECT CARE STAFF CFR(s): 483.430(d)(1-2)</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on observation and interviews, the facility failed to ensure sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. The finding is:</p> <p>Observations upon arrival to the group home upon on 2/16/23 at 10:45 AM revealed the home manager (HM) to be the only staff in the home with all six clients present. Continued observations at 11:45 AM revealed the program manager (PM) to arrive at the group home.</p> <p>Interview with the HM on 2/16/23 revealed she started her shift at 7:00 AM and the 3rd shift staff left the home at 8:00 AM. Continued interview with the HM revealed the 2nd shift staff is schedule to arrive at 3:00 PM. Interview with PM on 2/16/23 revealed the staffing ratio for 1st shift is 2:6. Continued interview with the PM revealed they were unaware there was only one staff on 1st shift. Further interview with the PM revealed it</p>	W 186			

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: 02/17/2023
FORM APPROVED
OMB NO. 0938-0391

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W 186	Continued From page 1 is agency protocol for staff to call and inform management when the home is understaffed.	W 186			