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	34G262	A. BUILDING _____ B. WING _____	12/18/2024

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VOCA-WOODLAND	123 WOODLAND DR RUTHERFORDTON, NC 28139

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W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure medications were administered in accordance with physician's orders. This affected 4 clients (#2, #4, #5 and #6) observed during medication administration. The finding is: A. During observations in the home on 12/17/24 at 5:10 PM, client #2 was observed to enter the medication room with staff and to be administered Risperidone 1 mg - 1 tablet. Review on 12/18/24 of client #6's physician's orders revealed that the Risperidone should be administered at 4:00 PM. Interview on 12/18/24 with the Director of Nursing (DON) confirmed the Risperidone should have been administered between 3:01 PM and 4:59 PM, and that administering the medication outside of that window constitutes a medication error. B. During observations in the home on 12/17/24 at 5:10 PM, client #4 was observed to enter the medication room with staff and to be administered Lansoprazole 30 mg - 1 tablet. Review on 12/18/24 of client #4's physician's orders revealed that the Lansoprazole should be administered at 4:00 PM. Interview on 12/18/24 with the DON confirmed	W 368		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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the Lansoprazole should have been administered between 3:01 PM and 4:59 PM, and that administering the medication outside of that window constitutes a medication error.

C. During observations in the home on 12/18/24 at 9:07 AM, client #5 was observed to enter the medication room with staff and to be administered the following medications: Famotidine 20 mg - 1 tablet, Cetirizine 10 mg - 1 tablet, Olmesa Medex 5 mg - 1 tablet, Vitamin D3 5,000 IU - 1 capsule, Fluticasone 50 mg nasal spray. Client swallowed all of the oral medications with water at 9:13 AM and did not receive any additional medications or treatments prior to boarding the van at 9:35 AM.

Review on 12/18/24 of client #5's physician's orders dated 10/14/24 indicated that client #5 should have received Budesinide, Klayesta POW 100000 and Nystatin cream along with the other morning medications. Continued review of the physician's order revealed that all of client #5's medications listed above should be administered at 7:00 AM.

Interview on 12/18/24 with the DON confirmed that client #5 should have received the Budesinide, the Klayesta and the Nystatin cream during the morning medication pass, and that failure to provide those medications constitutes a medication error. Continued interview with the DON revealed that client #5's morning medications should have been administered between 6:01 AM and 7:59 AM, and that administering the medication outside of that window constitutes a medication error.

D. During observations in the home on 12/18/24

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W 368	Continued From page 2 at 8:38 AM, client #6 was observed to enter the medication room with staff and to be administered the following medications: Benztropine 1 mg - 1 tablet, Topiramate 100 mg - 1 tablet, Fanapt 8 mg - 1 tablet, Clobazam 20 mg - 1 tablet, Briviact 100 mg - 1 tablet, Lactulose 30 ml sol - 10gm/15 ml - 30 ml, Nystatin 5 ml liquid. Review on 12/18/24 of client #6's physician's orders dated 10/14/24 indicated that client #6 should receive Vitamin D3 1,000 IU - 1 tablet and Loratadine 10 mg at 8:00 AM, along with the other morning medications. Continued review of the physician's order revealed that the Benztropine, Topiramate, Fanapt, Clobazam, Briviact, Lactulose and Nystatin should be administered at 7:00 AM. Interview on 12/18/24 with the DON confirmed that client #5 should have received the Vitamin D3 1,000 IU - 1 tablet, Loratadine 10 mg during the morning medication pass, and that failure to provide those medications constitutes a medication error. Continued interview with the DON revealed that client #6's Benztropine, Topiramate, Fanapt, Clobazam, Briviact, Lactulose and Nystatin should have been administered between 6:01 AM and 7:59 AM, and that administering the medication outside of that window constitutes a medication error.	W 368		
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	W 436		

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interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to ensure that clients were taught to use and make informed choices about the use of eyeglasses. This affected 5 of 6 adult clients in the home (#1, #2, #3, #5, and #6). The findings are:

A. During observations in the home on 12/17/24 from 4:30 PM until 7:15 PM, client #1 was observed to spend time in his bedroom, move around the group home in a wheelchair which he propelled himself, socialize with staff, participate in medication administration, and watch a movie. Staff asked client #1 one time if he would like to wear his prescribed glasses and client #1 refused. At no time were client #1's glasses visible or offered to him by staff.

During observations in the home on 12/18/24 from 7:00 AM until 9:38 AM, client #1 was observed to spend time in the dining room, participate in medication administration, move around the group home in a wheelchair which he propelled himself, socialize with staff, and board the van to ride to the vocational center. At no time did staff prompt client #1 to wear his glasses. At no time were client #1's glasses visible or offered to him by staff.

Review on 12/17/24 of client #1's Individual Support Program (ISP) dated 8/19/24 revealed client #1 should be wearing his prescribed eyeglasses.

Interview on 12/18/24 with the Program Manager (PM) revealed that client #1 often refuses to wear his eyeglasses, but that staff should prompt client

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W 436	Continued From page 4 #1 on a regular schedule to wear the eyeglasses. When asked where client #1's eyeglasses were, staff were unable to locate them in the home. B. During observations in the home on 12/17/24 from 4:30 PM until 7:15 PM, client #2 was observed to eat a snack, move around the group home in a wheelchair which he propelled himself, socialize with staff, participate in medication administration, help decorate a holiday tree, assist with table setting, eat dinner, and watch a movie. Staff prompted client #2 to put on his hearing aids, which he did. However, at no time was client #2 prompted to wear his prescribed eyeglasses, nor were client #2's glasses visible or offered to him by staff. During observations in the home on 12/18/24 from 7:00 AM until 9:38 AM, client #2 was observed to spend time in the dining room, participate in medication administration, move around the group home in a wheelchair which he propelled himself, socialize with staff, decorate the holiday tree, and board the van to ride to the vocational center. At no time did staff prompt client #2 to wear his glasses. At no time were client #2's glasses visible or offered to him by staff. Review on 12/17/24 of client #2's ISP dated 6/14/24 revealed client #2 should be wearing his prescribed eyeglasses. Interview on 12/18/24 with the PM revealed that staff should prompt client #2 to wear his prescribed eyeglasses. When asked where client #2's eyeglasses were, staff were unable to locate them in the home.	W 436		

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C. During observations in the home on 12/17/24 from 4:30 PM until 7:15 PM, client #3 was observed to eat a snack, help decorate a holiday tree, assist with food preparation, eat dinner, and watch a movie. At no time did staff prompt client #3 to wear his prescribed eyeglasses, nor were client #3's glasses visible or offered to him by staff.

During observations in the home on 12/18/24 from 7:00 AM until 9:38 AM, client #3 was observed to spend time in the dining room, participate in medication administration, move around the group home in a wheelchair which he propelled himself, socialize with staff, decorate the holiday tree, and board the van to ride to the vocational center. At no time did staff prompt client #3 to wear his glasses. At no time were client #3's glasses visible or offered to him by staff.

Review on 12/17/24 of client #3's ISP dated 9/12/24 revealed client #3 should be wearing his prescribed eyeglasses.

Interview on 12/18/24 with the PM revealed that staff should prompt client #3 to wear his prescribed eyeglasses. When asked where client #3's eyeglasses were, staff were able, after much searching, to find a pair of glasses in a file cabinet drawer in a case with client #3's initials on it.

D. During observations in the home on 12/17/24 from 4:30 PM until 7:15 PM, client #5 was observed to eat a snack, move around the group home in a wheelchair which he propelled himself, socialize with staff, assist with meal preparation, set utensils on the dining room table, and eat

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dinner. At no time was client #5 prompted to wear his prescribed eyeglasses, nor were client #5's glasses visible or offered to him by staff.

During observations in the home on 12/18/24 from 7:00 AM until 9:38 AM, client #5 was observed to spend time in the dining room, participate in medication administration, move around the group home in a wheelchair which he propelled himself, socialize with staff, and board the van to ride to the vocational center. At no time did staff prompt client #5 to wear his glasses. At no time were client #5's glasses visible or offered to him by staff.

Review on 12/17/24 of client #5's ISP dated 3/15/24 revealed client #5 should be wearing his prescribed eyeglasses.

Interview on 12/18/24 with the PM revealed that that staff should prompt client #5 to wear his prescribed eyeglasses. When asked where client #5's eyeglasses were, staff were unable to locate them in the home.

E. During observations in the home on 12/17/24 from 4:30 PM until 7:15 PM, client #6 was observed to eat a snack, walk around the group home, socialize with staff, help prepare juice, help decorate a holiday tree, listen to music and watch videos on a tablet, assist staff to put his laundry in the wash, eat dinner, and watch a movie. At no time was client #6 prompted to wear his prescribed eyeglasses, nor were client #6's glasses visible or offered to him by staff.

During observations in the home on 12/18/24 from 7:00 AM until 9:38 AM, client #6 was observed to spend time in his bedroom,

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W 436	Continued From page 7 participate in medication administration, and board the van to ride to the vocational center. At no time did staff prompt client #6 to wear his glasses. At no time were client #6's glasses visible or offered to him by staff. Review on 12/17/24 of client #6's ISP dated 7/26/24 revealed client #6 should be wearing his prescribed eyeglasses. Interview on 12/18/24 with the PM revealed that that staff should prompt client #6 to wear his prescribed eyeglasses. When asked where client #6's eyeglasses were, staff were unable to locate them in the home.	W 436		