DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROV									
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391		
	TEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         PLAN OF CORRECTION       IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED			
		34G262	B. WING			12/	18/2024		
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE				
VOCA-W	OODLAND				123 WOODLAND DR RUTHERFORDTON, NC 28139				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
TAG W 368	DRUG ADMINISTR CFR(s): 483.460(k) The system for drug that all drugs are ad the physician's orde This STANDARD is Based on observati interview, the facilit were administered orders. This affecte observed during me finding is: A. During observati at 5:10 PM, client # medication room wi administered Rispe Review on 12/18/24 orders revealed tha administered at 4:0 Interview on 12/18/4 (DON) confirmed th been administered PM, and that admir outside of that wind error. B. During observati at 5:10 PM, client # medication room wi administered Lanso	ATION (1) g administration must assure dministered in compliance with ers. s not met as evidenced by: tion, record review and y failed to ensure medications in accordance with physician's ed 4 clients (#2, #4, #5 and #6) edication administration. The ons in the home on 12/17/24 2 was observed to enter the ith staff and to be ridone 1 mg - 1 tablet. 4 of client #6's physician's t the Risperidone should be 0 PM. 24 with the Director of Nursing he Risperidone should have between 3:01 PM and 4:59 histering the medication low constitutes a medication ons in the home on 12/17/24 4 was observed to enter the	TAG W 3		DEFICIENCY)	RIATE	DATE		
		t the Lansoprazole should be							
		24 with the DON confirmed			TITLE				
LABORATORY	INTECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		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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		34G262	B. WING			12/ <sup>,</sup>	18/2024
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
VOCA-WOODLAND					23 WOODLAND DR UTHERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 368	between 3:01 PM a administering the m window constitutes C. During observati at 9:07 AM, client # medication room wi administered the fo Famotidine 20 mg - tablet, Olmesa Med 5,000 IU - 1 capsule spray. Client swallo with water at 9:13 A additional medication boarding the van at Review on 12/18/24 orders dated 10/14/ should have receive 100000 and Nystati morning medication physician's order re medications listed a at 7:00 AM. Interview on 12/18/2 that client #5 should Budesinide, the Kla during the morning failure to provide th medication error. C DON revealed that medications should between 6:01 AM a administering the m window constitutes	hould have been administered and 4:59 PM, and that hedication outside of that a medication error. ions in the home on 12/18/24 5 was observed to enter the ith staff and to be illowing medications: - 1 tablet, Cetirizine 10 mg - 1 dex 5 mg - 1 tablet, Vitamin D3 e, Fluticasone 50 mg nasal wed all of the oral medications AM and did not receive any ons or treatments prior to t 9:35 AM. 4 of client #5's physician's /24 indicated that client #5 ed Budesinide, Klayesta POW in cream along with the other ns. Continued review of the evealed that all of client #5's above should be administered 24 with the DON confirmed d have received the systa and the Nystatin cream medication pass, and that ose medications constitutes a continued interview with the client #5's morning I have been administered and 7:59 AM, and that nedication outside of that a medication error.	W 3	68			
	D. During observati	ions in the home on 12/18/24					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	34G262 B. WING					12/ <sup>,</sup>	18/2024
NAME OF P	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-W	OODLAND				23 WOODLAND DR UTHERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
W 368	medication room wi administered the fo Benztropine 1 mg - 1 tablet, Fanapt 8 m - 1 tablet, Fanapt 8 m - 1 tablet, Briviact 1 ml sol - 10gm/15 m Review on 12/18/24 orders dated 10/14/ should receive Vitat Loratadine 10 mg a other morning medic the physician's orde Benztropine, Topira Briviact, Lactulose a administered at 7:0 Interview on 12/18/2 that client #5 should D3 1,000 IU - 1 tabl the morning medica provide those medic medication error. C DON revealed that Topiramate, Fanapt Lactulose and Nysta administered betwee that administering t window constitutes SPACE AND EQUIF CFR(s): 483.470(g)	<ul> <li><sup>6</sup>6 was observed to enter the ith staff and to be illowing medications:</li> <li>1 tablet, Topiramate 100 mg - ng - 1 tablet, Clobazam 20 mg 00 mg - 1 tablet, Lactulose 30 nl - 30 ml, Nystatin 5 ml liquid.</li> <li><sup>4</sup> of client #6's physician's /24 indicated that client #6 min D3 1,000 IU - 1 tablet and at 8:00 AM, along with the ications. Continued review of er revealed that the amate, Fanapt, Clobazam, and Nystatin should be 0 AM.</li> <li><sup>24</sup> with the DON confirmed d have received the Vitamin let, Loratadine 10 mg during ation pass, and that failure to cations constitutes a continued interview with the client #6's Benztropine, t, Clobazam, Briviact, atin should have been een 6:01 AM and 7:59 AM, and he medication error.</li> <li>PMENT</li> </ul>	W 3				
	choices about the u	use of dentures, eyeglasses, communications aids, braces,					

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		AND HUMAN SERVICES				FORM	12/23/2024 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		l` í			(X3) DATE SURVEY COMPLETED		
34G262			B. WING			12/	18/2024
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
VOCA-W	OODLAND				23 WOODLAND DR RUTHERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
W 436	interdisciplinary tea This STANDARD is Based on observati interviews, the facil were taught to use about the use of ey adult clients in the f The findings are: A. During observati from 4:30 PM until observed to spend around the group h propelled himself, s in medication admin Staff asked client # wear his prescribed refused. At no time visible or offered to During observations from 7:00 AM until observed to spend participate in medic around the group h propelled himself, s the van to ride to th time did staff promp glasses. At no time visible or offered to Review on 12/17/24 Support Program (I client #1 should be eyeglasses. Interview on 12/18/ (PM) revealed that	m as needed by the client. s not met as evidenced by: tions, record reviews and ity failed to ensure that clients and make informed choices eglasses. This affected 5 of 6 nome (#1, #2, #3, #5, and #6). ons in the home on 12/17/24 7:15 PM, client #1 was time in his bedroom, move ome in a wheelchair which he socialize with staff, participate nistration, and watch a movie. 1 one time if he would like to d glasses and client #1 were client #1's glasses him by staff. s in the home on 12/18/24 9:38 AM, client #1 was time in the dining room, cation administration, move ome in a wheelchair which he socialize with staff, and board e vocational center. At no ot client #1 to wear his were client #1's glasses	W 2	136			

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		AND HUMAN SERVICES				FORM	12/23/2024 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		` ´		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G262	B. WING			12/	18/2024
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-W	OODLAND				23 WOODLAND DR UTHERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
W 436	<ul> <li>#1 on a regular sch When asked where staff were unable to</li> <li>B. During observation from 4:30 PM until 10 observed to eat a sind home in a wheelchar socialize with staff, administration, help assist with table set movie. Staff prompt hearing aids, which was client #2 prompt eyeglasses, nor we offered to him by state During observations from 7:00 AM until 9 observed to spend 10 participate in medic around the group he propelled himself, sind the holiday tree, and vocational center. A client #2 to wear his client #2's glasses vistaff.</li> <li>Review on 12/17/24 6/14/24 revealed cliin prescribed eyeglass</li> </ul>	edule to wear the eyeglasses. e client #1's eyeglasses were, o locate them in the home. ons in the home on 12/17/24 7:15 PM, client #2 was nack, move around the group air which he propelled himself, participate in medication o decorate a holiday tree, tting, eat dinner, and watch a ted client #2 to put on his he did. However, at no time oted to wear his prescribed re client #2's glasses visible or aff. s in the home on 12/18/24 9:38 AM, client #2 was time in the dining room, eation administration, move ome in a wheelchair which he socialize with staff, decorate d board the van to ride to the At no time did staff prompt s glasses. At no time were visible or offered to him by	W 4	36			

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		AND HUMAN SERVICES				FORM	12/23/2024 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ì í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G262	B. WING			12/	18/2024
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
VOCA-WOODLAND					23 WOODLAND DR RUTHERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
W 436	C. During observati from 4:30 PM until observed to eat a s tree, assist with foo watch a movie. At r #3 to wear his press client #3's glasses of staff. During observations from 7:00 AM until observed to spend participate in medic around the group he propelled himself, s the holiday tree, and vocational center. A client #3 to wear his client #3's glasses of staff. Review on 12/17/24 9/12/24 revealed cli prescribed eyeglass Interview on 12/18/2 staff should prompt prescribed eyeglass #3's eyeglasses we searching, to find a cabinet drawer in a it. D. During observati from 4:30 PM until observed to eat a s home in a wheelcha socialize with staff,	ons in the home on 12/17/24 7:15 PM, client #3 was nack, help decorate a holiday of preparation, eat dinner, and no time did staff prompt client cribed eyeglasses, nor were visible or offered to him by s in the home on 12/18/24 9:38 AM, client #3 was time in the dining room, cation administration, move ome in a wheelchair which he socialize with staff, decorate d board the van to ride to the At no time did staff prompt s glasses. At no time were visible or offered to him by	₩ 2	136			

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		AND HUMAN SERVICES				FORM	: 12/23/2024 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		ì í			(X3) DAT	(X3) DATE SURVEY COMPLETED	
		34G262	B. WING	i		12/	18/2024
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-W	OODLAND				123 WOODLAND DR RUTHERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 436	dinner. At no time v his prescribed eyeg glasses visible or of During observations from 7:00 AM until observed to spend participate in medic around the group h propelled himself, s the van to ride to th time did staff promy glasses. At no time visible or offered to Review on 12/17/24 3/15/24 revealed cl prescribed eyeglass Interview on 12/18/ that staff should pro prescribed eyeglass #5's eyeglasses we them in the home. E. During observati from 4:30 PM until observed to eat a s home, socialize with decorate a holiday videos on a tablet, a the wash, eat dinner time was client #6 p prescribed eyeglass glasses visible or of During observations from 7:00 AM until	vas client #5 prompted to wear glasses, nor were client #5's ffered to him by staff. s in the home on 12/18/24 9:38 AM, client #5 was time in the dining room, cation administration, move ome in a wheelchair which he socialize with staff, and board e vocational center. At no ot client #5 to wear his were client #5's glasses him by staff. 4 of client #5's ISP dated ient #5 should be wearing his	W 4	436			

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		AND HUMAN SERVICES				FORM	12/23/2024 APPROVED 0938-0391
		. ,		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
34G262		B. WING			12/	18/2024	
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-W	OODLAND				23 WOODLAND DR UTHERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 436	participate in medic board the van to ric no time did staff pro- glasses. At no time visible or offered to Review on 12/17/24 7/26/24 revealed cl prescribed eyeglas Interview on 12/18/ that staff should pro- prescribed eyeglas	2 cation administration, and le to the vocational center. At compt client #6 to wear his were client #6's glasses him by staff. 4 of client #6's ISP dated ient #6 should be wearing his	W 4	136			

Facility ID: 942795

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