

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

PRINTED: 06/02/2025
FORM APPROVED
OMB NO. 0938-0391

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 05/28/2025
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 5/28/25 for intake #NC00230168. The allegation was substantiated and deficiencies were 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, record review and interviews, the facility failed to provide sufficient direct care staff to manage and supervise 5 of 5 clients in the home. The finding is:</p> <p>Observation in the group home on 5/28/25 at 10:10 AM revealed the Home Manager (HM) to be the only staff present with five clients. Continued observations revealed two clients sitting in the living room, one client sitting in the kitchen, one client sitting in the dining room, and one client in their bedroom. Further observations revealed the Quality Assurance (QA) Manager to arrive at 10:25 AM.</p> <p>Review of the facility staff schedule on 5/28/25 revealed no first shift staff to be scheduled from 5/27/25 - 6/2/25.</p> <p>Interview with the HM on 5/28/25 revealed the facility is short staffed. Continued interview with the HM revealed they arrived at the group home around 7:00 AM, at which time the third shift staff</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.

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W 186	Continued From page 1 left. Further interview with the HM revealed two staff are scheduled to work second shift. Interview with the QA Manager on 5/28/25 revealed they were unaware the facility was short staffed on first shift. Continued interview with the QA Manager revealed at least two staff should always be present on first and second shift. Further interview with the QA Manager revealed the HM should have notified their supervisor that the facility was short staffed.	W 186			