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 _____	C 09/19/2025

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 000	INITIAL COMMENTS A complaint survey was completed from 9/18/25-9/19/25 for intake #NC00233307. The intake was substantiated and deficiencies were cited. A Condition of Participation (CoP) was cited for Health Care Services.	W 000		
W 318	HEALTH CARE SERVICES CFR(s): 483.460 The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: The facility failed to: provide services in accordance with client's needs (W331); ensure staff were sufficiently trained on documenting medication errors (W340); ensure drugs were administered in compliance with physicians orders (W368); ensure drug administration errors were documented (W375); and report all drug administration errors to the physician (W376). The cumulative effects of these systemic practices resulted in the facility's failure to provide mandated healthcare services.	W 318	All direct care and nursing staff received re-training on identifying and documenting medication errors. A sign-in sheet and post-test verified completion and comprehension. Nursing staff will provide training to all staff on the Rights of medication administration, including how and when to document medication errors and how to properly report all medication errors to the Physician and upper management, with compliance training on administering drugs per the Physicians Order. The facility will ensure that all staff are trained on Medication Oversight and Medication Exception Reporting. To prevent further occurrence: The DON will train Nursing staff on all required monthly monitoring, including med closet audits, medication management, medication observations, Controlled substance logs, and review of all Physician Orders. The facility will provide staff training on monthly core team meetings to discuss any medication changes and or concerns. Completion Date:11/3/2025	11/3/2025
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record reviews and interviews, nursing services failed to meet the needs of 4 of 6 sampled clients (#1, #2, #3 and #4) by failing to ensure prescribed medications were available in the home for medication administration. The	W 331	All direct care and nursing staff received re-training on identifying and documenting medication errors. A sign-in sheet and post-test verified completion and comprehension. Nursing staff will provide training to all staff on the Rights of medication administration, including how and when to document medication errors and how to properly report all medication errors to the Physician and upper management, with compliance training on administering drugs per the Physicians Order. The facility will ensure that all staff are trained on Medication Oversight and Medication Exception Reporting. To prevent further occurrence: The DON will train Nursing staff on all required monthly monitoring, including med closet audits, medication management, medication observations, Controlled substance logs, and review of all Physician Orders. The facility will provide staff training on monthly core team meetings to discuss any medication changes and or concerns. Completion Date:11/3/20	11/3/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nichol Bumpas — TITLE: Exec Dir. — (X6) DATE: 10/1/25

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 331	Continued From page 1 findings are: A. Review of the medication administration records (MAR) for client #1 from 6/25 through 9/25 revealed the following missed dosages of medications: - Aripiprazole 30mg, 7/27 - 7/31/25 - Trazodone 100mg , 7/7/25 and 7/31/25; - Clonidine 0.1mg, 8/1/25 - 8/25/25 - Oxcarbazepine - 300 mg on 8/7/25 - 8/26/25 - Trazodone 100mg on 8/9/25 - 8/24/25 - Fluoxetine Cap 20mg on 8/9/25 - 8/25/25, - Aripiprazole 30mg on 9/8/25 - Clonidine Tab 0.1mg on 9/6/25 8:00PM and 9/8/25 7AM - Divalproex 7AM on 9/8/25 - Fluoxetine Cap 40mg on 9/8/25 - Oxcarbazepine 600mg on 9/1/25 1 tab at 7AM, and 8PM, 9/6/25 1 tab at 8PM B. Review of the MAR for client #2 from 6/25 through 9/25 revealed the following missed dosages of medications: - Chlorhexidine Gluconate 0.12% solution on 6/3/25 - 6/27/25 - Melatonin chew 5mg on 6/18/25, 6/19/25, 6/20/25 - Cobenfy 100-200mg on 6/28/25, 6/29/25, 6/30/25, - Cobenfy CAP 100-20mg on 7/1/25, 7/2/25, 7/27/25, 7/28/25, 7/30/25 and 7/31/25 - Biotene Liquid Dry Mouth on 7/24/25. - Cobenfy Cap 100mg - 20mg on 8/1/25- 8/21/25, 8/23/25, 8/24/25, 8/31/25 - Cetirizine Chew 10mg on 9/13/25- 9/17/25 C. Review of the MAR for client #3 from 6/25 through 9/25 revealed the following missed dosages of medications:	W 331	All direct care and nursing staff received re-training on identifying and documenting medication errors. A sign-in sheet and post-test verified completion and comprehension. Nursing staff will provide training to all staff on the Rights of medication administration, including how and when to document medication errors and how to properly report all medication errors to the Physician and upper management, with compliance training on administering drugs per the Physicians Order. The facility will ensure that all staff are trained on Medication Oversight and Medication Exception Reporting. To prevent further occurrence: The DON will train Nursing staff on all required monthly monitoring, including med closet audits, medication management, medication observations, Controlled substance logs, and review of all Physician Orders. The facility will provide staff training on monthly core team meetings to discuss any medication changes and or concerns. Completion Date:11/3/2025	113/2025

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W 331	Continued From page 2 - Levetiraceta Tab 500 mg on 6/2/25- 6/3/25 - Lansoprazole cap 30mg on 7/1/25, 7/14/25, 7/16/25, 7/17/25, 7/18/25, 7/21/25, 7/22/25, 7/23/25, 7/24/25, 7/26/25, 7/27/25, 7/28/25, and 7/29/25 - Aripiprazole Tab 2mg on 7/1/25 - GNP Melatonin 3mg tab on 7/28/25 - Aripiprazole Tab 5mg on 8/2/25 - 8/16/25, 8/18/25 - 8/24/25, 8/29/25 - 8/31/2 - Aripiprazole Tab 5mg on 9/5/25, 9/8/25, 9/10/25, 9/14/25 D. Review of the MAR for client #4 from 6/25 through 9/25 revealed the following missed dosages of medications: -Chlorpromax tab 25mg on 6/1/25, 6/13/25, 6/16/25 - 6/30/25 - Gabapentin cap 100mg on 6/25/25, 6/26/25 - Oxcarbazepine 300mg tab on 6/25/25 - Divalproex 250mg tab on 6/25/25- 6/30/25 - Clonazepam 1mg tab on 7/1/25 - 7/6/25 - Chlorpromaz 25mg tab on 7/1/25 - 7/25/25 - Gabapentin 100 mg cap on 7/1/25, 7/31/25 - Divalproex 250mg on 7/1/25 - Quetiapine 300mg tab on 7/30/25, 7/31/25 - Gabapentin 100mg cap on 8/1/25 -8/5/25, 8/7/25, 8/8/25, 8/19/25, 8/20/25 - Quetiapine 300mg tab on 8/1/25- 8/10/25,8/12/25 - Clonazepam 1mg tab on 8/3/25 - 8/5/25, 8/15/25 -8/21/25, 8/25/25, 8/31/25 - Sodium Chloride 1gm tab on 8/10/25 - Clonazepam on 9/1/25 and 9/2/25. Interview on 9/19/25 with facility staff revealed the missing medications were reported to the previous site supervisor (SS). Continued interview with facility staff revealed they utilize a nursing triage service on a regular basis.	W 331	All direct care and nursing staff received re-training on identifying and documenting medication errors. A sign-in sheet and post-test verified completion and comprehension. Nursing staff will provide training to all staff on the Rights of medication administration, including how and when to document medication errors and how to properly report all medication errors to the Physician and upper management, with compliance training on administering drugs per the Physicians Order. The facility will ensure that all staff are trained on Medication Oversight and Medication Exception Reporting. To prevent further occurrence: The DON will train Nursing staff on all required monthly monitoring, including med closet audits, medication management, medication observations, Controlled substance logs, and review of all Physician Orders. The facility will provide staff training on monthly core team meetings to discuss any medication changes and or concerns. Completion Date:11/3/2025	11/3/25

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W 331	Continued From page 3 Interview with the director of nursing (DON) on 9/19/25 revealed the physician's orders dated 5/25 are the current orders. Further interview with the DON revealed that the responsibility of monitoring and ordering medications, as well as medicine closet checks, are primarily the responsibility of the SS assigned to the home. Continued interview with the DON revealed she was not made aware of medications not being available in the homes for administration for clients #1, #2, #3 and #4 during the months of 6/26 - 8/25 until the area supervisor (AS) stepped into the role of site supervisor (SS) for the facility in late 8/25.	W 331	All direct care and nursing staff received re-training on identifying and documenting medication errors. A sign-in sheet and post-test verified completion and comprehension. Nursing staff will provide training to all staff on the Rights of medication administration, including how and when to document medication errors and how to properly report all medication errors to the Physician and upper management, with compliance training on administering drugs per the Physicians Order. The facility will ensure that all staff are trained on Medication Oversight and Medication Exception Reporting. To prevent further occurrence: The DON will train Nursing staff on all required monthly monitoring, including med closet audits, medication management, medication observations, Controlled substance logs, and review of all Physician Orders. The facility will provide staff training on monthly core team meetings to discuss any medication changes and or concerns. Completion Date:11/3/2025	11/3/25
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure staff were sufficiently trained in properly documenting medication errors for 4 of 6 sampled clients (#1, #2, #3 and #4). The findings are: A. Review of the medication administration records (MAR) on 9/19/25 for client #1 from 6/25 through 9/25 revealed the following missed dosages of medications: - Aripiprazole 30mg, 7/27 - 7/31/25 - Trazodone 100mg , 7/7/25 and 7/31/25 - Clonidine 0.1mg, 8/1/25 - 8/25/25	W 340	All direct care and nursing staff received re-training on identifying and documenting medication errors. A sign-in sheet and post-test verified completion and comprehension. Nursing staff will provide training to all staff on the Rights of medication administration, including how and when to document medication errors and how to properly report all medication errors to the Physician and upper management, with compliance training on administering drugs per the Physicians Order. The facility will ensure that all staff are trained on Medication Oversight and Medication Exception Reporting. To prevent further occurrence: The DON will train Nursing staff on all required monthly monitoring, including med closet audits, medication management, medication observations, Controlled substance logs, and review of all Physician Orders. The facility will provide staff training on monthly core team meetings to discuss any medication changes and or concerns. Completion Date:11/3/2025	11/3/25

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W 340	Continued From page 4 - Oxcarbazepine - 300 mg on 8/7/25 - 8/26/25 - Trazodone 100mg on 8/9/25 - 8/24/25 - Fluoxetine Cap 20mg on 8/9/25 - 8/25/25 - Aripiprazole 30mg on 9/8/25 - Clonidine Tab 0.1mg on 9/6/25 8:00PM and 9/8/25 7AM - Divalproex 7AM on 9/8/25 - Fluoxetine Cap 40mg on 9/8/25 - Oxcarbazepine 600mg on 9/1/25 1 tab at 7AM, and 8PM, 9/6/25 1 tab at 8PM B. Review of the MAR for client #2 from 6/25 through 9/25 revealed the following missed dosages of medications: - Chlorhexidine Gluconate 0.12% solution on 6/3/25 - 6/27/25 - Melatonin chew 5mg on 6/18/25, 6/19/25, 6/20/25 - Cobenfy 100-200mg on 6/28/25, 6/29/25, 6/30/25, - Cobenfy CAP 100-20mg on 7/1/25, 7/2/25, 7/27/25, 7/28/25, 7/30/25 and 7/31/25 - Biotene Liquid Dry Mouth on 7/24/25. - Cobenfy Cap 100mg - 20mg on 8/1/25- 8/21/25, 8/23/25, 8/24/25, 8/31/25 - Cetirizine Chew 10mg on 9/13/25- 9/17/25 C. Review of the MAR for client #3 from 6/25 through 9/25 revealed the following missed dosages of medications: - Levetiraceta Tab 500 mg on 6/2/25- 6/3/25 - Lansoprazole cap 30mg on 7/1/25, 7/14/25, 7/16/25, 7/17/25, 7/18/25, 7/21/25, 7/22/25, 7/23/25, 7/24/25, 7/26/25, 7/27/25, 7/28/25, and 7/29/25 - Aripiprazole Tab 2mg on 7/1/25 - GNP Melatonin 3mg tab on 7/28/25 - Aripiprazole Tab 5mg on 8/2/25 - 8/16/25, 8/18/25 - 8/24/25, 8/29/25 - 8/31/2	W 340	All direct care and nursing staff received re-training on identifying and documenting medication errors. A sign-in sheet and post-test verified completion and comprehension. Nursing staff will provide training to all staff on the Rights of medication administration, including how and when to document medication errors and how to properly report all medication errors to the Physician and upper management, with compliance training on administering drugs per the Physicians Order. The facility will ensure that all staff are trained on Medication Oversight and Medication Exception Reporting. To prevent further occurrence: The DON will train Nursing staff on all required monthly monitoring, including med closet audits, medication management, medication observations, Controlled substance logs, and review of all Physician Orders. The facility will provide staff training on monthly core team meetings to discuss any medication changes and or concerns. Completion Date:11/3/2025	

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W 340	Continued From page 5 - Aripiprazole Tab 5mg on 9/5/25, 9/8/25, 9/10/25, 9/14/25. D. Review of the MAR for client #4 from 6/25 through 9/25 revealed the following missed dosages of medications: -Chlorpromax tab 25mg on 6/1/25, 6/13/25, 6/16/25 - 6/30/25 - Gabapentin cap 100mg on 6/25/25, 6/26/25 - Oxcarbazepine 300mg tab on 6/25/25 - Divalproex 250mg tab on 6/25/25- 6/30/25 - Clonazepam 1mg tab on 7/1/25 - 7/6/25 - Chlorpromaz 25mg tab on 7/1/25 - 7/25/25 - Gabapentin 100 mg cap on 7/1/25, 7/31/25 - Divalproex 250mg on 7/1/25 - Quetiapine 300mg tab on 7/30/25, 7/31/25 - Gabapentin 100mg cap on 8/1/25 -8/5/25, 8/7/25, 8/8/25, 8/19/25, 8/20/25 - Quetiapine 300mg tab on 8/1/25-8/10/25,8/12/25 - Clonazepam 1mg tab on 8/3/25 - 8/5/25, 8/15/25 -8/21/25, 8/25/25, 8/31/25 - Sodium Chloride 1gm tab on 8/10/25 - Clonazepam on 9/1/25 and 9/2/25. Subsequent review of records for clients #1, #2, #3 and #4 revealed Nursing did not have evidence of following up with staff. Further review revealed Nursing did not have evidence of any in-service training with staff to ensure communication regarding missed dosages of medications not being available for administration to the client which resulted in medication errors. Continued review did not reveal any med errors documented from 6/25 - 9/25 by staff. Interview on 9/19/25 with the director of nursing (DON) revealed that medications that have not been administered as ordered should be	W 340	All direct care and nursing staff received re-training on identifying and documenting medication errors. A sign-in sheet and post-test verified completion and comprehension. Nursing staff will provide training to all staff on the Rights of medication administration, including how and when to document medication errors and how to properly report all medication errors to the Physician and upper management, with compliance training on administering drugs per the Physicians Order. The facility will ensure that all staff are trained on Medication Oversight and Medication Exception Reporting. To prevent further occurrence: The DON will train Nursing staff on all required monthly monitoring, including med closet audits, medication management, medication observations, Controlled substance logs, and review of all Physician Orders. The facility will provide staff training on monthly core team meetings to discuss any medication changes and or concerns. Completion Date:11/3/2025	

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W 340	Continued From page 6 documented as a med error by staff. Continued interview with the DON revealed she had not been made aware of any med errors for clients #1, # 2, #3, and #4.	W 340		
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 record reviews and interviews, the system for drug administration failed to assure all drugs were administered in compliance with physician orders for 4 of 6 sampled clients (#1, #2, #3 and #4). The findings are: A. Record review on 9/19/25 for client #1 revealed a physician order (PO) dated 8/26/25. Further review of the PO revealed the following medications to be administered; Aripiprazole Tab 30mg at 7AM, Clonidine Tab 0.1mg twice a day at 7AM and 9PM, Divalproex Tab 500MG ER 2 tablets at 7AM, Fluoxetine Cap 40mg at 7AM, Oxcarbazepine 300 mg- Tab, 3 tablets (900mg) at 7AM and 8PM, Polyeth Glyc Pow 3350 mix 17mg (one capful) in 8 ounces of liquid at 7AM, Trazodone Tab 100mg take 2 tablets (200mg) at bedtime 8PM and PRN medications. Continued review of the medication administration records (MAR) for client #1 from 6/25 through 9/25 revealed the following missed dosages of medications: - Aripiprazole 30mg, 7/27 - 7/31/25 - Trazodone 100mg , 7/7/25 and 7/31/25 - Clonidine 0.1mg, 8/1/25 - 8/25/25 - Oxcarbazepine - 300 mg on 8/7/25 - 8/26/25	W 368	All direct care and nursing staff received re-training on identifying and documenting medication errors. A sign-in sheet and post-test verified completion and comprehension. Nursing staff will provide training to all staff on the Rights of medication administration, including how and when to document medication errors and how to properly report all medication errors to the Physician and upper management, with compliance training on administering drugs per the Physicians Order. The facility will ensure that all staff are trained on Medication Oversight and Medication Exception Reporting. To prevent further occurrence: The DON will train Nursing staff on all required monthly monitoring, including med closet audits, medication management, medication observations, Controlled substance logs, and review of all Physician Orders. The facility will provide staff training on monthly core team meetings to discuss any medication changes and or concerns. Completion Date:11/3/2025	

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W 368	Continued From page 7 - Trazodone 100mg on 8/9/25 - 8/24/25 - Fluoxetine Cap 20mg on 8/9/25 - 8/25/25 - Aripiprazole 30mg on 9/8/25 - Clonidine Tab 0.1mg on 9/6/25 8:00PM and 9/8/25 7AM - Divalproex 7AM on 9/8/25 - Fluoxetine Cap 40mg on 9/8/25 - Oxcarbazepine 600mg on 9/1/25 1 tab at 7AM, and 8PM, 9/6/25 1 tab at 8PM B. Record review for client #2 revealed a PO dated 5/6/25. Further review of the PO revealed the following medications to be administered; Benztropine Tab 1 mg at 7AM and 8PM, Biotene Liquid Dry Mouth 15ml at 7AM, Briviact Tab 100mg at 7AM and 8PM, Clobazam Tab 10mg 3 tabs (30MG) at 8PM, Clobazam Tab 8mg at 7AM, Cobenfy CAP 100-200mg 1 capsule at 7AM and 8PM "reorder when needed- not a cycle fill med", Fanapt Tab 8mg at 7AM and 8PM, Fycompa Tab 12mg at 8PM, GNP Vitamin D3 1000 unit at 20PM, Lactulose Solution 10GM/15 take 30ML at 7AM and 8PM, Loratadine Tab 10mg at 7AM, Melatonin Cap 10mg at 9PM, Melatonin 5mg (chew 2 tablets 10mg) at 9PM, Olanzapine Tab 5mg (dissolve one tab) at 9PM, Topiramate 100mg at 7AM and 8PM, PRN medications. Continued review of the MAR for client #2 from 6/25 through 9/25 revealed the following missed dosages of medications: - Chlorhexidine Gluconate 0.12% solution on 6/3/25 - 6/27/25 - Melatonin chew 5mg on 6/18/25, 6/19/25, 6/20/25 - Cobenfy 100-200mg on 6/28/25, 6/29/25, 6/30/25, - Cobenfy CAP 100-20mg on 7/1/25, 7/2/25, 7/27/25, 7/28/25, 7/30/25 and 7/31/25	W 368	All direct care and nursing staff received re-training on identifying and documenting medication errors. A sign-in sheet and post-test verified completion and comprehension. Nursing staff will provide training to all staff on the Rights of medication administration, including how and when to document medication errors and how to properly report all medication errors to the Physician and upper management, with compliance training on administering drugs per the Physicians Order. The facility will ensure that all staff are trained on Medication Oversight and Medication Exception Reporting. To prevent further occurrence: The DON will train Nursing staff on all required monthly monitoring, including med closet audits, medication management, medication observations, Controlled substance logs, and review of all Physician Orders. The facility will provide staff training on monthly core team meetings to discuss any medication changes and or concerns. Completion Date:11/3/2025	

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W 368	Continued From page 8 - Biotene Liquid Dry Mouth on 7/24/25. - Cobenfy Cap 100mg - 20mg on 8/1/25- 8/21/25, 8/23/25, 8/24/25, 8/31/25 - Cetirizine Chew 10mg on 9/13/25- 9/17/25 C. Record review for client #3 revealed a PO dated 5/6/25. Further review of the PO revealed the following medications to be administered; Aripiprazole Tab 2mg at 7AM, Budesonide Sus 0.5mg inhaler 2ml at 7AM, Clobazam Tab 20mg at 7AM and 8PM, Divalproex Tab 500mg at 7AM and 8PM, Ferrous Sulf Tab 324 mg at 7AM, Folic Acid Tab 1mg at 7AM, GNP Melatonin 3mg Tab at 8PM, Lamotrigine Tab 100mg at 7AM and 8PM, Lansoprazole 30mg at 7AM and 4PM, Levetiraceta 1000mg Tab at 7AM and 8PM, and PRN medications. Continued review of the MAR for client #3 from 6/25 through 9/25 revealed the following missed dosages of medications: - Levetiraceta Tab 500 mg on 6/2/25- 6/3/25 - Lansoprazole cap 30mg on 7/1/25, 7/14/25, 7/16/25, 7/17/25, 7/18/25, 7/21/25, 7/22/25, 7/23/25, 7/24/25, 7/26/25, 7/27/25, 7/28/25, and 7/29/25 - Aripiprazole Tab 2mg on 7/1/25 - GNP Melatonin 3mg tab on 7/28/25 - Aripiprazole Tab 5mg on 8/2/25 - 8/16/25, 8/18/25 - 8/24/25, 8/29/25 - 8/31/2 - Aripiprazole Tab 5mg on 9/5/25, 9/8/25, 9/10/25, 9/14/25. D. Record review of record for client #4 revealed a PO dated 5/6/25. Further review of the PO revealed the following medications to be administered; Chest Congestion 400 mg Tab 1 tab at 7AM, Chlorpromaz 25mg Tab 1 tablet at 12PM and 8PM, Citalopram 20mg Tab 1 tablet at 8PM,	W 368	All direct care and nursing staff received re-training on identifying and documenting medication errors. A sign-in sheet and post-test verified completion and comprehension. Nursing staff will provide training to all staff on the Rights of medication administration, including how and when to document medication errors and how to properly report all medication errors to the Physician and upper management, with compliance training on administering drugs per the Physicians Order. The facility will ensure that all staff are trained on Medication Oversight and Medication Exception Reporting. To prevent further occurrence: The DON will train Nursing staff on all required monthly monitoring, including med closet audits, medication management, medication observations, Controlled substance logs, and review of all Physician Orders. The facility will provide staff training on monthly core team meetings to discuss any medication changes and or concerns. Completion Date:11/3/2025	

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 _____	C 09/19/2025

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 368	Continued From page 9 Clonazepam 1mg Tab 1 tablet at 7AM, Divalproex 250mg Tab (3 tablets) at 8PM, Fish oil 1000mg (2 capsules 2000mg) at 7AM, Fluocin Acet Oil 0.01% on scalp on Mondays and Thursdays 4PM to 8PM, Gabapentin 100mg 1 capsule at 7AM, 4PM and 8PM, Loratadine 10 Tab 1 tablet at 7AM, Omeprazole 40mg Cap 1 capsule at 7AM, Oxcarbazepine-300mg 1 tablet at 7AM and 8PM, Oxybutynin 5mg Tab 1 tablet at 7AM, 4PM, and 8PM, Poleth Glyc Pow 3350 17gm at 7AM, Pot Chloride Tab 10MEQ ER 1 tablet at 7AM, Quetiapine Tab 300mg 1 tablet at 8PM, Vitamin D 50mcg 1 capsule at 7AM, and PRN medications. Continued review of the MAR for client #4 from 6/25 through 9/25 revealed the following missed dosages of medications: - Chlorpromax tab 25mg on 6/1/25, 6/13/25, 6/16/25 - 6/30/25 - Gabapentin cap 100mg on 6/25/25, 6/26/25 - Oxcarbazepine 300mg tab on 6/25/25 - Divalproex 250mg tab on 6/25/25- 6/30/25 - Clonazepam 1mg tab on 7/1/25 - 7/6/25 - Chlorpromaz 25mg tab on 7/1/25 - 7/25/25 - Gabapentin 100 mg cap on 7/1/25, 7/31/25 - Divalproex 250mg on 7/1/25 - Quetiapine 300mg tab on 7/30/25, 7/31/25 - Gabapentin 100mg cap on 8/1/25 -8/5/25, 8/7/25, 8/8/25, 8/19/25, 8/20/25 - Quetiapine 300mg tab on 8/1/25-8/10/25,8/12/25 - Clonazepam 1mg tab on 8/3/25 - 8/5/25, 8/15/25 -8/21/25, 8/25/25, 8/31/25 - Sodium Chloride 1gm tab on 8/10/25 - Clonazepam on 9/1/25 and 9/2/25. Interview on 9/19/25 with the director of nursing (DON) revealed the current physician's order are the most recent orders. Continued interview with	W 368	All direct care and nursing staff received re-training on identifying and documenting medication errors. A sign-in sheet and post-test verified completion and comprehension. Nursing staff will provide training to all staff on the Rights of medication administration, including how and when to document medication errors and how to properly report all medication errors to the Physician and upper management, with compliance training on administering drugs per the Physicians Order. The facility will ensure that all staff are trained on Medication Oversight and Medication Exception Reporting. To prevent further occurrence: The DON will train Nursing staff on all required monthly monitoring, including med closet audits, medication management, medication observations, Controlled substance logs, and review of all Physician Orders. The facility will provide staff training on monthly core team meetings to discuss any medication changes and or concerns. Completion Date:11/3/2025	

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	34G262	A. BUILDING _____ B. WING _____	C 09/19/2025

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W 368	Continued From page 10 the DON confirmed staff should have administered medications as prescribed on the physician's orders.	W 368		
W 375	DRUG ADMINISTRATION CFR(s): 483.460(k)(8) The system for drug administration must assure that drug administration errors and adverse drug reactions are recorded. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the system for medication administration recorded complete and accurate medication errors for 4 of 6 sampled clients (#1, #2, #3 and #4). The findings are: A. Record review on 9/19/25 for client #1's medication administration records (MAR) from 6/25 through 9/25 revealed the following missed dosages of medications: - Aripiprazole 30mg, 7/27 - 7/31/25 - Trazodone 100mg , 7/7/25 and 7/31/25 - Clonidine 0.1mg, 8/1/25 - 8/25/25 - Oxcarbazepine - 300 mg on 8/7/25 - 8/26/25 - Trazodone 100mg on 8/9/25 - 8/24/25 - Fluoxetine Cap 20mg on 8/9/25 - 8/25/25 - Aripiprazole 30mg on 9/8/25 - Clonidine Tab 0.1mg on 9/6/25 8:00PM and 9/8/25 7AM - Divalproex 7AM on 9/8/25 - Fluoxetine Cap 40mg on 9/8/25 - Oxcarbazepine 600mg on 9/1/25 1 tab at 7AM, and 8PM, 9/6/25 1 tab at 8PM B. Record review on 9/19/25 for client #2's MAR from 6/25 through 9/25 revealed the following missed dosages of medications:	W 375	All direct care and nursing staff received re-training on identifying and documenting medication errors. A sign-in sheet and post-test verified completion and comprehension. Nursing staff will provide training to all staff on the Rights of medication administration, including how and when to document medication errors and how to properly report all medication errors to the Physician and upper management, with compliance training on administering drugs per the Physicians Order. The facility will ensure that all staff are trained on Medication Oversight and Medication Exception Reporting. To prevent further occurrence: The DON will train Nursing staff on all required monthly monitoring, including med closet audits, medication management, medication observations, Controlled substance logs, and review of all Physician Orders. The facility will provide staff training on monthly core team meetings to discuss any medication changes and or concerns. Completion Date:11/3/2025	11/3/25

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W 375	Continued From page 11 - Chlorhexidine Gluconate 0.12% solution on 6/3/25 - 6/27/25 - Melatonin chew 5mg on 6/18/25, 6/19/25, 6/20/25 - Cobenfy 100-200mg on 6/28/25, 6/29/25, 6/30/25, - Cobenfy CAP 100-20mg on 7/1/25, 7/2/25, 7/27/25, 7/28/25, 7/30/25 and 7/31/25 - Biotene Liquid Dry Mouth on 7/24/25. - Cobenfy Cap 100mg - 20mg on 8/1/25- 8/21/25, 8/23/25, 8/24/25, 8/31/25 - Cetirizine Chew 10mg on 9/13/25- 9/17/25 C. Record review on 9/19/25 of record for client #3's MAR from 6/25 through 9/25 revealed the following missed dosages of medications: - Levetiraceta Tab 500 mg on 6/2/25- 6/3/25 - Lansoprazole cap 30mg on 7/1/25, 7/14/25, 7/16/25, 7/17/25, 7/18/25, 7/21/25, 7/22/25, 7/23/25, 7/24/25, 7/26/25, 7/27/25, 7/28/25, and 7/29/25 - Aripiprazole Tab 2mg on 7/1/25 - GNP Melatonin 3mg tab on 7/28/25 - Aripiprazole Tab 5mg on 8/2/25 - 8/16/25, 8/18/25 - 8/24/25, 8/29/25 - 8/31/2 - Aripiprazole Tab 5mg on 9/5/25, 9/8/25, 9/10/25, 9/14/25. D. Record review of record for client #4's MAR from 6/25 through 9/25 revealed the following missed dosages of medications: - Chlorpromax tab 25mg on 6/1/25, 6/13/25, 6/16/25 - 6/30/25 - Gabapentin cap 100mg on 6/25/25, 6/26/25 - Oxcarbazepine 300mg tab on 6/25/25 - Divalproex 250mg tab on 6/25/25- 6/30/25	W 375	All direct care and nursing staff received re-training on identifying and documenting medication errors. A sign-in sheet and post-test verified completion and comprehension. Nursing staff will provide training to all staff on the Rights of medication administration, including how and when to document medication errors and how to properly report all medication errors to the Physician and upper management, with compliance training on administering drugs per the Physicians Order. The facility will ensure that all staff are trained on Medication Oversight and Medication Exception Reporting. To prevent further occurrence: The DON will train Nursing staff on all required monthly monitoring, including med closet audits, medication management, medication observations, Controlled substance logs, and review of all Physician Orders. The facility will provide staff training on monthly core team meetings to discuss any medication changes and or concerns. Completion Date:11/3/2025	11/3/25

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W 375	Continued From page 12 - Clonazepam 1mg tab on 7/1/25 - 7/6/25 - Chlorpromaz 25mg tab on 7/1/25 - 7/25/25 - Gabapentin 100 mg cap on 7/1/25, 7/31/25 - Divalproex 250mg on 7/1/25 - Quetiapine 300mg tab on 7/30/25, 7/31/25 - Gabapentin 100mg cap on 8/1/25 -8/5/25, 8/7/25, 8/8/25, 8/19/25, 8/20/25 - Quetiapine 300mg tab on 8/1/25-8/10/25,8/12/25 - Clonazepam 1mg tab on 8/3/25 - 8/5/25, 8/15/25 -8/21/25, 8/25/25, 8/31/25 - Sodium Chloride 1gm tab on 8/10/25 - Clonazepam on 9/1/25 and 9/2/25. Review of records for clients #1, #2, #3 and #4, verified by interview with the director of nursing (DON) on 9/19/25, revealed no evidence of complete and accurate recording was available for medication errors from 6/25 through 9/25.	W 375		
W 376	DRUG ADMINISTRATION CFR(s): 483.460(k)(8) The system for drug administration must assure that drug administration errors and adverse drug reactions are reported immediately to a physician. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to report all drug administration errors to the physician for 4 of 6 audit clients (#1, #2, #3 and #4). The findings are: A. Record review on 9/19/25 for client #1 revealed a physician order (PO) dated 8/26/25. Further review of the PO revealed the following medications to be administered; Aripiprazole Tab 30mg at 7AM, Clonidine Tab 0.1mg twice a day at 7AM and 9PM, Divalproex Tab 500MG ER 2 tablets at 7AM, Fluoxetine Cap 40mg at 7AM,	W 376	All direct care and nursing staff received re-training on identifying and documenting medication errors. A sign-in sheet and post-test verified completion and comprehension. Nursing staff will provide training to all staff on the Rights of medication administration, including how and when to document medication errors and how to properly report all medication errors to the Physician and upper management, with compliance training on administering drugs per the Physicians Order. The facility will ensure that all staff are trained on Medication Oversight and Medication Exception Reporting. To prevent further occurrence: The DON will train Nursing staff on all required monthly monitoring, including med closet audits, medication management, medication observations, Controlled substance logs, and review of all Physician Orders. The facility will provide staff training on monthly core team meetings to discuss any medication changes and or concerns. Completion Date:11/3/2025	11/3/25

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W 376	Continued From page 13 Oxcarbazepine 300 mg- Tab, 3 tablets (900mg) at 7AM and 8PM, Polyeth Glyc Pow 3350 mix 17mg (one capful) in 8 ounces of liquid at 7AM, Trazodone Tab 100mg take 2 tablets (200mg) at bedtime 8PM and PRN medications. Continued review of the medication administration records (MAR) for client #1 from 6/25 through 9/25 revealed the following missed dosages of medications: - Aripiprazole 30mg, 7/27 - 7/31/25 - Trazodone 100mg , 7/7/25 and 7/31/25 - Clonidine 0.1mg, 8/1/25 - 8/25/25 - Oxcarbazepine - 300 mg on 8/7/25 - 8/26/25 - Trazodone 100mg on 8/9/25 - 8/24/25 - Fluoxetine Cap 20mg on 8/9/25 - 8/25/25 - Aripiprazole 30mg on 9/8/25 - Clonidine Tab 0.1mg on 9/6/25 8:00PM and 9/8/25 7AM - Divalproex 7AM on 9/8/25 - Fluoxetine Cap 40mg on 9/8/25 - Oxcarbazepine 600mg on 9/1/25 1 tab at 7AM, and 8PM, 9/6/25 1 tab at 8PM B. Record review on 9/19/25 for client #2 revealed a PO dated 5/6/25. Further review of the PO revealed the following medications to be administered; Benztropine Tab 1 mg at 7AM and 8PM, Biotene Liquid Dry Mouth 15ml at 7AM, Briviact Tab 100mg at 7AM and 8PM, Clobazam Tab 10mg 3 tabs (30MG) at 8PM, Clobazam Tab 8mg at 7AM, Cobenfy CAP 100-200mg 1 capsule at 7AM and 8PM "reorder when needed- not a cycle fill med", Fanapt Tab 8mg at 7AM and 8PM, Fycompa Tab 12mg at 8PM, GNP Vitamin D3 1000 unit at 20PM, Lactulose Solution 10GM/15 take 30ML at 7AM and 8PM, Loratadine Tab 10mg at 7AM, Melatonin Cap 10mg at 9PM, Melatonin 5mg (chew 2 tablets 10mg) at 9PM,	W 376		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 376	Continued From page 14 Olanzapine Tab 5mg (dissolve one tab) at 9PM, Topiramate 100mg at 7AM and 8PM, PRN medications. Continued review of the medication administration records (MAR) for client #2 from 6/25 through 9/25 revealed the following missed dosages of medications: - Chlorhexidine Gluconate 0.12% solution on 6/3/25 - 6/27/25 - Melatonin chew 5mg on 6/18/25, 6/19/25, 6/20/25 - Cobenfy 100-200mg on 6/28/25, 6/29/25, 6/30/25, - Cobenfy CAP 100-20mg on 7/1/25, 7/2/25, 7/27/25, 7/28/25, 7/30/25 and 7/31/25 - Biotene Liquid Dry Mouth on 7/24/25. - Cobenfy Cap 100mg - 20mg on 8/1/25- 8/21/25, 8/23/25, 8/24/25, 8/31/25 - Cetirizine Chew 10mg on 9/13/25- 9/17/25 C. Record review on 9/19/25 for client #3 revealed a PO dated 5/6/25. Further review of the PO revealed the following medications to be administered; Aripiprazole Tab 2mg at 7AM, Budesonide Sus 0.5mg inhaler 2ml at 7AM, Clobazam Tab 20mg at 7AM and 8PM, Divalproex Tab 500mg at 7AM and 8PM, Ferrous Sulf Tab 324 mg at 7AM, Folic Acid Tab 1mg at 7AM, GNP Melatonin 3mg Tab at 8PM, Lamotrigine Tab 100mg at 7AM and 8PM, Lansoprazole 30mg at 7AM and 4PM, Levetiraceta 1000mg Tab at 7AM and 8PM, and PRN medications. Continued review of the MAR for client #3 from 6/25 through 9/25 revealed the following missed dosages of medications: - Levetiraceta Tab 500 mg on 6/2/25- 6/3/25	W 376	All direct care and nursing staff received re-training on identifying and documenting medication errors. A sign-in sheet and post-test verified completion and comprehension. Nursing staff will provide training to all staff on the Rights of medication administration, including how and when to document medication errors and how to properly report all medication errors to the Physician and upper management, with compliance training on administering drugs per the Physicians Order. The facility will ensure that all staff are trained on Medication Oversight and Medication Exception Reporting. To prevent further occurrence: The DON will train Nursing staff on all required monthly monitoring, including med closet audits, medication management, medication observations, Controlled substance logs, and review of all Physician Orders. The facility will provide staff training on monthly core team meetings to discuss any medication changes and or concerns. Completion Date:11/3/2025	11/3/25

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W 376	Continued From page 15 - Lansoprazole cap 30mg on 7/1/25, 7/14/25, 7/16/25, 7/17/25, 7/18/25, 7/21/25, 7/22/25, 7/23/25, 7/24/25, 7/26/25, 7/27/25, 7/28/25, and 7/29/25 - Aripiprazole Tab 2mg on 7/1/25 - GNP Melatonin 3mg tab on 7/28/25 - Aripiprazole Tab 5mg on 8/2/25 - 8/16/25, 8/18/25 - 8/24/25, 8/29/25 - 8/31/2 - Aripiprazole Tab 5mg on 9/5/25, 9/8/25, 9/10/25, 9/14/25. D. Record review of record on 9/19/25 for client #4 revealed a PO dated 5/6/25. Further review of the PO revealed the following medications to be administered; Chest Congestion 400mg Tab 1 tab at 7AM, Chlorpromaz 25mg Tab 1 tablet at 12PM and 8PM, Citalopram 20mg Tab 1 tablet at 8PM, Clonazepam 1mg Tab 1 tablet at 7AM, Divalproex 250mg Tab (3 tablets) at 8PM, Fish oil 1000mg (2 capsules 2000mg) at 7AM, Fluocin Acet Oil 0.01% on scalp on Mondays and Thursdays 4PM to 8PM, Gabapentin 100mg 1 capsule at 7AM, 4PM and 8PM, Loratadine 10 Tab 1 tablet at 7AM, Omeprazole 40mg Cap 1 capsule at 7AM, Oxcarbazepine-300mg 1 tablet at 7AM and 8PM, Oxybutynin 5mg Tab 1 tablet at 7AM, 4PM, and 8PM, Poleth Glyc Pow 3350 17gm at 7AM, Pot Chloride Tab 10MEQ ER 1 tablet at 7AM, Quetiapine Tab 300mg 1 tablet at 8PM, Vitamin D 50mcg 1 capsule at 7AM, and PRN medications. Continued Review of the MAR for client #4 from 6/25 through 9/25 revealed the following missed dosages of medications: - Chlorpromax tab 25mg on 6/1/25, 6/13/25, 6/16/25 - 6/30/25 - Gabapentin cap 100mg on 6/25/25, 6/26/25 - Oxcarbazepine 300mg tab on 6/25/25 - Divalproex 250mg tab on 6/25/25- 6/30/25	W 376		

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W 376	Continued From page 16 - Clonazepam 1mg tab on 7/1/25 - 7/6/25 - Chlorpromaz 25mg tab on 7/1/25 - 7/25/25 - Gabapentin 100 mg cap on 7/1/25, 7/31/25 - Divalproex 250mg on 7/1/25 - Quetiapine 300mg tab on 7/30/25, 7/31/25 - Gabapentin 100mg cap on 8/1/25 -8/5/25, 8/7/25, 8/8/25, 8/19/25, 8/20/25 - Quetiapine 300mg tab on 8/1/25-8/10/25,8/12/25 - Clonazepam 1mg tab on 8/3/25 - 8/5/25, 8/15/25 -8/21/25, 8/25/25, 8/31/25 - Sodium Chloride 1gm tab on 8/10/25 - Clonazepam on 9/1/25 and 9/2/25. Review of records for clients #1, #2, #3 and #4, verified by interview with the director of nursing (DON) on 9/19/25, revealed no evidence of staff training or correspondence with the clients' physician's regarding missed doses of medications.	W 376	All direct care and nursing staff received re-training on identifying and documenting medication errors. A sign-in sheet and post-test verified completion and comprehension. Nursing staff will provide training to all staff on the Rights of medication administration, including how and when to document medication errors and how to properly report all medication errors to the Physician and upper management, with compliance training on administering drugs per the Physicians Order. The facility will ensure that all staff are trained on Medication Oversight and Medication Exception Reporting. To prevent further occurrence: The DON will train Nursing staff on all required monthly monitoring, including med closet audits, medication management, medication observations, Controlled substance logs, and review of all Physician Orders. The facility will provide staff training on monthly core team meetings to discuss any medication changes and or concerns. Completion Date:11/3/2025	11/3/25