STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G203	A. BUILDING _____ B. WING _____	10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-BLAIRFIELD	111 BLAIRFIELD COURT N WILKESBORO, NC 28659

(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 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 observations and interviews, the facility failed to ensure that clients were provided proper training in the area of medications. This affected 3 out of 4 clients observed during medication administration (#1, #2, and #5). The finding is: During medication administration observation in the home on 10/28/25 at 7:11 AM, staff A was observed to administer medications to clients #1. Further observation revealed staff A to tell client #1 the name of the first medication he prepared for administration. Continued observation revealed staff A to prepare and administer the remaining 7 medications without explaining what the medications were, what they are meant to treat, any side effects of the medication, or what to do in the event the client experienced side effects of the medication. During medication administration observation in the home on 10/28/25 at 7:43 AM, staff A was observed to administer medications to clients #2. Further observation revealed staff A to tell client #2 the name of the first medication he prepared for administration, as well as it's purpose, side effects and what to do in the event the client should experience side effects of the medication. Continued observation revealed staff A to prepare and administer the remaining 14 medications without explaining what the medications were,	W 340	W 340 Staff to be trained/ inserviced on providing proper medication education for individual client medications during all medication passes for all clients. Medication Administration observations will be completed a minimum of 2 days per week by the SS, RN, QP, AS, or PM. RECEIVED NOV 10 2025 DHSR-MH Licensure Sect	12-27-2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Malissa Bentley | TITLE: Program Manager | (X6) DATE: 11/5/2025

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 340	Continued From page 1 what they are meant to treat, any side effects of the medication, or what to do in the event the client experienced side effects of the medication. During medication administration observation in the home on 10/28/25 at 7:03 AM, staff A was observed to administer medications to client #5. Further observation revealed staff A to tell client #5 the name of the first medication he prepared for administration and to ask client #5 whether she knew what the medication was for. Continued observation revealed staff A to prepare and administer the remaining 3 medications without explaining what the medications were, what they are meant to treat, any side effects of the medication, or what to do in the event the client experienced side effects of the medication. Interview with the facility nurse confirmed that staff should have provided education to all clients regarding their medications, indicated uses, and potential side effects.	W 340	W 340 Staff to be trained/inserviced on providing proper medication education for individual client medications during all medication passes for all clients. Medication Administration observations will be completed a minimum of 2 days per week by the SS, RN, QP, AS, or PM.	12-27-2025
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all medications and biologicals remained locked except when being prepared for administration. The finding is: Medication observations in the home on 10/28/25 at 7:11 AM revealed staff A to begin preparing medications for client #1 while client #1 and surveyor were in the room. Further observations	W 382	W 382 Staff to be trained/inserviced on proper medication administration practices, to include keeping office door closed during all medication passes, keeping all medications locked in medication closet when not being used, and not leaving clients or medications during the medication pass. Medication Administration observations will be completed a minimum of 2 days per week by the SS, RN, QP, AS, or PM.	12-27-2025

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W 382	Continued From page 2 revealed Staff A to begin by setting a box containing client #1's medications on the desk next to client #1. Continued observation revealed staff A to leave the room in order to get client #1 a Boost from the kitchen, and to leave the box of medications on the desk next to client #1. Medication observations in the home on 10/28/25 at 7:43 AM revealed staff A to administer medications to client #2. Further observation revealed that upon completion of the medication administration, staff A walked out of the medication room with client #2, leaving an unlocked box of controlled medications on the desk and the medication room door open. At the time staff A left the room, surveyor was recording the medications administered to client #2, therefore all of client #2's medications remained out on the desk as well. Interview on 10/28/25 with the facility nurse revealed that all medications should be locked in the closet inside the medication room until staff prepare them for administration and that staff have been trained to not leave medications unlocked outside of that time.	W 382		