

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

PRINTED: 10/30/2025
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 10/22/2025
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	The facility will ensure that all allegations of mistreatment, neglect, or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.	12/21/2025	
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect, or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to assure that an inquiry or investigation was initiated based on an injury of unknown origin for 1 of 2 sampled clients (#1). The finding is: Observations at the day program on 10/22/25 between 10:00 AM and 11:00 AM, revealed client #1 to be seated in a wheelchair and to be wearing socks and shoes on both feet. Further observations revealed that when client #1's shoes and socks were removed, swelling and bruising were present on the client's left toes. The bruising appeared to be black and blue in color and the nail on the great toe was observed to be severely damaged. Continued observations revealed no bruising on client #1's right foot. Subsequent observations revealed client #1 to complain of pain when staff touched the bruised area. Review of facility documents revealed an after visit summary for client #1 dated 9/30/25. Further review of the summary revealed client #1 was seen by his primary care physician and the	W 153	A. QAM and OSS will educate all staff on reporting all injuries of unknown source immediately to Upper Management, including Local Nursing Staff. B. QAM and OSS will educate staff on properly documenting body checks and following up with the proper Incident Reporting Process. C. Nursing will complete a staff training on Change of Condition and signs and symptoms of illness.		

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DHSR-MH Licensure Sect

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Angelia B. Bess, MA, OSS

TITLE

(X6) DATE

11/10/25

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 153	<p>Continued From page 1</p> <p>following issues were addressed; Tinea pedis of left foot, left foot pain and swelling of left foot. Continued review of documentation revealed that medications clotrimazole and nystatin were prescribed.</p> <p>Further review of facility documents revealed an after-visit summary dated 10/7/25 from his primary care physician and the following issues were addressed; Tinea pedis of left foot, left foot pain and swelling of left foot. Additional review of facility documents did not reveal an inquiry initiated from the facility to determine the contributing factor of client's swollen and discolored toe.</p> <p>Review of body checks for client #1 for 9/25 through 10/25 revealed client #1's left big toe to be swollen on the following dates; 9/25/25, 9/26/25, 9/27/25 and 10/1/25 through 10/20/25. Further review did not reveal any communication between staff, nursing or the clinical team to determine origin of injury.</p> <p>Review of incidents reports for 9/25 through 10/25 revealed on 10/14/25 adult protective services (APS) came out to the facility at 10:45 AM to inquire about client' #1's toenail issue. The qualified intellectual developmental professional (QIDP) provided APS information relative to a scheduled podiatrist appointment scheduled for 11/5/25.</p> <p>Interview with the facility nurse on 10/22/25 revealed that she was not made aware that the client's toe was swollen or bruised. During an interview with the director of nursing (DON) on 10/22/25 surveyor presented pictures of client's foot taken at the day program earlier. Upon</p>	W 153			

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W 153	Continued From page 2 observing the pictures, the DON advised that the client be seen by urgent care today for further evaluation. Interview with site supervisor (SS) on 10/22/25 revealed that this morning client #1 did complain about having pain with his left foot. Further interview with SS revealed that when she looked at client #1's foot this morning, it did not look like that (when shown pictures of his foot taken while at the day program). Continued interview with the SS revealed there were no incident reports or inquiry completed following the 9/26/25 body check when staff indicated that client's big toe was swollen. Subsequent interview revealed that following client's 9/30/25 doctor's visit, it was noted that the client was diagnosed with Tinea pedis of left foot, left foot pain and swelling of left foot. Additional interview with the SS revealed the facility was unaware of how the client's foot became swollen. Interview with the QIDP on 10/22/25 revealed that on 10/14/25 APS came to visit the facility because allegations were made that client's foot was hurting and the agency wasn't doing anything. Further interview with the QIDP revealed she had shown APS the case notes on all that had been done and APS seemed satisfied. Continued review revealed APS reported that they will come back to see client #1 at 4pm that afternoon. Subsequent interview with the QIDP revealed the facility did not initiate an inquiry of injury unknown.	W 153			
W 192	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training	W 192			

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W 192	<p>Continued From page 3</p> <p>must focus on skills and competencies directed toward clients' health needs.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure staff were sufficiently trained relative to the changing of medical needs of 1 of 2 sampled clients (#1). The finding is:</p> <p>Observations in the day program on 10/22/25 between 10:00 AM and 11:00 AM, revealed client #1 to be seated in a wheelchair and to be wearing socks and shoes on both feet. Further observation revealed that when client #1's shoes and socks were removed, swelling and bruising were present on the client's left toes. The bruising appeared to be black and blue in color and the nail on the great toe was observed to be severely damaged. Continued observations revealed no bruising on client #1's right foot. Subsequent observation revealed client #1 to complain of pain when staff touched the bruised area.</p> <p>Additional observation revealed the Director of Nursing (DON) to arrive at the group home on 10/22/25 with client #1's medical records. Continued observation revealed that, when shown photos of client #1's feet taken that morning, the DON advised the Interim Site Supervisor (ISS) to take the client to urgent care for examination of the left foot.</p> <p>Interview with the day program director (DPD) on 10/22/25 revealed that there is not currently a nurse assigned to the day program, and that when there is a medical need, she is trained to contact the provider's triage unit for care management. Further interview with the DPD revealed that no staff from the group home had</p>	W 192	<p>The facility will ensure that all staff training is focused on skills and competencies directed toward client's health needs through established procedures.</p> <p>A. QAM and OSS will educate all staff on reporting all injuries of unknown source immediately to Upper Management, Including Local Nursing Staff B. QAM and OSS will educate staff on properly documenting body checks and following up with the proper Incident Reporting Process C. Nursing will complete a staff training on Change of Condition and signs and symptoms of illness.</p>	12/21/2025

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W 192	<p>Continued From page 4</p> <p>notified her of any issues involving client #1's feet.</p> <p>Interview with the ISS on 10/22/25 revealed that client #1 complained to her that morning of pain in his foot and that, upon inspection, she observed bruising on the foot which was not there the day before. Further interview with the ISS revealed that she contacted the triage unit that morning to request directions for care and was told not to take any action prior to a previously scheduled appointment on the following day with client #1's primary care physician, and that she should take the client to urgent care if the condition worsens. Continued interview with the ISS revealed that she had observed and documented swelling of client #1's left foot on several days in the weeks preceding this interview and that she had been directed to follow up with the podiatry clinic to try to have client #1 seen as soon as possible.</p> <p>Interview with the DON and the facility nurse revealed that there was no record of any call to the triage unit from the group home on that day. Further interview with the nurses revealed that nursing had never been advised about the bruising on client #1's foot until that day and that, if they had, they would have instructed staff to have the client seen by a medical provider immediately. Continued interview with the facility nurse revealed that staff had not reported any concerns relative to the swelling of client's foot, bruising of his toes or any changes in medical needs. Subsequent interview with the facility nurse revealed there were no documentation of staff reporting client's changes to nursing triage unit for care management.</p>	W 192		