

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

PRINTED: 02/26/2026
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 02/25/2026
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 340	<p>NURSING SERVICES CFR(s): 483.460(c)(5)(i)</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure that staff were adequately trained in medication administration. This affected 1 of 3 audit clients. The finding is:</p> <p>During morning observations in the group home on 2/25/26, client #3 was observed to enter the medication room with surveyor and staff A to receive morning medications. Further observations revealed a small cup containing several pills to be sitting on the counter and for staff A to hand the medication cup to client #3, instructing client #3 to swallow the pills in the cup. Continued observation revealed staff A to have no further conversation with client #3 prior to client #3 swallowing his medications.</p> <p>Review of records on 2/25/26 revealed a person-centered plan (PCP) for client #3 dated 9/25/25 which included aa goal to "name 2 of his daily medications during medication administration."</p> <p>Interview with staff A on 2/25/26 confirmed that she had punched all of client #3's medications into the cup prior to client #3 entering the medication room.</p> <p>Interview with the qualified intellectual disabilities</p>	W 340			

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 340	Continued From page 1 professional (QIDP) on 2/25/26 confirmed that client #3's PCP is current and that client #3 has a goal related to medication administration. The QDIP further stated that staff are trained to punch each medication out with as much assistance as possible from clients, and to discuss the name, purpose and side effects of each medication with the client.	W 340			
W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to serve food in a form consistent with the developmental levels and prescribed diets of 2 of 3 audited clients (#2 and #3). The findings are: A. The facility failed to ensure the prescribed diet for client #2. For example: Observations in the group home on 2/24/26 at 5:35 PM revealed the dinner meal to consist of chicken pot pie, mashed potatoes and slices of processed ham. Continued observations revealed staff to serve client #2 three whole slices of ham. Further observations revealed client #2 to pick up a slice of ham and consume it before staff cut the remaining slices into bite sized pieces. Record review on 2/25/26 revealed a Nutritional Assessment dated 9/19/25 for client #2 which states that client #2's prescribed diet is: soft, bite size, nectar thick liquids. Interview with the qualified intellectual disability	W 474			

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W 474	<p>Continued From page 2</p> <p>professional (QIDP) confirmed that client #2's Nutritional Assessment reflects the current prescribed diet and that all food served to client #2 should be bite sized consistency.</p> <p>B. The facility failed to ensure the prescribed diet for client #3. For example:</p> <p>Observations in the group home on 2/24/26 at 5:35 PM revealed the dinner meal to consist of chicken pot pie, mashed potatoes and slices of processed ham. Continued observations revealed staff to serve client #3 two whole slices of ham. Further observations revealed client #3 to pick up a slice of ham with a fork and consume it before staff cut the remaining slices into bite sized pieces.</p> <p>Record review on 2/25/26 revealed a Nutritional Assessment dated 9/19/25 for client #3 which states that client #3's prescribed diet is: 1800 calories, 1/4" consistency.</p> <p>Interview with the QIDP confirmed that client #3's Nutritional Assessment reflects the current prescribed diet and that all food served to client #3 should be in a 1/4" consistency.</p>	W 474			