DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FOR	MAPPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	<u> 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION		E SURVEY PLETED
34G095		B. WING			06	/19/2018	
NAME OF PI	ROVIDER OR SUPPLIER			Ś	STREET ADDRESS, CITY, STATE, ZIP CODE		
	EET GROUP HOME-ST.	MADK		1	1801 OAK STREET		
				0	CHARLOTTE, NC 28269		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)			(X5) COMPLETION DATE
	PROGRAM IMPLEMI CFR(s): 483.440(d)(1 As soon as the interd formulated a client's i each client must rece treatment program co interventions and serv and frequency to supp objectives identified in plan. This STANDARD is r Based on observatio interviews, the facility contained in the indiv were implemented as sampled clients (#2 a communication. The A. The team failed to interventions to addres needs for client #2. F 1. Observations in th 6/19/18 revealed client survey to participate i included nail care, dra magazine, washing h meals, taking dishes to packing her lunch and	ENTATION isciplinary team has ndividual program plan, ive a continuous active insisting of needed vices in sufficient number port the achievement of the n the individual program not met as evidenced by: ns, record review and staff failed to ensure objectives idual habilitation plan (IHP) prescribed for 2 of 3 nd #3) relative to findings are: assure sufficient ess the communication for example: e group home on 6/18 and nt #2 to be limited verbally with pointing and occasional #2 was observed during the n various activities that awing, looking at a er hands, setting the table, to the kitchen after meals, d loading the facility van for	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)		
	revealed client #2 to I included with her plac utilized to say the ble						
	Observation of the broken	eakfast meal on 6/19					
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E		TITLE		(X6) DATE

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

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.

PRINTED: 06/21/2018

TITLE

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 06/21/2018 1 APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
34G095		B. WING		_	06/19/2018		
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
OAK STREET GROUP HOME-ST. MARK			801 OAK STREET HARLOTTE, NC 28269	9			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 249	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		W 249				

Facility ID: 990150

If continuation sheet Page 2 of 6

CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) M						OMB NO. 0938-03		
IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		34G095	B. WING		06/19/2018			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI					
OAK STR	EET GROUP HOME-ST.	MARK		1801 OAK STREET CHARLOTTE, NC 28269				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE		
W 249	Continued From pag	e 2	W 24	9				
	-	ne group home on 6/18 and						
		ent #2 to be limited verbally						
	and to communicate with pointing and occasional							
	vocalizations. Client #2 was observed during the survey to participate in various activities that							
	included nail care, drawing, looking at a							
	magazine, washing her hands, setting the table,							
	meals, taking dishes to the kitchen after meals,							
	packing her lunch and loading the facility van for transport. Observation of the dinner meal on 6/18							
	revealed client #2 to have a voice output switch							
	included with her place setting that the client							
	utilized to say the ble	-						
		reakfast meal on 6/19 oice output switch to be						
		of the table, out of reach of						
	client #2 and unused							
		out the survey revealed staff						
		noices, directing the client to						
	direction.	n transitions only with verbal						
	Review of records fo	r client #2 on 6/19/18						
		ed 11/16/17. Review of the						
		nunication objective relative						
		Review of the objective ented with 2 photos, client #2						
		y pointing to/naming and						
	taking chosen photo	to indicate her desire for that						
	-	me with no more than 2						
		our consecutive months, Subsequent review of client						
	#2's record revealed	•						
	assessment dated 3/							
		Is of continuing to develop						
	ability to make choice presented in a variet	es from photos when v of situations and to						
	-	-						
	continue use of obied	ct based transition prompts,						

Facility ID: 990150

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 06/21/2018 1 APPROVED 2: 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
34G095		B. WING	_	06/19/2018			
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
OAK STREET GROUP HOME-ST. MARK				801 OAK STREET HARLOTTE, NC 2826	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 249	and use of a big mach Interview with the RM #2's communication of activity remains curre various leisure picture for outdoor plants, a r television and a board interview with the RM have been provided v during leisure opportu- communication object identified in the client assessment. B. The team failed to interventions to addre needs for client #3. F 1. Observations in th 6/19/18 revealed clien Client #3 was observe participate in various handling block object: her hands, meal prep kitchen after meals, p loading the facility van throughout the survey client #3 choices, dire and through transition Review of records for revealed an IHP date IHP revealed a comm to task initiation. Rev client #3 will activate voice output switch pa- indicate readiness for	k switch to comment. I on 6/19/18 verified client objective relative to leisure nt and provided a tool with es that included a water can magazine, outdoors, friends, d game. Continued revealed client #2 should with pictures to choose from unities as indicated in the tive to support needs 's current communication 's current communication for example: e group home on 6/18 and nt #3 to be non-verbal. ed during the survey to activities that included s from a basket, washing , meals, taking dishes to the packing her lunch and n for transport. Observation / revealed staff providing ecting the client to activities as only with verbal direction.	W 249				

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						O. 0938-03		
		. ,	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		34G095	B. WING		06	6/19/2018		
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO)E			
OAK STREET GROUP HOME-ST. MARK				1801 OAK STREET CHARLOTTE, NC 28269				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE		
W 249	Continued From page	e 4	W 24	.9				
		of the time, implemented	VV 24					
	· · ·	cord review revealed a						
		ssment dated 4/14/17 with						
	an updated concurrence statement by the speech							
	pathologist dated 3/6/18. Review of the current							
	communication needs of client #3 revealed the							
	client needs to continue to make transitions using visual symbols and simple verbal cues on an							
	integrated basis, to develop the ability to make							
	choices from photos, pictures and visual symbols							
	on an integrated basis and to continue to develop							
	activation skills for simple voice output in							
	designated situations	i.						
	Interview with the RM on 6/19/18 verified client #3							
	should have been prompted by staff to utilize a voice output device indicating "I'm ready" with							
	•	ransitioning the client from						
		I interview revealed client #3						
	-	tool with pictures cues for						
	-	ver, help cook, set table,						
		for meds. Interview with the						
		I staff should have used						
	communicating with o	es with verbal prompts in client #3.						
		e group home on 6/18 and						
		nt #3 to be non-verbal.						
		ed during the survey to						
		activities that included s from a basket, washing						
		, meals, taking dishes to the						
		backing her lunch and						
	loading the facility va	n for transport. Observation						
	throughout the survey	y revealed staff providing						
		ecting the client to activities						
	and through transition	ns only with verbal direction.						
			1					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 06/21/2018 / APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
34G095		B. WING				06/19/2018		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, 2	ZIP CODE		
OAK STREET GROUP HOME-ST. MARK					801 OAK STREET CHARLOTTE, NC 28269			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE CROSS-REFERENCED			(X5) COMPLETION DATE
W 249	revealed an IHP upda IHP revealed a comm to task completion. Re revealed client #3 will pre-programmed void a picture photo to indi- of routine group home given no more than 3 time, implemented 3/2 review revealed a com- dated 4/14/17 with an statement by the spect 3/6/18. Review of the needs of client #3 rev continue to make tran- and simple verbal cue develop the ability to pictures and visual sy basis and to continue for simple voice output Interview with the RM should have been pro- voice output device in every opportunity of the an activity. Additional has a communication washing hands, show brush teeth and time RM further confirmed	ated 6/10/18. Review of the nunication objective relative eview of the objective activate a simple e output switch paired with icate completion for a variety e activities with "I'm finished" verbal prompts 80% of the 2018. Additional record mmunication assessment updated concurrence ech pathologist dated e current communication realed the client needs to sistions using visual symbols es on an integrated basis, to make choices from photos, mbols on an integrated to develop activation skills at in designated situations.	w	249				

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