DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G195	B. WING _			10/	02/2018
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
VOCA-H	ARRISBURG ROAD G			6620 HARRISBURG ROAD			
1004-11				CHARLOTTE, NC 28277			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD	BE	(X5) COMPLETION DATE
	REGULATORY OR LA INDIVIDUAL PROG CFR(s): 483.440(c) The individual prog those clients who la skills essential for p (including, but not li personal hygiene, c bathing, dressing, g of basic needs), un that the client is dev acquiring them. This STANDARD is Based on observat review, the facility fa support plan (ISP) is address identified of sampled clients (#3 Observations in the 6:25 AM revealed of dining table prepari consisted of three r large sausage patties the dining table for #3 was observed to sausage patties wit bites. A staff memb client throughout th to re-direct the clier getting a knife. Review of the recor	SC IDENTIFYING INFORMATION) GRAM PLAN (6)(iii) ram plan must include, for ack them, training in personal privacy and independence mited to, toilet training, lental hygiene, self-feeding, prooming, and communication til it has been demonstrated velopmentally incapable of s not met as evidenced by: tion, interview and record ailed to ensure the individual ncluded objective training to lining needs for 1 of 3 b). The finding is: e group home on 10/2/18 at lient #3 sitting down at the ng to eat breakfast. The meal nedium sized waffles and two es. The only eating utensil at the client was a fork. Client o spear the waffles and the h the fork and then take large per was sitting next to the e meal and was not observed at or assist the client with and for client #3 on 10/2/18 ted 2/14/18, which included a		CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPF		
	assessment indicat knife for dining with	/Home Life Assessment. The ed client #3 was able to use a physical assistance. f the record did not reveal any					

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

TITLE

(X6) DATE

PRINTED: 10/03/2018

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.

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G195 NAME OF PROVIDER OR SUPPLIER VOCA-HARRISBURG ROAD GROUP HOME		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
		34G195	B. WING			10/02/2018	
			STREET ADDRESS, CITY, STATE, ZIP CODE 6620 HARRISBURG ROAD	10/02/2010			
VUCA-II	ARRISBURG RUAD G			CHARLOTTE, NC 28277			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE	
W 242		ued programming related to	W 24	2			
W 249	professional (QIDP #3 needed physical knife for dining, and programming relate The QIDP also indi from programming.	MENTATION	W 24	9			
	formulated a client's each client must re treatment program interventions and s and frequency to su	erdisciplinary team has s individual program plan, ceive a continuous active consisting of needed ervices in sufficient number upport the achievement of the d in the individual program					
	Based on observation interview, the facilit sampled clients (#3 sufficient number a achievement of an	s not met as evidenced by: tions, record review and y failed to assure 1 of 3 3) received interventions in nd frequency to support the objective prescribed in the blan (ISP). The finding is:					
	6:33 AM revealed of meal and then plac surface of a pass the between the dining	e group home on 10/2/18 at client #3 finishing his breakfast ing a plate and a fork on the nrough window located room and the kitchen. A staff rved to be seated next to the					

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			MB NO. 0938-039 (X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 34G195 NAME OF PROVIDER OR SUPPLIER			A. BUILDING			COMPLETED	
		B. WING			10/02/2018		
		STREET ADDRESS, CITY, STATE, ZIP COD					
VOCA-H	ARRISBURG ROAD (GROUP HOME		620 HARRISBURG ROAD CHARLOTTE, NC 28277			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
W 249	Continued From pa	age 2	W 249				
	client and did not d	irect the client in any way. At ember was observed taking the					
	revealed an ISP da contained a curren dishes into the dish verbal prompts and 80 percent success months. The instru	rd for client #3 on 10/2/18 ted 2/14/18. The ISP t objective for client #3 to load twasher with three or less d light physical assistance for s of trials for three consecutive actions for the objective putting all dishes in the ach meal.					
W 475	professional on 10/ current objective to dishwasher after m should have promp dishes into the kitcl the dishwasher. MEAL SERVICES CFR(s): 483.480(b		W 475				
	This STANDARD i Based on observa review, the facility f during the breakfas eating utensils for The finding is: Observations in the	ed with appropriate utensils. is not met as evidenced by: tion, interview, and record failed to ensure a place setting at meal included appropriate 1 of 3 sampled clients (#3). e group home on 10/2/18 at client #3 sitting down at the					

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	10/03/2018 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	
		34G195	B. WING		10/	02/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-H	ARRISBURG ROAD G	ROUP HOME		620 HARRISBURG ROAD CHARLOTTE, NC 28277		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 475	large sausage patti the dining table for #3 was observed to sausage patties wit bites. A staff membra client throughout th to re-direct the clier getting a knife. Review of the recor revealed an Individe 2/14/18, which inclu Community/Home I assessment indicat knife for dining with Interview with the q professional on 10/ should have been p have been physical	ies. The only eating utensil at the client was a fork. Client o spear the waffles and the th the fork and then take large ber was sitting next to the ne meal and was not observed nt or assist the client with rd for client #3 on 10/2/18 ual Support Plan (ISP) dated	W 475			

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