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

PRINTED: 12/07/2020 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  VOCA-OAK DRIVE GROUP HOME  STREET ADDRESS, CITY, STATE, ZIP CODE  5416 OAK DRIVE  CHARLOTTE, NC 28216   (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET)	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  VOCA-OAK DRIVE GROUP HOME  STREET ADDRESS, CITY, STATE, ZIP CODE  5416 OAK DRIVE  CHARLOTTE, NC 28216  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  W 000  INITIAL COMMENTS  A revisit was conducted on 12/1/2020 for all previous deficiencies cited on 1/14/2020. All deficiencies have been corrected, and no new noncompliance was found. The facility is in			34G201					
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		previous deficiencies deficiencies have bee noncompliance was f	cited on 1/14/2020. All en corrected, and no new ound. The facility is in					
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE	APORATO							(Ve) 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.