INTERNO OF DEPICENCES (M) PROVIDERSUPPLIERCLA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION INDE OF PROVIDER OR SUPPLIER 34G356 INVING (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION INVE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE (421/2021) INVE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE (421/2021) INVE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE (421/2021) W100 SUMMARY STATEMENT OF DEFICIENCES (CAL) CORRECTION (CAL) CORRECTION PREFIX IEAOCH DERVE CORRECTION (CAL) CORRECTION 0000E W 249 PROGRAM IMPLEMENTATION IP PERIX CROSS REFERENCE TO THE APPROPRIATE 0000E W 249 PROGRAM IMPLEMENTATION W 249 W 249 CORSUMENT CONTROL SALIVE 0000E This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure a continuous active treatment program consisting of needed interview treatment program construing on freeded interview treatment program construing on freeded interview treatment program construing of the edds of 2 of 3 sampled clients (#2, #4, and #6). The findings are: Observations in the home on 4/20/21 at 3:17 PM revealed staff already in the kitchen working on supper preparation including stiring, chopoping a		-	ID HUMAN SERVICES MEDICAID SERVICES					M APPROVED D. 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STATE, 2P CODE ENOCH DRIVE STREET ADDRESS. CITY. STATE, 2P CODE (Y4) ID PREFX ISUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MATS BE PRECEDED bY FULL REDULTORY OR LSC DEVIEWING INFORMATION) D PREFX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO IT & APPROFINATE DEFICIENCY) D PREFX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO IT & APPROFINATE DEFICIENCY) D PREFX W 249 PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) W 249 W 249 This STANDARD is not met as evidenced by: Based on observation, record review and interventions and services in sufficient number and frequency to support the achievement of the objectives identify failed to ensure a continuous active treatment program to address the needs of 2 of 3 sampled clients (#3 and #6) and 3 of 3 non-sampled clients (#3 and #6) and 3 of 3 non-sampled clients (#2, #4, and #6). The findings are: Observations in the home on 4/20/21 at 3:17 PM revealed staff aready in the kitchen working on supper preparation. Further observations revealed staff aready in the kitchen working on supper preparation. Further observations revealed staff aready in the kitchen working on supper preparation. Further observations revealed staff aready in the kitchen working on supper preparation. Further observations revealed staff aready in the kitchen working on serving food without client assistance except for limited help with 4 and #5 in the liwing room Morning observations in the home on 4/21/21 at 6:15 AM revealed client 4 and #5 in the liwing room	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPP		(X1) PROVIDER/SUPPLIER/CLIA	· /			(X3) DATE	SURVEY
ENOCH DRIVE 4109 ENOCH DRIVE CHARLOTTE, NC 228269 WILD TREETX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST RE PRECEDED BY FULL RECULATORY OR LSC DENTEYING INFORMATION) IP			34G356	B. WING	. WING		04	/21/2021
Image: Proceeding of the second process of the second proces of the second process of the second proc	NAME OF PI	ROVIDER OR SUPPLIER						
Precipitiv TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC. DENTIFYING INFORMATION) PREFIX TAG (EACH ORECORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APROPRIATE DEFICIENCY) W 249 PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) W 249 As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. W 249 This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure a continuous active treatment program to address the needs of 2 of 3 sampled clients (#2, #4, and #6). The findings are: The findings are: Observations in the home on 4/20/21 at 3:17 PM revealed staff already in the kitchen working on supper preparation. Further observations revealed staff already in the kitchen working on supper preparation. Further observations revealed staff already in the kitchen working on supper preparation. Further observations revealed staff already in the kitchen working on supper preparation. Further observations revealed staff already in the kitchen working on supper preparation. Further observations revealed staff already in the kitchen working on supper preparation. Further observations revealed staff already in the kitchen working on supper preparation. Further observations revealed staff already in the kitchen working on the table. Morning observations in the home on 4/21/21 at 6.15 AM revealed client #3 eating breakfast at the table with client #4 and #5 in the living room	ENOCH D	RIVE						
CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure a continuous active treatment program to address the needs of 2 of 3 sampled clients (#3 and #5) and 3 of 3 non-sampled clients (#2, #4, and #6). The findings are: Observations in the home on 4/20/21 at 3:17 PM revealed staff completed all aspects of meal preparation. Further observations revealed staff completed all aspects of meal preparation including stirring, chopping and serving food without client #3 eating breakfast at the table. Morning observations in the home on 4/21/21 at 16 C15 AM revealed client #3 eating breakfast at the table with client #4 and #5 in the living room	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	(X5) COMPLETION DATE
ready for the day. Interview with staff revealed client #4 and client #5 had already eaten and their breakfast was prepared by 3rd shift staff before they left the group home at the end of their shift.	W 249	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 serve and frequency to suppo objectives identified in plan. This STANDARD is r Based on observatio interview the facility fa active treatment prog 2 of 3 sampled clients non-sampled clients (findings are: Observations in the h revealed staff already supper preparation. If revealed staff comple preparation including serving food without of limited help with setting the table. Morning observations 6:15 AM revealed client table with client #4 arr ready for the day. Inter client #4 and client #5 breakfast was prepare they left the group ho) isciplinary team has ndividual program plan, ive a continuous active insisting of needed vices in sufficient number port the achievement of the in the individual program not met as evidenced by: in, record review and ailed to ensure a continuous ram to address the needs of a (#3 and #5) and 3 of 3 #2, #4, and #6). The ome on 4/20/21 at 3:17 PM in the kitchen working on Further observations ted all aspects of meal stirring, chopping and client assistance except for ing cups and silverware on in the home on 4/21/21 at ent #3 eating breakfast at the id #5 in the living room erview with staff revealed is had already eaten and their ed by 3rd shift staff before me at the end of their shift.	W 2	249	DEFICIENCY)		
A. The facility failed to ensure continuous active Itel (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE				-		TITI E		

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ___ 34G356 B. WING 04/21/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4109 ENOCH DRIVE ENOCH DRIVE CHARLOTTE, NC 28269 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 249 Continued From page 1 W 249 treatment to address the needs of client #3. For example: Observation in the group home of client #3 on 4/20/21 at 3:17 PM revealed client #3 to be in his bedroom resting after returning from an outing. Continued observation of client #3 on 4/20/21 at 4:24 PM revealed the client to exit his bedroom wearing pajamas and walk with staff to take his medications. Further observation of client #3 on 4/20/21 at 4:33 PM revealed the client to finish his medications and return to his bedroom. Subsequent observation revealed client #3 on 4/20/21 at 4:50 PM to be prompted by staff to wash his hands and to set the table. Additionally, observation of client #3 on 4/20/21 revealed the client to set the table by placing napkins and spoons on the table. Morning observations of client #3 in the group home on 4/21/21 at 6:20 AM revealed client #3 to take his breakfast dishes to the kitchen and to go take his medications. Further observation of client #3 on 4/21/21 revealed the client to finish his medications and go to the living room to watch TV. Additional observation on 4/21/21 at 7:00 AM revealed client #3 to leave the living room and client to go into his bedroom. Review of records for client #3 on 4/21/21 revealed an ISP dated 5/28/20 with information in it dated 5/30/19. Review of the ISP revealed client #3 to have strengths to include: likes arts and crafts, helpful, able to choose leisure activities, able to understand and follow directions, able to communicate needs and wants, self-sufficient in most daily living skills. Continued review of records for client #3 revealed a community home life assessment dated 5/30/20

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Facility ID: 080760

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 04/23/2021 APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES (X* AND PLAN OF CORRECTION				TIPLE		(X3) DATE SURVEY COMPLETED		
		34G356	B. WING			_	04/	21/2021
NAME OF PI	ROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
ENOCH D	RIVE				109 ENOCH DRIVE CHARLOTTE, NC 28269	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 249	which noted client #3 all meals accurately w review of records for of revealed a training pro- Review of the training #3 revealed a program in domestic cooking. Interview with the qua- professional (QIDP) of can participate in mor Further interview and verified the client espi- has many skills in this B. The facility failed to treatment to address example: Observation in the gro 4/20/21 at 3:17 PM re- the hallway rocking ba- observation of client # revealed the client to and touch the mouse stand and rock back a observation of client # revealed the client to approximately 2 seco hallway to stand and Subsequent observat 4/20/21 at 5:00 PM to table and drink his juid observation of client # client's dinner meal to the dining room table	can set, clean and prepare vith verbal cues. Further client #3 on 4/21/21 ogram record dated 8/2020. I program record for client in for the client to participate alified intellectual disabilities in 4/21/21 verified client #3 re activities in the home. review of client #3's record ecially enjoys cooking and a area. o ensure continuous active the needs of client #5. For bup home of client #5 on evealed client #5 to stand in ack and forth. Continued 45 on 4/20/21 at 3:35 PM walk over to his computer and return to the hallway to and forth. Further 45 on 4/20/21 at 4:06 PM operate the computer for nds and return to the rock back and forth. ion revealed client #5 on e stand at the dining room ce and water. Additionally, 45 on 4/20/21 revealed the be prepared and placed on	W	249				

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		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 04/23/2021 FORM APPROVED OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		34G356	B. WING		_	04/21/2021		
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE			
ENOCH D	RIVE			109 ENOCH DRIVE	9			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)	DATE		
W 249	be dressed and stand computer. Continued 4/21/21 at 6:32 AM re the computer unplugg of the monitor and to the back of the monitor client #5 on 4/21/21 a client was prompted the Additional observation client #5 revealed the Review of records for revealed an ISP date revealed client #5 to H ambulatory, able to for directions/instructions needs/desires, perfor activities with limited s verbal prompting nece record for client #5 re life assessment date #5 can prepare meals assistance and use ki microwave, stove, an- spoons with verbal ar Interview with the qua professional (QIDP) of can participate in mor Further interview and verified the client can and engage in activitie C. The facility failed to treatment to address clients (#2, #4 and #6	ling in the living room at the observation of client #5 on evealed the client to stand at ging the cords from the back replace the cords back into or. Further observation of t 7:19 AM revealed the oy his staff to wipe the table. In on 4/21/21 at 7:30 AM of client was in his bedroom. client #5 on 4/21/21 d 9/24/20. Review of the ISP have strengths to include: illow simple a, can indicate ms most daily living staff assistance and some essary. Continued review of vealed a community home d 9/24/20 which noted client a accurately with physical tchen appliances such as d measuring and mixing ad gestural cues. dified intellectual disabilities in 4/21/21 verified client #5 re activities in the home. review of client #5's record assist with meal preparation res.	W 249					

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ___ 34G356 B. WING 04/21/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4109 ENOCH DRIVE ENOCH DRIVE CHARLOTTE, NC 28269 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 249 Continued From page 4 W 249 revealed client's #2 and #4 to primarily remain in the main living area with client #2 working on stacking blocks at the table or playing with a keyboard in the living room. Client #4 was observed to either sit in a recliner in the living room or put peas in a board at the table. Neither client was observed to participate in any cooking or household chore activities during the afternoon. Further observations during the afternoon revealed client #6 to stay in his room until 4:50 PM when he was prompted to come out of his room and place the cups and drinks for supper on the table. Morning observations in the group home on 4/21/21 from 6:15 AM until 7:30 AM revealed limited activities for these clients. Client #4 was observed to be up and ready at 6:15 AM and sitting in his recliner in the living room. Interview with staff revealed the client had already eaten breakfast before observations began. Further observations revealed except for using a walker to walk to the office to take his medications at 6:45 AM, the client was unengaged in any activity. Morning observations of client #4 and client #6 revealed both clients to get up around 7:00 AM and take their medications. Further observations revealed after taking their medications the clients (#4 and #6) sat down at the table for breakfast after which client #4 sat in the living room playing his keyboard and client #6 returned to his bedroom. The clients were not observed to participate in any activities other than loading their plates in the dishwasher after breakfast. Review of client #2's, client #4's and client #6's ISPs dated 11/5/20, 12/1/20 and 2/26/19, respectively, substantiated by interview with the

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 34G356 B. WING 04/21/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4109 ENOCH DRIVE **ENOCH DRIVE** CHARLOTTE, NC 28269 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 249 Continued From page 5 W 249 home manager and the QIDP, revealed each of the clients to have the ability to participate in activities such as cooking, household chores and activities to promote independence and ensure a continuous active treatment program. W 255 **PROGRAM MONITORING & CHANGE** W 255 CFR(s): 483.440(f)(1)(i) The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: The facility failed to assure objectives contained in the individual support plans (ISPs) for 2 of 3 sampled clients (#3 and #5) were reviewed and revised when the clients met criteria as evidenced by interviews and record verification. The findings are: A. For client #3, review of client #3's ISP dated 5/28/20 but with information dated 5/20/19 revealed 4 of 7 objectives where the client met criteria without any revisions. For example: 1. Review of ISP revealed a laundry program objective for the client to complete his laundry. Review of program progress revealed the client to have met criteria during 12/2020 at 100%, 1/2021 at 100%, 2/2021 at 100%. Further review revealed the progress through 3/2021 remained at 100% without any changes to the program. Interview with the qualified intellectual disabilities professional (QIDP) revealed he and the program manager have worked at the facility for less than a month and have not worked with revising any

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	-	ID HUMAN SERVICES				FORM	APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		34G356	B. WING			04/	21/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ENOCH D	DIVE			4	109 ENOCH DRIVE		
ENOCH				c	CHARLOTTE, NC 28269		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 255	objective for the client of program progress in met criteria during 12 100%, 2/2021 at 100% the progress through without any changes with the QIDP revealed manager have worked a month and have no programs at this point 3. Review of ISP revealed during 12/2020 at 100 2/2021 at 100%. Furt progress through 3/20 without any changes with the QIDP revealed manager have worked a month and have no programs at this point 4. Review of ISP revealed the client to identify sup program progress revealed the client to identify sup program progress revealed the client to identify sup rogram progress revealed the client to identify sup program progress revealed the progress at 100% without any of Interview with the QIDP	t. ealed a flossing program t to floss his teeth. Review revealed the client to have /2020 at 100%, 1/2021 at %. Further review revealed 3/2021 remained at 100% to the program. Interview ed he and the program d at the facility for less than t worked with revising any t. ealed a bathe/shower t. Review of program e client to have met criteria 0%, 1/2021 at 95.45%, and ther review revealed the 021 remained at 100% to the program. Interview ed he and the program d at the facility for less than t worked with revising any t. ealed a vocational goal for afety signs. Review of realed the client to have met 0 at 85.71%, 1/2021 at 100%. Further review a through 3/2021 remained changes to the program. DP revealed he and the ve worked at the facility for d have not worked with		255			
	B. For client #5, revie	w of client #5's ISP dated					

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PRINTED: 04/23/2021 FORM APPROVED

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ___ 34G356 B. WING 04/21/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4109 ENOCH DRIVE ENOCH DRIVE CHARLOTTE, NC 28269 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 7 W 255 W 255 9/24/20 revealed 6 of 12 objectives where the client met criteria without any revisions. For example: 1. Review of ISP revealed an oral hygiene flossing for the client. Review of program progress revealed the client to have met criteria during 12/2020 at 92.54%, 1/2021 at 95.45%, and 2/2021 at 100%. Further review revealed the progress through 3/2021 remained at 100% without any changes to the program. Interview with the QIDP revealed he and the program manager have worked at the facility for less than a month and have not worked with revising any programs at this point. 2. Review of ISP revealed an oral hygiene goal for the client to brush teeth. Review of program progress revealed the client to have met criteria during 12/2020 at 100%, 1/2021 at 98.51%, and 2/2021 at 100%. Further review revealed the progress through 3/2021 remained at 100% without any changes to the program. Interview with the QIDP revealed he and the program manager have worked at the facility for less than a month and have not worked with revising any programs at this point. 3. Review of ISP revealed a communication goal for the client to have expressive communication. Review of program progress revealed client to have progress 12/2020 at 77.73% and to have met criteria 1/2021 at 95.45% and 2/21 at 94.45%. Further review revealed progress through 3/2021 was at 100% without any changes to the program. Interview with the QIDP revealed he and the program manager have worked at the facility for less than a month and have not worked with revising any programs at this point.

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 04/23/2021 MAPPROVED). 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	l`´´		CONSTRUCTION	(X3) DATE	
		34G356	B. WING			04/	21/2021
NAME OF PF	ROVIDER OR SUPPLIER		•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
ENOCH DI	RIVE				109 ENOCH DRIVE HARLOTTE, NC 28269		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
W 255	Continued From page	8	w	255			
	client reduce rate of e progress revealed clie 12/2020 at 96.83%, 1 at 98.48%. Further re through 3/2021 remai changes to the progra revealed he and the p worked at the facility f	ealed a dining goal for the eating. Review of program ent to have met criteria /2021 at 100%, and 2/2021 eview revealed progress ned 100% without any am. Interview with the QIDP program manager have for less than a month and revising any programs at					
	client to close the batt program progress rev criteria 12/2020 at 100 2/2021 at 100%. Furt progress through 3/20 any changes to the pr QIDP revealed he and have worked at the fat	ealed a privacy goal for the hroom door. Review of realed client to have met 0%, 1/2021 at 100%, and ther review revealed 021 remained 100% without rogram. Interview with the d the program manager cility for less than a month with revising any programs					
W 257	for the client to have a (day). Review of prog met criteria 12/2020 a and 2/2021 at 100%. progress through 3/20 any changes to the pro QIDP revealed he and have worked at the fa and have not worked at his point.	ealed a communication goal expressive communication gram revealed client to have at 90.32%, 1/2021 at 100% Further review revealed 021 remained 100% without rogram. Interview with the d the program manager cility for less than a month with revising any programs	w	257			
vv 257	CFR(s): 483.440(f)(1)			<u>2</u> 57			

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	-	D HUMAN SERVICES MEDICAID SERVICES				PRINTED: 04 FORM API OMB NO. 09	PROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		_	(X3) DATE SURVEY COMPLETED	
		34G356	B. WING			04/21/2	021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
ENOCH D	RIVE			4109 ENOCH DRIVE CHARLOTTE, NC 2826	69		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)	-	(X5) MPLETION DATE
W 257	Continued From page	9	W 25	57			
	least by the qualified professional and revis but not limited to situa	sed as necessary, including, ations in which the client is /ard identified objectives					
	The facility failed to a in the individual suppo sampled clients (#1 a revised when the client	not met as evidenced by: assure objectives contained ort plans (ISPs) for 2 of 3 nd #5) were reviewed and hts were failing to make d by interviews and record ngs are:					
	9/25/20 revealed 5 of	w of client #1's ISP dated 9 objectives where the ake progress without any le:					
	objective for the client Review of program pro complete the objective review revealed progra remained at 0% without program. Interview we disabilities profession the program manager	revealed a communication to use a picture board. ogress revealed the client to e at 0% in 9/2020. Further ress through 3/2021 has out any changes to the ith the qualified intellectual al (QIDP) revealed he and thave worked at the facility d have not worked with s at this point.					
	objective for the client he wants to interact w	revealed a communication t to touch/point to an object with. Review of program client to complete the 020. Further review					

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 34G356 B. WING 04/21/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4109 ENOCH DRIVE **ENOCH DRIVE** CHARLOTTE, NC 28269 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 257 Continued From page 10 W 257 revealed progress through 3/2021 has remained at 0% without any changes to the program. Interview with the QIDP revealed he and the program manager have worked at the facility less than a month and have not worked with revising any programs at this point. 3. Review of the ISP revealed a program for the client to remain clothed in common areas. Review of program progress revealed the client to complete the objective at 0% in 9/2020. Further review revealed progress through 3/2021 has remained at 0% without any changes to the program. Interview with the QIDP revealed he and the program manager have worked at the facility less than a month and have not worked with revising any programs at this point. 4. Review of the ISP revealed a program for the client to participate in an activity for 20 minutes. Review of program progress revealed the client to complete the objective at 0% in 9/2020. Further review revealed progress through 3/2021 has remained at 0% without any changes to the program. Interview with the QIDP revealed he and the program manager have worked at the facility less than a month and have not worked with revising any programs at this point. 5. Review of the ISP revealed a program for the client to participate in a community outing. Review of program progress revealed the client to complete the objective at 0% in 11/2020 when the program was new. Further review revealed progress through 3/2021 has remained at 0% without any changes to the program. Interview with the QIDP revealed he and the program manager have worked at the facility less than a month and have not worked with revising any

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 34G356 B. WING 04/21/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4109 ENOCH DRIVE ENOCH DRIVE CHARLOTTE, NC 28269 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 257 Continued From page 11 W 257 programs at this point. B. Review of client #5's ISP dated 9/24/20 revealed 2 of 12 objectives where the client was failing to make progress without any revisions. For example: 1. Review of ISP revealed a safety awareness objective for the client to identify safety signs. Review of program progress revealed the client to complete the objective of 0% 12/2020. Further review revealed the progress through 3/2021 has remained at 0% without any changes to the program. Interview with the QIDP revealed he and the program manager have worked at the facility for less than a month and have not worked with revising any programs at this point. 2. Review of ISP revealed a communication objective for the client to have expressive communication (initiating). Review of program progress revealed the client to complete the objective 0% 9/2020. Further review revealed the progress through 3/2021 has remained at 0% without any changes to program. Interview with the QIDP revealed he and the program manager have worked at the facility for less than a month and have not worked with revising any programs at this point. W 260 **PROGRAM MONITORING & CHANGE** W 260 CFR(s): 483.440(f)(2) At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by:

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	-	ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 04/23/2021 FORM APPROVED OMB 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
		34G356	B. WING		_	04/21/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	
ENOCH D	RIVE			109 ENOCH DRIVE	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 BE NCED TO THE APPROPRIA DEFICIENCY)	DATE
W 260	individual support pla the group home (#3 a updated at least annu evidenced by intervie The finding is: Review of client #3's revealed the ISPs ava current. For client #3 client's ISP was dated information contained and appointments the 2019. For client #6, a cover ISP was dated 2/20/2 manager revealed he qualified intellectual of (QIDP) having a more client #6 in 2/2021, he	have evidence that the ns (ISPs) for 2 of 6 clients in and #6) were revised and ually as required as w and record verification. and client #6's ISPs ailable for review were not a coversheet for the d 5/28/20 but the date on I 5/30/19. In addition, d in the ISP related to events e client had in 2018 and sheet for the most available co. Interview with the home remembers the previous disabilities professional e recent meeting regarding owever no updated ISP was r use by the team to direct	W 260			

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