DEPART	MENT OF HEALTH	AND HUMAN SERVICES			·		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				E SURVEY PLETED
		34G220	B. WING			07/	10/2024
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	ILSON AVENUE GRO			2	103 WILSON AVENUE		
VUCA-W	ILSON AVENUE GRO			C	HARLOTTE, NC 28208		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	REGULATORY OR L EP Testing Require CFR(s): 483.475(d) §416.54(d)(2), §418 §460.84(d)(2), §482 §485.542(d)(2), §482 §485.542(d)(2), §48 §485.542(d)(2), §48 §485.542(d)(2), §48 *[For ASCs at §416 at §485.542, OPO, §485.727, CMHCs §491.12, and ESRE (2) Testing. The [fact to test the emergen must do all of the for (i) Participate in a fut community-based of (A) When a comm accessible, conduct exercise every 2 yet (B) If the [facilitt natural or man-made activation of the emergen exempt from engage community-based of functional exercise actual event. (ii) Conduct an add years, opposite the	SC IDENTIFYING INFORMATION) ments (2) 8.113(d)(2), §441.184(d)(2), 2.15(d)(2), §483.73(d)(2), 34.102(d)(2), §485.68(d)(2), 35.625(d)(2), §485.727(d)(2), 91.12(d)(2), §494.62(d)(2). 6.54, CORFs at §485.68, REHs "Organizations" under at §485.920, RHCs/FQHCs at D Facilities at §494.62]: cility] must conduct exercises here a state and the second se			CROSS-REFERENCED TO THE APPROP		
	this section is cond not limited to the fo (A) A second full-so community-based of functional exercise; (B) A mock disaster	ucted, that may include, but is llowing: cale exercise that is or individual, facility-based ; or r drill; or					
		cise or workshop that is led by					
LABORATOR	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE		TITLE		(X6) DATE

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

PRINTED: 07/11/2024

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.

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		TE SURVEY	
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	CO	MPLETED	
		34G220	B. WING _		07	07/10/2024	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2103 WILSON AVENUE			
VOCA-W	ILSON AVENUE GRO	UP HOME		CHARLOTTE, NC 28208			
(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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETIC DATE	
E 039	a facilitator and incl a narrated, clinically scenario, and a set directed messages, designed to challen (iii) Analyze the [fac maintain document exercises, and emer [facility's] emergend *[For Hospices at 4 (2) Testing for hosp patient's home. The exercises to test the annually. The hosp (i) Participate in a f community based et (A) When a commu- accessible, conduct functional exercise (B) If the hospice ex- man-made emerge the emergency plar engaging in its next community-based functionset of the emergency (ii) Conduct an addo opposite the year the exercise under para is conducted, that no to the following: (A) A second full-sec community-based of exercise; or (B) A mock disaster (C) A tabletop exert	udes a group discussion using y-relevant emergency of problem statements, or prepared questions ge an emergency plan. Sility's] response to and ation of all drills, tabletop ergency events, and revise the cy plan, as needed. 18.113(d):] bices that provide care in the e hospice must conduct e emergency plan at least bice must do the following: full-scale exercise that is every 2 years; or unity based exercise is not t an individual facility based every 2 years; or xperiences a natural or ncy that requires activation of n, the hospital is exempt from a required full scale exercise or individual onal exercise following the ency event. Itional exercise every 2 years, he full-scale or functional agraph (d)(2)(i) of this section may include, but is not limited cale exercise that is or a facility based functional	E 03	39			

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		AND HUMAN SERVICES				FORM	07/11/2024 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		34G220	B. WING			07/	10/2024
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
VOCA-W	VILSON AVENUE GRO				103 WILSON AVENUE CHARLOTTE, NC 28208		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 039	a narrated, clinically scenario, and a set directed messages designed to challen (3) Testing for hosp care directly. The h exercises to test the year. The hospice (i) Participate in an is community-based (A) When a commu- accessible, conduct facility-based functi (B) If the hospice et man-made emerge the emergency plar engaging in its next based or facility-based following the onset (ii) Conduct an ador may include, but is (A) A second full-s- community-based or exercise; or (B) A mock disaste (C) A tabletop exer facilitator that include narrated, clinically-r and a set of probler messages, or prepa- challenge an emerge (iii) Analyze the ho- maintain document exercises, and emerge	y-relevant emergency of problem statements, or prepared questions age an emergency plan. bices that provide inpatient hospice must conduct e emergency plan twice per must do the following: a annual full-scale exercise that d; or unity-based exercise is not a annual individual ional exercise; or xperiences a natural or ency that requires activation of n, the hospice is exempt from t required full-scale community sed functional exercise of the emergency event. ditional annual exercise that not limited to the following: cale exercise that is or a facility based functional er drill; or rcise or workshop led by a des a group discussion using a relevant emergency scenario, m statements, directed ared questions designed to	EO	139			

Facility ID: 922891

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	RS FOR MEDICARE OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED	
		BERTHIO, THOR HOWBER.	A. BUILDIN	G			
		34G220	B. WING		•	/10/2024	
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	Ē		
VOCA-W	ILSON AVENUE GRO	UP HOME		2103 WILSON AVENUE CHARLOTTE, NC 28208			
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
E 039	Continued From pa	ige 3	E 03	9			
	§482.15(d), CAHs a (2) Testing. The [Pf conduct exercises of twice per year. The do the following: (i) Participate in an is community-based (A) When a commu accessible, conduct facility-based function (B) If the [PRTF, Ho actual natural or ma requires activation [facility] is exempt f required full-scale of facility-based function (facility-based function) [facility-based function (ii) Conduct an and that may include following: (A) A second full-sc community-based of functional exercises (B) A mock (C) A tabletop of led by a facilitator at discussion, using a emergency scenari statements, directed questions designed plan. (iii) Analyze the maintain document	RTF, Hospital, CAH] must to test the emergency plan e [PRTF, Hospital, CAH] must a annual full-scale exercise that d; or unity-based exercise is not t an annual individual, ional exercise; or ospital, CAH] experiences an an-made emergency that of the emergency plan, the rom engaging in its next community based or individual, ional exercise following the ency event. a [additional] annual exercise or de, but is not limited to the cale exercise that is or individual, a facility-based					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		34G220	B. WING _		07/10/2024
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	
VOCA-W	ILSON AVENUE GRO	UP HOME		2103 WILSON AVENUE CHARLOTTE, NC 28208	
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMPLETIC IE APPROPRIATE DATE
E 039	 (2) Testing. The PA exercises to test the annually. The PACE following: (i) Participate in an is community-based (A) When a commu- accessible, conduct facility-based functii (B) If the PACE exp man-made emerged the emergency plane engaging in its next based or individual, exercise following to event. (ii) Conduct an years opposite the exercise under para is conducted that may the following: (A) A second full-second full-second functional exercise; (B) A mock disaster (C) A tabletop exert a facilitator and inclusing a narrated, cl scenario, and a set directed messages designed to challent 	CE organization must conduct e emergency plan at least E organization must do the annual full-scale exercise that d; or unity-based exercise is not t an annual individual, ional exercise; or periences an actual natural or ency that requires activation of n, the PACE is exempt from t required full-scale community facility-based functional he onset of the emergency additional exercise every 2 year the full-scale or functional agraph (d)(2)(i) of this section hay include, but is not limited to cale exercise that is or individual, a facility based ; or	E 03	9	

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TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED	
		34G220	B. WING _		07	07/10/2024	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
VOCA-W	ILSON AVENUE GRO	UP HOME		2103 WILSON AVENUE CHARLOTTE, NC 28208			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
E 039	test the emergency including unannoun emergency procedu ICF/IID] must do the (i) Participate in an is community-based (A) When a commu- accessible, conduct facility-based functi (B) If the [LTC facility actual natural or ma- requires activation of LTC facility is exem- required a full-scale individual, facility-ba- following the onset (ii) Conduct an add may include, but is (A) A second full-sc community-based of functional exercise; (B) A mock disaste (C) A tabletop exer a facilitator includes narrated, clinically-r and a set of probler messages, or prepa- challenge an emerg (iii) Analyze the [LT and maintain docur exercises, and emergent [LTC facility] facility *[For ICF/IIDs at §4 (2) Testing. The ICF to test the emergent The ICF/IID must d	 plan at least twice per year, need staff drills using the ures. The [LTC facility, e following: annual full-scale exercise that d; or unity-based exercise is not t an annual individual, onal exercise. ty] facility experiences an an-made emergency that of the emergency plan, the of the emergency plan, the of the emergency event. ditional annual exercise that not limited to the following: cale exercise that is or an individual, facility based is or er drill; or rcise or workshop that is led by a group discussion, using a relevant emergency scenario, m statements, directed ared questions designed to gency plan. C facility] facility's response to nentation of all drills, tabletop ergency events, and revise the 's emergency plan, as needed. 83.475(d)]: F/IID must conduct exercises or year. 	E 03	39			

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TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED	
		34G220	B. WING_		07	07/10/2024	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI 2103 WILSON AVENUE	•		
OCA-W	ILSON AVENUE GRO	UP HOME		CHARLOTTE, NC 28208			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
E 039	is community-based (A) When a commu accessible, conduc facility-based functi (B) If the ICF/IID ex- man-made emerge the emergency plar engaging in its next community-based of functional exercise emergency event. (ii) Conduct an add may include, but is (A) A second full-so community-based of functional exercise; (B) A mock disaster (C) A tabletop exerce a facilitator and inclusing a narrated, cl scenario, and a set directed messages designed to challen (iii) Analyze the ICF maintain document exercises, and emergent least annually. The (i) Participate in a fu community-based; (A) When a cor accessible, conduc	d; or unity-based exercise is not t an annual individual, onal exercise; or. speriences an actual natural or ncy that requires activation of n, the ICF/IID is exempt from t required full-scale or individual, facility-based following the onset of the itional annual exercise that not limited to the following: cale exercise that is or an individual, facility-based for r drill; or cise or workshop that is led by ludes a group discussion, inically-relevant emergency of problem statements, , or prepared questions ige an emergency plan. F/IID's response to and ation of all drills, tabletop ergency events, and revise the cy plan, as needed.	Ε 0	39			

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TATEMEN	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
		34G220	B. WING		07	14010004
	PROVIDER OR SUPPLIER	040220		STREET ADDRESS, CITY, STATE, ZIP	•	/10/2024
	ILSON AVENUE GRO	UP HOME		2103 WILSON AVENUE CHARLOTTE, NC 28208	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
E 039	 (B) If the HHA or man-made emeries of the emergency pengaging in its next community-based of functional exercise emergency event. (ii) Conduct an add opposite the year the exercise under parais conducted, that limited to the follow (A) A second functional exercise; (B) A mock disa (C) A tabletop of functional exercise; (B) A mock disa (C) A tabletop of led by a facilitator a discussion, using a emergency scenari statements, directe questions designed plan. (iii) Analyze the HH documentation of a emergency plan, as *[For OPOs at §486 (d)(2) Testing. The to test the emerger of following: (i) Conduct a paper workshop at least a led by a facilitator a discussion, using a emergency scenari 	experiences an actual natural rgency that requires activation lan, the HHA is exempt from the required full-scale or individual, facility based following the onset of the itional exercise every 2 years, the full-scale or functional agraph (d)(2)(i) of this section at may include, but is not ing: ill-scale exercise that is or an individual, facility-based for aster drill; or exercise or workshop that is and includes a group narrated, clinically-relevant o, and a set of problem d messages, or prepared I to challenge an emergency A's response to and maintain II drills, tabletop exercises, and and revise the HHA's is needed.	Ε 03	39		

If continuation sheet Page 8 of 16

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY MPLETED	
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING				
		34G220	B. WING			•	/10/2024	
					EET ADDRESS, CITY, STATE, ZIP CODE 3 WILSON AVENUE	E		
VOCA-W	ILSON AVENUE GRO	DUP HOME		CHARLOTTE, NC 28208				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
E 039	Continued From pa	age 8 I to challenge an emergency	EC	39				
	plan. If the OPO ex- man-made emerger the emergency plan engaging in its nex following the onset (ii) Analyze the OPO documentation of a emergency events, OPO's] emergency *[RNCHIs at §403. (d)(2) Testing. The exercises to test th must do the followi (i) Conduct a paper least annually. A ta discussion led by a clinically-relevant e of problem statement prepared questions emergency plan. (ii) Analyze the RN maintain document and emergency even emergency plan, as This STANDARD in Based on record re failed to conduct bi emergency prepare finding is: Review on 7/9/24 c	cperiences an actual natural or ency that requires activation of n, the OPO is exempt from t required testing exercise of the emergency event. O's response to and maintain all tabletop exercises, and , and revise the [RNHCI's and plan, as needed.						

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STATEMENT	OF DEFICIENCIES	KOMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· /	TE SURVEY MPLETED	
			A. BUILDING			IVIPLE I ED	
		34G220	B. WING			/10/2024	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	E		
VOCA-W	ILSON AVENUE GRO	OUP HOME	2103 WILSON AVENUE CHARLOTTE, NC 28208				
(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 APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
E 039	facility had no evide community or facili	ence of an additional full-scale ty-based training, or an	E 039				
W 249	additional mock dri PROGRAM IMPLE CFR(s): 483.440(d	MENTATION	W 249				
	formulated a client each client must re- treatment program interventions and s and frequency to s	erdisciplinary team has is individual program plan, eceive a continuous active consisting of needed ervices in sufficient number upport the achievement of the d in the individual program					
	Based on observa interviews, the facil clients (#5) receive treatment program	is not met as evidenced by: tions, record reviews, and lity failed to ensure that 1 of 6 d a continuous active as identified in the Individual relative to implementing finding is:					
	survey on 7/9/24 - participate in the di Continued observa prepared the dinne no client participati revealed that client breakfast meal qui the air. At no time of staff observed to p	e group home throughout the 7/10/24 revealed client #5 to nner meal and breakfast meal. tions revealed that staff r meal and breakfast meal with on. Further observations #5 ate both his dinner and ckly while holding his plate in during the observations was rompt client #5 to pace himself nsure the client is not at risk for					

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		AND HUMAN SERVICES				FORM	07/11/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G220	B. WING	;		07/ [,]	10/2024
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
VOCA-W	ILSON AVENUE GRO	UP HOME			2103 WILSON AVENUE CHARLOTTE, NC 28208		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 249	revealed a ISP date of the ISP revealed provided with 2 veri during mealtimes a months. The goal w Interview with the q professional (QIDP client #5's PCP is c with the QIDP confi implementing client DRUG ADMINISTR CFR(s): 483.460(k) The system for drug that all drugs, inclus self-administered, a This STANDARD is Based on observat interview, the facilit were administered ((#5) observed durin The finding is: Observation in the g AM revealed staff to medication packets the client. Further of educated client #5 a medications into a f was observed to tal water. Review of records f	on 7/10/24 for client #5 ed 4/30/24. Continued review a goal for client #5 to be bal prompts to pace himself t 85% for 3 consecutive vas implemented on 1/16/24. ualified intellectual disabilities) on 7/10/24 confirmed that urrent. Continued interview irmed that staff should be t #5's training goals. CATION (2) g administration must assure	w :)		
	revealed physicial	5 5 46 5 42 64 7/ 10/24.					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		E SURVEY
	of CORRECTION	IDENTIFICATION NOWBER.	A. BUILDIN	G		IFLE I ED
		34G220	B. WING		07/	/10/2024
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-W	ILSON AVENUE GRO	OUP HOME		2103 WILSON AVENUE CHARLOTTE, NC 28208		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
W 369	medications to adm Bisacodyl Tab 5 MG ER (2 tablets), Esc Vitamin D 2000 Un 0.5 MG, Multivitam Tab, and Vraylar Ca medication adminis staff was observed for client #5 except is equivalent to Ativ Additionally, the su	age 11 /24 physician's orders revealed hinister at 8:00 AM to be G EC, Divalproex Tab 500 MG italopram Tab 20 MG, GNP it (50MCG), Lorazepam Tab in Tab, Trihexyphenidyl 2 MG ap 4.5 MG. During survey stration observation of staff, to administer all medications : Lorazepam Tab 0.5MG which van 1.5 MG for anxiety. rveyor notified the facility nurse on reconciling current	W 36	9		
W 436	confirmed the 7/10 #5 to be current. Co facility nurse revea medications as pre- the facility nurse re- discontinued in error authorized the staff administer client #5 time prescribed. SPACE AND EQUI CFR(s): 483.470(g)(2)	W 43	6		
	and teach clients to choices about the u hearing and other of and other devices i interdisciplinary tea This STANDARD i Based on observa interview, the facilit	rnish, maintain in good repair, o use and to make informed use of dentures, eyeglasses, communications aids, braces, dentified by the am as needed by the client. s not met as evidenced by: tions, record review and by failed to assure that adaptive hished as prescribed for 1 of 6				

Facility ID: 922891

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		AND HUMAN SERVICES & MEDICAID SERVICES				FOF	ED: 07/11/2024 MAPPROVED O. 0938-0391			
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED			
		34G220	B. WING			0	7/10/2024			
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE					
VOCA-W	ILSON AVENUE GRO	UP HOME	2103 WILSON AVENUE CHARLOTTE, NC 28208							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE			
W 436	Continued From pa clients (#5). The fin	•	W 4	36						
	During bservations in the group home during recertification survey 7/9/24 -7/10/24 revealed client #5 to participate in the dinner meal and breakfast meal. Continued observations revealed client #4 to be provided the following adaptive equipment: a high sided deep dish for the meals. At no point during the observations was client #5 observed to be provided his prescribed high sided divided dish.									
	revealed an individu 4/30/24. Continued occupational therap 4/6/22 for client #5 dish to maintain spi	for client #5 on 7/10/24 ual support plan (ISP) dated review of ISP revealed an by feeding assessment dated to use a high sided divided llage and to slow client's pace crease his choking risk.								
W 475	professional (QIDP #5 has a prescribed Continued interview client #5 should be adaptive equipment		W 4	75						
	This STANDARD is Based on observat interviews, the facili clients (#1, #5, #6) appropriate utensils independently as po	ed with appropriate utensils. s not met as evidenced by: ions, record review and ity failed to ensure that 3 of 5 were provided with s to allow them to eat as ossible. The findings are: d to provide client #1 with								

Facility ID: 922891

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		AND HUMAN SERVICES				FORM	07/11/2024 APPROVED 0938-0391			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ·		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
		34G220	B. WING	i		07/ [.]	10/2024			
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE					
VOCA-W	ILSON AVENUE GRO	UP HOME	2103 WILSON AVENUE CHARLOTTE, NC 28208							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
W 475	appropriate utensils Observations in the PM revealed the dir dinner meal with cli consisting of a regu and a bowl. Continu #1 to be served the chicken breast, bak cantaloupe, juice ar revealed client #1 to breast with his fork Observations in the 6:40 AM revealed th breakfast with clien of a regular plate, a Continued observation each food item and Record review on 7 Support Plan (ISP) Nutritional Evaluation client #1 does not ro mealtimes. Continu Home Life Assessin states that client #1 regular or adaptive verbal cues for knife Interview with the q professional (QIDP client #1 should be	s. For example: e group home on 7/9/24 at 5:15 ning room table set for the ient #1's place setting ular plate, a regular cup, a fork ued observation revealed client e dinner meal of buffalo (ad beans, mixed vegetables, nd water. Further observation o pick up his entire chicken and eat it one bite at a time. e group home on 7/10/24 at he dining room table set for it #1's place setting consisting a regular cup and no utensils. tion revealed client #1 to be onsisting of one boiled egg, wheat bread, juice and milk. n revealed client #1 to pick up l eat them with his hands. 7/10/24 revealed a Individual for client #1 which includes a on dated 4/2/24 stating that require adaptive equipment at ued record review revealed a ment dated 12/29/23 which 1 "Uses all utensils as needed; (independent with spoon, fork, ie)."	W 2	175						

Facility ID: 922891

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MUL A. BUILDI		· · ·	(X3) DATE SURVEY COMPLETED	
		B. WING			07/10/2024		
NAME OF PROVIDER OR SUPPLIER				STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-W	ILSON AVENUE GRO	OUP HOME		2103 CHA			
(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 APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 475	Continued From pa	age 14	W 4	75			
	 B. The facility failed to provide client #5 with appropriate utensils. For example: Observations in the group home on 7/9/24 at 5:15 PM revealed the dining room table set for the dinner meal with client #5's place setting consisting of two high sided plates, a regular cup, a spoon and a bowl. Continued observation revealed client #5 to be served the dinner meal of buffalo chicken breast, baked beans, mixed vegetables, cantaloupe, juice and water. Further observation revealed client #5 to consume his entire meal with a spoon. 						
	6:40 AM revealed t breakfast with clien of a high sided plat utensils. Continued to be served breakt egg, two slices of w milk. Further obser	e group home on 7/10/24 at he dining room table set for it #5's place setting consisting e, a regular cup and no l observation revealed client #5 fast consisting of one boiled whole wheat bread, juice and vation revealed that, while g his food with his hands, staff a fork and spoon.					
	client #5 dated 4/30	7/10/24 revealed a ISP for 0/24 stating that client #5 n sided divided dish as t at mealtimes.					
	client #5 should be	QIDP on 7/10/24 confirmed that offered a full set of utensils at to provide him with the ndependence.					
	C. The facility failed appropriate utensils	d to provide client #6 with					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) Mul ⁻ A. Buildi		00000000000000000000000000000000000000			
		B. WING					
NAME OF PROVIDER OR SUPPLIER							ST 21 C
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		HARLOTTE, NC 28208 PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE
W 475	PM revealed the d dinner meal with c consisting of a reg spoon and a bowl. revealed client #6 buffalo chicken brev vegetables, cantale observation reveal pieces of the chick hands. Observations in the 6:40 AM revealed breakfast with clien of a regular plate, a Continued observation each food item and Record review on client #6 which inc Evaluation dated 9 independent at sel review revealed a 7/3/23 which states fork and knife inde	ining room table set for the lient #6's place setting ular plate, a regular cup, a Continued observation to be served the dinner meal of east, baked beans, mixed oupe, juice and water. Further ed client #6 to pick small ten breast off and eat it with her e group home on 7/10/24 at the dining room table set for nt #6's place setting consisting a regular cup and no utensils. ation revealed client #6 to be consisting of one boiled egg, e wheat bread, juice and milk. n revealed client #6 to pick up d eat them with her hands. 7/10/24 revealed a ISP for ludes an Occupational Therapy 0/30/21 stating that client #6 is f-feeding. Continued record Home Life Assessment dated s that client #6 uses a spoon, opendently. QIDP on 7/10/24 confirmed that e offered a full set of utensils at r to provide her with the	W 4	.75			

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