PRINTED: 05/24/2024 FORM APPROVED OMB NO. 0938-0391

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	34G165	B. WING		05/23/202		
OCA-WOODBRIDGE ROAD	GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP COD 5901 WOODBRIDGE ROAD CHARLOTTE, NC 28227	E		
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
developmental lev This STANDARD is Based on observation interviews, the faci form consistent with prescribed diets of The findings are:  A. Observations is at 5:08 PM revealed dinner meal consist homemade pepper cocktail and sugar observation revealed assistance from states sized pieces. Furth #3 to consume one including her pizzated during the dinner meal modified to a chopper prescribed diet order revealed a nutrition for client #2 which is a chopped diet.  Interview with the fate 5/23/24 confirms clied current. Continued confirms staff should meal in chopped continued continued confirms staff should meal in chopped continued contin	red in a form consistent with the el of the client. In some that as evidenced by: tions, record review, and lity failed to serve food in a high the developmental level and a of 6 clients (#2, #5, and #6). In the group home on 5/22/24 did client #3 to participate in the ting of the following: oni pizza, broccoli, fruit free punch. Continued and client #2 to receive off in cutting her pizza into bite are observation revealed client hundred percent of her meal, and fruit cocktail. At no point and fruit cocktail. At no point and fruit cocktail. At no point and fruit cocktail are consistency per her ers.  In 5/23/24 for client #2 and assessment dated 5/9/24 and assessment dated 5/9/24 and cates that client #2 requires cility registered nurse (RN) on an ent #2's chopped diet is interview with the RN di have presented client #2's insistency as prescribed.  The group home on 5/22/24 client #5 to participate in the ang of the following:		Facility will ensure food is serve appropriate consistency at all tinclient diet order.  To ensure needs are met: A. QII review client #2, #5 and #6 diet of document. in a core team note.  To prevent reoccurrence: B. QID all staff on client #2, #5, #6 and a individual diets.  C. QIDP and Site Supervisor will conduct weekly meal observationme and document on meal obsform.  Person (s) Responsible: QIDP and Supervisor  RECEIVED  IVIN 0 5 2024  DHSR-MH Licensure Sect	DP will border and P will train all		

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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DA	(X3) DATE SURVEY COMPLETED	
		34G165	B. WING	;		0.5	5/23/2024	
VOCA-W	PROVIDER OR SUPPLIER			5901 V	T ADDRESS, CITY, STATE, ZIP CODE WOODBRIDGE ROAD RLOTTE, NC 28227		72012024	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	25.55	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
	cocktail and sugar f observation revealed assistance from state into bite size pieces revealed client #5 to percent of her meal, cocktail. At no point client #5's pizza cut her prescribed diet of Review of records of revealed a nutritional for client #5's which requires her food to consistency.	oni pizza, broccoli, fruit ree punch. Continued ad client #5 to receive ff in cutting her whole pizza. Further observations o consume one hundred including her pizza and fruit during the dinner meal was into ½" chopped pieces per orders.  In 5/23/24 for client #5 al assessment dated 5/9/24 indicates that client #5 be of ½" chopped	W	174				
	½" chopped consisted the RN revealed clie Continued interview should have present: ½"chopped consisted C. Observations in	ency. Continue interview with nt #5's diet is current. with the RN confirms staff ed client #5's meal in ncy as prescribed.						
1 1 0 5	dinner meal consistir homemade pizza, bronectar thickened sug observation revealed be presented to her it thick resulting in cought dinner meal. Furtishat staff did nothing client #6's pureed for swallow without cought.	client #6 to participate in the ng of the following: pureed occoli, fruit cocktail and ar free punch. Continued client #6's pureed pizza to n a consistency that was too ghing episodes throughout her observation revealed to change the consistency of od in order to allow her to hing.						
,	AM to 7:18 AM reveal	led client #6 to participate in						

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CTATEMENT OF DESIGNATION		1				<u> </u>		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
Charles Control of the Control of th	IDENTIFICATION NOWBER.		A. BUILDING			C	COMPLETED	
		34G165						
NAME OF	PROVIDER OR SUPPLIER	346165	B. WINC			0	05/23/2024	
					TREET ADDRESS, CITY, STATE, ZIP CODE			
VOCA-V	VOODBRIDGE ROAD	GROUP HOME			901 WOODBRIDGE ROAD			
0(0)15	CHAMADYOT			CI	HARLOTTE, NC 28227			
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	IV.	PROVIDER'S PLAN OF CORRECTION	ON (X5)		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	) BE RIATE	COMPLETION	
					DEFICIENCY)			
101.47.4								
VV 4/4	Continued From page		W	174				
	the breakfast meal	consisting of the following:						
	pureed cheerios cer	real with milk and honey						
	thickened apple juic	e. Continued observation						
	revealed client #6 to	eat from a scoop bowl which						
	was placed on her v	wheelchair table top with no						
	assistance from star	ff, while her juice cup was						
	Further observation	room table, out of her reach. at 7:18 AM revealed staff to						
	hand client #6 her n	ectar thickened apple juice						
	with instructions to o	frink and clear her food.						
	Subsequent observa	ation at 7:19 AM revealed						
	staff removed client	#6's beverage and returned						
	her bendable spoon	to allow her to resume eating						
	independently. Addit	tional observation revealed						
client #6's cheerios to be of a thicker consistency								
which resulted in frequent coughing throughout								
	the breakfast meal, v	which was consumed absent						
	appropriate staff sup	ervision.						
	Review of client #6's	record on 5/23/24 revealed						
	a nutritional assessm	nent dated 5/9/24 for client						
	#6's diet as follows: r	egular, pureed, sugar and						
	dairy free with no ice	cream or Jell-O (gelatin).						
	Honey thickened liqu	ids. Must be elevated at 90						
	degrees during meals	times. Paced eating program						
	to include alternating	two bites and one sip.						
	Spoon should be held	d at 180 degrees, level with						
	her mouth	5/00/D4						
		on 5/23/24 confirmed client						
1	#6's prescribed diet is	royallad aliant #01-						
,	diet consistency show	revealed client #6's pureed Ild be moistened to a						
,	consistency similar to	creamy mashed potatoes.						
ì	Further interview con	firmed specially modified						
	diets should always h	e followed as prescribed.						
	Subsequent interview	with the RN revealed client						
#	#6 really enjoys her n	neals and the correct						
C	consistency would red	duce the coughing						
E	experienced during m	ealtime when presented as					1	

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STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DA	(X3) DATE SURVEY COMPLETED	
		34G165	B. WING		0,	5/23/2024
	PROVIDER OR SUPPLIER	67 1-2-27-880	5	STREET ADDRESS, CITY, STATE, ZIP CODE 5901 WOODBRIDGE ROAD CHARLOTTE, NC 28227	0	0/23/2024
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 474	Continued From payordered, with all guid	ge 3 delines/protocols followed.	W 474			