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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G201	A. BUILDING ______ B. WING ______	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-OAK DRIVE GROUP HOME	**5416 OAK DRIVE CHARLOTTE, NC 28216**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A complaint survey was completed on 10/8/24 for intake #NC00222748. The complaint was substantiated, and deficiencies were cited.	W 000		
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation and interviews, the governing body and management failed to exercise general policy and operating direction over the facility by failing to maintain a sanitary and orderly interior. The findings are: Observations in the home on 10/8/24 from 7:15AM through 8:45AM revealed the home to have a strong odor of urine and body odor, in the hallways and coming from some of the client's bedrooms. Interview on 10/8/24 with the area supervisor confirmed the smell of urine and body odor throughout the hallways and coming from some of the bedrooms. Interview on 10/8/24 with the qualified intellectual disabilities professional (QIDP) revealed staff are to utilize a daily checklist that includes ensuring the home is cleaned. The QIDP also confirmed the home should not smell like urine or body odor. B. Observations in the home on 10/8/24 revealed the home to have two pantries with a limited amount of food in each. Continued observations revealed the hallway pantry to have some expired	W 104		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) 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.

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W 104	Continued From page 1 food items to include cookies, oatmeal crème pies (12 pack), a box of crackers, as well as other food items to expire in one month. Further observations revealed the last shopping date on all the food items located in the hallway pantry was dated 10/3 and there was no evidence of any current groceries stored in the pantry or emergency food supply. Subsequent observations revealed there were no fresh, canned or frozen fruits, orange or apple juice, and no sugar free syrup per menu items at the facility. Furthermore, there was no current menu posted at the home for the week of 10/7/24-10/13/24 for staff to follow. Review on 10/8/24 of the facility's grocery receipts dated 10/2023 through 10/2024 revealed there was no evidence of a receipt for 10/3/24 to verify food items were recently purchased. Interview on 10/8/24 with the QIDP revealed staff are responsible for purchasing groceries based on what is listed on the facility's approved weekly menus or as needed. Further interview with the QIDP revealed food items should be rotated to prevent food items from expiring.	W 104		
W 250	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(2) The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. This STANDARD is not met as evidenced by: Based on observation, record review, and interview the facility failed to develop an individualized active treatment schedule and a	W 250		

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W 250	Continued From page 2 monthly activity/outing calendar for 6 of 6 clients (#1,#2, #3,#4, #5 and #6) The finding is: Observations on 10/8/24 from 7:15-8:45am revealed staff to prepare breakfast while clients were sitting in their bedrooms. Continued observations revealed staff to serve breakfast to the clients and completed other tasks around the facility without prompting the clients to participate. Further observations revealed there was no individualized active treatment schedules and no monthly activity/outing calendar posted at the facility for staff to follow. Review on 10/8/24 of the six client's clinical records revealed personal schedules dated 2024 with a start/end time of 6:00am-6:00am Monday-Sunday to include bedtime, med pass, mealtimes, chores, choices, and a group activity. Continued review revealed all six clients had the same personal schedule and were not individualized. Further review revealed the personal schedules did not provide evidence of a block time frame for formal activities/ training programs that are relevant and/or purposeful based on each individual need or interest. Interview on 10/8/24 with the Area Supervisor (AS) revealed there was an activity calendar on the wall in hallway but was knocked down by a client and had not been replaced. Further interview with the AS revealed she provided the surveyors with a Oak Drive Group Home Outing July-October (no year) schedule with the following outings: July (Freedom Park, Mountain Island Lake and Airport), August (Nascar Raceway, charlotte festival), September (Airport, Camp Green Park), and October 4th (Rescare End of Summer Lu'au Event).	W 250		

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W 250	Continued From page 3 Interview on 10/8/24 with the qualified intellectual disabilities professional (QIDP) confirmed that the personal schedules were not individualized and none of the six clients attend an outside day program. The QIDP also revealed that the clients should be going on outings at least twice a week in the community. The QIDP did not provide the surveyors with a monthly activity calendar prior to exiting.	W 250		