	-	ID HUMAN SERVICES MEDICAID SERVICES				0	FORM APPROVED MB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´				(3) DATE SURVEY COMPLETED
		34G158	B. WING				03/18/2025
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-MA	LLARD DRIVE				119 MALLARD DRIVE CHARLOTTE, NC 28227		
(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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
E 039	CFR(s): 483.475(d)(2 §416.54(d)(2), §418.1 §460.84(d)(2), §482.1 §483.475(d)(2), §484.1 §483.475(d)(2), §484.1 §485.542(d)(2), §485.5 §485.542(d)(2), §485.1 *[For ASCs at §416.5 at §485.542, OPO, "C §485.727, CMHCs at §491.12, and ESRD F (2) Testing. The [facilit to test the emergency must do all of the follow (i) Participate in a full- community-based ever (A) When a commun accessible, conduct an exercise every 2 year (B) If the [facility] natural or man-made activation of the emerent exempt from engaging community-based or in functional exercise for actual event. (ii) Conduct an addition years, opposite the year functional exercise unt this section is conduct not limited to the follow (A) A second full-scall community-based or in functional exercise; or (B) A mock disaster d) 113(d)(2), §441.184(d)(2), 5(d)(2), §483.73(d)(2), 102(d)(2), §485.727(d)(2), 625(d)(2), §485.727(d)(2), 12(d)(2), §494.62(d)(2). 4, CORFs at §485.68, REHs Organizations" under §485.920, RHCs/FQHCs at Facilities at §494.62]: ty] must conduct exercises r plan annually. The [facility] owing: -scale exercise that is ery 2 years; or ity-based exercise is not facility-based functional s; or experiences an actual emergency that requires gency plan, the [facility] is g in its next required individual, facility-based llowing the onset of the onal exercise at least every 2 ear the full-scale or ider paragraph (d)(2)(i) of ted, that may include, but is wing: e exercise that is individual, facility-based r	E	039			

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TITLE

(X6) DATE

PRINTED: 03/20/2025

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.

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 34G158 B. WING 03/18/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6119 MALLARD DRIVE **VOCA-MALLARD DRIVE** CHARLOTTE, NC 28227 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) E 039 Continued From page 1 E 039 a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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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 34G158 B. WING 03/18/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6119 MALLARD DRIVE **VOCA-MALLARD DRIVE** CHARLOTTE, NC 28227 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) E 039 Continued From page 2 E 039 a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 922792

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 03/20/2025 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE	
		34G158	B. WING			_	03/	18/2025
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE	•	
				6	119 MALLARD DRIVE			
VOCA-MA	LLARD DRIVE			c	HARLOTTE, NC 2822	7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	*[For PRFTs at §441. §482.15(d), CAHs at § (2) Testing. The [PRT conduct exercises to a twice per year. The [I do the following: (i) Participate in an ar is community-based; (A) When a communit accessible, conduct a facility-based function (B) If the [PRTF, Hosp actual natural or man- requires activation of [facility] is exempt from required full-scale cor facility-based function onset of the emergent (ii) Conduct an [a and that may include, following: (A) A second full-scal community-based or if functional exercise; on (B) A mock of (C) A tabletop exel led by a facilitator and discussion, using a na emergency scenario, statements, directed r questions designed to plan. (iii) Analyze the [if maintain documentati	184(d), Hospitals at §485.625(d):] F, Hospital, CAH] must test the emergency plan PRTF, Hospital, CAH] must nnual full-scale exercise that or ty-based exercise is not n annual individual, al exercise; or bital, CAH] experiences an -made emergency that the emergency plan, the m engaging in its next nmunity based or individual, al exercise following the cy event. additional] annual exercise or but is not limited to the le exercise that is ndividual, a facility-based r disaster drill; or ercise or workshop that is a includes a group arrated, clinically-relevant and a set of problem messages, or prepared o challenge an emergency facility's] response to and on of all drills, tabletop ency events and revise the plan, as needed.	E	039				

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		MEDICAID SERVICES	0.000			NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G		ATE SURVEY OMPLETED
		34G158	B. WING			03/18/2025
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY	, STATE, ZIP CODE	
VOCA-MA	LLARD DRIVE			6119 MALLARD DRIVE CHARLOTTE, NC 28	227	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COF	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
E 039	Continued From page	e 4	EO	39		
		E organization must conduct				
		emergency plan at least				
	annually. The PACE following:	organization must do the				
		annual full-scale exercise that				
	is community-based;					
		ity-based exercise is not				
	accessible, conduct a facility-based function					
	-	riences an actual natural or				
		cy that requires activation of				
		the PACE is exempt from				
		equired full-scale community				
		acility-based functional e onset of the emergency				
	event.	consector the emergency				
		dditional exercise every 2				
		ear the full-scale or functional				
		raph (d)(2)(i) of this section				
		y include, but is not limited to				
	the following:					
	(A) A second full-sca	individual, a facility based				
	functional exercise; o					
	(B) A mock disaster					
	. ,	ise or workshop that is led by				
	a facilitator and inclue	des a group discussion,				
		ically-relevant emergency				
		f problem statements,				
		or prepared questions				
	(iii) Analyze the PAC	e an emergency plan. E's response to and				
	•	ion of all drills, tabletop				
		gency events and revise the				
	PACE's emergency p					
	*[For LTC Facilities a	t \$483 73(d)·1				
		3 100.10(0).1	1	1		1

Facility ID: 922792

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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 34G158 B. WING 03/18/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6119 MALLARD DRIVE **VOCA-MALLARD DRIVE** CHARLOTTE, NC 28227 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) E 039 Continued From page 5 E 039 test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based: or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise: or (B) A mock disaster drill: or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 922792

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 03/20/2025 / APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G158	B. WING				03/	18/2025
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
VOCA-MA	LLARD DRIVE				6119 MALLARD DRIVE CHARLOTTE, NC 28227			
		ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORREC			(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE		(X5) COMPLETION DATE
E 039	accessible, conduct a facility-based function (B) If the ICF/IID exper- man-made emergence the emergency plan, t engaging in its next re community-based or i functional exercise fol emergency event. (ii) Conduct an addition may include, but is no (A) A second full-scale community-based or a functional exercise; of (B) A mock disaster d (C) A tabletop exercise a facilitator and includ using a narrated, clini scenario, and a set of directed messages, o designed to challenge (iii) Analyze the ICF/II maintain documentatii exercises, and emerg ICF/IID's emergency p *[For HHAs at §484.1 (d)(2) Testing. The HH to test the emergency least annually. The HI (i) Participate in a full- community-based; or (A) When a comm	or ty-based exercise is not in annual individual, hal exercise; or. eriences an actual natural or by that requires activation of the ICF/IID is exempt from equired full-scale individual, facility-based llowing the onset of the onal annual exercise that bit limited to the following: e exercise that is an individual, facility-based r rill; or se or workshop that is led by des a group discussion, cally-relevant emergency f problem statements, r prepared questions e an emergency plan. ID's response to and on of all drills, tabletop uency events, and revise the plan, as needed. 02] HA must conduct exercises r plan at HA must do the following: -scale exercise that is munity-based exercise is not	E	039				
	accessible, conduct a facility-based function or.	al exercise every 2 years;						

Facility ID: 922792

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		D HUMAN SERVICES MEDICAID SERVICES					FORM): 03/20/2025 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G158	B. WING			-	03/	18/2025
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				6	119 MALLARD DRIVE			
VOCA-MA	LLARD DRIVE			C	CHARLOTTE, NC 28227			
(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	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA REFICIENCY)		(X5) COMPLETION DATE
E 039	or man-made emerge of the emergency plar engaging in its next re community-based or i functional exercise fol emergency event. (ii) Conduct an addition opposite the year the exercise under paragu- is conducted, that limited to the following (A) A second full- community-based or a functional exercise; on (B) A mock disass (C) A tabletop ex- led by a facilitator and discussion, using a na emergency scenario, statements, directed r questions designed to plan. (iii) Analyze the HHA's documentation of all of emergency events, ar emergency plan, as n *[For OPOs at §486.3 (d)(2) Testing. The OF to test the emergency following: (i) Conduct a paper-ba- workshop at least anr led by a facilitator and discussion, using a na emergency scenario,	<pre>kperiences an actual natural ancy that requires activation and the HHA is exempt from equired full-scale ndividual, facility based lowing the onset of the anal exercise every 2 years, full-scale or functional raph (d)(2)(i) of this section t may include, but is not g: scale exercise that is an individual, facility-based r ter drill; or ercise or workshop that is a includes a group arrated, clinically-relevant and a set of problem messages, or prepared o challenge an emergency s response to and maintain drills, tabletop exercises, and nd revise the HHA's eeded.</pre>	E	039				

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	-	ID HUMAN SERVICES					FORM	03/20/2025
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		34G158	B. WING			_	03/	18/2025
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
VOCA-MA	LLARD DRIVE				119 MALLARD DRIVE HARLOTTE, NC 2822	7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	questions designed to plan. If the OPO exper man-made emergency the emergency plan, te engaging in its next re following the onset of (ii) Analyze the OPO's documentation of all te emergency events, ar OPO's] emergency plan. *[RNCHIs at §403.74 (d)(2) Testing. The RM exercises to test the emust do the following: (i) Conduct a paper-bale least annually. A table discussion led by a fa clinically-relevant emet of problem statements prepared questions de emergency plan. (ii) Analyze the RNHC maintain documentatii and emergency event emergency plan, as n This STANDARD is n Based on record revit facility failed to condu emergency preparedr The finding is: Review of the facility I of a full-scale or comr exercise. Continued m manual revealed a table conducted on 2/19/23	 b challenge an emergency eriences an actual natural or cy that requires activation of the OPO is exempt from equired testing exercise the emergency event. as response to and maintain tabletop exercises, and nd revise the [RNHCI's and an, as needed. 18]: NHCI must conduct emergency plan. The RNHCI : ased, tabletop exercise at etop exercise is a group trilitator, using a narrated, ergency scenario, and a set s, directed messages, or esigned to challenge an CI's response to and on of all tabletop exercises, ts, and revise the RNHCI's needed. not met as evidenced by: ew and interviews, the tot exercises to test the ness plan (EPP) annually. EPP revealed no evidence munity-based training eview of the facility EPP bletop exercise was 	E	039				

	S FOR MEDICARE &	MEDICAID SERVICES				IO. 0938-039		
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			TE SURVEY MPLETED		
		34G158	B. WING		0	3/18/2025		
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	CODE			
VOCA-MA	LLARD DRIVE			119 MALLARD DRIVE HARLOTTE, NC 28227				
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE		
E 039	(PM) on 3/18/25 conf been a full-scale com	and the program manager irmed that there has not	E 039					
W 130	PROTECTION OF CI CFR(s): 483.420(a)(7		W 130					
	The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure privacy while in a personal bedroom during awake hours for 1 of 6 clients (#1) relative to use of a visual monitor kept in the living room. The finding is:							
(; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ;	3/17-18/25 survey rev living room of the gro to all clients and staff observation revealed the living room throug play uno card games tv shows. Further obs	roup home during the vealed a visual monitor in the up home left on and visible using the room. Continued all clients to have access to ghout survey to exercise, watch cartoons and watch servation revealed clients to ble where the visual monitor by running.						
	professional (QIDP) or revealed the visual m turned off during awa privacy. Further inter staff have been traine	alified intellectual disabilities on 3/18/25 for client #1 onitor should have been ke hours to ensure her view with the QIDP revealed ed on use of the visual hould be off during client						

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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 34G158 B. WING 03/18/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6119 MALLARD DRIVE **VOCA-MALLARD DRIVE** CHARLOTTE, NC 28227 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 472 Continued From page 10 W 472 CFR(s): 483.480(b)(2)(i) Food must be served in appropriate quantity. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure 3 of 6 clients (#3, #4 and #6) received the appropriate quantity of food relative to their prescribed diets. The findings is: A. The facility failed to ensure client #3 received the American Diabetic Association diet (ADA) to manage weight. For example: Observations in the group home on 3/17/25 at 5:00 PM revealed the dinner meal to include a corned beef casserole with cabbage, potatoes and carrots, two canned biscuits, applesauce, water and a sugar free beverage. Continued observation revealed client #3 to independently server herself with a large black handled silicone cooking spoon two scoops of the corned beef casserole and two canned biscuits, water and the sugar free beverage. Further observation revealed client #3 to eat the first serving and to then serve herself a second portion of the corned beef casserole and to eat her yogurt. Subsequent observation revealed staff B to ask client if she needed seconds due to weight controlled diet to which client #3 responded, yes and served herself the second portion of corned beef casserole. Additional observation revealed client #3 to consume 100% of her meal. Observation in the group home on 3/18/25 at 7:44 AM revealed client #3 to participate in the breakfast meal to include oatmeal, one slice of buttered toast, 2% milk and apple juice. Continued observation of client #3's breakfast

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 922792

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						<u>IO. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	IPLE CONSTRUCTION	· · ·	TE SURVEY MPLETED
		34G158	B. WING		0	3/18/2025
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VOCA-MA	LLARD DRIVE			6119 MALLARD DRIVE CHARLOTTE, NC 28227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
W 472	Continued From page	e 11	W 4	.72		
		endently serve herself using slicone cooking spoon two				
	scoops of oatmeal. F	urther observation revealed				
	•	da straight from the bag Subsequent observation of				
	the breakfast meal re	vealed client #3 to nerself seconds of the				
		ge black handled silicone				
		again use the tablespoon to bag to add to her oatmeal.				
	÷ .	t #3 direction to apply less				
	•	e oatmeal well. Subsequent				
		client #3 to consume a half vith client #2 that client #1				
		n she did not want to eat with				
	Review of records for revealed a nutritional	client #3 on 3/18/25 assessment (NA) dated				
		view of the NA for client #3				
	Diabetes Association					
		e NA indicate client #3's etween 110 - 107 pounds.				
	, ,	NA revealed client #3's				
		was 234 pounds; December				
	pounds.	nd November 2024 - 226				
	Interview with the qua	alified intellectual disabilities				
		on 3/18/25 revealed the NA t. Further interview with the				
		ave been trained on client				
		interview with the QIDP				
		ale and appropriate serving hat staff have been trained				
	to use with all meals.	Subsequent interview with				
	the QIDP reveal staff and use of measuring	will be retrained on diets				

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	-	ID HUMAN SERVICES					FORM): 03/20/2025 MAPPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	LE CONSTRUC			(X3) DATE	0. 0938-0391 SURVEY LETED
		34G158	B. WING				03/	18/2025
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDR	RESS, CITY, STATE, Z	ZIP CODE		
VOCA-MA	LLARD DRIVE			6119 MALLAR	RD DRIVE E, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN EACH CORRECTIVE OSS-REFERENCED DEFICI	ACTION SHOULD B		(X5) COMPLETION DATE
W 472	Continued From page	9 12	W 47	2				
	•	o ensure client #4 received c Association diet (ADA) to example:						
	5:00 PM revealed the corned beef casserole and carrots, two cann water and a sugar free observation revealed server herself with a la cooking spoon two so casserole and two can sugar free beverage. revealed client #4 to e	eat the first serving and to second portion of the corned						
	AM revealed client #4 breakfast meal to incl buttered toast, 2% mi Continued observatio revealed her to indep a large black handled scoops of oatmeal. F client #4 to add splen using a tablespoon. S the breakfast meal rev independently serve h oatmeal using the larg cooking spoon and to get splenda from the b Review of records for revealed a nutritional	ude oatmeal, one slice of lk and apple juice. n of client #4's breakfast endently serve herself using silicone cooking spoon two urther observation revealed da straight from the bag Subsequent observation of vealed client #4 to nerself seconds of the ge black handled silicone again use the tablespoon to bag to add to her oatmeal. client #3 on 3/18/25 assessment (NA) dated						
	1/6/25. Continued revealed a current die	view of the NA for client #4 et order of American						

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	-	D HUMAN SERVICES				FORM	0: 03/20/2025
STATEMENT C	S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		34G158	B. WING		_	03/'	18/2025
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE	•	
VOCA-MA	LLARD DRIVE			119 MALLARD DRIVE HARLOTTE, NC 2822	7		
(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)		(X5) COMPLETION DATE
W 472	Diabetes Association Continued review of the ideal body weight is b Further review of the January 2025 weight 2024 - 184 pounds an pounds. Interview with the qua professional (QIDP) of for client #4 is current QIDP revealed staff h #4's diet. Continued i revealed there is a sc utensils in the home th to use with all meals. the QIDP reveal staff and use of measuring C. The facility failed th a 1500 calorie diet to example: Observation in the gro AM revealed client #6 breakfast meal to inclu- buttered toast, 2% mil Continued observation revealed her to independ a large black handled scoops of oatmeal. F client #6 to add splend using a tablespoon. Review of records for revealed a current die	to manage weight. he NA indicate client #4's etween 189 -190 pounds. NA revealed client #4's was 186 pounds; December ad November 2024 - 193 dified intellectual disabilities in 3/18/25 revealed the NA . Further interview with the ave been trained on client interview with the QIDP ale and appropriate serving hat staff have been trained Subsequent interview with will be retrained on diets utensils for serving. o ensure client #6 received manage weight. For bup home on 3/18/25 at 7:44 to participate in the ude oatmeal, one slice of k and apple juice. n of client #6's breakfast endently serve herself using silicone cooking spoon two urther observation revealed da straight from the bag	W 472				

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		ID HUMAN SERVICES MEDICAID SERVICES					MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		34G158	B. WING			03/	18/2025
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
VOCA-MA	LLARD DRIVE				6119 MALLARD DRIVE CHARLOTTE, NC 28227		
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
W 472	ideal body weight is b Further review of the January 2025 weight 2024 - 174 pounds ar pounds. Interview with the qua professional (QIDP) of for client #6 is current QIDP revealed staff h #6's diet. Continued revealed there is a so utensils in the home to to use with all meals.	between 100 - 106 pounds. NA revealed client #6's was 162 pounds; December and November 2024 - 170 alified intellectual disabilities on 3/18/25 revealed the NA t. Further interview with the nave been trained on client interview with the QIDP cale and appropriate serving that staff have been trained Subsequent interview with will be retrained on diets	W	472			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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