

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

PRINTED: 06/13/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G356		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2025	
NAME OF PROVIDER OR SUPPLIER ENOCH DRIVE				STREET ADDRESS, CITY, STATE, ZIP CODE 4109 ENOCH DRIVE CHARLOTTE, NC 28269			
(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 474	<p>MEAL SERVICES CFR(s): 483.480(b)(2)(iii)</p> <p>Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure food was served in a form consistent with the developmental level for 1 of 3 audit clients (#2). The findings are:</p> <p>During an observation in the home on 6/9/25 at 5:11 PM, client #2 was observed eating dinner which consisted of a serving of lasagna, mixed salad chopped into smaller pieces, sugar free juice, and a bowl of cantaloupe. The mixed salad was served with ranch dressing. Continued observation revealed client #2 completed 100% of his dinner. Further observation revealed that at no point did staff offer any lactose free salad dressing to client #2.</p> <p>Review on 6/9/25 of client #2's ISP dated 12/18/24 revealed a diet order consisting of 1/4 inch chopped consistency, no concentrated sweets, caffeine free, lactose free; offer lactose free milk and water with meals.</p> <p>Interview on 6/10/25 with the facility nurse confirmed client #2's diet order is current and staff should have offered another salad dressing other than the ranch dressing.</p>			W 474			

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.