		ID HUMAN SERVICES MEDICAID SERVICES					M APPROVED O. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		DNSTRUCTION	(X3) DAT	E SURVEY IPLETED
		34G174	B. WING			12	2/18/2018
NAME OF PI	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
STARNES	GROUP HOME				STARNES ROAD ARLOTTE, NC 28214		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 120	SERVICES PROVIDE SOURCES CFR(s): 483.410(d)(3 The facility must assumeet the needs of ea) ire that outside services	W 1	20			
	Based on observatio interviews, the facility contracting agency pr services was providin relative to meeting an of 3 sampled clients (Observations in the o program services for 12:50 PM until 1:15 P a table with game car to begin a new game table. Additional obse for daily activities with vocational training op activities included bre	g sufficient active treatment id addressing the needs of 1 #5). The finding is: utside agency providing day client #5 on 12/17/18 from M revealed client #5 to sit at ds, socialize with staff and with other clients at his ervation revealed a schedule in no specific identified portunities. Scheduled eakfast, group activity, art, exercise/music, snack and					
	revealed an admissio 11/8/18. Continued re revealed the client to intellectual disability, impairment. Review of (ISP) dated 12/6/18 for identified vocational of client #5's training ob relative to cooking, m	of the individual support plan for client #5 revealed no objectives. Further review of jectives revealed training					
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURI	 E		TITLE		(X6) DATE

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

(X6) DATE

PRINTED: 12/27/2018

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 12/27/2018 MAPPROVED). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		(X3) DATE	
		34G174	B. WING			-	12/	18/2018
NAME OF PF	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STA	TE, ZIP CODE		
STARNES	GROUP HOME				2823 STARNES ROAD CHARLOTTE, NC 28214			
		ATEMENT OF DEFICIENCIES			-	PLAN OF CORRECTION		(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
W 120	Continued From page	91	w	120				
	Interview with staff at	client #5's day program on						
		e client to be active, social						
		with his cards and socially nd other clients.Further						
	interview with staff at	the day program confirmed						
		ndicating exercise activities						
		f motion exercises and sting of participation in						
	games or socially app	propriate activity. Interview						
		essional (QP) at the day t #5 has been attending the						
		ears before residing at his						
	÷ .	The QP at the day program						
		#5 seems to be doing well better hygiene, attending						
	-	im regularly, wearing clean						
	clothing and more con							
	objectives at the place	verified client #5 has no ement that have been						
	-	address vocational needs						
	and no training object	-						
	documented or tracke	5 u .						
		further verified she had not						
	-	am meeting of the client to ls. Interview with the facility						
	÷	lisabilities professional						
	· · ·	erified she had not been to						
	· · · ·	m and she had not met with el regarding vocational						
	training for the client.	The facility QIDP further						
		vly assigned to the group						
		t know why the day program the client's team meeting						
	on 12/6/18.							
W 137	PROTECTION OF CL CFR(s): 483.420(a)(1		W	137				

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	-	ID HUMAN SERVICES				FORM): 12/27/2018 1 APPROVED
STATEMENT C	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		34G174	B. WING		_	12/	18/2018
NAME OF PF	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
STARNES	GROUP HOME			823 STARNES ROAD CHARLOTTE, NC 2821	4		
(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 B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 137	Continued From page	2	W 137				
	Therefore, the facility	ure the rights of all clients. must ensure that clients n and use appropriate s and clothing.					
	The facility failed to a (#1 and #3) were provided clothing in good repai	not met as evidenced by: assure 2 of 5 sampled clients vided with clean appropriate ir as evidenced by view. The findings are:					
	12/18/18 observations oversized, ill-fitting gr addition, continued of #1 wore tops that wer observations on 12/17 PM revealed client #1	rvey period 12/17/18 through s revealed client #1 wore ay colored sweatpants. In oservations revealed client re also ill-fitting. Subsequent 7/18 at approximately 5:10 went out on a community ime oversized, ill-fitting					
	(QIDP) confirmed clie better fitting clothing. revealed they were re	lisabilities professional ent #1 is in need of new, Continued interview eviewing client #1's clothing o purchase new, better fitting					
	12/18/18 observations oversized, ill-fitting blu continued observation black belt with his ove Subsequent observat	ns revealed client #3 wore a ersized, ill-fitting blue jeans. ions and interviews 8 with staff (1) in client #3's					

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DEPARTMENT OF HEALTH A					FORM	: 12/27/2018 APPROVED
CENTERS FOR MEDICARE 8 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	-	(X3) DATE	
	34G174	B. WING			12/ [,]	18/2018
NAME OF PROVIDER OR SUPPLIER	•	ST	TREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
STARNES GROUP HOME			323 STARNES ROAD HARLOTTE, NC 2821	4		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC 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
 sizes 38 and one fas ripped-busted knee, to be too short for cl had more jeans and pants. Subsequent of approximately 5:10 for out on a community oversized, ill-fitting of Interview conducted confirmed client #3 is clothing. Continued reviewing client #3's to purchase new, be Christmas presents. W 189 STAFF TRAINING F CFR(s): 483.430(e)() The facility must pro- initial and continuing employee to perform efficiently, and comp This STANDARD is Based on observati failed to assure adea privacy and meal pro- (#1, #2, #3, #4, #5 at A. The facility failed relative to privacy for example: Observation in the g 	as multiple tops, an and cargo shorts comprised of shionable, distressed, blue jeans which appeared ient #3. Staff thought client #3 he should wear size 34 observations on 12/17/18 at PM revealed client #3 went outing wearing the same clothing. on 12/17/18 with the QIDP s in need of new, better fitting interview revealed they were clothing needs and planned etter fitting clothing for PROGRAM (1) wide each employee with g training that enables the m his or her duties effectively,	W 137				

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	2: 12/27/2018 1 APPROVED 2: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE COMP	SURVEY
		34G174	B. WING		_	12/	18/2018
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
STARNES	GROUP HOME			823 STARNES ROAD HARLOTTE, NC 2821	4		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 189	observation revealed and open the bathrood knocking and enter th Additional observation #1 to enter the hallway shave. Subsequent of to enter the hallway at on client #6 without kno exited the bathroom at Interview with the faci disabilities profession should always knock of opening them. The Q benefit from additional in the group home. B. The facility failed to relative to meal prepa #4, #5 and #6. Observation in the group 7:45 AM revealed stat for client #2 while the room. After exiting the was observed to sit at his breakfast. Staff #1 cold cereal, toast and client. Staff #1 then to client at the table. Ob home menu for the me hot cereal, whole whe Observation of the group	1 to shave. Continued staff #2 to enter the hallway m door on client #3 without en exit the bathroom. In at 6:55 AM revealed staff y bathroom with client #6 to observation revealed staff #2 nd open the bathroom door nocking. Staff #2 was bathroom door on client #6 ocking before the client at 7:05 AM. lity qualified intellectual al (QIDP) verified staff on bathroom doors before QIDP confirmed staff could al training relative to privacy o assure staff training tration for clients #1, #2, #3, bup home on 12/18/18 at ff #1 to prepare breakfast client was in the medication e medication room, client #2 t the kitchen table waiting for 1 was observed to prepare pour beverages for the ook all prepared items to the oservation of the group orning of 12/18/18 revealed eat bread and beverages.	W 189				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(¥3) DA	TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			MPLETED
		34G174	B. WING		1	2/18/2018
NAME OF P	ROVIDER OR SUPPLIER		ST	IREET ADDRESS, CITY, STATE, ZIP CODE	E	
STARNES	GROUP HOME			323 STARNES ROAD HARLOTTE, NC 28214		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY 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 189	client to report he wa like staff fixing his br reported he had ask breakfast because h Interview with staff # did not look at the m for client #2 as he w client likes. Interview had also served client cereal with toast for interview with staff # hot cereal when its of there was any hot cereal	ge 5 #4 on 12/17/18 revealed the as doing good but he did not eakfast. Client #4 further ed staff not to make his e could do it but they still do. 41 on 12/18/18 revealed he enu prior to making breakfast as making what he knew the w with staff #2 revealed he nts #1, #3, #4, #5 and #6 cold breakfast. Additional 22 revealed he never makes on the menu and was not sure ereal in the group home. did not know what hot cereal	W 189			
W 227	following the menu w meal preparation. Fu verified all clients in assisting with meal p The QIDP further ve preparing client mea the client and servin INDIVIDUAL PROGI CFR(s): 483.440(c)(The individual progra objectives necessary as identified by the c	RAM PLAN	W 227			

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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 34G174 B. WING 12/18/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2823 STARNES ROAD STARNES GROUP HOME CHARLOTTE, NC 28214 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) W 227 Continued From page 6 W 227 support plan (ISP) for 1 non-sampled client (#1) included objective training to meet the client's behavioral needs relative to staff supervision. The finding is: Observation throughout the 12/17-18/2018 survey revealed staff to attempt to support client #1 with a 1:1 staffing ratio. Staff were observed to remain within evesight of client #1 at all times and at arms length of client #1 throughout most of the survey observations. Additional observation in the group home revealed client #1 to have a daily schedule for home based activity due to not going to an outside day program. Review of records for client #1 on 12/18/18 revealed an ISP dated 5/24/18. Review of the ISP revealed a behavior support plan dated 5/24/18 to address target behaviors of self injurious behavior, tantrum/throwing self to the ground and non-compliance. Continued review of client #1's behavior plan revealed no prevention strategy relative to 1:1 staffing. Interview with staff supporting client #1 on 12/17-18/2018 revealed client #1 does not go to a day program and the client is provided a staff to support the client with his daily activities pertaining to hygiene routine, community activities and programs in the group home. Additional interview with staff revealed the client likes to go shopping, visit the duck pond and various community places. Interview with the QIDP revealed client #1 does not go to a day program although she was not sure why but thought it was due to behaviors. Further interview with the QIDP revealed she did not know why the client's record did not reflect the need for a 1:1 staff and she also did not know why the client needed a 1:1

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 952399

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PRINTED: 12/27/2018

		MEDICAID SERVICES		CONSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· ,			MPLETED
		34G174	B. WING		1	2/18/2018
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP COD	DE	
STARNES	GROUP HOME		_	23 STARNES ROAD HARLOTTE, NC 28214		
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
W 227	Continued From page	e 7	W 227			
	QIDP verified the clie reflect 1:1 staffing for need of further evalua prevention strategies					
W 247	INDIVIDUAL PROGR CFR(s): 483.440(c)(6		W 247			
	Based on observation interview, the facility residing in the home were provided opport	nt choice and not met as evidenced by: n, record review and failed to assure 6 of 6 clients (#1, #2, #3, #4, #5 and #6) runities for choice and self to meal preparation and				
	revealed all clients to Continued observation individual plates for en- to another staff that p correct client. Staff w plates and serve each Observation on 12/18 staff to prepare break	8/18 at 7:45 AM revealed fast for client #2 while the				
	the medication room, sit at the kitchen table Staff was observed to and pour beverages t all prepared items to should be noted on 1	ication room. After exiting client #2 was observed to e waiting for his breakfast. o prepare cold cereal, toast for the client. Staff then took the client at the table. It 2/18/18 at 6:30 AM when he group home, clients #1,				

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	: 12/27/2018 APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE COMP	
		34G174	B. WING		_	12/ [,]	18/2018
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
STARNES	GROUP HOME			323 STARNES ROAD HARLOTTE, NC 28214	4		
(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 247	Review of records on revealed a community dated 4/24/18. Review revealed the client to of all utensils as need food to others and abl others with a verbal co Review of records on revealed a community dated 12/4/17. Review revealed the client to of all utensils as need others with physical a Review of records on revealed a community dated 4/26/18. Review revealed the client to of all utensils as need food to others and ind food from others. Review of records on revealed a community dated 8/27/18. Review revealed the client to of all utensils as need food to others and ind food from others. Review of records on revealed the client to of all utensils as need food to others and ind food from others. Review of records on revealed a community dated 12/6/18. Review revealed the client to of all utensils as need food to others and ind food from others.	12/18/18 for client #1 //home life assessment w of the assessment be independent with the use led, independent in passing le to request food from ue. 12/18/18 for client #2 //home life assessment be independent with the use led and able to pass food to ssistance. 12/18/18 for client #3 //home life assessment be independent with the use led, independent in passing lependent with requesting 12/18/18 for client #4 //home life assessment be independent with the use led, independent in passing lependent with requesting 12/18/18 for client #4 //home life assessment be independent in passing lependent with requesting 12/18/18 for client #5 //home life assessment be independent with the use led, adle to pass food to ue and able to request food	W 247				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 12/27/2018 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE	
		34G174	B. WING		_	12/	18/2018
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
STARNES	GROUP HOME			823 STARNES ROAD HARLOTTE, NC 2821	4		
(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 247	dated 7/23/18. Review revealed the client to of all utensils as need food to others and ind food from others. Interview with the faci disabilities profession should not have fixed served each client at meal on 12/17/18. Fu QIDP verified each cli meal service to the let additionally revealed of some level of fixing th pouring their own bev B. Observation in the 7:45 AM revealed stat breakfast consisting of beverages with no clie then observed to take client at the table. Of home menu for the m hot cereal, whole whe Observation of the gro 12/18/18 revealed oat cereal. At no time wa a choice in food items Interview with staff on not look at the menu p client #2 as he was m client likes. Interview revealed he had also and #6 cold cereal with	12/18/18 for client #6 //home life assessment w of the assessment be independent with the use led, independent in passing lependent with requesting lity qualified intellectual al (QIDP) revealed staff each client's plate and the table during the evening wither interview with the tent should participate in vel they are able. The QIDP each client is capable at teir own plate at meals and erages. group home on 12/18/18 at ff to prepare client #2's of cold cereal, toast and ent assistance. Staff was all prepared items to the oservation of the group orning of 12/18/18 revealed eat bread and beverages. Dup home pantry on tmeal as a option for hot s client #2 observed to have a. 12/18/18 revealed he did orior to making breakfast for aking what he knew the with additional staff served clients #1, #3, #4, #5	W 247				

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPI F (CONSTRUCTION		10. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· /			MPLETED
		34G174	B. WING		1	2/18/2018
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
STARNES	GROUP HOME			23 STARNES ROAD IARLOTTE, NC 28214		
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
W 247	Continued From page	e 10	W 247			
		wed at each meal. The client choice should be eal items.				
W 249	PROGRAM IMPLEM CFR(s): 483.440(d)(1		W 249			
	formulated a client's each client must rece treatment program co interventions and ser and frequency to sup	As soon as the interdisciplinary team has prmulated a client's individual program plan, each client must receive a continuous active reatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program alan.				
	Based on observation interview, the team far interventions to addre 1 non-sampled client Observation in the gr revealed a daily sche	roup home on 12/17/18 edule for client #1 posted on				
	the schedule reveale morning hygiene rout transport to day prog exercise, activity cho	area. Further observation of d the client to have a tine, ride the facility van for rams for other clients, ice, lunch, art/music activity, d an afternoon activity				
	revealed an individua 5/24/18. Review of the revealed vocational of the revealed vocational of the revealed vocation of t	r client #1 on 12/18/18 al support plan (ISP) dated raining objectives in the ISP objectives relative to participation. Review of				

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	-	D HUMAN SERVICES				FORM	2: 12/27/2018 APPROVED
STATEMENT (S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	
		34G174	B. WING		_	12/ ⁻	18/2018
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
STARNES	GROUP HOME			823 STARNES ROAD HARLOTTE, NC 2821	4		
(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 B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 249 W 252	client #1's recycling o implementation date of Additional review rever methodology of: with a prompts and unlimited #1 will process recycl success for three con Interview with client # revealed he does not any recycling activities staff revealed he was program of client #1. 12/18/18 verified recy currently identified in Additional interview w was not aware of the although from notes in program remains curr PROGRAM DOCUME CFR(s): 483.440(e)(1 Data relative to accom specified in client indi objectives must be do terms. This STANDARD is r Based on record revi failed to ensure data f individual support plan prescribed for 2 of 4 s The findings are: A. The team failed to	bjective revealed an of 8/5/16 and revised 5/1/17. ealed the objective to have a 3 verbal prompts, 2 model d physical assistance, client able items with 65% secutive months. 1's 1:1 staff on 12/18/18 take client #1 to work on s. Further interview with unaware of any recycling Interview with the QIDP on cling activity was not the client's daily schedule. rith the QIDP revealed she client's recycling program n the client's record the rent. ENTATION) nplishment of the criteria	W 249				

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-						FORM): 12/27/2018 APPROVED
F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>				(X3) DATE	
	34G174	B. WING				12/	18/2018
OVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE	E, ZIP CODE		
			2823	STARNES ROAD			
GROUP HOME			СНА	ARLOTTE, NC 28214			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	((EACH CORRECTI CROSS-REFERENCE	VE ACTION SHOULD BI		(X5) COMPLETION DATE
#3 was collected as p	rescribed.	W 2	52				
revealed an ISP dated objective "Given 3 ver physical assistance, [strengthening/exercise three consecutive mo- direction indicated dat Continued review of the data collection, using for this objective as for 10/18 - 3 of 31 days; a days. Subsequent re- #4's list of medical dia Osteoporosis and Cer-	d 4/26/18 which included an rbal prompts and light client #3] will complete e activity 70% of trials for nths." The program ta was to be collected daily. he record revealed monthly a one quarter review period, ollows: 9/18 - 7 of 30 days; and 11/18 - only 1 of 30 view on 12/18/18 of client agnoses includes rebral Palsy.						
 collection for this obje prescribed. Additional verified the lack of dational objective prevented the necessary. B. The team failed to acquisition objectives #4 was collected as p 1. Review of client # revealed an ISP dated objective "With 1 physic complete the steps consuccess for three con- program direction indii collected daily. Continented the steps of revealed monthly data 	active was not completed as al interview with the QIDP ta collection for this ne ability to revise as ensure data for 1 of 4 skill listed on the ISP for client rescribed. 4's record on 12/18/18 d 9/21/18 which included an sical prompt [client #4] will bok a simple breakfast 80% secutive months. The icated data was to be inued review of the record a collection, using a one						
	S FOR MEDICARE & I F DEFICIENCIES CORRECTION OVIDER OR SUPPLIER GROUP HOME Continued From page #3 was collected as p 1. Review of client #3 revealed an ISP dated objective "Given 3 ver physical assistance, [strengthening/exercis three consecutive mo direction indicated dat Continued review of tl data collection, using for this objective as fc 10/18 - 3 of 31 days; a days. Subsequent re #4's list of medical dia Osteoporosis and Cel Interview with the qua professional (QIDP) o collection for this obje prescribed. Additiona verified the lack of dat objective prevented th necessary. B. The team failed to acquisition objectives #4 was collected as p 1. Review of client # revealed an ISP dated objective "With 1 phys complete the steps co success for three con program direction indi collected daily. Cont revealed monthly data quarter review period.	CORRECTION IDENTIFICATION NUMBER: 34G174 OVIDER OR SUPPLIER GROUP HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 #3 was collected as prescribed. 1. Review of client #3's record on 12/18/18 revealed an ISP dated 4/26/18 which included an objective "Given 3 verbal prompts and light physical assistance, [client #3] will complete strengthening/exercise activity 70% of trials for three consecutive months." The program direction indicated data was to be collected daily. Continued review of the record revealed monthly data collection, using a one quarter review period, for this objective as follows: 9/18 - 7 of 30 days; 10/18 - 3 of 31 days; and 11/18 - only 1 of 30 days. Subsequent review on 12/18/18 of client #4's list of medical diagnoses includes Osteoporosis and Cerebral Palsy. Interview with the qualified intellectual disabilities professional (QIDP) on 12/18/18 confirmed data collection for this objective was not completed as prescribed. Additional interview with the QIDP verified the lack of data collection for this objective prevented the ability to revise as necessary. B. The team failed to ensure data for 1 of 4 skill acquisition objectives listed on the ISP for client #4 was collected as prescribed. 1. Review of client #4's record on 12/18/18 revealed an ISP dated 9/21/18 which included an objective "With 1 physical prompt [client #4] will complete the steps cook a simple breakfast 80% success for three consecutive months. The program direction indicated data	S FOR MEDICARE & MEDICAID SERVICES F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A BUILDIN 34G174 B. WING_ OVIDER OR SUPPLIER 34G174 GROUP HOME ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 12 W 2 #3 was collected as prescribed. W 2 1. Review of client #3's record on 12/18/18 revealed an ISP dated 4/26/18 which included an objective "Given 3 verbal prompts and light physical assistance, [Client #3] will complete strengthening/exercise activity 70% of trials for three consecutive months." The program direction indicated data was to be collected daily. Continued review of the record revealed monthly data collection, using a one quarter review period, for this objective as follows: 9/18 - 7 of 30 days; 10/18 - 3 of 31 days; and 11/18 - only 1 of 30 days. Subsequent review on 12/18/18 of client #4's list of medical diagnoses includes Osteoporosis and Cerebral Palsy. Interview with the qualified intellectual disabilities professional (QIDP) on 12/18/18 confirmed data collection for this objective was not completed as prescribed. Additional interview with the QIDP verified the lack of data collection for this objective prevented the ability to revise as necessary. B. The team failed to ensure data for 1 of 4 skill acquisition objectives listed on the ISP for client #4 was collected as prescribed. 1. Review of client #4's record on 12/18/18 revealed an ISP dated 9/2	S FOR MEDICARE & MEDICAID SERVICES F DEFICIENCIES F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIENCLIA IDENTIFICATION NUMBER: 346174 DIDENTIFICATION NUMBER: 346174 B. WING CONDER OR SUPPLIER GROUP HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 #3 was collected as prescribed. 1. Review of client #3's record on 12/18/18 revealed an ISP dated 4/26/18 which included an objective "Given 3 verbal prompts and light physical assistance, [client #3] will complete strengthening/exercise activity 70% of trials for three consecutive months." The program direction indicated data was to be collected daily. Continued review of the record revealed monthly data collection, using a one quarter review period, for this objective as follows: 9/18 - 7 of 30 days; 10/18 - 3 of 31 days; and 11/18 - only 1 of 30 days. Subsequent review on 12/18/18 of client #4's list of medical diagnoses includes Osteoporosis and Cerebral Palsy. Interview with the qualified intellectual disabilities professional (QIDP) on 12/18/18 confirmed data collection for this objective was not completed as prescribed. Additional interview with the QIDP verified the lack of data collection for this objective prevented the ability to revise as necessary. B. The team failed to ensure data for 1 of 4 skill acquisition objectives listed on the ISP for client #4 was collected as prescribed.	SPOR MEDICARE & MEDICAID SERVICES FPERICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A BUILDING	EINT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICARD SERVICES repercision (x1) PROVIDERSUPPLEACLA IDENTIFICATION NUMBER: 346174 346174 STREET ADDRESS, CITY, STATE, ZIP CODE 223 STARKES ROAD CHARLOTTE, NC 28214 STREET ADDRESS, CITY, STATE, ZIP CODE 223 STARKES ROAD CHARLOTTE, NC 28214 StREET ADDRESS, CITY, STATE, ZIP CODE 223 STARKES ROAD CHARLOTTE, NC 28214 StREET ADDRESS, CITY, STATE, ZIP CODE 223 STARKES ROAD CHARLOTTE, NC 28214 StREET ADDRESS, CITY, STATE, ZIP CODE 223 STARKES ROAD CHARLOTTE, NC 28214 StREET ADDRESS, CITY, STATE, ZIP CODE 233 STARKES ROAD CHARLOTTE, NC 28214 StREET ADDRESS, CITY, STATE, ZIP CODE 233 STARKES ROAD CHARLOTTE, NC 28214 StREET ADDRESS, CITY, STATE, ZIP CODE 233 STARKES ROAD CHARLOTTE, NC 28214 StREET ADDRESS, CITY, STATE, ZIP CODE 243 WAS COLLECTOR ON STREET OF DEFICIENCES TARKES ROAD CHARLOTTE, NC 28214 Continued From page 12 W 252 #3 was collected as prescribed. W 252 Continued revealed an ISP dated 4/26/18 which included an objective Cive as follows: 9147 OTS of drials for three consecutive months." The program direction indicated data was to be completed daily. Continued revealed an 12/18/18 confirmed data collection for this objective as not completed as prescribed. Additional interview with the QUIP verified the lack of data collection for this objective Prevented the ability to revise as necessary. B. The te	HENT OF HEALTH AND HUMAN SERVICES PORM FOR MEDICARE & MEDICALD SERVICES OMB NC PERFORMED (R1) PROVIDERSUMPLENCUA DEPTRETATION NUMBER (R2) MULTIPLE CONSTRUCTION (R3) OMB NC CONDER OR SUPPLER 34G174 R. WING 12/ OWIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE 223 STARIES ROAD 12/ COUDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE 223 STARIES ROAD 12/ CONDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE 223 STARIES ROAD 12/ CONDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE 223 STARIES ROAD 12/ Continued From page 12 W 252 In PROVIDERS PLAN OF CORRECTION (cACH OERICINA AND OF CORRECTION) (cACH OERICINA AND OERICINA AND OERICINA AND OF CORRECTION) (cACH OERI

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	-	ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 12/27/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		34G174	B. WING			12/18/2018
NAME OF PF	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STA	TE, ZIP CODE	
STARNES	GROUP HOME			323 STARNES ROAD HARLOTTE, NC 28214		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)	DATE
W 252	Continued From page and 11/18 - 1 of 30 da		W 252			
W 288	data collection for this completed as prescrit with the QIDP verified for this objective prev accurately review and necessary.	bed. Additional interview d the lack of data collection rented the ability to d revise programs as	W 288			
		le inappropriate client be used as a substitute for rogram.				
	Based on observation interview, the facility f to manage the behaving clients (#1 and #2) was for an active treatment A. The facility failed to client #1 within the ide	not met as evidenced by: n, record review and failed to assure it's technique ior of 2 of 3 non-sampled as not used as a substitute nt program. The finding is: o manage the behavior of entified techniques of the n (BSP). For example:				
	survey revealed client times. Staff was obse of client #1 while also most observations. C home the morning of to sit in a rocking chai TV and holding blocks	hout the 12/17-18/2018 t #1 to have a 1:1 staff at all erved to stay within eyesight o at arms length throughout Observations in the group 12/18/18 revealed client #1 ir of the living room watching s throughout the morning. ed to get up from his chair				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 12/27/2018 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE : COMPI	SURVEY
		34G174	B. WING		_	12/1	18/2018
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
STARNES	GROUP HOME			823 STARNES ROAD CHARLOTTE, NC 28214	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 288	with staff's verbal proposed with staff's verbal promotes staff to get uverbal prompts, staff to sit back down. Clied directed to sit down in staff. Client #1 was obdirectives from staff to Client #1 was observed chair from 6:30 AM ur at 8:15 AM except du was prompted by staff medications and hygid Review of records for revealed a individual s5/24/18. Review of the dated 5/24/18. Further revealed client #1 to be injurious behavior, tar ground and non-comp strategies to address revealed no strategy of need to restrict the client disabilities profession unsure why client #1 to facility began the QI Further interview with the facility began the QI Further interview with fact allowed to ambulate for the client #1 to the disabilities profession unsure why client #1 to the disabilities profession unsure why client #1 to fact the client #1 to the disabilities profession unsure why client #1 to th	mpts regarding his morning a at times when client #1 up from his chair without would directly tell the client ent #1 was observed to be his chair multiple times by bserved to follow all o sit back down in his chair. ed to sit in his living room ntil leaving the group home ring the various times he f regarding morning ene tasks. client #1 on 12/18/18 support plan (ISP) dated he ISP revealed a BSP also er review of the BSP have target behaviors of self ntrum/throwing self on the oblance. Review of client #1's behaviors utilizing a 1:1 staff or the ent from ambulating group home. lity qualified intellectual al (QIDP) revealed she was has a 1:1 staff as she only DP role at the group home. the QIDP verified client #1 ng included in the BSP.	W 288				

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCT A. BUILDING	ON (X3) [NO. 0938-0391 ATE SURVEY OMPLETED
34G174 B. WING		12/18/2018
NAME OF PROVIDER OR SUPPLIER STREET ADDRE	SS, CITY, STATE, ZIP CODE	
STARNES GROUP HOME 2823 STARNES CHARLOTTE		
	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 288 Continued From page 15 W 288 Observations in the group home during the 12/17-18/2018 survey revealed client #2 to make multiple attempts to walk into the kitchen area, toward the refrigerator and the pantry area of the group home. With each attempt, observations revealed staff to block the client by physically holding the client's arms or hands and verbally redirecting the client arms or hands and verbally redirecting the client out of the area. Review of records for client #2 on 12/18/18 revealed a BSP dated 1/25/18. Review of client #2's BSP revealed the client to have target behaviors of self injurious behavior, food seeking, physical aggression, disruptive behavior and elopement. Review of prevention strategies in the client's BSP revealed no form of physically blocking the client or restricting the client from the kitchen area. W 331 W 331 Interview with the QIDP on 12/18/18 revealed staff should not be physically blocking the client from entering the kitchen area of the group home. NURSING SERVICES W 331 W 331 This STANDARD is not met as evidenced by: Based on observation, record review and interview, nursing services failed to assure services were provided in accordance with client needs relative to medication administration for 1 of 4 sampled clients (#1). The finding is: During morning observations on 12/18/18 at 7:49 AM revealed staff accompanying client #1 to the		

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 12/27/2018 1 APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMPI	
		34G174	B. WING			12/ [,]	18/2018
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STAT	TE, ZIP CODE		
STARNES	GROUP HOME			823 STARNES ROAD HARLOTTE, NC 28214			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
W 331	bathroom to brush his observations revealed cylindrical tube from a squeeze the white par- tube onto client #1's to thoroughly brush clier teeth. Continued obse- to fully comply with in- client #1's teeth. After client #1's teeth, staff remaining white paste observations revealed toothbrushing supplie cylindrical tube back i Desitin. At this point the surve to show her the box la cylindrical tube he had much of the contents tube was gone. The s labeling and the label tube used by the invo- teeth and found both cylindrical tube labelin prescribed as "PRN" lettering) for client #1 diaper rash four times perineal skin irritation Immediate interview of the involved staff reve- client #1's toothpaste made a mistake after and questioning of wr interview with the invol-	a teeth. Continued a staff remove a white a box labeled Desitin, ste from the white cylindrical pothbrush and proceed to at #1's upper and lower ervations revealed client #1 structions as staff brushed r staff completed brushing helped client #1 wipe off the a around his mouth. Further d staff gathering up s and returning the white nside the box labeled evor asked the involved staff abeled Desitin and the white d used and first noticed inside the white cylindrical urveyor examined the box ing on the white cylindrical lived staff to brush client #1's the box and the white ng was Desitin Cream (identified in black bold with instructions to apply to a daily as needed for on 12/18/18 at 8:05 AM with ealed he thought he had and only realized he had the surveyor's examination the had used. Continued blved staff revealed he has n training and has been	W 331				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	2: 12/27/2018 1 APPROVED 2: 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		34G174	B. WING				12/ [,]	18/2018
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
STARNES GROUP HOME					2823 STARNES ROAD CHARLOTTE, NC 28214			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE		(X5) COMPLETION DATE
W 331	1.1% Brush Teeth Thu Periodontal Disease A daily at 8:00 AM, 6 Pf Review on 12/18/18 of Physician's Order rev Apply To Diaper Rash Needed For Perineal identified as a "PRN" Immediate interview of qualified intellectual d (QIDP) and subseque Director of Nursing (D staff did not use proper to ensure he had the confirmed staff should teeth with his prescrib interviews on 12/18/1 and facility managem staff has been employ 5/4/15, completed me and recently transferr 9/26/18. In addition, interviews revealed the facility w	of client #1's current ealed "SF 5000Plus Cre ree Times Daily For After Meals For Oral Health" M, and 8 PM. of client #1's current ealed "Desitin Cre 13% of Four Times Daily As Skin Irritation" which is medication and treatment. on 12/18/18 with the isabilities professional	W	33	1			
W 369	and will consistently of to all clients residing i DRUG ADMINISTRA CFR(s): 483.460(k)(2	TION) administration must assure	w	369	9			

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			A / - · · · · · · · · · · · · · · · · · ·			
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		34G174	B. WING		12	2/18/2018
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STARNES	GROUP HOME			823 STARNES ROAD CHARLOTTE, NC 28214		
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
W 369		e 18 e administered without error.	W 369			
	The facility failed to a administered to 1 of 3 administered without observation, interview The finding is: During morning obse approximately 7:49 A accompanying client his teeth. Continued or remove a white cylind labeled Desitin, sque white cylindrical tube and proceed to thorow and lower teeth. Cont client #1 to fully comp brushed client #1's te brushing client #1's te wipe off the remaining mouth. Further obser gathering up toothbru	3 sampled clients (#1) was error as evidenced by v and record verification. rvations on 12/18/18 at M revealed staff #1 to the bathroom to brush observations revealed staff				
	to show her the box la cylindrical tube used contents inside the w gone. The surveyor e and the labeling on th found both the box ar labeling was Desitin (eyor asked the involved staff abeled Desitin and the white and noticed much of the hite cylindrical tube was examined the box labeling the white cylindrical tube and and the white cylindrical tube Cream prescribed as "PRN" Id lettering) for client #1 with o diaper rash four times				

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 12/27/2018 / APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G174	B. WING			_	12/	18/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
STARNES	GROUP HOME				2823 STARNES ROAD CHARLOTTE, NC 28214	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRE) CROSS-REFERE	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 369	Continued From page	2 19	w	369	9			
	Immediate interview of the involved staff rever client #1's toothpaste made a mistake after and questioning of wh interview with the invo completed medication administering medicat Review on 12/18/18 of Physician's Order rev 1.1% Brush Teeth Thr Periodontal Disease A daily at 8:00 AM, 6 PM Review on 12/18/18 of Physician's Order rev Apply To Diaper Rash Needed For Perineal identified as a "PRN" Immediate interview of qualified intellectual d (QIDP)revealed the im proper medication add had the correct medic should have brushed prescribed toothpaster with the Director of Ne manager and facility r confirmed staff should teeth with his prescrib interviews revealed the employed with the fac	on 12/18/18 at 8:05 AM with ealed he thought he had and only realized he had the surveyor's examination nat he had used. Continued olved staff revealed he has a training and has been tions for 3 years. of client #1's current ealed "SF 5000Plus Cre ree Times Daily For After Meals For Oral Health" M, and 8 PM. of client #1's current ealed "Desitin Cre 13% a Four Times Daily As Skin Irritation" which is medication and treatment. on 12/18/18 with the isabilities professional hvolved staff did not use ministration to ensure he eation and confirmed staff client #1's teeth with his a Subsequent interviews ursing (DON), the program management on 12/18/18 d have brushed client #1's bed toothpaste. Continued he involved staff has been cility since 5/4/15, completed in 8/31/15, and recently						
	In addition, the DON	revealed the facility will						

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/27/2018 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY PLETED
		34G174	B. WING			12	/18/2018
NAME OF P	ROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE		
STARNES GROUP HOME					2823 STARNES ROAD CHARLOTTE, NC 28214		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 369	implement immediate all staff are properly to	e corrective actions to ensure rained to administer nts, and will consistently afe care to all clients	W	369			

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