	-	ID HUMAN SERVICES					MAPPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G095		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 06/19/2019		
							NAME OF P
OAK STR	EET GROUP HOME-ST. I	MARK			1801 OAK STREET CHARLOTTE, NC 28269		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE	
W 104) nust exercise general policy, g direction over the facility.	w	104			
	This STANDARD is not met as evidenced by: Based on observation and interviews, the governing body and management failed to exercise general policy, budget and operating direction over the facility by failing to assure damage to the facility van was repaired in a timely manner. The finding is: Observations conducted of the group home van on 6/18/19 at 4:50 PM revealed damage to van seats with duct tape used to cover the damage of the seats. Further observation of seat damage revealed two large holes in the material covering the back of the driver seat revealing inner insulation of the seat beginning to protrude through the holes. Continued observation of the interior of the facility van revealed the seat cover to the 1st row back seat closest to the van door to be coming apart from the chair at the frame.						
	damage to the interio least since 9/2018 alt when the damage ha facility home manage aware of the condition van as she had place damage. The facility administration was co facility van although r that she was aware o	on 6/18/19 revealed the r of the van had been at hough she did not know ppened. Interview with the r (HM) verified she was n on the interior of the facility d tape on the seats to cover HM further verified onsidering replacing the no decision had been made f. Interview with the QIDP of the interior of the facility					

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

TITLE

(X6) DATE

PRINTED: 06/22/2019

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.

CENTERS FOR MEDICARE & MEDICAID SERVICES				CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY		
AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE//CLIA IDENTIFICATION NUMBER: 34G095			. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		B. WING	06/19/2019				
NAME OF PROVIDER OR SUPPLIER OAK STREET GROUP HOME-ST. MARK			STF	· · ·			
			180 CH				
(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)			
W 104	Continued From page	e 1	W 104				
W 369			W 369				
	that all drugs, includir	administration must assure ng those that are e administered without error.					
	Based on observatio interview, the facility were administered wi	not met as evidenced by: n, record review and failed to assure all drugs thout error for 1 of 3 clients administration (#2). The					
	revealed client #2 ent administration area a Escitalopram 20 mg, Vitamin D tablet, Oys and FOS powder (1 to to take all medication poured by staff. Revi administration record pass revealed Amlod schedule for 8:00 AM administered for 6/19 of client #2's morning	nd received medications of Levothyroxine 50 mcg, ter Shell Calcium 500 mg, sp). Client #2 was observed s followed by water that was iew of the medication following the medication opine Besylate 10 mg l, had been checked as /19. Additional observation medications revealed 10 mg tablet remained in					
	revealed current quar included, in addition t as administered, an o Besylate 10 mg, 8:00	for client #2 on 6/19/19 rterly physician orders which to the medications observed order for Amlodopine AM. Interview with the /19 confirmed Amlodopine					

If continuation sheet Page 2 of 5

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				ECONSTRUCTION		OMB NO. 0938-039 (X3) DATE SURVEY		
AND PLAN OF CORRECTION (X1) PROVIDENSOPPLIER/CLIA 34G095				A. BUILDING				
		B. WING		06/19/2019				
NAME OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	i			
OAK STREET GROUP HOME-ST. MARK				1801 OAK STREET CHARLOTTE, NC 28269				
(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 SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE		
W 369	Continued From page	e 2	W 369					
		Id have been administered nedication pass for client #2						
W 371			W 371					
	that clients are taugh medications if the inte determines that self-a	administration of medications ective, and if the physician						
	Based on observation interview, the system failed to assure 2 of 3 observed during med provided the opportune	lication administration were						
	assure client #2 was	ug administration failed to provided the opportunity to tion self-administration. The						
	revealed client #2 en administration area a Escitalopram 20 mg, Vitamin D tablet, Oys and FOS powder (1 t conducted during the for client #2 revealed medication (staff E) to	nd received medications of Levothyroxine 50 mcg, ther Shell Calcium 500 mg, sp). Continued observation medication administration the staff administering						

Facility ID: 990150

If continuation sheet Page 3 of 5

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	: 06/22/2019 APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		34G095	B. WING		-	06/ [,]	19/2019
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
OAK STR	EET GROUP HOME-ST. N	IARK		801 OAK STREET CHARLOTTE, NC 28269			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA IEFICIENCY)		(X5) COMPLETION DATE
W 371	medications to the clie was observed to take water that was poured Review of records for revealed a daily living 10/29/18. Review of f revealed client #2 is a assistance and get wa with supervision. Fur assessment revealed a level of skill that the activity with gestures, modeling or demonstr B. The system for dru assure client #1 was p participate in medicat finding is: Observations conduct revealed client #1 ent administration area an ordered per the curren physician orders. Con conducted during the for client #1 revealed medications from a cli individually from a bul medications to the clie was observed to take water poured initially l assistance. Staff E w for client #1 for multip assistance or offering participation. Review of records for	ent in a med cup. Client #2 all medications followed by d by staff. client #2 on 6/19/19 skills assessment dated the 10/29/18 assessment able to dispense pills with ater to take with medication ther review of the 10/29/18 supervision is identified as individual performs the verbal direction and ration. ug administration failed to provided the opportunity to ion self-administration. The ted on 6/19/19 at 7:42 AM ered the medications as in administration record and ninued observation medication administration staff E to retrieve client #1's oset, punch out medications oble pack and hand ent in a med cup. Client #1 all medications without client the choice of client	W 371				

If continuation sheet Page 4 of 5

	-	ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 06/22/2019 RM APPROVED IO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G095	B. WING			0	6/19/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
OAK STR	EET GROUP HOME-ST. I	MARK			1801 OAK STREET CHARLOTTE, NC 28269		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 371	4/2/19. Review of the revealed client #1 is a supervision and get w independently. Furth assessment revealed a level of skill that the activity with gestures, modeling or demonstr Interview with Staff E #1 and #2 are capabl medication administra hand assistance durin the facility nurse verif capable of accessing medication closet, pu	e 4/2/19 assessment able to dispense pills with vater to take with medication er review of the 4/2/19 supervision is identified as a individual performs the verbal direction and ration. on 6/19/19 verified clients e of participation in ation with at least hand over ng most tasks. Interview with ied clients #1 and #2 are medications from the nching medications from uring water for medications	W	371			

Facility ID: 990150

If continuation sheet Page 5 of 5