STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G095	A. BUILDING _____ B. WING _____	06/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK STREET GROUP HOME-ST. 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation and interviews, the governing body and management failed to exercise general policy, 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. Interview with staff B on 6/18/19 revealed the damage to the interior of the van had been at least since 9/2018 although she did not know when the damage happened. Interview with the facility home manager (HM) verified she was aware of the condition on the interior of the facility van as she had placed tape on the seats to cover damage. The facility HM further verified administration was considering replacing the facility van although no decision had been made that she was aware of. Interview with the QIDP verified the condition of the interior of the facility	W 104		

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

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W 104	Continued From page 1 van was not acceptable and needed repair.	W 104		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure all drugs were administered without error for 1 of 3 clients observed during drug administration (#2). The finding is: Observation conducted on 6/19/19 at 7:25 AM revealed client #2 entered the medication administration area and received medications of Escitalopram 20 mg, Levothyroxine 50 mcg, Vitamin D tablet, Oyster Shell Calcium 500 mg, and FOS powder (1 tsp). Client #2 was observed to take all medications followed by water that was poured by staff. Review of the medication administration record following the medication pass revealed Amlodopine Besylate 10 mg schedule for 8:00 AM, had been checked as administered for 6/19/19. Additional observation of client #2's morning medications revealed Amlodopine Besylate 10 mg tablet remained in the bubble pack for 6/19/19. Review of the record for client #2 on 6/19/19 revealed current quarterly physician orders which included, in addition to the medications observed as administered, an order for Amlodopine Besylate 10 mg, 8:00 AM. Interview with the facility nurse on 6/19/19 confirmed Amlodopine	W 369		

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W 369	Continued From page 2 Besylate 10 mg should have been administered during the morning medication pass for client #2 on 6/19/19.	W 369		
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the system for drug administration failed to assure 2 of 3 clients (#1 and #2) observed during medication administration were provided the opportunity to participate in medication self-administration. The findings are: A. The system for drug administration failed to assure client #2 was provided the opportunity to participate in medication self-administration. The finding is: Observation conducted on 6/19/19 at 7:25 AM revealed client #2 entered the medication administration area and received medications of Escitalopram 20 mg, Levothyroxine 50 mcg, Vitamin D tablet, Oyster Shell Calcium 500 mg, and FOS powder (1 tsp). Continued observation conducted during the medication administration for client #2 revealed the staff administering medication (staff E) to retrieve client #2's medications from a closet, punch out medications individually from a bubble pack and hand	W 371		

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W 371	Continued From page 3	W 371		

medications to the client in a med cup. Client #2 was observed to take all medications followed by water that was poured by staff.

Review of records for client #2 on 6/19/19 revealed a daily living skills assessment dated 10/29/18. Review of the 10/29/18 assessment revealed client #2 is able to dispense pills with assistance and get water to take with medication with supervision. Further review of the 10/29/18 assessment revealed supervision is identified as a level of skill that the individual performs the activity with gestures, verbal direction and modeling or demonstration.

B. The system for drug administration failed to assure client #1 was provided the opportunity to participate in medication self-administration. The finding is:

Observations conducted on 6/19/19 at 7:42 AM revealed client #1 entered the medication administration area and received medications as ordered per the current administration record and physician orders. Continued observation conducted during the medication administration for client #1 revealed staff E to retrieve client #1's medications from a closet, punch out medications individually from a bubble pack and hand medications to the client in a med cup. Client #1 was observed to take all medications followed by water poured initially by client #1 with staff assistance. Staff E was observed to pour water for client #1 for multiple medications without client assistance or offering the choice of client participation.

Review of records for client #1 on 6/19/19 revealed a daily living skills assessment dated

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W 371	Continued From page 4 4/2/19. Review of the 4/2/19 assessment revealed client #1 is able to dispense pills with supervision and get water to take with medication independently. Further review of the 4/2/19 assessment revealed supervision is identified as a level of skill that the individual performs the activity with gestures, verbal direction and modeling or demonstration. Interview with Staff E on 6/19/19 verified clients #1 and #2 are capable of participation in medication administration with at least hand over hand assistance during most tasks. Interview with the facility nurse verified clients #1 and #2 are capable of accessing medications from the medication closet, punching medications from bubble packs and pouring water for medications with hand over hand assistance.	W 371		