STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G174	A. BUILDING _____ B. WING _____	C 01/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARNES GROUP HOME	2823 STARNES ROAD CHARLOTTE, NC 28214

(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 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide nursing services to 1 of 6 clients (#4) relative to medication administration. Review of records for client #4 on 1/6/21 revealed an admission date of 6/3/19. Continued record review for client #4 revealed a behavior support plan (BSP) dated 6/16/20 that included the following target behaviors: aggression, property destruction, false accusations, verbal aggression, and attention seeking behaviors. Further record review for client #4 revealed a behavior intervention data sheet dated 12/2020 which indicated that client #4 had three episodes of verbal aggression and/or property destruction on 12/1/20, 12/10/20, and 12/16/20. Review of the behavior intervention data sheet further revealed that client #4's behaviors in 12/2020 were escalated by client #4 not being able to have his way, being told no and after a phone call with his guardian. Continued review of records for client #4 revealed a physician's order dated 11/23/20 to administer Depakote 500mg BID. Review of the 12/2020 medication administration record (MAR) revealed that client #4 missed his AM and PM medication dosage of Depakote 500 mg from 12/1/20-12/27/20 and AM dosage from 12/30/20 - 12/31/20. Subsequent review of the MAR on 1/6/21 for other clients in the group home did not reveal any missed medication dosages from	W 331		

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

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12/2020 to date.

Review of the record for client #4 on 1/6/21 revealed a medical consult dated 12/28/20 which indicated that client #4 had a psychiatrist appointment to further discuss his medication regime, the guardian's requests for a medication dosage increase and current behaviors. Review of the 12/28/20 psych consult revealed psychiatrist recommendations to resume Depakote 500 mg BID with lab work to be completed in a week.

Interview with the home manager (HM) on 1/6/21 verified that on 12/1/20 he discovered that client #4 would not have enough of his Depakote medication to cover the entire month and immediately sent an email to the facility nurse. Further interview with the HM verified that he immediately contacted the pharmacy on 12/1/20 and attempted to get client #4's Depakote medication refilled. Continued interview with the HM verified that he contacted the facility nurse a total of two times by email to report that client #4 was out of his Depakote medication and requested assistance in getting the medication refilled. The HM also verified during the interview that he had been out of the office for the last two weeks and could not provide an update on client #4's Depakote medication. The HM verified that he never received a response from the facility nurse regarding client #4's Depakote medication.

Interview with the facility nurse on 1/6/21 verified that she became aware that client #4 was out of his medication (Depakote) on 12/28/20 during a psychiatric meeting with client #4's treatment team. Further interview with the nurse verified that she immediately contacted the pharmacy on

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12/28/20 and hand-delivered client #4's Depakote medication to the group home on the same day. The nurse confirmed that the Depakote medication for client #4 served as a mood stabilizer. The facility nurse verified during the interview that she did not receive an email from staff or management regarding client #4's Depakote medication issues. Subsequent interview with the facility nurse verified that to date client #4's labs had not been completed due to a self-quarantine relative to a 12/24/20 COVID-19 exposure in the group home. The nurse additionally verified during the interview that she did not complete a nurse's note for the medication errors for client #4 from 12/1/20-12/27/20 and 12/30/20-12/31/20. Interview with the facility nurse also verified that she was not aware that client #4 was out of his Depakote medication prior to 12/28/20. The nurse confirmed during the interview that to date client #4 is now receiving all medications.

Interview with the behaviorist on 1/6/21 verified that client #4 had three episodes of physical and/or verbal aggression in 12/2020 that required staff intervention. The behaviorist also verified during the interview that client #4 did not have an increase in target behaviors due to being off of his Depakote medication in 12/2020.

Interview with the qualified intellectual disabilities professional (QIDP) on 1/6/21 verified he was aware on 12/1/20 that client #4 was out of his Depakote medication. The QIDP further verified during the interview he was unaware that client #4 was not administered his Depakote medication from 12/1/20-12/27/20 and 12/30/20-12/31/20. The QIDP also verified during interview that client #4's behaviors did not

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W 331	Continued From page 3 increase while the client was out of his Depakote medication in 12/2020. Subsequent interview with the QIDP confirmed that on 12/28/20 the nurse hand delivered client #4's medication to the group home. Additional interview with the QIDP verified that he was unsure why client #4 did not receive his Depakote medication dosage from 12/30/20-12/31/20. The QIDP confirmed that client #4 should have received all medications as ordered. Interview with administration staff on 1/6/21 verified that she was out of the office and unaware that client #4 was not administered his Depakote medication for a total of 29 days. Continued interview with administration staff confirmed that client #4 had resumed his Depakote medication on 1/1/2021. Further interview with the administration staff confirmed nursing services had failed to ensure that client #4 received proper monitoring relative to his medication needs.	W 331		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on record review and interview, the system for drug administration failed to assure all drugs were administered according to physician's orders for 1 of 6 clients (#4). The finding is: Review of the record for client #4 on 1/6/21 revealed a physician's order dated 11/23/20 which	W 368		

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indicated that client would receive Depakote 500 mg BID. Continued review of the record revealed a medication administration record (MAR) dated 12/2020-1/2021. Further review of the 12/2020 MAR confirmed that client #4 had not recieved his AM or PM medication dosage of Depakote 500 mg from 12/1/20-12/27/20 and AM dosage from 12/30/20 - 12/31/20. Subsequent review of the MAR indicated "medication not available" beside the missed dosages.

Interview with the facility nurse on 1/6/21 verified that she became aware that the client was out of his medication (Depakote) on 12/28/20 during a psychiatric meeting with client #4's treatment team. The nurse confirmed that the Depakote medication for client #4 served as a mood stabilizer. Continued interview with the nurse verified that she immediately contacted the pharmacy on 12/28/20 and hand-delivered client #4's medication to the group home on the same day. Interview with the faciltiy nurse additionally verified that she was not aware that client #4 was out of his Depakote medication prior to 12/28/20. Subsequent interview with the facility nurse confirmed that client #4 is now receiving all medications as prescribed.

Interview with the qualified intellectual disabilities professional (QIDP) on 1/6/21 verified he was unaware that client #4 was not administered his Depakote medication from 12/1/20-12/27/20 and 12/30/20-12/31/20. The QIDP confirmed during the interview that the nurse hand delivered client #4's medication to the group home on 12/28/20 and he received his Depakote as prescribed on the same day. The QIDP could not verify why client #4 did not receive his Depakote medication dosage from 12/30/20-12/31/20. The QIDP

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W 368	Continued From page 5 confirmed that client #4 should have received all of his medications as prescribed. Interview with administration staff on 1/6/21 verified that she was out of the office and was unaware that client #4 was not administered his Depakote medication for a total of 29 days in 12/2020. Continued interview with administration staff confirmed that client #4 had resumed his Depakote medication as of 1/1/21. Further interview with the administration staff confirmed that client #4 should have been administered all of his medication as prescribed.	W 368		