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

PRINTED: 12/09/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G328	B. WING _			11/30/2	021
	NAME OF PROVIDER OR SUPPLIER  GAIL B HANKS GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5917 ROWAN WAY CHARLOTTE, NC 28214		DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
W 000	INITIAL COMMENTS		W 0	00			
W 371	No deficiencies were complaint survey com Intakes #NC0018325 DRUG ADMINISTRA' CFR(s): 483.460(k)(4	ppleted on 11/30/21 for 2. ΓΙΟΝ	W 3	71			
	that clients are taught medications if the interest determines that self-as is an appropriate object does not specify other. This STANDARD is represented a specify other. Based on observation interview, the system failed to assure 2 of 2 observed during med provided the opporture medication self-adminer.  A. The system for druct assure client #5 was participate in medicate example:  Observation in the gree 6:13 AM revealed cliem medication room and prepared and adminisclient. Continued observation in the gree in the sanitize her own in medications from a being medication record, purclient #5 into a medication take all medication that was poured by states.	administration of medications active, and if the physician rwise. Not met as evidenced by: In, record review and for drug administration actions (#5 and #6) action administration were not to participate in histration. The findings are: In g administration failed to provided the opportunity to ion self-administration. For a pup home on 11/30/21 at the series of the stered medications to the servation revealed staff B to hands, reconcile					

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.

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		34G328	B. WING			11/	30/2021
NAME OF PROVIDER OR SUPPLIER  GAIL B HANKS GROUP HOME		<b>'</b>	5	STREET ADDRESS, CITY, STATE, ZIP CODE 1917 ROWAN WAY CHARLOTTE, NC 28214	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 371	Review of records for revealed an individual 11/10/21. Continued #5 revealed a daily liv 11/9/20. Review of the revealed client #5 to be gestural cue to get a with a physical cue to punch pills.  Interview with the fact verified client #5 show opportunity to particip administration to the capable.  B. The system for drassure client #6 was participate in medicate example:  Observation in the gradical example:  observed and administic client. Continued observed and administic client #6 into a medication record for client #6 into a medication supplement medical example was gradient. Staff B was further identification of any medication of any medicat	client #5 on 11/30/21 Il support plan dated review of records for client ving skills assessment dated are 11/2020 skill assessment dave the ability with a med cup and to have ability pour from a pitcher and are in medication extent the client was  ag administration failed to provided the opportunity to ion self-administration. For a coup home on 11/30/21 at ent #6 to enter the to sit in a chair while staff B astered medication to the servation revealed staff B to a from a bubble pack with II, punch all pill medications dication cup and then give on cup. Client #6 was nedications whole with a	W	371			

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		34G328	B. WING _			11/30/2021	
	ROVIDER OR SUPPLIER  ANKS GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP COD 5917 ROWAN WAY CHARLOTTE, NC 28214	E		
(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 CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	CTIVE ACTION SHOULD BE COMPLETION NCED TO THE APPROPRIATE		
W 371	revealed an individual Continued review of a daily living skills as Review of the 6/2021 client #6 to have the get a med cup and proverbal cue.  Interview with staff B had not been trained or provide education medication to a client Interview with the face	r client #6 on 11/30/21 al support plan dated 6/30/21. records for client #6 revealed sessment dated 6/18/21. skill assessment revealed ability with a physical cue to unch the correct pill with a  on 11/30/21 revealed she to ensure client participation or identification of a during the medication pass. iility nurse on 11/30/21 uld have been provided the pate in medication	W3	371			