STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G328	A. BUILDING _____ B. WING _____	11/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GAIL B HANKS GROUP HOME	5917 ROWAN WAY 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 000	INITIAL COMMENTS No deficiencies were cited as a result of a complaint survey completed on 11/30/21 for Intakes #NC00183252.	W 000		
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 2 clients (#5 and #6) 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 #5 was provided the opportunity to participate in medication self-administration. For example: Observation in the group home on 11/30/21 at 6:13 AM revealed client #5 to enter the medication room and to sit in a chair while staff B prepared and administered medications to the client. Continued observation revealed staff B to her sanitize her own hands, reconcile medications from a bubble pack with the medication record, punch all medications for client #5 into a medication cup and client #5 to then take all medications whole followed by water that was poured by staff. Staff B was further observed to provide no identification of any	W 371		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G328	A. BUILDING _____ B. WING _____	11/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GAIL B HANKS GROUP HOME	5917 ROWAN WAY CHARLOTTE, NC 28214

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W 371	Continued From page 1	W 371		

medication or education regarding purpose or side effects to the client.

Review of records for client #5 on 11/30/21 revealed an individual support plan dated 11/10/21. Continued review of records for client #5 revealed a daily living skills assessment dated 11/9/20. Review of the 11/2020 skill assessment revealed client #5 to have the ability with a gestural cue to get a med cup and to have ability with a physical cue to pour from a pitcher and punch pills.

Interview with the facility nurse on 11/30/21 verified client #5 should have been provided the opportunity to participate in medication administration to the extent the client was capable.

B. The system for drug administration failed to assure client #6 was provided the opportunity to participate in medication self-administration. For example:

Observation in the group home on 11/30/21 at 6:25 AM revealed client #6 to enter the medication room and to sit in a chair while staff B prepared and administered medication to the client. Continued observation revealed staff B to reconcile medications from a bubble pack with the medication record, punch all pill medications for client #6 into a medication cup and then give client #6 the medication cup. Client #6 was observed to take all medications whole with a nutritional supplement drink that staff had measured and mixed polyethylene glycol powder in. Staff B was further observed to provide no identification of any medication or education regarding purpose or side effects to the client.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G328	A. BUILDING _____ B. WING _____	11/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GAIL B HANKS GROUP HOME	5917 ROWAN WAY CHARLOTTE, NC 28214

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W 371	Continued From page 2 Review of records for client #6 on 11/30/21 revealed an individual support plan dated 6/30/21. Continued review of records for client #6 revealed a daily living skills assessment dated 6/18/21. Review of the 6/2021 skill assessment revealed client #6 to have the ability with a physical cue to get a med cup and punch the correct pill with a verbal cue. Interview with staff B on 11/30/21 revealed she had not been trained to ensure client participation or provide education or identification of medication to a client during the medication pass. Interview with the facility nurse on 11/30/21 verified client #6 should have been provided the opportunity to participate in medication administration to the extent the client was capable.	W 371		