| 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 _____ | 05/04/2022 |

| 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 |
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| W 242 | INDIVIDUAL PROGRAM PLAN<br>CFR(s): 483.440(c)(6)(iii)<br><br>The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.<br>This STANDARD is not met as evidenced by:<br>Based on observation, record review and interview, the facility failed to ensure the individual habilitation plan (IHP) included training objectives to address observed needs for 1 of 4 sampled clients (#5) relative to privacy during toileting and handwashing. The finding is:<br><br>Observations in the group home on 5/4/22 at 6:40 AM revealed client #5 to enter into the bathroom. Continued observations revealed client #5 to use the toilet with the door remaining open. Further observations revealed client #5 to flush the toilet and exit the bathroom without washing her hands. Additional observations revealed client #5 to walk down the hallway and enter her bedroom with her pants unbuckled and unzipped. Observations at 6:45 AM revealed client #5 to exit her room with pants fastened and walk into the medication room to prepare for medication administration.<br><br>Subsequent observations on 5/4/22 at 7:30 AM revealed client #5 to enter into the bathroom and again use the toilet with the door remaining open. Continued observations revealed client #5 to flush the toilet and exit the bathroom without washing her hands. Further observations revealed client #5 to enter into the living room | W 242 | | |

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

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| W 242 | Continued From page 1<br>area and watch television with her peers.<br><br>Review of the record for client #5 on 5/4/22 revealed an IHP dated 8/18/21 which indicated the following program goals: change linens on her bed, make bed every morning, shower in the evening for at least 5 minutes, load the washing machine with clothing, participate in preparing a healthy menu item 2 times weekly, and brush teeth in the AM/PM for at least 60 seconds. Review of the record for client #5 did not reveal training objectives relative to privacy during toileting and handwashing.<br><br>Interview with the qualified intellectual disabilities professional (QIDP) on 5/4/22 revealed he does not recall client #5 having any problems with washing her hands and privacy during toileting. Continued interview with the QIDP verified that to his knowledge client #5 is pretty independent as it relates to grooming and toileting. Further interview with the QIDP verified that client #5 would benefit from training objectives relative to hand washing and privacy during toileting. | W 242 | | |
| W 249 | PROGRAM IMPLEMENTATION<br>CFR(s): 483.440(d)(1)<br><br>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. | W 249 | | |

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| W 249 | Continued From page 2 | W 249 | | |

This STANDARD is not met as evidenced by:
The facility failed to assure the individual habilitation plan (IHP) for 1 of 4 sampled clients (#3) included needed interventions and services to support the client's ambulation needs as evidenced by observation, interview and record verification. The finding is:

Afternoon observations in the group home on 5/3/22 from 4:05 PM until supper at 5:35 PM revealed client #3 to sit on the couch in the living room. Further observations revealed staff to periodically engage client #3 and ask the client if she wanted to participate in an activity with peers or participate in a household chore. Each time the client was observed to say no and refuse to get up. The client was observed to get up from the couch at supper at 5:35 PM with staff assisting the client by holding her hand and supporting her around the waist as she walked. Continued observations after supper revealed the client to again walk back to the couch with the assistance of staff in the same manner.

Morning observations in the group home on 5/4/22 at 6:15 AM again revealed client #3 to be sitting on the couch. The client was noted to walk to and from breakfast with staff assistance of holding her hand with a supportive hand on her waist. The client was initially observed to refused to get up off the couch for medications but did get up to walk to the medication room with the assistance of the qualified intellectual disabilities professional (QIDP).

Observations during the 5/3-4/22 survey, interview with the QIDP and substantiated by review of the client's IHP dated 2/17/22 revealed client #3 to be unsteady in her gait and require

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| W 249 | Continued From page 3<br>staff assistance to ambulate safely. Further interview with the QIDP and review of the IHP, revealed the client to be recommended a gaitbelt for safety during a physical therapy (PT) consult on 3/1/22. Continued interview with the QIDP revealed the client to be resistive to the use of the gaitbelt and refuses to allow it to be put on. The QIDP noted that staff continue to attempt to get the client to wear the gaitbelt but have been unsuccessful to date. Subsequent interview with the QIDP revealed the client has another PT appointment on 5/10/22 to discuss the client's leg supports and will consult with the PT about the use of the gaitbelt also.<br><br>Continued review of record revealed client #3 fell on 4/4/22 while ambulating and sustained a laceration to her right scalp which required glue and steri-strips. Additional review of the IHP, substantiated by interview with the QIDP, revealed no additional interventions, objective training or services have been put into place to assist with the client's resistance to the gaitbelt, the need for safer ambulation or to train staff on better ways to work with client #3's non-compliance with using a gaitbelt while ambulating. | W 249 | | |
| W 382 | DRUG STORAGE AND RECORDKEEPING<br>CFR(s): 483.460(l)(2)<br><br>The facility must keep all drugs and biologicals locked except when being prepared for administration.<br>This STANDARD is not met as evidenced by:<br>The facility failed to assure all medications were secured appropriately as required as evidenced by observations and interviews. The finding is: | W 382 | | |

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| W 382 | Continued From page 4<br>Morning observations in the group home on 5/4/22 at 6:40 AM revealed staff B beginning the process of starting the morning medication pass by getting the keys to the medication closet from an unlocked drawer next to the medication closet. Interview with the qualified intellectual disabilities professional (QIDP) revealed this is the usual place the medication keys are kept in the group home.<br><br>Further observations from 6:47 AM until 7:55 AM during the medication pass revealed staff B to exit the medication room after each client was administered their medications to prompt staff A to come check the medications that were given to detect any potential errors. Each time the staff member left the medications room, for periods of up to a couple of minutes, the medication door was left open and clients medications were left out on the counter. Continued observations revealed staff B at times would sometimes be within eyesight of the medication room and other times would walk into the kitchen or living room out of sight of the medications.<br><br>As the facility failed to assure the medication keys are kept secure and that staff were observed to repeatedly leave the medication room unattended and unlocked during the medication pass, the facility failed to assure client medications were locked and secured as required. | W 382 | | |