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 _____	12/20/2022

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 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 (#1 and #3) 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 #1 was provided the opportunity to participate in medication self-administration. For example: Observation in the group home on 12/19/22 at 3:45 PM revealed client #5 to enter the medication room and to sit in a chair while staff C prepared and administered medications to the client. Continued observation revealed staff C to her sanitize her own hands, reconcile medications from a bubble pack with the medication record, punch all medications for client #1 into a medication cup and client #1 to then take all medications whole followed by water that was poured by staff. Staff C was further observed to provide no identification of any medication or education regarding purpose or side effects to the client. Review of records for client #1 on 11/30/21 revealed an individual support plan (ISP) dated 10/5/22. Continued review ISP revealed a	W 371		

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

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diagnosis to include: moderate IDD, cerebral palsy, seizure disorder, GERD, and allergic rhinitis. Further review of records for client #1 did not reveal a current daily living skills assessment.

Interview with the facility nurse on 12/20/22 verified client #1 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 #3 was provided the opportunity to participate in medication self-administration. For example:

Observation in the group home on 12/19 at 3:55 PM revealed client #3 to enter the medication room and to sit in a chair while staff C prepared and administered medication to the client. Continued observation revealed staff C to reconcile medications from a bubble pack with the medication record, punch all pill medications for client #3 into a medication cup and then give client #3 the medication cup. Client #3 was observed to take all medications whole with a spoon inside a cup of water mixed with thick it. Staff B was further observed to provide no identification of any medication or education regarding purpose or side effects to the client.

Review of records for client #3 on 12/20/22 revealed an ISP dated 2/9/22. Continued review ISP revealed a diagnosis to include: Mild IDD, TBI, and loss of vision right eye. Further review of records for client #3 did not reveal a current daily living skills assessment.

Interview with staff B on 12/19/22 revealed she

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W 371	Continued From page 2 had 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 12/20/22 verified client #3 should have been provided the opportunity to participate in medication administration to the extent the client was capable.	W 371		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to assure that adaptive equipment was furnished or used as prescribed relative to eyeglasses for client #2. The finding is: Observations in the facility during the recertification survey from 12/19/22-12/20/22 revealed on 12/20/22 between 6:15 AM through 7:45 AM client #2 to participate in various activities to include breakfast meal, medication administration, exercise activities and watch tv. At no point during the observation period was client #2 prompted or offered to wear his eyeglasses. Review of the record for client #2 on 12/20/22 revealed a individual support plan (ISP) dated 3/2/22 which indicates the client has the following adaptive equipment: wheelchair, high sided divided dish, skid mat, adaptive spoon and	W 436		

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W 436	Continued From page 3 eyeglasses. Continued review revealed a vision consult dated 5/24/22 to include a new prescription for a new pair of glasses if needed. Further review of the 5/22 vision consult revealed client #2 to wear his eyeglasses while eating, watching tv and for things up close. Interview with staff D on 12/20/22 revealed client #2 does wear glasses and that staff will ensure he gets his glasses before loading on the van. Continued interview with the medical director revealed client #2 wears prescribed glasses as tolerated and will refuse to wear them at times. Interview with the residential director (RD) on 12/20/22 revealed client #2 does wear prescribed glasses. Further interview with the RD also verified client #2 should wear eyeglasses as prescribed.	W 436		
W 508	COVID-19 Vaccination of Facility Staff CFR(s): 483.430(f)(1)-(3)(i)-(x) § 483.430 Condition of Participation: Facility staffing. (f) Standard: COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. (1) Regardless of clinical responsibility or client contact, the policies and procedures must apply	W 508		

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to the following facility staff, who provide any care, treatment, or other services for the facility and/or its clients:
(i) Facility employees;
(ii) Licensed practitioners;
(iii) Students, trainees, and volunteers; and
(iv) Individuals who provide care, treatment, or other services for the facility and/or its clients, under contract or by other arrangement.
(2) The policies and procedures of this section do not apply to the following facility staff:
(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with clients and other staff specified in paragraph (f)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with clients and other staff specified in paragraph (f)(1) of this section.
(3) The policies and procedures must include, at a minimum, the following components:
(i) A process for ensuring all staff specified in paragraph (f)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its clients;
(iii) A process for ensuring the implementation of

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W 508	Continued From page 5 additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (f)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19	W 508		

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vaccination requirements for staff based on the recognized clinical contraindications;
(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and
(x) Contingency plans for staff who are not fully vaccinated for COVID-19.

Effective 60 Days After Publication:
(ii) A process for ensuring that all staff specified in paragraph (f)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations;
This STANDARD is not met as evidenced by:
Based on observation, record review and interviews, the facility failed to ensure policies and procedures were implemented for 1 of 3 sampled staff (#3) relative to assuring staff are fully vaccinated for COVID-19. The finding is:

Observations during the survey on 12/19/22-12/20/22 revealed an office personnel staff to present the staff listing for the facility. Further review of the listing revealed proof of vaccination and/or exemption status for 2 of 3 sampled staff (#1 & #2). Observations did not reveal vaccination or exemption status for staff #3

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W 508	Continued From page 7 during the survey. Record review on 12/20/22 revealed a staff listing consisting of staff that have direct contact with the clients within the facility. Review of staff vaccination and/or exemption status revealed both staff were fully vaccinated. Review of staff vaccination status did not reveal vaccination or exemption status for staff #3 during the survey. Review of the facility COVID-19 vaccination policy for staff (dated 1/25/22) on 12/20/22 revealed that all ICF employees shall be fully vaccinated for the COVID-19 virus. Continued review of the policy revealed that employees who fail to comply with the vaccine policy are subject to disciplinary action, including termination. Interview on 12/20/22 with the residential services director (RSD) verified the facility has written policies and procedures to ensure all staff are fully vaccinated for COVID-19. Continued interview with the residential services director verified that staff #3 has no proof of vaccination or exemption status on file.	W 508		