

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

PRINTED: 04/12/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G174		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/10/2023	
NAME OF PROVIDER OR SUPPLIER STARNES GROUP HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 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 000	INITIAL COMMENTS			W 000			
W 154	<p>Intake #NC00200313 and #NC00200382.</p> <p>STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3)</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to thoroughly investigate allegations of abuse for 1 of 1 audit clients (#1). The finding is:</p> <p>Review on 4/10/23 of the facility's internal investigation revealed 3/25/23 revealed that on 3/22/23, client #1 and client #2 became physically aggressive towards each other. Staff A and Staff B separated the two clients. Client #1 hit Staff A. Staff B's written statement revealed she told client #2 to hit client #1 back.</p> <p>Review on 4/10/23 of the video footage of the incident showed Staff A and Staff B separating client #1 and client #2. Client #2 was taken to the van. Client #1 was observed to hit Staff A. Staff B was heard to say "Hit him." Staff A stated, "Hit him?" Staff B stated "Hit him back." Staff A was observed to begin physically assaulting client #1.</p> <p>Interview on 4/10/23 with the Program Manager (PM) and Executive Director (ED) revealed the facility's internal investigation did not thoroughly investigate Staff B's encouragement for Staff A to hit client #1. Further interview with the ED confirmed the facility does not support this type of staff behavior.</p>			W 154			

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.