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 _____	01/28/2025

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 129	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the right to privacy for 1 of 4 audit clients (#2) related to personal space. The finding is: During observations in the home on 1/27/25 from 3:30pm to 5:15pm, client #5 was observed to repeatedly enter client #2's bedroom and lay on his bed. During the observations, staff were observed to go to client #2's bedroom and check on client #5, but did not prompt client to exit client #2's bedroom, nor prompted to ask client #2's permission for client #5 to use his bedroom. Interview on 1/28/25 with Staff A revealed client #5 goes into his peers bedrooms often to lay on their beds. Interview on 1/28/25 with the residential manager (RM) and qualified intellectual disabilities professional (QIDP) confirmed that client #5 should not be allowed to enter his peers bedrooms and lay on their beds, as it violates client #5's right to personal space and privacy.	W 129		
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that privacy	W 130		

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

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W 130	Continued From page 1 was maintained for 1 of 4 audit clients (#5). The finding is: During observations in the home on 1/27/25 at 4:25pm, client #5 was observed to go the bathroom, pull his pants down, and begin urinating. The qualified intellectual disabilities professional (QIDP) was observed to go to the bathroom, stand in the doorway, and prompt client #5 to wash his hands once he was done. The door to the bathroom remained opened, with client #5 visible from the hallway. Review of records on 1/27/25 of client #5's individual support plan (ISP) dated 7/10/24 revealed client #5 needs reminders from staff to close the bathroom door for privacy. Interview on 1/28/25 with the residential manager (RM) and QIDP confirmed staff should have prompted client #5 to close the bathroom door, and if not, staff should have closed the door for him to maintain his privacy.	W 130		
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure 1 of 4 audit client's (#2) individual support plan (ISP) included specific interventions to support the use of a wheelchair harness. The finding is: During observations in the home throughout the survey on 1/27/25 - 1/28/25, staff were repeatedly	W 240		

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W 240	Continued From page 2 observed to verbally tell client #2 to sit up in his wheelchair and to not lean over. Review of records on 1/27/25 of client #2's ISP dated 10/9/24 revealed the following adaptive equipment: walker, eyeglasses, wheelchair, leg brace and gait belt. Review of records on 1/28/25 of client #2's annual medical assessment revealed the following adaptive equipment: walker, eyeglasses, wheelchair, leg brace, gait belt and wheelchair harness. Interview on 1/28/25 with the qualified intellectual disabilities professional (QIDP) revealed she thinks the physical therapist had recommended or mentioned a harness previously. The QIDP confirmed client #2 would benefit from a harness, and this was a need not met by the facility.	W 240		
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure 1 of 4 audit clients (#2) had the opportunity for choice and self management. The finding is: During observations in the home on 1/28/25 at 6:56am, client #2 was observed eating breakfast. Staff E was observed the go to the table, and ask client #2 to come take his medications. Client #2 stated "no" several times. Staff E was observed to tell him he could come back to eat after he was	W 247		

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W 247	Continued From page 3 done, but needed to take his medications. Client #2 again stated no, he wanted to finish eating. At 6:58am, Staff E was observed to lean over, unlock client #2's wheelchair, pull him away from the table and push him into the medication room. Client #2 was still saying "no." Interview on 1/28/25 with the residential manager (RM) and qualified intellectual disabilities professional (QIDP) confirmed client #2 should have had the opportunity to eat his breakfast and then take his medications, and staff should not have pulled him away from the table after saying "no."	W 247		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure a technique to address client #5's inappropriate behavior was included in a formal active treatment plan. This affected 1 of 4 audit clients. The finding is: During observations in the home on 1/27/25 from 3:30pm to 5:15pm, client #5 was observed to repeatedly go to his bedroom door and try to open the door, which was locked. At 4:23pm, client #5 once again attempted to open his bedroom door, but was told by the qualified intellectual disabilities professional (QIDP) that he could not go into his room because he needed to do his programming. The QIDP was observed to state, "He will try to go lay down but needs to do	W 288		

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W 288	Continued From page 4 his programs." Review of records on 1/27/25 of client #5's individual support plan (ISP) dated 7/10/24 and behavior support plan (BSP) dated 6/29/24 revealed no interventions that included locking client #5's bedroom door to keep him from laying down. Interview on 1/27/25 with Staff A revealed staff lock client #5's bedroom door to keep him from going to lay back down on his bed. Interview on 1/28/25 with the residential manager (RM) and QIDP confirmed that locking client #5's bedroom door was not an approved intervention to prevent him from laying down, and confirmed the door should not be locked.	W 288		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all staff were sufficiently trained in health and hygiene methods to prevent cross contamination. This potentially affected 2 of 4 audit clients (#2 and #3). The finding is: During observations in the home on 1/28/25 at 7:13am, client #2 was in the medication room. Client #2's plate of food and cup of coffee were sitting on the dining room table. Client #3 was	W 340		

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W 340	Continued From page 5 observed to propel himself to the table, pick up client #2's cup of coffee, and drink from the straw in the cup. Staff D was observed to tell client #3 to put the cup of coffee down, that it was not his. Staff D was observed to assist client #3 with propelling around to the other side of the table to where his cup of coffee sat. Client #2's cup of coffee remained on the table. Additional observation at 7:17am revealed client #2 to come to the table, finish his breakfast, and drink from the same cup and straw that client #3 had used. At no time during the observation did staff replace the cup and straw. Interview on 1/28/25 with the residential manager (RM) and qualified intellectual disabilities professional (QIDP) confirmed staff should have replaced client #2's cup and straw with a clean one after client #3 drank from it.	W 340		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure all medications were administered in accordance with physician's orders. This affected 1 of 2 audit clients (#1) observed receiving medications. The finding is: During observations of medication administration in the home on 1/27/25 at 3:48pm, client #1 received 2 puffs by mouth from an albuterol inhaler.	W 368		

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W 368	Continued From page 6 During additional observations of medication administration in the home on 1/28/25 at 6:39am, client #1 received 10 milliliters of Sucralfate 1mg/10ml solution; and 1 puff by mouth from an Fluticasone inhaler. Review of records on 1/28/25 of client #1's physician's orders dated 12/13/24 revealed an order for an albuterol inhaler (Inhale 1 puff once daily); an order for Fluticasone inhaler (Inhale 2 puffs by mouth); and an order for Sucralfate 1mg/10mls (to be given at 5:00am, 11:00am, 5:00pm and 11:00pm). Additional review of client #1's physician orders revealed an order for Bethanectol 25mg (take 1 tablet daily at 7:00am and 8:00pm), which was not given to client #1 during his medication pass. Interview on 1/28/25 with the facility nurse confirmed that client #1 should have been given 1 puff of the albuterol inhaler and 2 puffs of the Fluticasone inhaler. Additionally, the nurse stated that medications can be given up to one hour before or one hour after their scheduled time. The nurse confirmed the Sucralfate solution was given outside of the scheduled time frame. Further interview with the nurse confirmed client #1 should have received the Bethanectol tablet as prescribed on the physician's orders.	W 368		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility	W 382		

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W 382	Continued From page 7 failed to ensure all drugs were kept locked except during administration. The finding is: During observations in the home on 1/28/25 at 6:34am, the surveyor, client #1 and Staff E entered the medication room for medication administration. Prior to entering the medication room, the door to the medication room and medication closet was left open, with multiple bottles and blister packs of medications left laying out on the desk and table. In addition, a medication cup with 4 pre-punched pills belonging to client #1 was observed sitting on the desk. During the observation, Staff E was observed to exit the room to get some paper towels out of the bathroom, leaving the surveyor and client #1 in the room, alone,with the medications sitting out in the room and the medication closet left unlocked. At 6:53am, the surveyor, client #1 and Staff E exited the room. The room door and medication closet door remained open and medications remained sitting out on the desk and table. Continued observations in the home up to 7:30am revealed Staff E to enter and exit the medication room several times to pass meds. Throughout the entire observation, the door to the room and closet in the room remained opened and unlocked, and the bottles and blister packs of medications remained laying out in the open. Interview on 1/28/25 with the facility nurse confirmed that medications are not supposed to be left laying out unless they are being administered. Continued interview with the facilty nurse also confirmed the medication room and closet should be locked and secured when medications are not being administered.	W 382		

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W 383	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) Only authorized persons may have access to the keys to the drug storage area. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure only authorized persons have access to the keys to the drug storage area. The finding is: During observations in the home on 1/28/25 from 6:30am to 7:30am, the medication room and medication closet door remained opened and unlocked. Throughout the observations, the keys to the medication room and closet were observed sitting on a table right inside the door of the room. Interview on 1/28/25 with the facility nurse revealed that staff responsible for administering medications is supposed to keep the keys to the room and closet on their person. The nurse confirmed the keys to the medication room and closet should not be left laying out in the open for anyone to have access to.	W 383		
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 interviews, the facility failed to ensure client #3 was taught to use and make informed choices about the use of his magnified visual adaptors. This affected 1 of 4 audit clients. The finding is:	W 436		

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W 436	Continued From page 9 During observations in the home throughout the survey on 1/27/25 - 1/28/25, client #3 was not observed to use or be prompted to use a magnified visual adaptor during any of his activities of daily living and leisure time. Review of records on 1/27/25 of client #3's individual support plan (ISP) dated 2/14/24 revealed client #2 is supported with adaptive equipment, including a magnified visual adaptor. Interview on 1/28/25 with the residential manager (RM) and qualified intellectual disabilities professional (QIDP) revealed client #3 uses a magnifying glass throughout his activities of daily living, particularly when he is coloring, doing activities, etc. The RM and QIDP confirmed staff should be prompting client #3 to his use magnifying glass.	W 436		
W 448	EVACUATION DRILLS CFR(s): 483.470(i)(2)(iv) The facility must investigate all problems with evacuation drills, including accidents. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to investigate any problems with fire evacuation drills, including the reason for extended times needed for evacuations. The finding is: Review of records on 1/29/25 of the facility's fire evacuation drills from January 2024 - December 2024 revealed multiple drills with extended evacuation times to include: 1/19/24 (6 minutes 48 seconds); 2/8/24 (7 minutes); 3/22/24 (8 minutes 7 seconds); 4/28/25 (8 minutes 47	W 448		

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W 448	Continued From page 10 seconds); 5/22/24 (6 minutes); 10/30/24 (6 minutes 10 seconds); 11/28/24 (8 minutes); and 12/28/24 (7 minutes). Interview on 1/28/25 with the residential manager (RM) and qualified intellectual disabilities professional (QIDP) confirmed the drills should have been evaluated to determine the issues of the extended evacuation times and a plan of correction should have been developed.	W 448		
W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure food and liquids were served in a form consistent with the developmental level for 2 of 4 audit clients (#2 and #3). The findings are: A. During observations in the home on 1/27/25 at 3:38pm, client 2 was observed sitting at the table, eating his afternoon snack. The snack consisted of small, round cheese puffs and one oatmeal cream pie, served whole. During the observations, client #2 was observed to pick the oatmeal cream pie up in one piece and eat from it. Review of records on 1/27/25 of client #2's individual support plan (ISP) dated 10/9/24 revealed a diet order consisting of low fat, low cholesterol, mechanical soft (food cut into bite size pieces). Interview on 1/28/25 with Staff D revealed client	W 474		

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W 474	Continued From page 11 #2's diet is mechanically soft by cutting all foods into bite size pieces. Interview on 1/28/25 with the residential manager (RM) and qualified intellectual disabilities professional (QIDP) confirmed client #2's oatmeal cream pie should have been cut into bite size pieces as directed in his diet order. B. During observations in the home on 1/27/25 at 4:58pm revealed Staff B to pour coffee into a cup, grab a container of creamer from the fridge and pour some into the coffee. Staff B stirred the coffee and then added more coffee to the cup and sit the cup on the counter. At 5:02pm, Staff A picked up the cup of coffee and gave it to client #3. During the dinner observations, client #3 was observed to drink the cup of coffee. Review of records on 1/27/25 of client #3's ISP dated 2/14/24 revealed a diet order consisting of low cholesterol, mechanical soft diet with honey thick liquids, and 1000 cc fluid restriction. Interview on 1/28/25 with Staff D revealed client #3's liquids are thickened utilizing a container of thickener sitting on top of the refrigerator. Interview on 1/28/25 with the RM and QIDP confirmed client #3's coffee should have been thickened to a honey thick consistency as directed in his diet order.	W 474		