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

PRINTED: 04/02/2025
FORM APPROVED
OMB NO. 0938-0391

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 _____	C 03/24/2025

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 000	INITIAL COMMENTS A complaint survey was completed on 3/24/25 for intake #NC00227621. The allegations were unsubstantiated and deficiencies were cited unrelated to the allegations.	W 000		
W 385	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(3) The facility must maintain records of the receipt and disposition of all controlled drugs. This STANDARD is not met as evidenced by: The facility failed to maintain records regarding the disposition of controlled drugs prescribed for 1 of 6 clients (client #1) residing in the home, as evidenced by review of controlled drug count sheets and the medication administration record (MAR), verified by interviews. The finding is: During an investigation survey on 3/24/25 at the group home at 6:15 AM revealed a controlled drug count sheet for client #1. Further review of the controlled drug count sheet revealed a prescribed medication listed as Lacosmide 100 mg tab. Continued review of the controlled drug count sheet revealed several missing initials of med staff and initials of checker for the entire month of 3/25. Subsequent review of the controlled drug count sheet revealed a discrepancy in the count. Additional review revealed the following counts noted: 1. 3/22/25 Morning count, starting amount 19 pills with no ending count or initials of med staff or initials of checker. 2. 3/22/25 Afternoon count, starting amount 19 pills with no ending count or initials of med staff or initials of checker. 3. 3/22/25 Evening count, starting amount 19 pills with no ending count or initials of med staff or	W 385		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Executive Director/CEO

(X6) DATE: 4/8/25

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.

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W 385	Continued From page 1 initials of checker. 4. 3/23/25 Morning count, starting amount 18 pills with AW initials of med passer and 17 ending count with AW initials. 5. 3/23/25 Afternoon count, no information was documented for starting amount or ending count or initials of med staff or initials of checker. 6. 3/23/25 Evening count, no information was documented for starting amount or ending count or initials of med staff or initials of checker. 7. 3/24/25 Morning count, no information was documented for starting amount or ending count or initials of med staff or initials of checker. Surveyor requested that staff count the controlled drug Lacosmide 100 mg tab for client #1. Further request and observation revealed 16 pills in the blister pack as staff counted the number of pills in the blister pack two additional times. Observations at 7:10 AM revealed client #1 to come to the medication room to participate in medication administration. Further observations revealed client #1 to punch his pills into the medication cup as staff A provided education. Continued observations revealed client #1 to receive the following medications: Calcium 600 mg, Carbamazepine 100 mg, Folic acid 1mg, Lacomide 100 mg, Lactulose 22.5 ml, Minevin Cream, Solifenacin 5mg, Polyethylene drop, and Timolol maleaxe drops. Further observations did not reveal staff A to sign the control medication count sheet for client #1 after administering his medications. Interview with staff A on 3/24/25 revealed the process for documenting on the control count is to have another staff present while counting the pills in the blister pack. Further interview with staff	W 385	QIDP will ensure that all staff involved in handling and documenting controlled medications undergo mandatory in-service on proper medication handling, counting procedures, and the requirements for accurate record-keeping. The PC will ensure a daily count of controlled drugs is documented in the logbook, signed and dated by the DSP. QIDP will conduct random audits of the controlled drug logs every month to ensure appropriate drug storage and record keeping. To be completed by 05/8/25	05/08/25

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W 385	Continued From page 2 A revealed since he works third shift he has to count off with 1st shift. Interview on 3/24/25 with the newly hired facility nurse revealed on 3-19-25 she implemented that all medications should be checked at least twice a week to ensure there is enough medications and/or if the control medication count is accurate. Interview on 3/24/25 with the qualified intellectual disabilities professional (QIDP) revealed that controlled medications are kept in a lock box, which remain in the medication closet and that is also kept locked. Further interview with the QIDP also revealed the process for completing the control medication count is that when staff come in, the control meds are counted, and another staff signs the control count before medications are administered. Continued interview with the QIDP revealed when the next shift comes in, the control meds are also counted with the staff going off shift and both staff initials the document. Subsequent interview revealed that the pharmacy completes audits by completing medication reviews, checks, count, at least twice annually or more. The last pharmacy audit was completed in 2/25. Additional interview with the QIDP revealed when staff notice a discrepancy in any med count, staff should immediately contact the nurse who will provide insights on what needs to happen next. The QIDP also revealed that staff have been trained on what needs to be done and is also aware that if there are any discrepancies, staff will be removed from administering medications and required to participate and pass a medication administration class.	W 385		

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W 476	Continued From page 3 MEAL SERVICES CFR(s): 483.480(b)(3) Food served to clients individually and uneaten must be discarded. This STANDARD is not met as evidenced by: The facility failed to assure health and safety of 2 of 6 clients (#4 and #5) in the facility by not ensuring food consumed was discarded prior to the expiration date. The finding is: Observations in the group home on 3/24/25 at 6:15 AM revealed the clients #4 and #5 to participate in the breakfast meal consisting of cereal, milk and juice. Further observations revealed client #4, client #5 to consume the breakfast meal. Continued observations revealed the milk served in the refrigerator to have an expiration date of 3/16/24. Subsequent observations revealed two additonal gallons of unopened milk in the refrigerator that were not expired. Interview on 3/25/25 with the qualified intellectual disabilities professional (QIDP) revealed that fresh milk was available for the clients in the refrigerator. Further interview with the QIDP confirmed that expired foods should not be provided to the clients.	W 476	To ensure client safety, ASMC's QIDP and/or PC will remove all expired food from the kitchen and refrigerator. The QIDP will conduct in-service training for staff on the food safety manual, reinforcing the importance of discarding expired food. The PC will conduct bi-weekly food inventory audits to identify and promptly remove expired items. To be completed by 05/08/25	05/08/25