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 10/01/2025

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 October 1, 2025 for intake # NC00233620, NC00233621, and NC00233730. The intake was substantiated. Deficiencies were cited.	W 000		
W 157	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(4) If the alleged violation is verified, appropriate corrective action must be taken. This STANDARD is not met as evidenced by: Based on documentation review and interviews, the facility failed to show evidence of appropriate corrective action for an incident of neglect for 1 of 6 clients (#4). The finding is: Review of facility documentation during a complaint investigation survey on 10/1/25 revealed a plan of protection relative to an abuse incident involving client #4. Further review of the plan of protection dated 9/17/25 indicated that on 9/6/25 around 11:00 PM, Staff A barricaded client #4 in his room for approximately 7 hours. Continued review of the plan of protection and incident report dated 9/12/25 indicated the client has an insomnia diagnosis and can't sleep at night. The client is non-verbal and was pacing in the kitchen and dining room areas on the date of the incident during third shift hours. The client (#4) was sent to his room and staff A barricaded the client's bedroom door by pushing a dresser across the door. Additional review of the plan of protection and incident report verified client #4 was in his room screaming and crying for 7 hours and was released from his room at 6:00 AM. Client #4 also defecated and urinated on himself as he was barricaded in his room.	W 157		

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

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W 157	Continued From page 1 Subsequent review of the plan of protection dated 9/17/25 indicated the following steps were necessary to protect the client (#4): all direct support staff will receive immediate re-training on Client's Rights and Prohibited Interventions to include seclusion, physical barriers or room restriction. The qualified intellectual disabilities professional (QIDP) or program coordinator (PC) will observe staff interactions with clients twice per week and document in the Therap system for 30 days. Review of the facility documentation did not reveal documentation to verify that client rights and prohibited interventions training was provided to facility staff and no QIDP or Management documentation to verify that client #4 received clinical oversight and monitoring twice a week since the incident occurred on 9/6/25. Interview with the Residential Co-Director on 10/1/25 verified that she has spoken to staff on all shifts, however training in client rights and prohibited interventions has not been completed to date. Further interview with the Co-Director revealed clinical oversight and monitoring has not been consistent and documentation has not been completed as required in the plan of protection for client #4 dated 9/17/25.	W 157		
W 253	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(2) The facility must document significant events that are related to the client's individual program plan and assessments. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to document significant events, specifically relative to appropriate assessments completed	W 253		

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W 253	Continued From page 2	W 253		

after an alleged incident and accurately tracking sleep data, affecting 2 of 6 clients (#4 and #6). The findings are:

A. The qualified intellectual disabilities professional (QIDP) and The Behavioral Specialist (BS) failed to document or complete an assessment after an alleged incident for client #4.

Record review on 10/1/25 during a complaint investigation survey for client #4 revealed a General Event Report (GER) dated 9/11/25. Continued review of the GER revealed "on 9/6/25 client #4 was roaming the home in the late hours of the night unable to sleep and keep quiet". Between 10:58pm-6:58am a staff member barricaded client #4 in his bedroom. The staff member pushed his dressed in front of the entrance of his bedroom, he was blocked in his bedroom until the next morning. Client #4 "stood there screaming and reaching his hands out wanting to get out; he screamed the entire night." Further record review revealed no QIDP documentation of an inter disciplinary team (IDT) meeting or note addressing the incident, debriefing, follow-up, or prevention measures completed to address the incident. Additional record review revealed no assessment or note documented by the Behavioral Specialist addressing the incident and debriefing/counseling with client #4.

Additional record review on 10/1/25 for client #4 revealed a behavior support plan (BSP) dated 10/30/24 revealed target behaviors to include: Self-injurious behaviors (SIB): Stimming, Non-compliance, Agitation/anxiety, Inappropriate touching others and Pica.

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Interview with the Co-Residential Director on 10/1/25 confirmed no assessments or notes were completed by the QIDP and BS regarding the incident that occurred on 9/6/25 for client #4.

B. The QIDP and BS failed to document or complete an assessment after an alleged incident for client #6.

Record review on 10/1/25 during a complaint investigation survey for client #6 revealed a General Event Report (GER) dated 9/11/25. Continued review of the GER revealed "on 9/5/25 staff member recalled prior incidents where client #6 engaged in undressing behaviors and a staff member made comments describing the client"s private area as "stiff" and "at attention". Staff as stated "thing was swinging" when the client ran through the kitchen, undressed. The staff member caressed the clients' arm to calm him down." Further record review revealed no QIDP documentation of an IDT meeting or note addressing the incident, debriefing, follow-up, or prevention measures to address the incident. Additional record review revealed no assessment or note documented by the Behavioral Specialist addressing the incident and debriefing/counseling with client #6.

Additional record review on 10/1/25 for client #6 revealed a behavior support plan (BSP) dated 6/25/25 revealed target behaviors to include: Food Seeking, Non-Compliance, Agitation, self-injurious behaviors (SIBs), Property Misuse, and Inappropriate Sexual Behavior.

Interview with the Co-Residential Director on 10/1/25 confirmed no assessments or notes were completed by the QIDP and BS regarding the

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W 253	Continued From page 4 incident that occurred on 9/5/25 for client #6. C. The staff failed to document significant events relative to hourly sleep checks for client # 4. Record review on 10/1/25 for client #4 revealed sleep data sheets from 07/1/25 - 9/30/25. Continued review of the sleep data sheets for client #4 revealed no data recorded during the hours of 9:00pm - 7:00am for 24 out of 92 days. Further review revealed missing data for hours between 9:00pm- 7:00am for 91 out of 92 days. Interview with the Co-Residential Director on 10/1/25 confirmed missing data collected during the months of July, August, and September of 2025. Continued interview with the Co-Residential Director revealed sleep data is to be documented daily for client #4.	W 253		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, documentation review and interview, the facility failed to provide nursing services in accordance with the needs of 1 of 6 clients (#4) by not ensuring appropriate assessment and monitoring after a significant event. The finding is: Review of the record for client #4 during a complaint investigation survey on October 1, 2025 revealed an incident reporting indicating that on 9/6/25 at 11:00 PM, the client was barricaded in his room for approximately 7 hours with a dresser that was pushed in front of the client's	W 331		

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bedroom door. Further review of the record revealed client #4 was not provided access to a bathroom during the 7 hour period.

Review of the incident report (9/12/25) and plan of protection (9/12/25) indicated client #4 screamed and cried all night. Continued review of the incident report revealed client #4 urinated and defecated on himself throughout the night. Additional review of the incident report and the facility's plan of protection revealed client #1 was removed from his room at 6:00 AM. Review of the documentation relative to the incident involving client #4 did not reveal body checks, a nursing assessment, or nurses' notes to determine if the client had any injuries or needed medical attention after the incident.

Subsequent review of the record for client #4 revealed a person centered plan (PCP) dated 6/30/25 which indicated the client has an insomnia, unspecified diagnosis.

Interview with the facility nurse on 10/1/25 revealed she was made aware of the incident involving client #4 and an assessment or body checks were not completed. Further interview with the facility nurse revealed client #4 was displaying behaviors which did not indicate the need for an assessment or involvement with nursing services.

Interview with the Residential Co-Director on 10/1/25 verified client #4 was involved in an emotional and mental abuse incident and the client exhibited no targeted behaviors that led up to the incident. Further interview with the Co-Director revealed client #4 paces and walks throughout the night when he is not able to sleep.

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W 331	Continued From page 6 Continued interview with the Co-Director verified client #4 does not exhibit target behaviors when he has a hard time sleeping. Additional interview with the Co-Director agreed it is the responsibility of nursing to complete an assessment to rule out if medical treatment was needed and the assessment should have been documented in the client record.	W 331		