STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034168	A. BUILDING: _____ B. WING _____	C 08/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIS HOUSE AT BETHABARA	2020 CLYDE HAYES DRIVE WINSTON SALEM, NC 27106

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V 000	INITIAL COMMENTS A complaint survey was completed on 8/11/20. The complaints were substantiated (intake #NC00167640 and NC00167932). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G. 5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 106	27G .0201 (A) (8-18) (B) GOVERNING BODY POLICIES 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (8) use of medications by clients in accordance with the rules in this Section; (9) reporting of any incident, unusual occurrence or medication error; (10) voluntary non-compensated work performed by a client; (11) client fee assessment and collection practices; (12) medical preparedness plan to be utilized in a medical emergency; (13) authorization for and follow up of lab tests; (14) transportation, including the accessibility of emergency information for a client; (15) services of volunteers, including supervision and requirements for maintaining client confidentiality; (16) areas in which staff, including nonprofessional staff, receive training and continuing education; (17) safety precautions and requirements for facility areas including special client activity areas; and	V 106		

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V 106	Continued From page 1 (18) client grievance policy, including procedures for review and disposition of client grievances. (b) Minutes of the governing body shall be permanently maintained. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure its policy regarding safety precautions as related to infectious diseases (Covid-19) was implemented. The findings are: This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. *The date of the interviews and the titles of two of the four staff interviewed were not provided as to allow the staff to remain anonymous* Interviews on 7/28/20, 7/30/20 and 7/31/20 with the Director of IDD (Intellectual Developmental Disabilities) Ministries revealed: - While she was not aware a complaint had been made to the Division of Health Service Regulation (DHSR), she was aware a complaint had been submitted about the number of residents and clients present in the facility during a training on 7/21/20 via their "Lighthouse" system - As a result of the complaint, she had already begun an investigation into the concerns raised by the complainant - On 7/21/20, a medication administration training organized by the facility's Qualified Professional (QP) was held at the facility	V 106		

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V 106	Continued From page 2 - The facility's guidelines were to have only ten persons present in the facility at any given time - While the training was being held, there were nineteen individuals were present in the facility - These nineteen individuals included ten staff, six clients who resided at the facility and three clients from a sister facility - Prior to the start of the training, the clients and staff had their temperatures taken and their oxygen levels were measured via the use of a pulse oximeter -- Staff were seated throughout the facility, the six residents of the facility were in their rooms and the three clients from the sister facility were seated in the office of the facility - Staff wore masks, however, the clients did not wear masks - The training was scheduled to begin at 10 and last until 12 or 1 pm; however, it did not conclude until 1:30 pm - When she spoke with the QP, the QP reported that she believed she met the guidelines because she had only ten participants in the training - The QP had not understood that the number of clients present in the home had to be counted as well - The QP was informed that going forward, there should never be more than ten individuals gathered in the facility at one time - This would also be addressed again with the QP during her supervision meeting - She did not believe the QP meant to place any of the staff or clients at risk to contract Covid-19. Review on 8/3/20 of a complaint made anonymously via the "hotline" of the agency which oversaw the operation of the facility on 7/22/20 revealed:	V 106		

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V 106	Continued From page 3 - " ...This is about a staff member Supervisor [QP], she held a training at the home yesterday 7/21. During this training she did not follow agency procedures. She put the staff and residents at risk for Covid-19. The first thing that happened, there should only be 10 people at a time gathering and there was a total of 19 in the home. That included residents from three different homes. Also there were too many people in the home, so we were unable to social distance ourselves from each other. The residents were coming in to the training area where the staff was training. The residents were not wearing masks but were interacting with the staff. This is a group home and we are expected to be wearing masks. [The QP] is a supervisor and she is expected to keep the staff and residents safe." Review on 8/3/20 of the facility's "Infection Control Plan for COVID-19 and other related Diseases" revealed: - "Baptist Children's Home (BCH) Intellectual and Developmental Disabilities Ministries program has designed an Infectious Control Plan. This is to keep our residents and staff safe and healthy in the event of any COVID-19 outbreak in our homes or other related infectious disease that may arise in our facilities. We strive to keep our resident's health and safety top priority as we continue to improve our infection control practices and help to prevent the spread of any viruses ..." - " ...Implement universal facemask use by all people in the facility (source control), including all staff, residents, and visitors ..." - No date listed on the plan which reflected the date the plan was developed or by whom Review on 8/3/20 of the "Guidance for Smaller Residential Settings Regarding Visitation,	V 106		

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V 106	Continued From page 4 Communal Dining, Group and Outside Activities" from the North Carolina Department of Health and Human Services (NC DHHS) and dated 6/26/20 revealed: - For facilities of six or fewer beds, guidelines documented that staff in residential facilities should "...ensure face covering for all individuals; maintain social distance wherever possible, particularly in community settings. It is important to avoid close contact (being within 6 feet for 15 minutes or longer); limit group size such that infection prevention measures such as hand hygiene, use of cloth face covering, and social distancing can be appropriately followed..." Review on 8/3/20 of emails sent between the IDD Director and the Special Ministries Director and Program Analyst (SMD/PA) on 7/22/20 in response to the complaint shared via the "Lighthouse" system revealed: - From the IDD Director: "Thank you, I was told this morning that this (gathering of nineteen individuals in the facility on 7/21/20). I will look into it more. From my understanding, the Davis House residents were in their rooms. The [name of the sister facility located next door] ladies were all on the front porch and the visiting [clients from sister facility located in another county] were in the QP's office and not in the main living area (there were 3 residents). All the residents were separated and not in one area. The staff did have their mask on, but the residents did not have their mask on." - The SMD/PA responded: "It would be hard for 19 staff to social distance in the group home, even if residents were not in there. Thanks for finding out more info." - An email sent by the IDD Director to the SMD/PA on 7/23/20 revealed: "I talked with [QP] and asked that she not have more than 10 people	V 106		

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V 106	Continued From page 5 in their home at time, no matter if the residents were in their room or not. She said she understood." Interview with staff revealed: - They attended a medication administration training on 7/21/20 - There were nineteen individuals in the facility which included the clients who resided in the home, three clients from a sister facility, staff and the training instructor who was not an employee of the facility or the agency which operated the facility - Prior to the training, staff had been under "strict orders" to follow the DHHS guidelines which addressed how to respond to the Covid-19 crisis - These guidelines included minimizing visitors, the use of face masks and monitoring others for the possible symptoms of Covid-19 (temperature readings and oxygen level) - Staff were also told to keep the number of individuals at in-person gatherings at the facilities to no more than ten - They were not sure if the limit of ten was an agency guideline or a DHHS guideline; however, knowing this, they were surprised to see the number of persons in the facility - The staff were wearing masks; however, the clients were not wearing masks - They felt that having nineteen persons in the home and with the clients not wearing masks had placed the clients as well as the staff "at risk." Interview with staff revealed: - They attended a medication administration on 7/21/20 - There were thirteen individuals including the instructor present for the training - There were also nine clients (six who resided	V 106		

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V 106	Continued From page 6	V 106		

in the facility and three from a sister facility) also present in the facility
- The six residents of the facility were in their individual rooms and the three clients from the sister facility were sitting in the QP's office
- Everyone who attended the training were seated on chairs which had been spaced throughout the room
- Although precautions were taken (masks, availability of hand sanitizer and temperature readings), staff stated, "I would have been more comfortable if they had divided the training into two sessions."
- "Quite honestly, I thought they shouldn't have that many people in one space."

Interviews on 8/6/20 and 8/7/20 with the QP revealed:
- She scheduled a medication administration training for 7/21/20, a training which was a requirement for staff
- She made staff aware of the training "a couple of weeks" prior to 7/2120 by sending an email to her supervisor and the QPs of the sister facilities
- Some staff called to inform her they planned to attend; however, she was not fully aware of all the staff who planned to be present at the training until the day of the training
- She knew at least "her staff (staff from the facility and the sister facility located next door) and maybe one more" planned to come to the training
- The training was scheduled from 10 am until 1 pm; however, it ended at approximately 1:30 pm
- Along with the ten staff and the training instructor, there were the six residents of the facility present in the home as well as three clients from a sister facility who were seated in

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V 106	Continued From page 7 her office - Her understanding of the facility's Covid-19 policy for in-person gatherings was there should be no more than ten persons in the facility at a time; however, she believed that the gathering of ten did not include clients because "staff and clients were in and out of the homes all of the time." - She now understood this was a mistake on her part. Interview on 8/11/20 with the Director of the IDD Ministry revealed: - The policy of keeping in-person gatherings to no more than ten was related to an initial DHHS guidance on Covid-19 and those in residential settings - She had revised the infection control plan for facilities to follow in March or April of 2020 and utilized information provided by the DHHS in the revision of their plan - Staff were aware that in person gatherings should be kept to no more than ten persons - She would be meeting with the QP today for her supervision and to continue discussion of this specific incident and how to address situations such as this going forward.	V 106		