STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G061	A. BUILDING _____ B. WING _____	01/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGIA COURT	107 MISS GEORGIA COURT CARY, NC 27511

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W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure the governing body put in place measures to prevent the spread of COVID-19 from one group home to another. The finding is: During interviews on 1/19 and 1/20/2021, the facility's qualified intellectual disability professional (QIDP) and the assistant to the executive director indicated the group home manager would not be there today because he was working at another home. They further indicated he was working at a sister facility that had COVID-19 however this was his assigned home also. When asked if he was coming back, the assistant to the executive director stated she did not know when he would be back but that he would. When asked about the spread of COVID and his taking time off between working at the homes, she indicated she did not know if he would take time off. They both indicated he was COVID negative and that they have nothing in place for COVID positive non-symptomatic people to work in only COVID positive facilities. The QIDP stated he thought the group home manager takes time off as that is what he did once before when he worked over there. He indicated he was not sure what to call the time off. Neither manager was sure how much time off exactly. On 1/20/2021, the management team	W 104		

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

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W 104	Continued From page 1 indicated he would probably not come back to work in that group home at all. When asked to see the policy or written procedure for sharing staff between a COVID negative and a COVID positive homes, they indicated there was not a policy or procedure. Additionally, the management indicated the program manager was COVID positive but could not ascertain the exact date she had last been in this home. On 1/20/2021, the management indicated she had not been in this home since her exposure to COVID 19 at the other sister facility. They indicated a return to work policy is in place and she could return to work in 10 days if no symptoms. no repeat test is done and their policy does not require testing of individual clients when they have had exposure unless they are symptomatic. Review on 1/20/2021 of the COVID Pandemic Policy did not include any information about staff working in both COVID positive homes and COVID negative homes. It further indicated the process when an employee tests positive for COVID 19 the facility is to determine and notify any close contact with other employees and exposed clients will be entered in the tracker.	W 104		
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 observations, record reviews and interviews, the facility failed to assure privacy for	W 130		

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W 130	Continued From page 2 1 of 3 audit clients (#4). The finding is: During observations on 1/19/2021 at approximately 4:30pm, client #4 went into the bathroom. Client #6 went in the bathroom shortly thereafter. The door was open but this bathroom was located in the bedroom which also had an open door. After a few minutes client #6 came out. When he returned to the kitchen staff asked him to go back and wash his hands. He stated "[Client #4] is in the bathroom." Staff said, "Oh okay wash your hands in here." Client #4 remained in the bathroom until he was finished and then came out to the dining room. Interview on 1/20/2021 with staff A about privacy revealed the clients do a good job managing privacy on their own. Review of Client #4's IPP on 1/19/2021 revealed he has a diagnosis of "Profound mental retardation." Review of the record revealed a presentation of his rights (including the right to privacy) to his guardian and him. The assessment of his life skills completed 5/1/2020 noted he was independent at assuring privacy. Interview on 1/20/2021, with the qualified intellectual disability professional (QIDP) confirmed client #4 needs assistance to protect his right to privacy as he will fail to do so sometimes.	W 130		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active	W 249		

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W 249	Continued From page 3 treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure the clients were encouraged to be independent at mealtime. This affected 2 of 3 audit clients (#4 and #5). The finding is: During observations of lunch and dinner on 1/19/2021 and breakfast on 1/20/2021, the clients were not given the opportunity to eat family style and at dinner on 1/19/2021 and breakfast on 1/20/2021 they were not given the opportunity to pour any of their beverages. At lunch plates with sandwiches, chips and cookies were placed before the individuals and at dinner plates were served by a staff and items were taken by the staff behind the individuals to the next person as he scooped and served them baked beans and french fries. Review of the individual program plans for client #4 (dated 8/20/2020) and #5 (dated 7/3/2020) indicated that they can serve themselves and pour their beverages. Interview with the qualified intellectual disability professional (QIDP) on 1/20/2021 revealed all clients should have participated in family style dining and in pouring their own beverages.	W 249		
W 340	NURSING SERVICES	W 340		

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W 340	Continued From page 4 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, record review and staff interviews, the nurse failed to ensure competency when training staff to prevent cross contamination, while providing services to 5) as well as failed to maintain the cleaning log as per the guidelines established for COVID19 and failed to screen visitors. This potentially affected all clients residing in the facility. The findings are: During observations in the facility on 1/19/2021 and 1/20/2021, the facility staff did not do any cleaning. Additionally, the staff did not screen this surveyor upon initial entrance into the facility. After being asked about it, the staff offered to take the surveyor's temperature upon return from a lunch break. At that time, the staff (D) did not ask any questions of the surveyor but checked off answers on a questionnaire and signed the first name of the surveyor. Later, there was a knock at the door and a woman appeared. She told the staff she wanted to see a client. The client then came to the door where the two embraced and some items were given to the client. The lady said a few sentences to the client then hugged him again and left. Review on 1/20 and 1/21/2021 of the emergency plan revealed, "Pandemic COVID-19 Crisis Plan."	W 340		

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W 340	Continued From page 5 This plan was established to "oversee/manage preparedness and prevention strategies." The plan noted that only mandatory staff and no visitors were allowed. It also noted that the QEM should assure a "designated staff" had been assigned for each shift to give hourly reminders for others to wash hands and wipe down surfaces as well as complete the cleaning prevention checklist in the am and PM. Manager or designee was to review to ensure continued compliance. Interview with the staff (3) on 1/19 and 1/20/21 revealed a log which was in a cabinet for documenting cleaning. Nothing had been documented since 8/20/2020. Staff A confirmed the cleaning part is not being done and said, "Out of sight out of mind I guess." Interview with the qualified intellectual disability professional (QIDP) on 1/20/2021 revealed the cleaning should be done according to the plan and that all people entering the home should be screened. Further interview with the QIDP and assistant director on 1/20/2021 revealed that it is a self screening process that should occur upon entrance. When asked how do you know if someone has symptoms, the staff stated, "That if someone has a fever they will know it when they take their temperature." When asked who checks the screening logs the QIDP did not know.	W 340		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills at least quarterly for each shift of personnel.	W 440		

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W 440	Continued From page 6 This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure one fire drill per shift per quarter occurred. The finding is: Review of the fire drill records indicated there were no fire drills for first and second shifts for the quarter of July, August and September. The only drill was noted to be conducted for 3rd shift in October. Additionally, for the quarter of April, May and June, there were no fire drills for first shift. A drill for third shift occurred in April and for second shift occurred in May. Interview with the qualified intellectual disability professional (QIDP) on 1/20/2021 confirmed there were no more fire drills and thus they had not completed one per shift per quarter.	W 440		