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E 020	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.475(b)(3) §403.748(b)(3), §416.54(b)(2), §418.113(b)(6)(ii), §441.184(b)(3), §460.84(b)(3), §482.15(b)(3), §483.73(b)(3), §483.475(b)(3), §485.68(b)(1), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b)(1), §494.62(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCIs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance.	E 020		

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

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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E 020	Continued From page 1 * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop specific policies and procedures to address emergency preparedness (EP) including evacuating locations based on a community and facility based risk assessment. This had the potential to affect all clients (#1, #2, #3, #4 and #5). The findings is: Review on 2/8/22 of the facility's EP dated 9/7/21 revealed the plan did not include any information in regards to the facility's evacuation locations in the event of flood, fire, tornado, hurricane, storms, bio-terrorism and other emergencies. Interview on 2/8/22 with the residential manager (RM) revealed that she was unaware that it was a requirement.	E 020		
E 022	Policies/Procedures for Sheltering in Place CFR(s): 483.475(b)(4) §403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i),	E 022		

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E 022	Continued From page 2 §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3). (b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This STANDARD is not met as evidenced by: Based on interview and record review of the facility's Emergency Preparedness (EP) manual, failed to develop policy and procedures on sheltering in place. This potentially affected all clients (#1, #2, #3, #4 and #5) in the home. The finding is: Review on 2/8/22 of the facility's EP dated 9/7/21 did not include language for situations that would	E 022		

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E 022	Continued From page 3 call for clients and staff to shelter in place. Interview on 2/8/22 with the residential manager (RM) revealed that she was not aware that the policy was required.	E 022		
E 025	Arrangement with Other Facilities CFR(s): 483.475(b)(7) §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The	E 025		

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E 025	Continued From page 4 development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This STANDARD is not met as evidenced by: Based on interview and review of the facility's Emergency Preparedness (EP) Manual, the facility failed to document pre-arranged accommodations for clients in the event services could not be delivered in the home. This potentially affected all clients (#1, #2, #3, #4 and #5) in the home. The finding is: Review on 2/7/22 of the facility's EP dated 9/7/21, revealed instructions to call the county's emergency services (911) to find out where to evacuate. Interview on 2/8/22 with the residential manager (RM) and qualified intellectual disabilities professional (QIDP) revealed that previously they would evacuate to an area high school for shelter but it was no longer in effect.	E 025		
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	W 340		

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W 340	Continued From page 5 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 that staff were sufficiently trained in proper personal protective (PPE) equipment mask use. This had the potential to affect all clients in the home (#1, #2, #3, #4 and #5). The findings are: During observations throughout the survey 2/7/22-2/8/22, the residential manager (RM) and qualified intellectual disabilities professional (QIDP) were observed to frequently wear their face masks loose fitting with their noses exposed, when in their office and in client areas. Interview with the RM and QIDP on 2/8/22 acknowledged that they did not maintain the face masks over their nose when inside the office. RM acknowledged that she tried to readjust her mask when in client areas but was not always consistent. Interview with the nurse on 2/8/22 revealed that staff have been trained when the COVID policy went into effect at the start of the pandemic and that she offers a refresher every 6 months. The nurse revealed that staff have been trained to wear their face masks over the nose and mouth.	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:	W 368		

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W 368	Continued From page 6 Based on observation, record review and interviews, the facility failed to assure the system of administrating medications as ordered was implemented. This affected 1 of 4 audit clients (#3). The finding is: During morning observations in the home on 2/8/22, staff A had a medicine cup of 7 medications for client #3 that had been removed from the blister pack. Staff A opened a container of chocolate pudding and dumped all of the pills in the pudding, including a capsule of Omeprazole 20 mg. Staff A then fed the medicine in the pudding to client #3 who swallowed the contents without incident. Review on 2/8/22 of the medication blister pack and physician orders signed on 10/21/21 instructed anyone administering the medication to "Open and mix 1 capsule (Omeprazole) in pudding or applesauce QD (daily)." Interview on 2/8/22 with staff A revealed she did not notice the instructions on the blister pack or on the orders and thought she only had to mix the capsule into the applesauce. Interview on 2/8/22 with the nurse revealed she speculated staff A might have been nervous being observed and made a mistake.	W 368		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.	W 460		

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W 460	Continued From page 7 This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed ensure dietary orders for modified diets for 1 of 4 audit clients (#1) were followed as written. The finding is: During evening observations in the home on 2/7/22 at 5:30 PM, Staff C prepared dinner and placed a plate of chopped chicken alfredo, chopped cooked broccoli, a bowl of regular tossed salad plus a container of strawberry yogurt in front of client #1. Client #1 ingested the food with brief coughing. An additional observation of client #1 on 2/8/22 at 7:30 AM, staff C prepared dried cereal and toasted bread in a blender and scooped the contents into a divided plate. Staff C took the plate to client #1 and poured a cup of milk into the finely chopped cereal. The cereal particles were able to float in the milk and were fed to client #1. Client #1 was observed at 7:50 AM to cough briefly and spit up some food contents on his clothing protector. Review on 2/8/22 of client #1's dietary orders dated 1/20/21 placed inside the kitchen cabinet confirmed he should receive pureed food and staff should monitor for signs of difficulty. Interview on 2/8/22 with staff C revealed that she used the food processor to puree client #1's breakfast. Staff C stated that the food needed to be pureed because client #1 had no teeth. Interview on 2/8/22 with the nurse revealed that she was responsible for going over dietary orders and meal guidelines with the staff but had not trained Staff C yet. The nurse also acknowledged that chopped food was not pureed and that client #1 should have not received cereal in milk or any	W 460		

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W 460	Continued From page 8 type of salad. The nurse affirmed that not pureeing client #1's food could put him at risk of aspiration.	W 460		
W 488	DINING AREAS AND SERVICE CFR(s): 483.480(d)(4) The facility must assure that each client eats in a manner consistent with his or her developmental level. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure clients ate in a manner which was not stigmatizing. This affected 1 of 4 audit clients (#1). The finding is: During breakfast observation in the home on 2/8/22 at 7:30 AM, staff C sat down next to client #1 to help feed him. Staff C placed a clothing protector around client #1's neck and took the bottom material and placed it on the table in front of him. Staff C then took the plate of food and placed it on top of the clothing protector and began feeding client #1. While feeding, client #1 was noted to have food debris on the top portion of his clothing protector but none on the table setting. Review on 2/8/22 of the individual program plan (IPP) dated revealed that client #1 only needed a non slip mat underneath his plate during meals. Interview on 2/8/22 with the nurse revealed that ordinarily she reviews meal guidelines with new employees and did not have the opportunity yet to offer training to staff C. The nurse stated that clothing protector should not be placed underneath the plate during meals.	W 488		
W 508	COVID-19 Vaccination of Facility Staff	W 508		

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W 508	Continued From page 9 CFR(s): 483.430(f)(1)-(3)(i)-(x) § 483.430 Condition of Participation: Facility staffing. (f) Standard: COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. (1) Regardless of clinical responsibility or client contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its clients: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its clients, under contract or by other arrangement. (2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with clients and other staff specified in paragraph (f)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with clients and other staff specified in	W 508		

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W 508	Continued From page 10 paragraph (f)(1) of this section. (3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (f)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its clients; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (f)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all	W 508		

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W 508	Continued From page 11 documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: (ii) A process for ensuring that all staff specified in paragraph (f)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the	W 508		

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W 508	Continued From page 12 vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to develop policies and procedures which include contingency plans for staff who are not fully vaccinated for COVID-19. The findings are: Review on 2/8/22 of the facility's Employment during COVID-19 Policy dated 1/13/22 focused on the employees degrees of risk of exposure, testing positive and quarantine instructions. The policy did not comment on any contingency plan for unvaccinated staff. An internal email from the Vice President of Operations (VP) and the qualified intellectual disabilities professional (QIDP) on 1/14/22 discussed the federal government's final rule mandating healthcare workers to be vaccinated against COVID-19. The email acknowledged compliance deadlines and that staff must have the first dose of COVID-19 by 1/27/22. Further review on 2/8/22 of staff working in the group home's vaccination status revealed staff E had presented COVID-19 vaccination record card to the facility on unknown date. The vaccination record revealed the 1st dose was given on 11/24/21. On the card, the manufacturer of the vaccine, and the expiration date for the dose were not documented, as evidenced on other vaccination cards reviewed. Interview on 2/8/22 with the residential manager (RM) revealed that staff E had worked at the	W 508		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G037	A. BUILDING _____ B. WING _____	02/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALLARD LANE CENTER	142 MALLARD LANE ROCKINGHAM, NC 28379

(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 508	Continued From page 13 home on 2/6/22. The RM revealed she had not seen the vaccination record for staff E before today and that she could not determine what staff E's vaccination status was by looking at the vaccination record. Interview on 2/8/22 with the VP revealed that staff E uploaded the vaccination record on the facility's website on 1/26/22. They had not investigated prior to today the validity of staff E's vaccination record. The VP suggested that the lot number on the card indicated the first dose of the vaccine was from Moderna. The VP also revealed that she was not aware of any staff working in the home being exempted from taking the COVID-19 vaccine for medical or religious reasons. The VP revealed that if an unvaccinated staff did not meet the fully vaccinated requirement by the 2/28/22 deadline they could transfer to any facility outside of their intermediate care facility (ICF) residential services or be terminated.	W 508		