STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G272	A. BUILDING _____ B. WING _____	C 02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST ROAD GROUP HOME	114 GREENHOUSE LANE SOUTHERN PINES, NC 28387

(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	W 000		
W 153	A complaint survey was completed 2/11/22 - 2/14/22. Deficiencies were cited as a result of the complaint investigation for NC00184590. STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to immediately notify the administrator, law enforcement, department of social services (DSS) and the state agency, once discovering an injury of unknown origin. This affected 1 of 1 former clients (FC #1). The finding is: Review on 2/11/22 of a handwritten note written by the home manager (HM) on 12/21/21 regarding FC #1 revealed HM had transported him to the dentist. When they returned home on 12/21/21, she took FC #1 to the bathroom to be changed. The HM wrote that she noticed small blotches on FC #1's skin that were light color. A further review revealed on 12/23/21, the HM left a note for FC #1's guardian who was picking him up for an extended holiday visit. The note provided a list of injuries: small sores on arm, redness and peeling both knees and small dark spots on right hip, lower back and buttocks. The guardian signed and dated the injury report on 12/23/21.	W 153	DHSR - Mental Health MAR 14 2022 Lic. & Cert. Section	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deana Stone | TITLE: OLDP | (X6) DATE: 3/1/22

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 153	Continued From page 1 Review on 2/14/22 of the facility's Consumer Incident Reporting 8/1/16 policy defined a Level II incident as: Those incidents which are not life threatening but are very serious and require swift investigation. If the incident results in injury, bruises, scrapes, serious unexplained injuries...or a complaint oversight agency. An incident review committee shall be convened as a subcommittee of the quality assurance committee. The purpose of this committee will be review and make recommendations for follow-up on all reported Level II incidents. Interview on 2/11/22 with the home manager (HM) revealed on 12/21/21, she took FC #1 to the restroom to change him and noticed small bruises on buttocks and right hip at the lower back. FC #1 was non-verbal and unable to tell her what happened. The HM revealed that she had witnessed FC #1 dropping to the floor before and that he would rest his buttocks on the heels of his shoes. The HM concluded that the bruises were caused by a self-injurious behavior (SIB) therefore she did not start an investigation. Interview on 2/11/22 with the qualified intellectual disabilities professional (QIDP) revealed she had no evidence that the incident report for FC #1 had been forwarded to her to start an investigation. Interview on 2/14/22 with the administrator revealed that incidents that results in bruises should be immediately reported.	W 153	By 3/11/2022 all staff will be in serviced on the reporting on the reporting procedures of all incidents,, discovery of bruises and accidents per agency policy. All occurrences will be reviewed for policy procedure per occurrence. The process will be monitored per incident by the Home Manger, Hab Specialist, Nurse ,QIDP and Program Administrator	3/11/2022
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated.	W 154		

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W 154	Continued From page 2 This STANDARD is not met as evidenced by: Based on interview and record reviews, the facility failed to conduct a thorough investigation for injuries of unknown origin. This affected 1 of 1 former clients (FC #1). The finding is: Review on 2/11/22 revealed an handwritten note on FC #1 in an incident report folder dated 12/21/21. The note was from the home manager(HM) who revealed when returning from a dentist appointment with FC #1, she noticed an odor. FC #1 was not toilet trained and wore incontinence briefs. When the brief was removed, the HM noticed bruises on FC #1 buttocks and right hip. FC #1 was non-verbal and unable to explain what happened. There was no evidence that the report was filed in the incident reporting system (IRIS). Interview on 2/11/22 with the HM revealed that she did not launch an investigation on FC #1 because she believed the injuries were self inflicted. On 12/23/21, the HM revealed that FC #1 went home with his mother for a holiday visit and did not return. The mother arrived at the facility on 1/18/22 to pick up all of FC #1 personal belongings and medications. The HM had no evidence that the report was submitted to the qualified intellectual disabilities professional (QIDP) for review. The HM revealed she assumed the injuries developed on unknown date from FC #1 falling down on his knees. The HM acknowledged other staff were not sought for interviews because she did not suspect abuse. Interview on 2/11/22 with the QIDP revealed whenever there is an injury of unknown origin, staff should be interviewed, with statements collected and medical attention should be sought	W 154	The facility will investigate all incidents and include client /staff interviews ,medical treatment as needed, notification of guardians, administrators and oversight agencies. By 3/11/2022 all staff will be in serviced on the policy and procedure and monitored by the QIDP, Program Administrator for implementation per occurrence.	3/11/2022

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W 154	Continued From page 3 for the client if needed. The parent, guardian, social services and the QIDP should be notified of the discovery of bruises. The home manager should write up the incident on a Discovery of Bruises form to launch the investigation. If the incident was not observed, they need to investigate. The nurse, QIDP and Program Administrator should review the investigation so that it can be determined if the Health Care Personnel Registry should be notified. The QIDP said that FC #1's bruises were not investigated because he had a history of bumping into things and falling on his knee.	W 154		
W 286	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used for disciplinary purposes. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to prevent a restrictive technique to the manage the inappropriate behavior of 1 of 2 audit clients (#5). The finding is: Review on 2/11/22 of an incident report on Client #5 revealed on 12/6/21 at 4:30 PM, Client #5 would not follow instructions from Staff A. Staff A used a threat to remove a television from the room of Client #5 if he did not comply. Client #5 still ignored Staff A, who then went to remove the television from Client #5's bedroom. Client #5 responded by leaving the home and walking off the property. Staff B and Staff C had to follow Client #5 in their vehicles before the home manager (HM) could convince Client #5 to get in her vehicle.	W 286	By 3/11/2022 all staff will be in serviced on the techniques to manage in appropriate behaviors to include though not limited to behavior plans, guidelines and clients rights. Implementation of appropriate techniques will be monitored at a minimum by Home Manager daily, bi-monthly by Hab Spec and QIDP.	3/11/2022

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W 286	Continued From page 4 Interview on 2/11/22 with the HM revealed that she did not report the incident to the administrator for review. The HM confirmed that Client #5 was not on a behavior support plan (BSP). Interview on 2/11/22 with the qualified intellectual disabilities professional (QIDP) revealed that she was unaware of the incident and that Staff A should not remove the television from Client #5's room, because it would be a clients rights violation. Interview on 2/14/22 with the administrator revealed that staff cannot confiscate Client's personal property because it was a rights violation.	W 286		
W 508	COVID-19 Vaccination of Facility Staff 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	W 508	By 3/11/2022 all staff will be in serviced on the agency Covid-19 policy .Copies of documentation of vaccinations for Covid-19 or an approved exemption status is available.	3/11/2022

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W 508	Continued From page 5 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 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	W 508		

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W 508	Continued From page 6 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 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;	W 508		

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W 508	Continued From page 7 (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 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 that are based on Centers for Medicare and Medicaid Services (CMS) guidelines for staff who are not fully vaccinated for COVID-19. The findings are: Review on 2/14/22 of the facility's Mandatory Vaccination Policy, 2/9/21 revealed employees must be fully vaccinated no later than 4/9/22. Staff must obtain the first dose of a two dose vaccine no later than 3/5/22; and the second dose no later than 3/26/22 or obtain one dose of a single dose vaccine no later than 3/26/22. The facility will comply to determine each employee's	W 508		

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W 508	Continued From page 8 vaccination status and require vaccinated employees to provide acceptable proof of vaccine. Interview on 2/14/22 with the qualified intellectual professional (QIDP) revealed the facility was not aware of the CMS employee vaccine requirement until learned of the new mandate through media sources. The QIDP had met with the Administrator last week, to work on a new vaccination policy. The QIDP acknowledged there was a typo on the original policy and it should read, effective 2/9/22. The facility planned to train their staff on 2/17/22 regarding the new requirements. Interview on 2/14/22 with the Administrator revealed that a new policy was just developed and was going to be shared with employees on 2/17/22. The administrator did not have a full list of staff working with the clients and had not been doing vaccine tracking. The administrator acknowledged that there were 5 unvaccinated staff that work in the home; and she had not received requests for medical or religious exemptions approvals. The administrator's new policy planned to require staff to have their first COVID-19 vaccine by 3/9/22 and the second vaccine completed by 3/25/22. The administrator hoped to be fully compliant by 4/9/22.	W 508		