STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G103	A. BUILDING _____ B. WING _____	R-C 04/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY PLACE	1050 HOGAN STREET FAYETTEVILLE, NC 28301

(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 revisit was conducted on 4/22/2022 for all previous deficiencies cited on 2/16/2022. All deficiencies have not been corrected and new noncompliance was found. The facility is not compliance with all regulations surveyed.	{W 000}		
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 and interviews, the governing body failed to ensure the homes' sprinkler system was in working order. The finding is: During observations in the home on 4/22/22 when the surveyor entered the home at 9:17am, there was a notice on the front door which stated, "NOTICE Building Under Fire Watch Notice to all Occupants Per order of the Fire Marshall, as defined in Section 901.7 of the 2018 NC Fire Code, this building is under mandatory 24-HOUR FIRE WATCH (unless otherwise approved) because one or more of the required life safety features are not operational". During an interview on 4/22/22, the qualified intellectual disabilities professional (QIDP) stated the fire Marshall came out to the home on 2/23/22 to do the annual inspection of the sprinkler system and it was discovered then that is was not working. Further interview revealed a company came out to do an inspection of the sprinkler system so they could give the company an estimated price for the repairs. The QIDP stated that their estimate was to high according to	W 104		

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

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W 104	Continued From page 1 the director and another company will be coming out on 4/25/22 to do their own inspection. Additional review revealed the Fire Marshall had the home start doing documentation where every 15 minutes a staff person will go around and check/look at the sprinklers throughout the home. The QIDP also stated the documentation must continue until the system is fixed and they talk to the Fire Marshall directly.	W 104		
{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 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	{W 508}		

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{W 508}	Continued From page 2 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 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	{W 508}		

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{W 508}	Continued From page 3 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; (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	{W 508}		

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{W 508}	Continued From page 4 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 interview, the facility failed to implement their policies and procedures concerning their contingency plans for staff who are not fully vaccinated for COVID-19. The finding is: Review on 4/22/22 of the facility's staffing revealed there were was one staff who had not received their second COVID-19 vaccination; which is not 100% of staff being fully vaccinated. Additonal review revealed the staff received their first COVID-19 vaccination shot on 7/22/21. Review on 4/22/22 of the facility's policy and procedure on infection control revised 2/10/22 stated, "Contingency Plan: Vaccinated staff must comply with the CDC guidelines...2nds shots within the timeframe they have set according to the vaccine they have received". During an interview on 4/22/22, the qualified intellectual disabilites professional (QIDP) revealed the one staff who have not received their	{W 508}		

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{W 508}	Continued From page 5 second COVID-19 vaccination works on third shift and last worked on 4/21/22. Further interview revealed the QIDP stated that the staff in question will be removed from the schedule until they get the second COVID-19 vaccination.	{W 508}		