**HEATH AVENUE HOME PLAN OF CORRECTIONS**

**For**

**Recertification Survey conducted February 1-2, 2022**

**W 227 INDIVIDUAL PROGRAM PLAN**

The individual program plan states the specific objectives necessary to meet the client's needs as identified by the comprehensive assessment

QP and/or Habilitation Specialist will review client #4 training objectives and all other in the home for training needs and goals

Monitoring of adherence to the above will occur through monthly mealtime assessments as well as general observations for (3) consecutive months. The Assessments will be completed by the interdisciplinary team at a minimal of (2) a month for (3) consecutive months

Target Date: 04/02/2022

**W 249 PROGRAM IMPLEMENTATION**

Each client will continuously receive active treatment which consist of needed interventions and services as identified in the individual program plan (IPP) by the QP and/or Habilitation Specialist. After review of all aspects of each IPP, emphasis will be placed on the following. In the areas of meal prep, adaptive equipment use and self-help skills

QP//Habilitation Specialist will re-in-service staff on active treatment encouraging all people supported in the home to have the opportunity to be as independent as possible in the areas of food prep and family style dining with choices and self-management.

QP/ Habilitation Specialist will re-in-service all DSA's on client #5 ABI use of food processor/switch device to ground his food in the kitchen and all other individuals in the home use of adaptive equipment for meals.

Monitoring of adherence to usage of adaptive equipment and promoting independence with dining will occur through a minimum of (3) Mealtime Assessments per month for (2) consecutive months. The Mealtime Assessments and general observations will be completed by interdisciplinary team either of the following: QP, Habilitation Specialist, OT/PT assistant, Administrator, Home Manager, Vocational Coordinator, or the Nurse.

Target Date: 04/02/2022

**W 252 PROGRAM DOCUMENTATION**

Data relative to accomplishment of the criteria specified in the client individual program plan objectives must be documented in measurable terms.

Client#2, #3, and #4 and all others person supported programs will be reviewed by the QP/Habilitation Specialist. Hab. Spec/QP will in-service DSA's on person supported #2, #3 and #4 programs books and for any needed revisions to programs as well as all others ensuring program objectives are documented and data collection is consistent per program.

Monitoring of adherence to the above will occur through monthly interaction assessments as well as general observations for (3) consecutive months. The Assessments will be completed by the interdisciplinary team at a minimal of (2) a month for (3) consecutive months.

Target date: 04/02/2022

**W 263 PROGRAM MONITORING & CHANGE**

The committee should insure that these programs are conducted only with written informed consent of the client, parents (if the client is a minor) or legal guardian.

The QP will review all guardianship for documentation of all individuals. All documents requiring consents from all legal guardians will be reviewed by the QP/Behavior Specialist to ensure all guardians listed on the guardianship sign the documents (i.e.., restrictive Behavior Support Plan). Specifically, Client #3's Behavior Support Plan and all other individuals will be reviewed for the necessary guardian consents.

A written informed consent will be secured within the month of February 2022 by the Behavior Specialist for client #3 and placed in Client #3 record.

Monitoring to the adherence of the above will be through chart reviews at a minimum of (2) annually by interdisciplinary team either of the following: QP, Habilitation Specialist, Administrator, OT/PT assistant, Behavior Specialist, Vocational Coordinator and the Nurse.

Target Date: 04/02/2022

**W 312 DRUG USAGE**

Be used only as integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.

The IDT will review the BSPs of clients #3 and #4 as well as all other BSPs in the home. The IDT will assess to ensure all behavior medications are addressed in the BSP. The IDT will also review all plans to ensure reductions and/or elimination of all restrictive behavior medications have been considered. If lowest effective dose has been identified, the team will document as appropriate. Any changes to the BSPs will be reviewed with the staff in the home and other care team members. The team will review all BSPs through the chart review process. In the future, the QP will assure all medications are identified in the BSPs as well as considerations to reduce and/or eliminate restrictive behavior medications are documented.

Monitoring to the adherence of the above will be through chart reviews at a minimum of (2) annually by interdisciplinary team either of the following: QP, Habilitation Specialist, Administrator, OT/PT assistant, Behavior Specialist, Vocational Coordinator and the Nurse.

**Target Date: 04/02/2022**

**W 383 DRUG STORAGE AND RECORDKEEPING**

Only authorized persons may have access to the keys to the drug storage area

Nursing will re-in-service all med techs on med key responsibility authorized persons on having access to the med keys to the drug storage area. Each shift should sign med key responsibility form #8098 indicating he/she has the responsibility for the med key, and will keep the med key in their possession. At no time can the key be left unattended.

Monitoring of adherence to above (1) Medication observations per month for (3) consecutive months as well as general observations for (3) consecutive months by the interdisciplinary team

**Target Date: 04/02/2022**

**W 508: 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

Administrator/QP will in-service The Pandemic Team review of the policy and updated to include (identify cited area). The QP will complete training with all staff at the Heath home to ensure understanding of the updated policy.
Monitoring of adherence to above will occur annually as well as general observations conducted by the unit monthly for the next (2) consecutive months.

**Target Date: 04/02/2022**

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G044 | A. BUILDING _____ B. WING _____ | 02/02/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEATH AVENUE HOME | 105 EAST HEATH AVE SMITHFIELD, NC 27577 |

| (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 |
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| W 227 | INDIVIDUAL PROGRAM PLAN<br>CFR(s): 483.440(c)(4)<br><br>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.<br>This STANDARD is not met as evidenced by:<br>Based on observation, record review and interviews, the facility failed to ensure client #4's Individual Program Plan (IPP) included objectives to meet her needs as identified in the comprehensive functional assessment (CFA). This affected 1 of 4 audit clients. The finding is:<br><br>During breakfast observations in the home on 2/2/22 at 7:22am, Staff D began cutting up client #4's food on her plate as the client sat watching.<br><br>Interview on 2/2/22 with Staff D initially revealed client #4 cannot cut up her food. The staff then stated the client will assist "sometimes".<br><br>Review on 2/2/22 of client #4's Adaptive Behavior Inventory (ABI) last updated 12/29/21 revealed the client "could use a program" in the area of using a knife for cutting. Additional review of client #4's IPP dated 5/18/21 noted her food should be cut into 1/2 to 1 inch pieces. Additional review of the plan; however, did not include an objective to address her need to use a knife for cutting.<br><br>Interview on 2/2/22 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4 has not had formal training to use a knife for cutting. The QIDP acknowledged the training would be beneficial given her current diet consistency. | W 227 | | |
| W 249 | PROGRAM IMPLEMENTATION | W 249 | | |

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

Patrick Carver BAQP / for Nesheil Blue Administrator 2/11/22

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 249 | Continued From page 1<br>CFR(s): 483.440(d)(1)<br><br>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active 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.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and interviews, the facility failed to ensure 1 of 4 audit clients (#5) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of food preparation and family style dining. The findings are:<br><br>A. During dinner observations in the home on 2/1/22 at 6:12pm, client #5's food was put into small bowls and placed at his placesetting on the table. As client #5 sat at the table, Staff C served all food items onto the client's plate without his participation. The staff then poured his drinks for him without prompting him to assist.<br><br>Interview on 2/2/22 with Staff A revealed client #5 can assist with serving himself and pouring his drinks.<br><br>Review on 2/2/22 of client #5's Adaptive Behavior Inventory (ABI) last updated 11/5/21 revealed he can pour from a small pitcher with partial independence and serve himself from a | W 249 | | |

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| W 249 | Continued From page 2<br>bowl/platter with assistance.<br><br>Interview on 2/2/22 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #5 requires physical assistance to serve himself and pour his drinks.<br><br>B. During breakfast preparation in the home on 2/2/22, Staff D placed client #5's cooked food in a food processor, added broth and ground his food up in the processor. Client #5 did not assist with this task. It should also be noted that a large red button switch and able net box was on the counter next to the food processor.<br><br>Interview on 2/2/22 with Staff D revealed she did not know client #5 was using a switch device to grind up his food and she was not sure how to use it.<br><br>Review on 2/2/22 of client #5's IPP dated 4/23/21 revealed an objective to start the food processor 50% of the time for four consecutive review periods (implemented 10/26/21). Additional review of the objective indicated, "[Client #5] will hit the red button to start food processor...He can practice this at breakfast..." The plan also noted the client consumes a ground food consistency. Further review of client #5's ABI last updated 11/5/21 indicated, "Needs assistance from staff, can use able net to start appliances in kitchen."<br><br>Interview on 2/2/22 with the QIDP confirmed client #5 should be assisted to process his food using the switch device with staff assistance. | W 249 | | |
| W 252 | PROGRAM DOCUMENTATION<br>CFR(s): 483.440(e)(1) | W 252 | | |

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| W 252 | Continued From page 3<br>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.<br><br>This STANDARD is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to ensure data relative to the accomplishment of objective criteria specified in the Individual Program Plan (IPP) was documented in measurable terms. This affected 3 of 4 audit clients (#2, #4 and #6). The findings are:<br><br>A. Review on 2/1/22 of client #2's IPP dated 3/29/21 revealed objectives to participate in meal preparation with 65% independent prompts for six consecutive review periods (implemented 4/1/21), and to brush her teeth for 2 minutes with 80% verbal prompts for four consecutive review periods (implemented 1/22/22). Additional review on 2/2/22 of client #2's objective training book indicated the following data collection days:<br><br>Meal preparation:<br><br>January 2022 - 3 days noted "Program not run due to COVID"<br>- No other documentation was available<br><br>Toothbrushing:<br><br>January 2022 - No documentation was available<br><br>B. Review on 2/1/22 of client #3's IPP dated 6/15/21 revealed objectives to wipe herself with 90% verbal prompts for six consecutive review | W 252 | | |

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| W 252 | Continued From page 4<br>periods (implemented 12/9/21), to wash her upper body with 50% independent prompts for four consecutive review periods (implemented 11/2/21) and to use a knife to cut her food with 100% verbal prompts for six consecutive review periods (implemented 2/25/21). Additional review on 2/2/22 of client #3's objective training book indicated the following data collection days:<br><br>Wipe herself:<br><br>January 2022 - 8 days<br>- No other documentation was available<br><br>Wash upper body:<br><br>January 2022 - No documentation was available<br><br>Cutting food:<br><br>January 2022 - 3 days<br>- No other documentation was available<br><br>C. Review on 2/2/22 of client #4's IPP dated 5/18/21 revealed objectives to brush her teeth with 75% verbal prompts for four consecutive review periods (implemented 1/4/22), to wash her hands with 100% independent prompts for six consecutive review periods (implemented 11/5/21) and to close the bathroom door while participating in hygiene tasks 50% independent prompts for three consecutive review periods (implemented 11/5/21). Additional review of client #4's objective training revealed the following data collection days:<br><br>Toothbrushing:<br><br>January 2022 - 4 days | W 252 | | |

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| W 252 | Continued From page 5<br>- No other documentation was available<br><br>Handwashing:<br><br>January 2022 - No documentation was available<br><br>Close bathroom door:<br><br>January 2022 - No documentation was available<br><br>Interview on 2/2/22 with the Habilitation Specialist confirmed staff should be collecting objective data as indicated by the program for all clients. | W 252 | | |
| W 263 | PROGRAM MONITORING & CHANGE<br>CFR(s): 483.440(f)(3)(ii)<br><br>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure written informed consent was obtained from the guardian for client #3's restrictive Behavior Support Plan (BSP). This affected 1 of 4 audit clients. The finding is:<br><br>Review on 2/2/22 of client #3's BSP dated 11/23/21 revealed an objective to issue 0 negative remarks for a period of 12 consecutive months. The BSP incorporated the use of Latuda to address the inappropriate behavior. Additional review of the client's record did not include a written informed consent signed by the guardian for the BSP.<br><br>Interview on 2/2/22 with the Behavior Specialist confirmed no current written informed consent | W 263 | | |

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| W 263 | Continued From page 6<br>signed by the guardian was available for review. | W 263 | | |
| W 312 | DRUG USAGE<br>CFR(s): 483.450(e)(2)<br><br>be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure a drug used to manage client #4's inappropriate behaviors was used only as an integral part of her Individual Program Plan (IPP) and to ensure the interdisciplinary team (IDT) had considered a reduction and/or elimination of restrictive a behavior medication for client #3 after a decrease in target behaviors was identified. This affected 2 of 4 audit clients. The findings are:<br><br>A. Review on 2/2/22 of client #4's physician's orders dated 1/5/22 revealed an order for "Luvox 50mg, take 1 tablet by mouth daily, 8:00am". Additional review of the client's Behavior Support Plan (BSP) dated 9/3/21 revealed an objective to display 5 or fewer combined episodes of target behaviors for a period of 6 consecutive months". Further review of the plan identified the use of Perphenazine, Latuda and Klonopin to address behaviors; however, the plan did not include the use of Luvox.<br><br>Interview on 2/2/22 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4 ingests Luvox for behaviors related schizophrenia; however, the drug was not included in a formal active treatment program. | W 312 | | |

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| W 312 | Continued From page 7<br><br>B. Review on 2/2/22 of client #3's physician's orders from June 2019 - January 2022 revealed an order for Latuda 40mg to be taken initially in the mornings then beginning on 7/7/20 to be taken at 4:30pm prior to dinner. The record indicated client #4 has been prescribed Latuda 40 mg for at least the past 2 years and 7 months. The record did not indicate any changes in the drug's dosage during this time. Additional review of client #4's BSP dated 11/23/21 revealed an objective to issue 0 negative remarks for a period of 12 consecutive months. Further review of the objective's progress notes from August 2019 - October 2021 indicated the client has had only 3 behaviors related to this objective. Review of the record did not indicate the IDT had considered a reduction and/or elimination of the Latuda based on the minimal number of target behaviors over an extended period.<br><br>Interview on 2/2/22 with the Behavior Specialist confirmed client #3's need for a formal behavior objective incorporating the use of Latuda needs to be addressed by the interdisciplinary team. | W 312 | | |
| W 383 | DRUG STORAGE AND RECORDKEEPING<br>CFR(s): 483.460(l)(2)<br><br>Only authorized persons may have access to the keys to the drug storage area.<br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and interviews, the facility failed to ensure only authorized persons may have access to the keys to the drug storage area. The finding is:<br><br>Upon arrival to the home on 2/2/22 at 6:05am, the keys to the drug storage area were noted on the | W 383 | | |

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| W 383 | Continued From page 8<br>kitchen counter. The keys remained on the counter until 7:01am. From 6:05am - 7:01am, the keys to the medication storage area were accessible to anyone in the home.<br><br>Interview on 2/2/22 with the Medication Technician (MT) revealed keys to the medication storage area should remain on the MT "at all times".<br><br>Review on 2/2/22 of the facility's Nursing Policy and Procedure manual under Storage of Medications (revised October 2018) revealed, "Medication keys will be kept on the person of the nurse or Med Tech while the group home or vocational center is occupied."<br><br>Interview on 2/2/22 with the facility's nurse confirmed the MT for the shift should keep keys to the medication storage area "on them". The nurse indicated staff are taught this during MT training. The nurse further noted the keys should not be left lying around the home. | W 383 | | |
| W 508 | COVID-19 Vaccination of Facility Staff<br>CFR(s): 483.430(f)(1)-(3)(i)-(x)<br><br>§ 483.430 Condition of Participation: Facility staffing.<br>(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 | W 508 | | |

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| W 508 | Continued From page 9<br>the administration of all required doses of a multi-dose vaccine.<br>(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:<br>(i) Facility employees;<br>(ii) Licensed practitioners;<br>(iii) Students, trainees, and volunteers; and<br>(iv) Individuals who provide care, treatment, or other services for the facility and/or its clients, under contract or by other arrangement.<br>(2) The policies and procedures of this section do not apply to the following facility staff:<br>(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<br>(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.<br>(3) The policies and procedures must include, at a minimum, the following components:<br>(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 | W 508 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G044 | A. BUILDING _____ B. WING _____ | 02/02/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEATH AVENUE HOME | 105 EAST HEATH AVE SMITHFIELD, NC 27577 |

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| W 508 | Continued From page 10<br>vaccine prior to staff providing any care, treatment, or other services for the facility and/or its clients;<br>(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;<br>(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (f)(1) of this section;<br>(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;<br>(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;<br>(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;<br>(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:<br>(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 | W 508 | | |

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| W 508 | Continued From page 11<br>contraindications; and<br>(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;<br>(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<br>(x) Contingency plans for staff who are not fully vaccinated for COVID-19.<br><br>Effective 60 Days After Publication:<br>(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;<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to develop policies and procedures which include contingency plans for staff who are not fully vaccinated for COVID-19. The finding is:<br><br>Review on 2/1/22 of the facility's COVID-19 vaccination policy for employees dated 1/27/22 did not include a contingency plan for staff that are not fully vaccinated, will not get vaccinated | W 508 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| W 508 | Continued From page 12<br>and do not qualify for an exemption.<br><br>Interview on 2/2/22 with the facility's administrator confirmed the facility's current COVID-19 vaccination policy for employees did not include a contingency plan for unvaccinated staff who do not qualify for an exemption. | W 508 | | |