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

PRINTED: 02/14/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	34G239		R-C 02/07/2022

NAME OF PROVIDER OR SUPPLIER
THOMAS S DECATUR HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
7559 DECATUR DRIVE
FAYETTEVILLE, NC 28303

(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 2/7/22 for deficiencies previously cited on 10/18/21. Three of the deficiencies were corrected, three deficiencies were recited and additional non-compliance was found. The facility remains out of compliance.	{W 000}		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based record review and interviews, the facility failed to ensure all staff received training regarding the facility's COVID-19 vaccination policy and procedures. The finding is: Review on 2/7/22 of the facility's COVID-19 vaccination policy (no date) revealed, "It is our goal to have 100% of staff have received the necessary dose to complete the vaccine series (i.e. one dose of a single-dose vaccine or all doses of a multiple vaccine series)..." Interview on 2/7/22 with Staff D (unvaccinated per interview) and Staff E (vaccinated per interview) revealed they have not received formal training regarding the facility's vaccination policy for staff. The staff noted they've only had some informal discussions about vaccinations in the home. Interview on 2/7/22 with the Qualified Intellectual Disabilities Professional (QIDP) indicated he was not aware of any formal staff training regarding the facility's COVID-19 employee vaccination policy.	W 189	See attached. RECEIVED FEB 28 2022 DHSR-MH Licensure Sect	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brad Secrest
TITLE: BSQP
(X6) DATE: 2.23.22

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}	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 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 ensure each client received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Program (IPP) in the area of meal preparation. This affected 2 of 2 audit clients (#2 and #3). The findings is: During morning observations in the home on 2/7/22 at 6:43am, Staff B was noted preparing plates of food and drinks (cereal, toast, milk and water) at the kitchen counter while client #3 sat at the dining room table waiting. At 9:24am, Staff C entered the kitchen and began preparing snacks for each client without their participation. Interview on 2/7/22 with Staff C revealed she has never worked in the home before, has never met the clients and was not familiar with what they can assist with. Review on 2/7/22 of client #2's and client #3's Adaptive Behavior Scale (ABS) dated 9/12/18 and 11/13/18, respectively, indicated they can	{W 249}		

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{W 249}	Continued From page 2	{W 249}		
	prepare simple foods requiring no mixing or cooking i.e. sandwiches, cold cereal, etc. Interview on 2/7/22 with the Qualified Intellectual Disabilities Professional (QIDP) indicated the ABS assessments of food preparation for client #2 and #3 were the most recent and may need to be updated.			
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure a technique to manage client #2's inappropriate behavior was included in a formal active treatment program. This affected 1 of 2 audit clients. The finding is: During observations in the home on 2/7/22 from 6:50am - 2:50pm, the door to the laundry room was kept locked. Closer observation of the laundry room revealed a cabinet containing food items. Further observations revealed various staff utilizing a key to enter the room and obtain items. Interviews on 2/7/22 with Staff A and Staff E revealed the laundry room door is kept locked because of the food items inside. Additional interview indicated client #2 will attempt to get food from the room. Further interview revealed client #2 is not after food in the room but likes to manipulate certain bags containing the food. Review on 2/7/22 of client #2's Behavior Support	W 288		

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W 288	Continued From page 3 Plan (BSP) dated 9/25/19 revealed an objective to decrease episodes of inappropriate behaviors to 15 or fewer per month for four consecutive months. Additional review of the BSP identified target behaviors of noncompliance, aggression self-injury, pica, public masturbation, food stealing, loud vocalizations, sexually inappropriate behaviors and self-wetting. Further review of the plan did not indicate a technique of locking away food items to address inappropriate behaviors. Interview on 2/7/22 with the Qualified Intellectual Disabilities Professional (QIDP) acknowledged the laundry room door was kept locked to address client #2's obsession with certain paper bags. The QIDP confirmed locking the laundry room was not addressed in client #2's BSP.	W 288		
W 312	DRUG USAGE CFR(s): 483.450(e)(2) 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. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a drug used to manage client #2's inappropriate behaviors was used only as an integral part of her Individual Program Plan. This affected 1 of 2 audit clients. The finding is: Review on 2/7/22 of client #2's Behavior Support Plan (BSP) dated 9/25/19 revealed an objective to "...decrease her episodes of inappropriate behaviors to 15 or fewer per month for four consecutive months". Additional review of the client's physician's orders dated 9/16/21 revealed	W 312		

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W 312	Continued From page 4 orders for Vraylar, Clonidine, Propranolol, Citalopam Hydrobromide and Topamax. Further review of the BSP identified the use of Seroquel and Topamax to address behaviors. No other medications were included in the BSP. Interview on 2/7/22 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #2 ingests Vraylar, Clonidine, Propranolol, Citalopam Hydrobromide, and Risperdal for behaviors; however, these drugs are not included in a formal active treatment plan.	W 312		
{W 369}	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all medications were administered without error. This affected 1 of 1 clients observed receiving medications (#2). The finding is: During observations of medication administration in the home on 2/7/22 at 8:27am, client #2 ingested Celexa 20mg, Topamax 75mg, Inderal 10mg, Ibuprofen 800mg and Risperdal .25mg. Review on 2/7/22 of client #2's record did not reveal any physician's orders for Ibuprofen and Risperdal. Interview on 2/7/22 with the Qualfied Intellectual Disabilities Professional (QIDP) confirmed no physician's orders for the medications could be located.	{W 369}		

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{W 382}	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure all medications were kept locked except when being administered. The finding is: During observations in the home on 2/7/22 at 8:17am and 8:19am, Staff A left the door to the medication cabinet open and a bin of medications sitting unattended on the desk while he went into the laundry room and to retrieve a client. During these times, medication closet was unattended and drugs were accessible to anyone in the home. Interview on 2/7/22 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the medication cabinet should not be left unlocked and unattended by the staff.	{W 382}		
W 383	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) Only authorized persons may have access to the keys to the drug storage area. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure keys to the drug storage area were only accessible to authorized persons. The finding is: During morning observations in the home on 2/7/22 from 6:50am - 9:38am, the keys to the drug storage area were hanging from a thumb tack on the bulletin board in the kitchen of the home. The keys were accessible to anyone in	W 383		

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W 383	Continued From page 6 the home. Interview on 2/7/22 with Staff A (shift Medication Technician) revealed the keys to the medication closet are kept on someone "at all times" so they don't "get missing". The staff then indicated the keys can be kept out in the open so "you can visibly see them at all times". Interview on 2/7/22 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the keys to the medication closet should be kept on the person responsible for passing medications on the shift.	W 383		
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;	W 508		

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W 508	Continued From page 7 (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 who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of	W 508		

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W 508	Continued From page 8	W 508		

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;
(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be

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W 508	Continued From page 9 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 observations, record review and interviews, the facility failed to implement policies and procedures to ensure all staff are fully vaccinated for COVID-19. The findings are: A. Review on 2/7/22 of the facility's COVID-19 vaccination policy (no date) revealed, "[Provider name] will obtain acceptable proof of vaccination status, and maintain records and a roster of each staff and client vaccination status. This is for staff, trainees and those under contract who are in direct contact with clients. It is our goal to have 100% of staff have received the necessary does to complete the vaccine series (i.e. one does of a single-dose vaccine or all doses of a multiple vaccine series)..." Additional review of the policy noted, "All Direct Care staff must have received: A minimum, single-dose COVID-19 vaccine, or	W 508		

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W 508	Continued From page 10 the first dose of the primary vaccination series for a multi-does COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its clients." Further review of the policy noted staff must "provide the office with a copy of their Vaccination Card to be kept on file and recorded." Interview on 2/7/22 with the Qualified Intellectual Disabilities Professional (QIDP) and Deputy Director (via phone) revealed no proof of vaccination status was available for any staff working in the home per the facility's vaccination policy. B. During observations in the home on 2/7/22 from 6:40am - 2:50pm, 5 of 5 staff (Staff A, Staff B, Staff C, Staff D, and Staff E) wore surgical masks while working directly with clients in the home. No staff were observed to wear a N95 or equivalent mask covering their nose and mouth. Staff D briefly wore latex gloves during a leisure activity with the clients. Interviews on 2/7/22 with revealed 4 of the 5 staff (Staff A, Staff B, Staff D and Staff E) are assigned to the home and regularly work in the home as scheduled. Additional interview with Staff D revealed she has been working at the home for about a month. Staff D also indicated she is not vaccinated for COVID-19. Review on 2/7/22 of the facility's COVID-19 vaccination policy (no date) indicated, "The mitigation process to reduce the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19 are as follows: Identify opportunities to get vaccinated...Properly wear a use a NIOSH approved N95 or equivalent or	W 508		

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W 508	Continued From page 11 higher-level respirator for source control, covering nose and mouth, regardless of whether they are providing direct care to or other wise interacting with clients...Practice good personal hygiene and wash hands often." Interview on 2/7/22 with the QIDP indicated he did not know Staff D was not vaccinated for COVID-19. Additional interview revealed no N95 masks or equivalent type masks are currently available in the home for use by unvaccinated staff. C. Review on 2/7/22 of the facility's COVID-19 vaccination policy (no date) did not include a contingency plan for staff that are not fully vaccinated, will not get vaccinated and do not qualify for an exemption. Interview via phone on 2/7/22 with the Deputy Director 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. D. Review on 2/7/22 of the facility's COVID-19 vaccination policy (no date) revealed the facility will track and securely document "Staff for whom COVID-19 vaccination must be temporarily delayed and should track when the identified staff can safely resume their vaccination...We will provide evidence of this tracking for surveyor review..." Interview via phone on 2/7/22 with the Deputy Director indicated at least one staff's COVID-19 vaccination would likely be temporarily delayed for medical reasons. Additional interview revealed no documentation or process for tracking the	W 508		

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W 508	Continued From page 12 temporary delay for this particular staff or any staff with a temporary delay working in the home.	W 508		

Survey Corrections for Follow-up and Compliant Survey completed February 7, 2022 at Thomas Decatur Home, 7559 Decatur Dr. Fayetteville, NC 28303

W189 QIDP will complete formal training for COVID 19 policy with staff. QIDP will collect COVID Vaccination records from each staff member working directly with the people served residing in Thomas S. Decatur group home. This formal training along with the QIDP posting in the home for review will ensure staff are aware of the policy. QIDP will ensure corrections are in place by Friday, April 8, 2022.

W249 Interdisciplinary Team (IDT) will review and revise (if needed) the formal Individual Program Plan for clients #2 and #3. QIDP will formally train all staff working at Thomas S. Decatur group home to provide active treatment according to the individual's plan with current training goals for assisting with meal preparation in the kitchen. QIDP will also formally train the staff working at Thomas S. Decatur group home the company's standing policy to provide family-style dining which allows for greater independence to individuals by participating in family-style dining while they sit at the table. QIDP and/or home manager will monitor mealtimes weekly to ensure individuals served are participating in food preparation in the kitchen and participating in family-style dining at the table. QIDP will ensure corrections are in place by Friday, March 9, 2022.

W288 QIDP will formally train staff working at Thomas S. Decatur that the storage of food items in the laundry room at the Thomas S. Decatur group home is not allowed, and all food must be available to all clients in the kitchen cabinets. Cleaning supplies must be locked as per regulations and will remain in the locked laundry room. QIDP will also formally train staff on Client Rights. QIDP will review the behavior support plan for any inappropriate target behaviors client #2 is currently exhibiting and recommended interventions for these behaviors. QIDP and house manager will monitor staff interactions weekly to ensure that staff provide the correct intervention and redirection to client #2's inappropriate behaviors. QIDP will ensure corrections are in place by Friday, March 9, 2022.

W312 The IDT will review client #2's Behavior Support plan to ensure that client #2's current Behavior support plan includes the current medications ordered by her psychiatrist. QIDP will monitor medication orders once by 3.15.22 and monthly thereafter to ensure that the medications Client #2 receives are indicated in her Behavior Support Plan. QIDP will ensure corrections are in place by Friday, April 8, 2022.

W369 QIDP/Home Manager will review client #2's current medications and compare with the client's current physician's orders so Client #2 only receives medications ordered by her physician. QIDP will review the current medications once by 3.15.22 and monthly thereafter to ensure that the medications are provided to the individual per the client's physician's orders. QIDP will ensure corrections are in place by Friday, April 8, 2022.

W382 QIDP will complete a medication review to include medication storage with staff working at Thomas S. Decatur group home to pass medications according to regulations. Specifically, staff will ensure that medications are locked when unattended. QIDP and house manager will monitor medication administrations weekly to ensure that medications are administered as per regulations. QIDP will ensure corrections are in place by Friday, April 8, 2022.

W383 QIDP will complete a medication review to include keeping the keys on the medication administrating staff working at Thomas S. Decatur group home that the staff passing medications keep the keys to the medication storage room on their person while they are on shift. QIDP and home

manager will monitor medication administration weekly to ensure that staff keep the keys to the medication room on their person at all times. QIDP will ensure corrections are in place by Friday, April 8, 2022.

W508 (A) QIDP will complete formal training for COVID 19 policy with staff. QIDP to collect COVID Vaccination records or exemption letters from each staff member working directly with the people served residing in Thomas S. Decatur group home. The Deputy Director will create a comprehensive roster with the COVID 19 vaccinations and exemption letters received. The Deputy Director will collect vaccination cards or letters from physician's stating that the vaccination should not be given to a staff member for medical reasons or letters from staff stating that they are abstaining from receiving the COVID 19 vaccination due to religious objections. The Deputy Director will store a copy of the COVID 19 vaccination records or exemption letters in the central office. QIDP will obtain these vaccination records or exemption letters by the date stated in the company policy of March 1, 2022.

W508 (B) QIDP will provide N95 or equivalent masks for staff who are currently not fully vaccinated for COVID 19. QIDP and house manager to monitor the supply of N95 or equivalent masks available in the home weekly. QIDP will ensure corrections are in place by Friday, April 8, 2022.

W508 (C) Deputy Director will amend the company policy to include a contingency plan for staff that are not fully vaccinated, who will not get vaccinated, and do not qualify for an exemption. Deputy Director will ensure corrections are in place by Friday, April 8, 2022.

W508 (D) The Deputy Director will create a roster to include staff for whom COVID 19 vaccination must be temporarily delayed and will track when the identified staff can safely resume their vaccination. The Deputy Director will monitor the roster once by 3.7.22 and weekly thereafter to ensure that COVID vaccinations are received or if they are temporarily delayed when they can receive the COVID 19 vaccination. The Deputy Director will ensure corrections are in place by Friday, April 8, 2022.