STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G176	A. BUILDING _____ B. WING _____	05/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AIRPORT ROAD GROUP HOME	195 AIRPORT ROAD GOLDSBORO, NC 27530

(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 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 observation and interviews, the facility failed to furnish enough living room seating, to accommodate 6 of 6 clients (#1, #2, #3, #4, #5 and #6). The finding is: During observations in the home on 5/10/22 at 7:45am, clients were sitting in the living room watching television. Clients #1 and #4 sat on the love seat and Clients #2, #3 and #6 sat on the sofa. Client #5 removed a dining room chair from the living room, placing it next to the sofa, sat down and watched television. The clients watched television for the next hour until it was time to get ready to board the van for work. Interview on 5/10/22 with Staff B revealed a former client used to have a personal chair in the living room with the sofa and loveseat but it was removed when the client left. Staff B stated "a long time ago" she put a request in for new living room furniture so that everyone could have a seat. Once the request was made, the home manager was supposed to be contacted if the order was approved. Staff B stated she did not know the status of the furniture. Interview on 5/10/22 with the former home manager revealed she submitted a maintenance request in writing for new living room furniture because the sofa cushions would sink and were too low for the clients to rise. The former home manager stated the process included the quality assurance (QA) staff to follow up and approve the request. The former home manager does not	W 104		

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

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W 104	Continued From page 1 know the status of replacing the furniture. Interview on 5/10/22 with the QA revealed that she had not received a new furniture request. The QA stated she had visited the home last Friday (5/6/22) and she did not pay attention to the furniture since the clients were not home and she did not detect problems with available seating.	W 104		
W 129	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure 1 of 4 audit clients (#5) the privacy of medical information. The finding is: During evening observations in the home on 5/9/22 at 5:15pm, revealed a sign approximately on 8 x 10 paper was hung on the kitchen refrigerator and read: [Client #5] history of coconut allergy. Signed on 4/2/19 by nursing staff. The sign remained on the refrigerator on 5/10/22 at 8:00am. Interview on 5/10/22 with the nurse revealed that she was the author of the sign and hung it in the facility's kitchen regarding client #5. The nurse said she hung the sign to help remind staff while preparing food for client #5, to not add coconuts. The nurse acknowledged that she did not consider it a privacy concern when it was hung.	W 129		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel.	W 440		

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W 440	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation, document review and interview, the facility failed to ensure fire drills were conducted every shift, per quarter. This potentially affected all clients in the home (#1, #2, #3, #4, #5 and #6). The finding is: During observations in the home on 5/10/22 at 8:00am, a Facility Fire Drill Schedule hung on the hall outside of the office. The dates and times were pre-populated for conducting drills that would cover their two 12 hours shifts. Review on 5/9/22 of the facility's fire drill reports for May 2021-April 22 revealed the following: 6:00am-6:00pm Shift Drills 6/6/21 at 6:00am 6/9/21 at 12:00pm 10/11/21 at 3:15pm 11/16/21 at 3:20pm 4/5/22 at 1:40pm 6:00pm-6:00am Shift Drills 5/24/21 at 9:50pm 7/?/2021 at 2:45am 8/17/21 at 11:10pm 9/2/21 at 10:30pm 10/5/21 at 9:35pm 10/19/21 at 8:47pm 11/17/21 at 8:30pm 1/25/22 at 5:30am 4/13/22 at 10:00pm This resulted in missing morning shift drills from July 21-September 21 and Jan 22-March 22.	W 440		

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W 440	Continued From page 3 Interview on 5/10/22 with quality assurance staff (QA) revealed that they were aware that staff were not doing fire drills properly, ignoring the schedule and missing shifts.	W 440		
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 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)	W 508		

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W 508	Continued From page 4 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 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	W 508		

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W 508	Continued From page 5 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 monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19.	W 508		

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W 508	Continued From page 6 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, document review and interviews, the facility failed to implement their COVID-19 Vaccination Policy. The findings are: During morning observations in the home on 5/10/22 from 7:30am-7:38am, Staff C was administering medications to client #6. Staff C wore a surgical face mask and was in close proximity to client #6. Review on 5/9/22 of the facility's COVID-19 Vaccination Policy, dated 1/24/22 revealed: All employees and internal contractors must present proof of vaccine, unless a reasonable accommodation is approved. All eligible staff must have received the necessary shots to be fully vaccinated. Staff must present proof. If the worker has a qualifying religious exemption to a vaccine, the worker should submit written documentation to the personnel manager. Employees who refuse to take the vaccine without having initiated an ADA or religious accommodation discussion will be placed on administrative leave. Review of the religious exemption form revealed staff must complete a COVID-10 test once every 2 weeks to be done every other Monday. Test will be recorded in the personnel file. Exempted staff must complete as	W 508		

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W 508	Continued From page 7 much work as possible in the consumer's home when they are not present. Review on 5/10/22 of the facility's vaccine status list revealed Staff C was a direct care staff and had resigned on 10/16/21 and was rehired on 3/1/22. Staff D was also a direct care staff and was hired on 3/20/22. Neither Staff C or Staff D had evidence of full vaccination. Interview on 5/10/22 with Staff C revealed she was hired 1 1/2 months ago and was unvaccinated for COVID-19. Staff C revealed that no one asked her to identify her vaccine status or explain religious exemptions. Staff C also stated that she has not been required to take any COVID-19 tests for screening purposes. Interview on 5/10/22 with the Personnel Manager (PM) revealed that she was responsible for collecting vaccine statuses for all employees. The PM revealed that Staff D was originally hired to work part time. The PM was aware that Staff D received the Pfizer vaccine on 4/15/22 and did not realize the second Pfizer shot should have been completed in 21 days. The PM stated that Staff C was a rehire and she accidentally forgot to place Staff C on her vaccine shots tracking list. The PM acknowledged she did not ask Staff C for proof of vaccine on 3/1/22 and did not have a religious exemption for Staff C on file. The PM acknowledged that both Staff C and Staff D had actively worked in the home with the clients. Interview on 5/10/22 with the Program Director (PD) revealed their staff were either vaccinated or exempted. If staff were exempted, they are not permitted in homes with the clients.	W 508		