STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SILO DRIVE FACILITY-CHAPEL HILL	**111 SILO DRIVE CHAPEL HILL, NC 27514**

(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 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 4 of 4 audit clients (#1, #3, #5 and #6) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of meal preparation and family style dining. The findings are: During morning observations in the home on 6/21/22, staff prepared breakfast meal without the participation of clients. Food was prepared and served onto plates while drinks were prepoured and provided to clients at the dining room table. Clients were not prompted or encouraged to actively participate with meal preparation tasks or serving themselves at breakfast. Interview on 6/21/22 with Staff A revealed clients in the home are not participating with cooking tasks because of COVID-19. Review on 6/21/22 of client #1's Direct Support Evaluation (DSE) dated 1/4/22 noted, "[Client #1] is able to help prepare food...he enjoys assisting	W 249		

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

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 staff with meal prep, with close monitoring and instructions." Additional review of the evaluation indicated the client can pour liquids without assistance and serve his own plate. Review on 6/21/22 of client #3's IPP dated 12/18/20 revealed he "can help with cooking by reading written instructions." Additional review of the client's DSE indicated he "has the ability to pour his own drink he may need some help so he does not overflow the cup with drink...[Client #3] has the ability to serve himself food with limited to no assistance from staff." Review on 6/21/22 of client #5 and client #6's IPP dated 12/1/20 and 8/14/21, respectively, revealed a need for assistance with food preparation. Additional review of client #5's IPP noted in 2015 he had previously trained on an objective to serve himself at the dinner table. Interview on 6/20 - 6/21/22 with the Site Supervisor and ICF/IID Director indicated although the majority of the staff and all of the clients have been vaccinated against COVID-19 and there were no current cases or suspected cases in the home, they have not returned to allowing clients to fully participate with cooking tasks and family style dining.	W 249		
W 260	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Individual Program Plan (IPP)	W 260		

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W 260	Continued From page 2 for 2 of 4 audit clients (#3 and #5) was updated as appropriate at least annually. The findings are: Review on 6/20/22 of facility documents revealed client #3's most current IPP was dated 12/18/20 while client #5's most current IPP was dated 12/1/20. No current IPP was provided for client #3 and client #5. Interview on 6/21/22 with the Site Supervisor and ICF/IID Director confirmed no planning meetings were held in 2021 for client #3 and client #5, therefore, no current IPP was available for review.	W 260		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure staff were sufficiently trained regarding the appropriate use of latex gloves and the Medication Technician (MT) was trained to document on the Medication Administration Record (MAR) appropriately. The findings are: A. During observations of medication administration in the home on 6/21/22 at 7:15am and 7:55am, the MT initialed the MAR before each client ingested their medication. Interview on 6/21/22 with the MT revealed it was	W 340		

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Continued From page 3

acceptable to sign the MAR before or a client ingests their medication.

Review on 6/21/22 of the facility's Medication Administration Training policy and procedures revealed, "...A staff member may never sign off on the MAR prior to administering the prescribed order."

Interview on 6/21/22 with the ICF/IID Director indicated the MT should not initial the MAR until medications are ingested by the client. The Director noted the staff should initially place a dot in the appropriate space on the MAR when medications are dispensed and after the client has ingested or applied the medications, then the MT should sign their initials.

B. During observations throughout the survey in the home on 6/20 - 6/21/22, various staff consistently wore latex gloves while preparing food in the kitchen. For example, on 6/20/22 from 4:05pm - 5:27pm, Staff B wore latex gloves while preparing/handling food items in the kitchen. During this time, the staff repeatedly touched various surfaces, knobs, keys, and scratched their scalp without changing their gloves.

Interview on 6/20/22 with Staff B revealed it was their personal preference to wear gloves during meal preparation. The staff later indicated they had been trained to wear the gloves while preparing foods. Additional interview revealed gloves would become contaminated after handling trash.

Review of the facility's policy and procedures for Standard Universal Precautions (dated 12/15/21) revealed gloves should be used "when touching

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W 340	Continued From page 4 mucous membranes or contacting blood, body fluids, secretions, or excretions..." The policy did not indicate gloves should be worn during meal preparation tasks. Interview on 6/21/22 with the ICF/IID Director indicated latex gloves should be worn as indicated in the policy manual.	W 340		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire drills were held at least quarterly for each shift. This potentially affected all clients residing in the home. The finding is: Review on 6/20/22 of facility fire drills revealed documentation for six drills completed on 6/12/21, 7/22/21, 2/11/22, 4/11/22, and 6/11/22 (2 drills). No other fire drill reports were available for review. Interview on 6/20 - 6/21/22 with the Site Supervisor and ICF/IID Director indicated a total of twelve fire drills should be completed over a twelve month period, including one per shift per quarter.	W 440		
W 488	DINING AREAS AND SERVICE CFR(s): 483.480(d)(4) The facility must assure that each client eats in a manner consistent with his or her developmental level. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #5	W 488		

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W 488	Continued From page 5 ate in a manner which was not stigmatizing. This affected 1 of 4 audit clients. The finding is: During 3 of 3 mealtime observations in the home throughout the survey on 6/20 - 6/21/22, client #5 consumed his food with lower portion of his clothing protector spread across the table in front of him and the upper portion secured around his neck. While consuming his food, client #5's plate was positioned on top of the lower portion of his clothing protector. During the observations, the client consumed his meals independently using a built-up handled fork. Minimal spillage was noted throughout the observations. Interview on 6/21/22 with Staff A revealed client #5's clothing protector was positioned in this manner at meals so he wouldn't spill food on himself. Review on 6/21/22 of client #5's Individual Program Plan (IPP) dated 12/1/20 revealed he is able to feed himself. The plan did not indicate his clothing protector should be used in the manner previously described. During an interview on 6/21/22, the ICF/IID Director acknowledged using the clothing protector in this manner could be stigmatizing.	W 488		
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	W 508		

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W 508	Continued From page 6 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) 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	W 508		

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W 508	Continued From page 7 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 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	W 508		

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W 508	Continued From page 8 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. 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 ensure proof of vaccination for COVID-19 or an approved exemption was	W 508		

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W 508	Continued From page 9 provided for all staff working directly with clients in the facility. The finding is: Review on 6/20/22 of employee vaccination records revealed at least two staff who work directly with clients in the home had not provided proof of vaccination for COVID-19 or an approved medical or religious exemption. Interview on 6/21/22 with the Site Supervisor confirmed two staff working in the home had no proof of vaccination or an approved exemption available for review.	W 508		