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

PRINTED: 04/06/2022
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
	34G281	A. BUILDING ______ B. WING ______	04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-GREENWOOD GROUP HOME	**105 GREENWOOD CIRCLE SMITHFIELD, NC 27577**

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E 004	Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency	E 004	E 004 This deficiency will be corrected by the following actions: A. The Management will update the EPP preparedness book for the home to include current information for residents and administrative staff contact information. B. Management will monitor and document on this one time a week. C. Management will update all information regarding, consumers, guardians, staff and administrative staff. D. Site Supervisor will monitor and document this monthly. E. Qualified Professional will monitor and document this monthly. F. Management will monitor and document this monthly while conducting site review.	06.05.2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cynthia Bradford /QP
TITLE: Associate Executive Director
(X6) DATE: 12/Apr/2022

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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E 004	Continued From page 1 Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Emergency Preparedness (EP) plan was reviewed and/or updated as needed. The finding is: Review on 4/4/22 of the facility's EP plan revealed it was last updated on 6/28/18. The plan noted, "The information contained in this manual is current as of June 28, 2018. The manual will be revised and updated as necessary." Additional review of the plan did not include any information regarding a client who was recently admitted to the facility and information about a previous client remained in the plan. Interview on 4/5/22 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the EP plan should be updated with current information.	E 004		
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on record review, observation and interviews, the facility failed to ensure clients had the right to a legal guardian. This affected 1 of 4	W 125		

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W 125	Continued From page 2 audit clients (#6). The finding is: Review of 4/4/22 of client #6's record revealed she had been admitted to the home on 4/13/21. The client's Individual Program Plan (IPP) dated 5/1/21 indicated the client acted as her own guardian. Additional review of the record indicated the client was 27 years old and had a diagnosis of Moderate Intellectual Disability associated with anoxic brain injury with cord compression peripartum, somatoform disorder, schizophrenia, anxiety disorder, depression, obsessive compulsive disorder and oppositional defiance disorder. Review of client #6's nursing intake/assessment dated 5/7/21 reveals client "....cannot self administer meds." During observation of medication pass on 4/4/22 at 11:40am and 4:30pm, client #6 was able to identify her chewable antacid but did not participate in medication administration. Additional observations of the medication pass on 4/5/22 at 6:57 am client #6 was unable to name any medications and was unable to punch out pills from the package. During an interview on 4/4/22, client #6 responded "No" when asked if she knew the names of any of the medications she takes, what the medications were used for or why she was taking them. When asked if she knew what any of her diagnoses are or what her medications are used to treat, she again responded, "No." Interview on 4/5/22 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #6 was currently acting as her own guardian and	W 125	W125 This deficiency will be corrected by the following actions: A. All community/ home assessment will be reviewed to look at all current needs of persons served. B. Core Team will address all guardianship issues. C. Qualified professional will follow up with the Department of Social Services to petition their assistance with obtaining guardianship. D. Adequate supervision will be provided for consumers to ensure all current needs are being met until a guardian has been assigned. E. Qualified Professional will monitor and complete.	06.05.2022

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W 125	Continued From page 3 this was her status when she was admitted to the home. QIDP revealed that she had a conversation with client #6's father in early February 2022 about taking guardianship but he has not informed her of his decision. QIDP acknowledges client #6 needs a guardian and plans to petition the court if client #6's father is not willing to accept guardianship.	W 125		
W 210	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure the interdisciplinary team completed preliminary accurate assessments within 30 days after admission. This affected 1 newly admitted audit client (#6). The finding is: Review on 4/4/22 of client #6's individual program plan (IPP) dated 5/1/21 revealed he was admitted to the facility 4/13/21. Further review of client #6's record revealed no assessments were obtained in the areas of speech, vision, audiological, dental, nutritional or psychiatry within 30 days of admission. Interview on 4/5/22 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed that the team had not completed assessments in the areas of speech, vision, audiological, dental, nutritional or psychiatry within 30 days of admission.	W 210	W.210 This deficiency will be corrected by the following actions: A. The interdisciplinary team will perform accurate assessments within 30 days of admission. B. All assessments will be conducted, with recommendations to be added/discussed at the team meeting. C. The Qualified Professional will ensure that all the necessary items assessments are completed D. All initial assessment will be competed for all discipline, to determine if further follow up would be necessary E. IDT will meet to discuss and implement any recommendations.	06.05.2022

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W 210	Continued From page 4 During an interview on 4/5/22, the facility nurse acknowledged client #6's vision, audiological and dental exams have yet to be scheduled.	W 210	W249 This deficiency will be corrected by the following actions: A. All community / home life assessment will be reviewed/update and revised as needed to address the use of meal preparation B. ISP will be updated modified to meet the current needs of each consumer C. All current goals will be assessed, modified, update or discontinued to meet areas identified in assessments D. Consumers will be actively involved in food preparation E. Goals will be implemented after team/annual meeting addressing need of consumer, if warranted F. All people served will be afforded the opportunity to participate and assist in meal preparation G. All people served will be afforded the opportunity to be as independent while receiving continuous active treatment H. Staff will be in-serviced and trained on priority needs of the consumers I. Site Supervisor will monitor one time a week- per shift completing home observation form J. Qualified Professional will monitor one time a week. Per shift completing Observation sheet	06.05.2022
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 Plan (IPP) in the areas of cooking and family style dining. This affected 2 of 4 audit clients (#5 and #6). The findings are: A. During lunch preparation observations in the home on 4/4/22 from 10:48am - 12:00pm, Staff A prepared tuna pasta salad while Staff B cooked beets and placed Ritz crackers in a dish. During this time, client #6 walked in/out of the kitchen briefly and was only prompted to cut up boiled eggs and retrieve items from the refrigerator. During dinner preparation observations in the home on 4/4/22 from 4:15pm - 5:18pm, Staff B performed all tasks to prepare a shrimp and	W 249		

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W 249	Continued From page 5 vegetable stir-fry with white rice including cooking the shrimp and vegetables in pans on the stove and cooking a pot of instant rice. The staff also opened two cans of mandarin oranges and placed them in a bowl and heated rolls in the microwave. During this time, client #6 set items on the table, threw items in the trash and talked to the staff. Client #6 was not prompted or assisted to participate with any cooking tasks. Interview on 4/4/22 with client #6 revealed she loves to help in the kitchen. The client stated, "I like to help cook...clean and do dishes." During an interview on 4/4/22, when asked if the clients assist with cooking tasks, Staff B stated, "They can't touch the heat." Additional interview indicated she had recently began working at the home and other staff have told her that the clients cannot be around the heat of the stove and therefore, do not participate with cooking tasks. Review on 4/5/22 of client #6's Community/Home Life Assessment (CHLA) dated 4/13/21 revealed she can independently make foods with no cooking, foods with cooking but no mixing or foods with cooking and mixing, and operate a toaster and microwave. Additional review of the CHLA also indicated she can use the stove/oven and coffee maker with physical assistance. Interview on 4/5/22 with the Qualified Intellectual Disabilities Professional (QIDP) indicated clients should be assisting in the kitchen on a "consistent basis". The QIDP offered no explanation as to why clients could not assist with cooking on the stove but acknowledged clients could probably stir food using a long handled spoon.	W 249		

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W 249	Continued From page 6 B. During dinner observations in the home on 4/4/22 at 5:18pm, Staff A poured client #5's drinks and placed food items on her plate without prompting or assisting her to participate with these tasks. Interview on 4/4/22 with Staff A revealed they had performed those tasks because client #5 will "yell and run" out of the room if you try to prompt her to assist with tasks. Review on 4/5/22 of client #5's CHLA revealed she can independently pour liquids from a pitcher and eat family style. Interview on 4/5/22 with the QIDP can perform tasks such as serving herself and pouring drinks.	W 249		
W 255	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(i) The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Individual Program Plan (IPP) for 1 of 4 audit clients (#5) was reviewed and revised as needed after completion of objectives. The findings are: Review on 4/4/22 of client #5's Behavior Support Plan (BSP) dated 8/5/21 revealed objectives to display 3 or fewer episodes of noncompliance per month for 12 consecutive months, 1 or fewer episodes of self-injurious behaviors (SIB) per	W 255	W.255 This deficiency will be corrected by the following actions: A. ALL ISP will be reviewed and revised as necessary. B. ALL BSP will be reviewed and revised as necessary. C. All behavioral objectives will meet the needs of the person being served. D. All behavioral documentation will be reviewed E. All rights will be reviewed F. If there are any rights restrictions, they will be presented to HRC. G. All behaviors will be documented H. All staff will be in serviced on recording behavioral documentation I. Site Supervisor will monthly weekly J. Clinical Manager will monitor weekly K. Clinical manager will assess all behavioral documentation monthly	06.05.2022

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W 255	Continued From page 7 month for 12 consecutive months, and 1 or fewer episodes of physical aggression per month for 12 consecutive months. Additional review of monthly progress notes dated October '20 - February '22 revealed no documented episodes of SIB, noncompliance and physical aggression. Interview on 4/5/22 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed she was not aware of any noncompliance, SIB and aggressive behaviors exhibited by client #5 in a year and five months; however, her behavior plan remains in place.	W 255	W312 This deficiency will be corrected by the following actions: A. All community/ home assessment will be reviewed. B. All behavioral support plans will be reviewed. C. All Behavioral Support Plans will be updated to address the current medication regiment. D. Psychologist will review all plans. E. The IDT will meet to address any reduction or elimination of medications-based behavior documentation. F. IDT will ensure that all proper techniques will be used to manage behaviors. G. Qualified Professional will review and obtain guardian consent for a reduction or elimination of any medications. H. All guardians will be informed of any mediation changes. I. All staff will be in-service on all Behavioral Support Plans and proper documentation. J. Qualified Professional will review all behavior documentation monthly at core team meetings. K. Site Supervisor will monitor one time a week L. Qualified Professional will monitor one time a week	06.05.2022
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 all medications used to address client #6's inappropriate behaviors were included in a formal active treatment program. This affected 1 of 4 audit clients. The finding is: Review on 4/4/22 of client #6's Behavior Support Plan (BSP) dated 5/1/21 revealed an objective to display 3 or fewer episodes per month for 12 consecutive months. Additional review of the plan identified target behaviors of self-injurious, inappropriate verbalizations and inappropriate touching. The plan included the use of Ziprasidone. Further review of a physician's order for client #6 dated 2/2/22 revealed orders for Melatonin, Zisprasidone and Lorazepam. Further	W 312		

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W 312	Continued From page 8 review of client #6's consultation report for medication management dated 3/22/22 revealed to hold Lorazepam and start Clonazepam and also start Fanapt. Further review of client #6's BSP and an addendum to the BSP dated 1/24/22 did not include the use of Clonazepam, Fanapt or Melatonin to address her inappropriate behaviors. Interview on 4/5/22 with the Qualified Disabilities Professional confirmed Melatonin, Clonazepam and Fanapt are ordered for client #6 and should have been included in the BSP.	W 312		
W 323	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(i) The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 4 audit clients (#5) obtained an evaluation of her hearing and an annual physical examination as recommended. The findings is: A. Review on 4/5/22 of client #5's record revealed her last annual physical examination was completed on 2/22/21. Additonal review of the client's Medical Appointment Diary noted her next physical examination was due 2/22/22. Further review of the record did not reveal a physical examination had been completed since 2/22/21. Interview on 4/5/22 with the facility's nurse confirmed client #5 should have received her annual physical by 2/22/22 as indicated.	W 323	W.323 This deficiency will be corrected by the following actions: A. All medical appointment will be reviewed. B. The team will ensure appointments are scheduled and follow up. C. All the appointments will be reviewed and discussed at the monthly core team/quarterlies/annual ISP. Options for appointments that were unable to be completed will be added to meeting minutes. D. There will be supporting documentation for all appointments that were completed or the reason why it was unable to be completed. E. RN will review monthly F. Site Supervisor will monitor one time a week. G. Qualified Professional will monitor one time a week	06.05.2022

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W 323	Continued From page 9 B. Review on 4/5/22 of client #5's record revealed an audiological examination had been completed on 8/4/21. Additional review of the report noted the client's next audiological examination was due February '22. Review of the client's Medical Appointment Diary noted her next audiological appointment was due "2/2022". Further review of the record did not reveal an audiological examination had been completed since 8/4/21. Interview on 4/5/22 with the Area Supervisor confirmed the appointments noted on client #5's Medical Appointment Diary were current and included medical appointments which were due. Interview on 4/5/22 with the facility's nurse also confirmed the client's audio examination was due. She indicated she had sent an email on 1/31/22 to the Site Supervisor, Qualified Intellectual Disabilities Professional (QIDP) and Program Manager which listed all medical appointments currently due for client #5.	W 323		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure client #5 received recommended medical services as indicated. This affected 1 of 4 audit clients. The findings are: Review on 4/5/22 of client #5's record revealed the following medical services to be provided and/or recommendations:	W 331		

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W 331	Continued From page 10 Dental examination report dated 8/16/21 - "Dental cleaning...heavy plaque, gum inflammation...f/u - 2/21/22 @ 10:00am..." Mammogram report dated 12/10/20 - "Annual mammogram...Screening" Ob/Gyn report dated 9/19/19 - "Normal ultrasound - RTO in 1 yr for physical CPE." Hematology/Oncology report dated 3/9/20 - "Stage III colon cancer diagnosed 10/20/16...colonoscopy 3/27/18, benign...No invasive treatment...Plan/Recommendations: Continue annual follow-up." Additional review on 4/5/22 of client #5's Medical Appointment Diary indicated her Gynecology examination was due in 2020, "Schedule ASAP." The diary also noted the client was due for a Hematology/Oncology visit on 3/9/21, "Schedule ASAP." Further review of a quarterly nursing report dated 3/4/22 revealed under consultant recommendations, "Follow up with the following: Gyn, PPD, Dental, Hematology/Oncology." Interview on 4/5/22 with the Area Supervisor confirmed the appointments noted on client #5's Medical Appointment Diary were current and included medical appointments which were due. Interview on 4/5/22 with facility's nurse confirmed client #5 was due a follow-up dental cleaning, mammogram, Ob/Gyn visit and a Hematology/Oncology follow-up as indicated. She revealed she had sent an email on 1/31/22 to the Site Supervisor, Qualified Intellectual Disabilities Professional (QIDP) and Program Manager which listed all medical appointments	W 331	W331 This deficiency will be corrected by the following actions: A. All physician orders and medical consults will be reviewed at core team B. All medical appointments, annual screening, follow up appointments will be reviewed and completed. C. RN will update all quarterlies and maintain them on a quarterly basis. D. RN will ensure that all health care summaries are completed on all person served. E. RN will assess all orders and follow up with all medical orders F. RN will ensure that all assessments, month notes, progress notes and orders are filed in the appropriate location in the Master charts G. All assessment will be reviewed, and recommendations discussed in core team, quarterly, or ISP. IF a special team meeting needs to take place QP will address. H. RN will complete Health service summaries I. RN will monitor monthly J. Qualified Professional will monitor monthly– at core team meetings	06.05.2022

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W 331	Continued From page 11 currently due for client #5.	W 331		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure 1 of 4 audit clients (#1) was taught to use and make informed choices about the use of eyeglasses and continuous positive airway pressure machine (CPAP). The findings are: A. During observations in the home on 4/4/22 from 9:30am until 6:25pm, client #1 was not wearing eyeglasses. Additional observations in the home on 4/5/22 from 6:15am til 1:15pm, client #1 was not wearing eyeglasses. At no time during the observations was client #1 prompted to wear eyeglasses. Review on 4/4/22 of client #1's Individual Program Plan (IPP) dated 3/16/22 revealed she is supported by wearing eyeglasses. B. Record review on 4/4/22 of client #1's IPP dated 3/16/22 revealed client #1 has a diagnosis of obstructive sleep apnea and is to use a CPAP machine at night during sleep. Interview with client #1 reveals she is unsure when she last used her CPAP because she does not like it and thinks the nose piece to the mask	W 436	W.436 This deficiency will be corrected by the following actions: A. All equipment will be maintained and in good working conditions, teaching people served on the use of said equipment B. All people severed will have full access to all equipment and encouraged to use said items C. Any equipment that is not assessable or consumer choices not to use will be address in ISP. D. If there are any rights restrictions, they will be presented to HRC. E. All people served will be in service on equipment F. All staff will be in-service on their equipment working conditions, an teaching people served on the use of said equipment G. Site Supervisor will monitor one time a week. H. Qualified Professional will monitor one time a week	06.05.2022

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W 436	Continued From page 12 might be broken. Interview on 4/5/22 with Staff C reveals client #1 is supposed to wear glasses but never does. Staff C reveals client #1 has not used her CPAP since last year some time and she believes it was discontinued. Interview on 4/5/22 with the facility's nurse confirmed client #1 should be wearing eyeglasses at all times when she is awake and using CPAP machine at night for sleep.	W 436		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure 1 of 4 audit clients (#2) received a modified diet as prescribed. The findings is: During lunch observations in the home on 4/4/22 at 12:20pm, client #2 consumed pureed tuna pasta salad and beets. While the beets were moist and smooth, the tuna pasta salad was thick and lumpy with visible bits of pasta and tuna. Client #2 consumed the food items without difficulty. During dinner observations in the home on 4/4/22 at 5:18pm, client #2 consumed a shrimp and vegetable stir-fry. The stir-fry consisted of pureed cooked shrimp, mixed vegetables and rice. Once	W 460	W.460 This deficiency will be corrected by the following actions: A. Nutritionist will complete and assessment on consumers B. Recommendations will be added based upon assessment C. Nutritional assessments will be conducted to ensure proper food consistency D. All people served will receive a nourishing, well-balanced diet including modified and specially prescribed diets. E. All staff will be in service on Food consistency orders F. Site Supervisor will monitor one time a week. G. Clinical Manager will monitor one time a week	06.05.2022

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W 460	Continued From page 13 served, the mixture was thick, dry and lumpy. There were also visible bits of vegetables and rice throughout. Client #2 consumed the stir-fry without difficulty. During breakfast observations in the home on 4/5/22 at 8:12am, client #2 consumed a ground up sausage patty which had been processed in the blender with beef broth added. The sausage was moist and chunky. Client #2 consumed the sausage without difficulty. Interview on 4/4/22 with Staff A revealed client #2 receives a pureed diet and her food should "creamy'. Additional interview with Staff B indicated the client's food should look like baby food. Review on 4/4/22 of a food consistency chart posted in the kitchen of the home revealed under a picture of pureed food, "Blended/Smooth". Review on 4/4/22 of client #2's Individual Program Plan (IPP) 1/12/22 revealed she receives a 1500 cal, ADA, pureed diet. Interview on 4/5/22 with the Area Supervisor confirmed client #2 should receive pureed foods at meals. Additional interview noted her food should be "creamy...baby food, smooth and creamy". Further interview indicated a food processor was needed to better assist staff with processing client #2's food instead of the blender which is currently used in the home. Interview on 4/5/22 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #2's food should be pureed smooth and a new blender has been requested in order to ensure	W 460		

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W 460	Continued From page 14 the food is processed more thoroughly.	W 460		
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) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of	W 508	W,508 This deficiency will be corrected by the following actions: A. The facility will develop and maintain policy and procedures addressing person who have not completed a primary vaccination service for COVID-19 A. Strategies will be implemented addressing the COVID-19 emergency situations. B. Staff will be in in serviced on the emergency preparedness plan C. A process will be put in place to address collecting and tracking the COVID-19 vaccinations status. D. The plan will include contingency plans for staff who are not fully vaccinated. E. The policy will include how the organization will track the vaccination status of staff with a temporary delay in obtaining their vaccination F. Management will implement G. Management will have the plan updated annually.	06.05.2022

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W 508	Continued From page 15 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 documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff	W 508		

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W 508	Continued From page 16 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. Effective 60 Days After Publication: (ii) A process for ensuring that all staff specified in paragraph (f)(1) of this section are fully	W 508		

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W 508	Continued From page 17 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 develop policies and procedures which include a process for tracking staff with temporary delays with obtaining their COVID-19 vaccination and contingency plans for staff who are not fully vaccinated for COVID-19. The findings are: A. Review on 4/5/22 of the facility's COVID-19 vaccination policy for employees (dated 1/28/22) 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 on 4/5/22 with the Qualified Intellectual Disabilities Professional (QIDP) 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. Additional interview indicated the facility's corporate office would be working on revising the current policy. B. Review on 4/5/22 of the facility's COVID-19 vaccination policy for employees (dated 1/28/22) did not include a process for ensuring the tracking and secure documentation of the vaccination status for staff if their vaccination must be delayed. Interview on 4/5/22 with the QIDP confirmed the facility's current COVID-19 vaccination policy for	W 508		

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

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W 508	Continued From page 18 employees did not include a process for tracking the vaccination status of staff with a temporary delay in obtaining their vaccination. Additional interview indicated the facility's corporate office should be working on revising the current policy.	W 508		