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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G182	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC EDGEWOOD GROUP HOME	77 EDGEWOOD DR CHOCOWINITY, NC 27817

(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
E 022	Policies/Procedures for Sheltering in Place CFR(s): 483.475(b)(4) §403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3). (b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to develop policy and procedures in their emergency preparedness (EP) plan for sheltering in place. This had the potential to affect 5 of 5 clients (#1, #2, #3, #4 and #5). The finding is:	E 022	E022: The facility will ensure that policies and procedures are updated to address sheltering in place. This update will be included in the Emergency Preparedness Plan. This will outline procedures to be followed by staff when the need to shelter in place in executed. The updated plan will be shared with all facilities and included in the current Disaster Plan. All staff will receive an updated training session. The plan will be reviewed every two years by the LIFE, Inc. QA/QI team. Review dates will be included. Additionally, the procedures will be reviewed by local team members and documented in the Roundtable discussion annually. RECEIVED MAY 04 2022 DHSR-MH Licensure Sect	6-5-2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Director [illegible] (X6) DATE 4-29-22

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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E 022	Continued From page 1 Review on 4/5/22 of the facility's EP plan dated 12/9/21, revealed no identified means for clients and staff to shelter in place, in the event an evacuation cannot be executed. Interview on 4/5/22 with the qualified intellectual disabilities professional (QIDP) revealed that after reviewing the EP plan, he could only detect the mention of sheltering in place for a biohazard spill. The QIDP did not know what to do in other circumstances.	E 022		
W 446	EVACUATION DRILLS CFR(s): 483.470(i)(2)(ii) The facility must make special provisions for the evacuation of clients with physical disabilities. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to develop alternative techniques to achieve a protective position during tornado drills for 1 of 1 former client (FC#4) with medical conditions. The finding is: Review on 4/4/22 of FC#4's bone density exam on 6/24/21 revealed she had osteoporosis. Review on 4/4/22 of the FC#4's incident reporting system (IRIS) investigation initiated on 3/2/22 revealed during at 11:30am tornado drill in the home, FC#4 remained standing despite verbal cues to lower herself to the floor. In review of written statement by the home manager (HM), she saw staff E and staff F in the hallway trying to get FC#4 and client #5 to squat down on the floor and they were being fussy. The HM told staff E and staff F, due to the clients ages, to put their backs against the closet down, to help slide them	W 446	W446: The facility will review all disaster plans and ensure special provisions that may be needed for individuals to be safely evacuated, are included. This will include provisions for clients with physical disabilities or other needs as determined by the team. All clients will be assessed and any provisions needed will be included in their My LIFE Plan. All staff will be inserviced on all changes made. The disaster plan will also be updated to note this change. The plans will be reviewed annually by the appropriate team members and changes made as necessary. Additionally, the provisions implemented will be reviewed monthly by the QP, HM and LPN, during the scheduled disaster drill to ensure compliance.	6-5-2022

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W 446	Continued From page 2	W 446		

to the ground to sit and demonstrated to staff how to do it, before leaving the area to answer the doorbell. The HM returned to the hall after a few minutes and saw staff E and staff F getting the FC#4 up from the floor but FC#4 was unable to stand and went back down to the floor. The HM tried to assist FC#4 up, but FC#4 began to scratch her and would not move. The HM asked staff E to stand in front of FC#4, while HM stood behind FC#4 to lift her off the floor, when HM noticed that FC#4's right foot was turned out to the right side, touching the floor. Staff E and HM lowered FC#4 back down to the floor. The HM noticed that FC#4's leg looked deformed and rubbedleg and felt a bump/knot. Staff E called the nurse and told her that it looked like FC#4's leg was broke and called 911. FC#4 was transported to the hospital, had x-rays which confirmed a closed fracture of upper end of right fibula and fractured shaft of right tibia. On 3/3/22, FC#4 had surgery on right leg and remained hospitalized for treatment.

Interview on 4/4/22 with client #1 revealed she participated in a tornado drill and saw FC#4 sitting down and unable to get up. Client #1 stated unnamed staff tried to get FC#4 up but her right foot turned sideways when she stood and then her knees buckled.

Interview on 4/5/22 with the qualified intellectual disabilities professional (QIDP) revealed that he was unsure if staff had guidance on how to transfer clients with mobility/medical issues who need to be lowered to the ground. The QIDP stated if clients were resistant to get on the ground, their behavior plan should be followed, if they refused to sit. The QIDP acknowledged that FC#4 was not being defiant. She had tried to

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W 446	Continued From page 3 make attempts to sit but was unable and it was her right to not have to sit down. The QIDP stated that there were alternatives, such as taking FC#4 to an interior room without windows, during the drill. The QIDP stated that he watched the video of the 3/2/22 tornado drill and he could see the frustration on FC#4's face and her discomfort trying to hunch down. The QIDP stated he told staff E, staff F and HM they could not do that kind of transfer again but have not conducted an in-service on safe transfers during drills. Interview on 4/5/22 with the nurse revealed that she discussed with the QIDP there was a problem with the 3/2/22 tornado drill. The nurse discussed with him what could have been done better but they did not do any formal training with staff.	W 446		
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	W 508	508: The current vaccination policy (to ensure that all staff are vaccinated) will be reviewed and revised to include contingency plans for individuals who have approved exemptions. The new plan will include language specifically to address what procedures will be added for individuals that are not fully vaccinated. The revised plan will be reviewed with all employees. The current vaccine policy will be reviewed annually by the Corp Team members.	6-5-2022

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W 508	Continued From page 4 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 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	W 508		

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W 508	Continued From page 5 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 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	W 508		

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W 508	Continued From page 6 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 interviews, the facility failed to develop policies and procedures which include contingency plans for staff who were approved for religious exemptions to the COVID-19 vaccine. The findings is: Review on 4/4/22 of the facility's Vaccination Policy dated 1/17/22 did not include language for staff who were unvaccinated for COVID-19 who were granted exemptions. Interview on 4/5/22 with the qualified intellectual disabilities professional (QIDP) revealed that if staff were not vaccinated, then they could not	W 508		

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W 508	Continued From page 7 enter the building. Interview on 4/5/22 with the nurse revealed there was no contingency plan, instead they used the COVID-19 questionnaire and took body temperature to determine risks.	W 508		

April 29, 2022

Esther Moore, BSW, QIDP
Facility Compliance Consultant I
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Re: Plan of Correction
LIFE, Inc. Edgewood Group Home

Dear Ms. Moore

Enclosed please find our written plan of correction for the recent survey at our Edgewood Group Home.

If there are questions or if additional information is needed, please feel free to contact me.

Thank you for your continued assistance to us in the operation of our facilities.

Sincerely,

Susan Ayers
Director of ICF/IID Services

Enclosure

Phone: (919) 778-1900
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