STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G212	A. BUILDING _____ B. WING _____	05/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOFFMAN GROUP HOME	104 TEAL STREET HOFFMAN, NC 28347

(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 observations and interviews, the governing body failed to assure facility furniture was in good repair as well as safeguard chemical agents from clients. This had the potential to affect 5 of 6 clients in the home (Clients #1, #2, #3, #4 and #5). The findings are: A. Observations in the backyard of the home on 5/2/22 at 4:30pm revealed 6 metal patio chairs, lacking upholstered covers. Each chair had two foam cushions for bottom and back support with white interface fabric covering foam. One vacant chair was left in the yard by the fence. Client #4 was observed sitting on a foam seat cushion at 4:45pm, with a noticeable dip from underneath the patio chair where she sat. Interview on 5/3/22 with the home manager (HM) suggested the patio chair cushions were removed because they were getting soiled from clients' incontinence. Interview on 5/3/22 with the qualified intellectual disabilities professional (QIDP) revealed that the patio chairs cushions lacked upholstered seat cushions when she was assigned to the home last Fall. B. Observations inside the home on 5/2/22 at 5:10pm, revealed the brown sofa in the living room, had beach towels stuffed underneath the seat cushions. Interview on 5/3/22 with the HM stated that the	W 104		

ATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Keisha H Bell	Administrator	6/16/2022

ficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that feguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 lowing the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued participation.

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W 104	Continued From page 1 sofa cushions sink and were damaged when jumped on by clients. The HM ackowledged the sofa had towels underneath cushions to help give support. Interview on 5/3/22 with the quality assurance staff (QA) revealed in February 2022 the QIDP made a request to the corporate office to get a new living room set. The QA was unaware of any request to improve the patio furniture. The QA stated that every home has a "capital tour" annually where furnishings are inspected. The QA stated before any furniture is replaced, there has to be an onsite visit to approve the expense. The QA did not know if the furniture had been ordered, but awaiting delivery due to a backlog. The QA stated that he would need to check with maintenance since he was unaware of the status. C. Observations in the home on 5/2/22 at 5:35pm revealed clients #1 and #5 were preparing dinner with Staff E supervising them. Next to the kitchen, was an unlocked utility closet, with door ajar. A sign was posted on the closet that read: "Keep door locked at all times. Individuals that enter this closet should have staff supervision." The surveyor opened the closet door and found multiple bottles of cleaning solution on a shelf. The closet was next to the side door to the home and near a half bathroom that clients used. The door remained ajar through 5:53pm, Interview on 5/3/22 with the HM revealed the utility closet contained cleaning agents and should be kept locked at all times.	W 104		
W 323	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(i)	W 323		

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W 323	Continued From page 2 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 review and staff interviews, the facility failed to ensure 1 of 4 audit clients (#5) received an evaluation for hearing as recommended. The finding is: Review on 5/2/22 of client #5's record revealed an audiological exam was performed on 3/3/21 prior to her 8/17/21 admission into the home. On the evaluation, it was recommended that client #5 have hearing retest in a year. The record did not contain any current hearing test. Interview on 5/3/22 with Nurse #1 revealed that based on the prior examiner's recommendation, she should have scheduled a new hearing test for client #5 last August when she was admitted.	W 323		
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 administer medications for 3 of 4 audit clients (#3, 5 and #6) without error. The findings are: A. During morning observations in the home on 5/3/22 between 7:45am-7:52am, Staff H administered Aripiprazole 20mg, Methimazole 5mg, Olanzapine 5mg, Propranolol 20mg, Vitamin D 50mg and Clonazepam 1mg to client #3. Client #3 was not observed getting nose	W 369		

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W 369	Continued From page 3 spray. Review on 5/3/22 of client #3's 7:00am physician's order signed on 3/1/22 revealed Flonase 50mg; spray each nostril 1 x. Interview on 5/3/22 with Nurse A revealed staff are expected to administer the medications as written in the physician's order. B. During morning observations in the home on 5/3/22 at 8:05am, Staff D attempted to give client #5 a dose of Lactulose medication, but it was not available for the 7:00am physician order. Staff D asked Staff H to help search the medication closet for the Lactulose; it was not recovered. Review on 5/3/22 of client #5's physician's order signed on 3/1/22 revealed Lactulose Sol 10gm at 7:00am. Interview on 5/3/22 with Staff D revealed that she learned from Staff H that Nurse A came to the home yesterday and removed client #5's medication. Staff D did not know the reason for the medication to be removed from client #5's medication bin. Interview on 5/3/22 with Nurse A revealed she was at the home on 5/2/22 and removed client #5's Lactulose medication because she intended to have the doctor change the order to bedtime. Nurse A acknowledged that she had not secured a new order for Lactulose before 7:00am today and did not notify group home staff of her intent. C. During morning observations in the home on 5/3/22 at 8:10am, Staff D administered Docusate SOD 100mg and Vitamin D3 50mcg to client #6.	W 369		

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W 369	Continued From page 4 No additonal medication was observed given or applied to client #5. Review on 5/3/22 of client #6's physician's order signed on 3/1/22 revealed an order to apply Erythromycin ointment 5mg. Staff should apply 1 cm to left eye at bedtime for eye lubricant. The times for dosage was noted to be 7:00am and 8:00pm. Interview on 5/3/22 with Nurse A revealed that the order for Erythromycin should have been transcribed to give at bedtime only. Nurse A acknowledged that staff were expected to follow the physician's orders as written.	W 369		
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 observations and interviews, the facility failed to ensure that medications were secured when medication technician was not present. This potentially affected all clients in the home (#1, #2, #3, #4, #5 and #6). The finding is: During morning observations in the home on 5/3/22 from 7:45am to 8:15am, Staff H kept the medication closet unlocked with door ajar, and kept the plastic file box containing narcotics, without padlock secured. The medications were administered in the hallway, outside the clients' bedrooms and the bathrooms. Staff H was observed to walk away from the medication closet, to the short hallway leading to the living room and call out for the next client. At 8:01am,	W 382		

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W 382	Continued From page 5 Staff H was observed leaving the hall, entering the living room, while client #5 sat across from an opened medication closet and had 3 blister packs of pills, left on the table next to her, unsupervised. Staff H was off the hall for a minute. An additional morning observation, revealed client #2 entering the hallway to go to the bathroom across from the medication closet unsupervised, before Staff F and Staff I could escort him on the hall. Interview on 5/3/22 with Nurse A revealed when medications are removed from the closet, it should be locked if the area was left, for any reason. Nurse A stated that medications should not be left unsupervised on the table, when the clients are present. Nurse A stated that if staff have their back to the unlocked medication closet, then staff are not capable of visually supervising if the medication remained secure.	W 382		
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	W 508		

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W 508	Continued From page 6 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 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	W 508		

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W 508	Continued From page 7 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 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	W 508		

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W 508	Continued From page 8 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 observations, record review and interviews, the facility failed to implement their COVID-19 Vaccination Policy. The findings are: A. Observation on 5/3/22 at 8:58am, revealed Staff A wearing a double face mask inside the group home, in the presence of clients. B. Observation on 5/3/22 at 9:10am, revealed Nurse A wearing a double face mask inside the group home, amongst staff. Review on 5/2/22 of the facility's COVID-19 Policy	W 508		

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W 508	Continued From page 9 dated 1/27/22 revealed if an employee declined the vaccination, an application for religious or medical exemption were available. If staff were not vaccinated, staff were required to wear additional personal protective equipment (PPE), for example double mask and face shield. Staff may be subject to work restrictions during moderate high COVID-19 virus activity within local community or work location. May be subject to virtual attendance for specific meetings. May be asked to test on a routine basis. Employees working in intermediate care facilities (ICF) must follow Center for Disease Control (CDC) guidelines for COVID-19 vaccinations. On 5/2/22 an additional review of staff vaccination or exemption status records revealed the following: Religious exemptions were granted to 3 staff, 23 staff were fully vaccinated and 1 staff was partially vaccinated from a Pfizer shot given on 8/13/21. The facility did not readily have a record on file of 2 staff full vaccination status. Interview on 5/2/22 with Nurse B at the vocational center revealed that she could not find proof of Staff C, Staff A and the home manager's vaccination records. Nurse B stated that Staff A might have decided to forego the second vaccine and became a religious exemption, but she did not have proof in her files. Interview on 5/2/22 with the qualified intellectual disability professional (QIDP) revealed that she had secured a copy of Staff A's religious exemption which was signed on 4/18/22. Interview on 5/2/22 with the Human Resource Coordinator revealed that the home manager and the nurse were supposed to monitor the	W 508		

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W 508	Continued From page 10 vaccination status of all staff working in the home, but due to staff turnover, some records were unknowingly incomplete. Interview on 5/3/22 with Staff A revealed that she received one dose of the vaccine last summer but got scared to get the second dose after unfavorable reports of complications broadcast on the news. Staff A revealed that she started working at the group home in February 2022 and she could not recall who she spoke to in human resources but made them aware that she did not want to get the second vaccine dose. Staff A stated that she was not told that she had the option to file an exemption if she did not plan to become fully vaccinated. Staff A acknowledged that the home manager (HM) instructed her if she was partially vaccinated she would have to wear two face masks or 1 mask and a face shield. Staff A further acknowledged that she did not seek religious exemption to the COVID-19 vaccine until recently. Interview on 5/3/22 with Nurse A revealed that staff with religious exemptions were instructed to wear a double mask only when working with clients. Nurse A stated that she was not aware that the updated policy also specified that a face shield should be worn. Interview on 5/3/22 with the Quality Assurance (QA) staff revealed that he confirmed with the corporate office that all unvaccinated staff, with an exemption, should wear a double mask plus a face shield.	W 508		

W104

QP/Home Manager will purchase new cushions for patio furniture. Umbrellas and shade coverings will be purchased and installed throughout the yard.
Administrator will order new living room furniture, maintenance will have all furniture installed by June 30, 2022.

QP will in-service staff on keeping utility closet door locked and closed at all times when not in use.
The clinical team will complete at a minimum of 4 Environmental assessments.
Target Date: July 1, 2022

W323

Nursing will review all annual physicals for all clients in the home for compliance through annual nursing assessment and ensure vision and audio exams are being scheduled and completed. Audio exam will be scheduled for client #5 as well as any other client in the home as needed.

Clinical team will conduct chart reviews focusing on vision and Audio exams.
Target Date July 1, 2022.

W369

DSA's will be in-serviced by the nurse on client #3 nasal spray medication as well as the nasal spray medications of all other clients in the home according to physician orders.

The clinical team will complete at a minimum 4 medication administration observations as assigned by the QP utilizing a 30 day schedule.
Target date: July 1, 2022

RN will review physician's orders for clients #5 and #6, as well as all other clients in the home for accuracy. The RN will in-service all med-techs on what to do if unable to locate medications and on clients #5 and #6 medications, as well as all other clients in the home according to physician's orders to ensure that medication is being administered per physician's orders.

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The clinical team will complete at a minimum 4 medication administration observations as assigned by the QP utilizing a 30 day schedule.
Target date: July 1, 2022

W382

RN will in-service all med-techs on the importance of keeping the Med-closet secured and medications stored in closet until administering to the appropriate client during medication administration.

The clinical team will is to complete at a minimum 4 medication administration observations as assigned by the QP utilizing a 30 day schedule.

Target date: July 1, 2022

W508

Nursing will in-service all DSA's on the proper procedure, policies, and wear of PPE. Nursing will conduct an audit for all vaccinations of staff to include follow-up on any outstanding vaccinations, a plan for new hire process and follow-up and review the policy based on RHA Health Services, LLC procedures for COVID-19 vaccinations.

The clinical team will complete a bi-weekly audit as assigned by the QP utilizing a 30 day schedule.
Target date: July 1, 2022