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	34G256	A. BUILDING _____ B. WING _____	05/03/2022

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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 observations, record reviews and interviews, the facility failed to ensure client #4 had the right to be treated with dignity and failed to ensure client #6 had the right to a legal guardian. This affected 2 of 6 audit clients. The findings are: A. During observations in the home throughout the survey on 5/2/22 through 5/3/22, client #4 was observed sitting in her wheelchair with an incontinence pad tucked underneath her. Throughout the observations, the pad was visible to anyone in the home. Interview on 5/3/22 with the Program Coordinator revealed at no time should an incontinence pad be placed under client #4. Interview on 5/3/22 with the ICF Program Director confirmed that the incontinence pad should not be placed under client #4 and she should be treated with dignity. B. Review on 5/3/22 of client #6's Individual Program Plan (IPP) dated 10/6/20 revealed client #6 has a diagnosis that includes Moderate Intellectual Disability, Hypertension, Diabetes and Anxiety Disorder. Further review of client #6's IPP revealed that on 10/6/20, the team met and determined that client #6 requires the support of a	W 125	The facility will ensure that each client is treated with dignity and respect and when appropriate has legal representation as determined by their capacity or lack thereof to exercise their rights. For Client #4, the QP will in-service all staff on the importance of promoting client dignity and respect such that the incontinent pad will not be placed under her wheelchair or under any such seating at no time in the future. The program manager will monitor in the home 2-3 times weekly to ensure compliance. The QP will monitor in the home weekly as well. For Client #6, a copy of the petition and notice of hearing is now in the file as the guardianship hearing is scheduled for 5/25/22. The QP will file the guardianship letters in Client #6' program record. The QP will ensure that legal representation is secured and/or a petition to the Clerk of Court is filed to obtain guardianship for all clients if needed -upon admission.	7/2/22 7/2/22 6/13/22 5/25/22 5/25/22

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

QA/MPA — QA/QP — 5-17-22

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.

DHSR - Mental Health
MAY 18 2022
Lic. & Cert. Section

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W 125	Continued From page 1 legal guardian as he does not have the capacity to fully understand guardianship. Continued review of client #6's IPP revealed that no guardian was established. Interview on 5/3/22 with the ICF Program Director confirmed client #6 does not have a legal guardian but would benefit from one.	W 125	For any identified client, where appropriate the facility will ensure the implementation of individual program plan (IPP) interventions to promote the use of a communication board and/or sign language.	7/2/22
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.	W 249	For client #6, the Life Skills Specialist will in-service all staff on the use of the communication board and/or sign language. The Program Manager and/or Life Skills Specialist will monitor in the home and day program 2-3 times wekly to ensure implementation of the communication system for client #6 and implementation of other training objectives for all clients as well. The QP will provide weekly observations in the home and day program to ensure implementation of the communications system for client #6 and other training as well.	7/2/22 7/2/22
	This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure 1 of 6 audit clients (#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 program implementation regarding the use of a communication board/sign language. The finding is: During observations at the day program and in the home throughout the survey on 5/2/22 through 5/3/22, client #6 did not use a communication board or sign language. At no time during the observations did staff utilize a			

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W 249	Continued From page 2 communication board or sign language. Review on 5/3/22 of client #6's IPP dated 10/6/20 revealed a training program that states, "[Client #6] will correctly use the communication board/signs to express his wants and needs." Further review of the IPP revealed the training is to be conducted 7 days a week. Interview on 5/3/22 with Staff E revealed client #6 does not use a communication board or signs. Interview on 5/3/22 with the Program Coordinator revealed staff do utilize a communication board and signs with client #6 but she had not seen it done throughout the survey. Interview on 5/3/22 with the ICF Program Director confirmed staff have been trained on the use of the communication board and signs and should be utilizing them daily.	W 249	The facility will ensure the individual program plan (IPP) is reviewed and revised as needed when clients have met objective criterion. The QIDP will schedule a team meeting to update client #2's behavior support plan. The psychologist will complete the update to the behavior support plan following the team discussion, after team input as well in the plan development.	7/2/22 7/2/22
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 6 audit clients (#2) was reviewed and revised as needed after completion of an objective. The finding is: Review on 5/2/22 of client #2's Behavior Support	W 255	The QP and/or Behavior Specialist will in-service all assigned staff on the updated behavior support plan (BSP) for client #2. The Regional Director and/or QA will monitor all client records quarterly to ensure that the BSPs and/or other training objectives are updated in situations when the client has met objective criteria.	7/2/22

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W 255	Continued From page 3 Plan (BSP) dated 9/30/20 revealed an objective which states, "By September 30, 2021, [Client #2] will exhibit one or fewer challenging behaviors per month for 11 consecutive months." Additional review of the monthly progress notes dated April 2021 through April 2022 revealed no documented behaviors. Additional review on 5/3/22 of client #6's behavior data collection book revealed no documented behaviors. Interview on 5/3/22 with the ICF Program Director confirmed that client #6's IPP and BSP should have been reviewed and revised after the completion of his objective.	W 255		
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 reviews and interviews, the facility failed to update the Individual Program Plans (IPP's) annually for 6 of 6 audit clients (#1, #2, #3, #4, #5 and #6). The findings are: A. Review on 5/3/22 of client #1's record revealed an IPP dated 9/28/20. Additional review of client #1's record revealed no updated IPP since 9/28/20. During observations at the day program and in the home throughout the survey on 5/2/22 through 5/3/22, staff and client #1 were observed to participate in meal preparation, setting the dining table, chores, and activities in the home. Interview on 5/3/22 with the ICF Program Director confirmed client #1's IPP has not been updated since 9/28/20.	W 260		

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W 260	Continued From page 4 B. Review on 5/2/22 of client #2's record revealed an IPP dated 10/6/20. Additional review of client #2's record revealed no updated IPP since 10/6/20. During observations at the day program and in the home throughout the survey on 5/2/22 through 5/3/22, staff and client #2 were observed to participate in meal preparation, setting the dining table, chores, and activities in the home. Interview on 5/3/22 with the ICF Program Director confirmed client #2's IPP has not been updated since 10/6/20. C. Review on 5/2/22 of client #3's record revealed an IPP dated 11/17/20. Additional review of client #3's record revealed no updated IPP since 11/17/20. During observations at the day program and in the home throughout the survey on 5/2/22 through 5/3/22, staff and client #3 were observed to participate in meal preparation, setting the dining table, chores, and activities in the home. Interview on 5/3/22 with the ICF Program Director confirmed client #3's IPP has not been updated since 11/17/20. D. Review on 5/3/22 of client #4's record revealed an IPP dated 1/14/21. Additional review of client #4's record revealed no updated IPP since 1/14/21. During observations at the day program and in the home throughout the survey on 5/2/22 through 5/3/22, staff and client #4 were observed to participate in meal preparation, setting the dining table, chores, and activities in the home. Interview on 5/3/22 with the ICF Program Director confirmed client #4's IPP has not been updated		The facility will ensure the individual program plan (IPP) for all clients are updated annually and/or as needed to address each client's habilitation needs and future planning. The QIDP will schedule team meetings to update the IPP for 6 of 6 clients in the home. The updated IPPs will be filed in each client's record. The Regional Director and/or QA will monitor all records quarterly to ensure that IPPS are updated annually or as need for each client.	7/2/22 7/2/22 7/2/22

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W 260	Continued From page 5 since 1/14/21. E. Review on 5/2/22 of client #5's record revealed an IPP dated 10/13/20. Additional review of client #5's record revealed no updated IPP since 10/13/20. During observations at the day program and in the home throughout the survey on 5/2/22 through 5/3/22, staff and client #5 were observed to participate in meal preparation, setting the dining table, chores, and activities in the home. Interview on 5/3/22 with the ICF Program Director confirmed client #5's IPP has not been updated since 10/13/20. F. Review on 5/3/22 of client #6's record revealed an IPP dated 10/6/20. Additional review of client #6's record revealed no updated IPP since 10/6/20. During observations at the day program and in the home throughout the survey on 5/2/22 through 5/3/22, staff and client #6 were observed to participate in meal preparation, setting the dining table, chores, and activities in the home. Interview on 5/3/22 with the ICF Program Director confirmed client #6's IPP has not been updated since 10/6/20.	W 260		
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and interview, the facility	W 262		

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W 262	Continued From page 6 failed to ensure the restrictive behavior techniques for 2 of 6 audit clients (#2 and #3) was reviewed and monitored by the human rights committee (HRC). The findings are: A. Review on 5/2/22 of client #2's Individual Program Plan (IPP) dated 10/6/20 revealed an objective to exhibit one or fewer challenging behaviors per month. Review on 5/2/22 of client #2's Behavior Support Plan (BSP) dated 9/30/20 revealed target behaviors consisting of aggression and self-injurious behavior. Further review on 5/2/22 of client #2's BSP revealed no review or consent by the HRC. Interview on 5/3/22 with the ICF Program Director confirmed that based on the consent located in the record, client #2's BSP was not reviewed or consented to by the HRC. B. Review on 5/2/22 of client #3's IPP dated 11/17/20 revealed an objective to exhibit four or fewer challenging behaviors per month for 11 consecutive months. Review on 5/2/22 of client #3's BSP dated 7/24/21 revealed challenging behaviors to include aggression, self-injurious behavior, property destruction, and AWOL. Further review on 5/2/22 of client #3's BSP revealed no consent by the HRC. Interview on 5/3/22 with the ICF Program Director confirmed that based on the consent located in the record, client #3's BSP was not consented to by the HRC.	W 262	The facility will ensure that all restrictive programs are reviewed, approved, and monitored by the human rights committee (HRC) to include but not just limited to behavior support plans incorporating the use of psychoactive medications and/or other restrictions. For Clients #2 and #3 the QP will present the behavior support plans (BSP) to HRC for review and approval. The HRC minutes will reflect the review and approval of the behavior support plans. The QP will review all clients' BSPs as applicable to ensure that HRC has reviewed and approved all restrictive behavior support plans. The QP and/or ICF Director will monitor all behavior support plans monthly to ensure compliance.	7/2/22 7/2/22 7/2/22
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii)	W 263		

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W 263	Continued From page 7 The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 2 of 6 audit clients (#3 and #5). The findings are: A. Review on 5/2/22 of client #5's Behavior Support Plan (BSP) dated 7/24/21 revealed an objective to exhibit one or fewer challenging behaviors per month for 11 consecutive months. Further review of the BSP revealed target behaviors consisting of severe disruptive behavior, aggression and failure to make responsible choices. Further review of the BSP revealed written informed consent had not been obtained by the legal guardian. Interview on 5/3/22 with the ICF Program Director confirmed that based on the information located in the record, written informed consent was not obtained by the legal guardian. B. Review on 5/2/22 of client #3's IPP dated 11/17/20 revealed an objective to exhibit four or fewer challenging behaviors per month for 11 consecutive months. Review on 5/2/22 of client #3's BSP dated 7/24/21 revealed challenging behaviors to include aggression, self-injurious behavior, property destruction, and AWOL. Review on 5/2/22 of client #3's record revealed a consent form submitted by the guardian on 5/21/21 for the use of restrictive program and psychotropic medications. No consent by the guardian was located on the BSP dated 7/24/21.	W 263	The facility will ensure that written informed consent is secured for all clients with behavior support plans incorporating the use of psychoactive medications and/or other restrictions. For Clients #3 and #5 the QP will secure written informed consent from the guardian on the behavior support plans (BSP) noted. The QP will review all clients' BSPs as applicable to ensure written informed consent to behavior support plans are obtained from the respective guardians and/or legal representatives. The QP and/or ICF Director will monitor monthly to ensure compliance.	7/2/22 7/2/22 7/2/22 7/2/22

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W 263	Continued From page 8 Interview on 5/3/22 with the ICF Program Director revealed consent was gained for the use of restrictive program and psychotropic medications from the guardian on 5/21/21 after the psychology evaluation. The ICF Program Director confirmed that based on the information located in the record, written informed consent was not obtained by the legal guardian for the BSP dated 7/24/21.	W 263	The facility will ensure that staff administer all medications, including eye drops in accordance with physician's orders.	7/2/22
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure medications were administered in accordance with physician's orders. This affected 1 of 6 audit clients (#4). The finding is: During observations of medication administration in the home on 5/2/22 at 4:13pm, the Program Coordinator was observed to administer to client #4 Artificial Tears eye drops, two drops in each eye. Review on 5/3/22 of client #4's Physician's Orders dated 2/16/22 revealed an order for Artificial Tears eye drops to be administered at 8am, 2pm and 8pm. Interview on 5/3/22 with the facility's nurse confirmed the eye drops were not administered at the correct time as indicated on the Physician's Orders.	W 368	The Nursing staff will provide in-service training to all staff on the importance of administering medications to include but not just limited to Client #4's eye drops on the schedule outlined in the physician's orders and MAR. The QP will conduct weekly morning and/or afternoon medication pass observations in the home to ensure that all medications and eye drops are administered in accordance with the physician's orders. . . The Nursing staff will monitor medication pass observations in the home once every 2 weeks to ensure continued compliance.	7/2/22 7/2/22

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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 interview, the facility failed to ensure all medications were kept locked except when being administered. The finding is:** **During observations in the home on 5/3/22 at 6:30am, the keys to the medication closet were observed hanging from the lock, and the door to the medication closet was unlocked. At 6:57am, Staff D was observed to walk to the door, lock it and remove the keys.** **Interview on 5/3/22 with the facility nurse confirmed the medication closet door should remained locked at all times unless staff are in the room administering medications.**	W 382	The facility will ensure that medications are always secured unless when preparing for administration. The QP will in-service all staff on the importance of securing the medication room. Staff will lock the medication room upon exiting and maintain the key on their person. The program manager and/or QP will monitor during the morning and evening routines in the home to ensure continued compliance.	7/2/22 7/2/22
W 383	**DRUG STORAGE AND RECORDKEEPING** **CFR(s): 483.460(l)(2)** **Only authorized persons may have access to the keys to the drug storage area.** **This STANDARD is not met as evidenced by:** **Based on observations and interviews, the facility failed to ensure only authorized persons have access to the keys to the drug storage area. The finding is:** **During observations in the home on 5/3/22 at 6:30am, the keys to the medication closet were observed hanging from the lock, and the door to the medication closet was unlocked. At 6:57am, Staff D was observed to walk to the door, lock it and remove the keys.**	W 383	The facility will ensure that the medication keys are with personnel authorized to administer medications and not left hanging from the lock, or out and accessible to others. QP will in-service all staff on the importance of limited access to the medication key for only authorized staff who administer medications. The program manager and/or QP will monitor during the morning and evening routines in the home to ensure continued compliance.	7/2/22 7/2/22

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W 383	Continued From page 10 Interview on 5/3/22 with the facility nurse confirmed that staff are to keep the keys to the medication closet on their person at all	W 383	The facility will ensure that clients are taught to use and maintain in good repair their assistive devices to include but not limited to eyeglasses. The QP will convene a team to address the development and implementation of training for Client #2 to wear his eye glasses. The QP will provide in-service training to all assigned staff on the implementation of the new training objective for client #2 to wear his eye glasses. The QP will review the IPPs on a quarterly basis for all clients to ensure each client is taught to use and wear assistive devices to include but not limited to eyeglasses. The QP and/or the program manger will monitor in the home weekly to ensure client #2 is wearing his eye glasses and that other assistive devices are in use as applicable to the IPP for the respective clients.	7/2/22 7/2/22 7/2/22 7/2/22
W 436	times. 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 6 audit clients (#2) was taught to use and make informed choices about the use of eyeglasses. The finding is: During observations at the day program and in the home throughout the survey on 5/2/22 through 5/3/22, client #2 was not wearing eyeglasses. Throughout the observations, client #2 was not prompted to wear eyeglasses. Review on 5/2/22 of client #2's Individual Program Plan (IPP) dated 10/6/20 revealed client #2 wears eyeglasses. Review on 5/2/22 of client #2's medical evaluation dated 10/5/21 revealed client #2 has a diagnosis of primary acquired melanosis of the left eye and bilateral vitreous floaters. Further review of the medical evaluation revealed client #2 was provided a prescription for eyeglasses and received a fitting for eyeglasses on 12/15/20. Interview on 5/3/22 with Staff B revealed client #2	W 436		

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	34G256	A. BUILDING _____ B. WING _____	05/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE RESIDENTIAL	353 ELM STREET FAIR BLUFF, NC 28439

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W 436	Continued From page 11 does not have eyeglasses and he has never seen client #2 with eyeglasses. Interview on 5/3/22 with the Program Coordinator revealed client #2 does have eyeglasses and should be wearing them. Interview on 5/3/22 with the ICF Program Director confirmed client #2 should be wearing eyeglasses and if he refuses, staff should prompt him throughout the day to wear them.	W 436	The facility will ensure that all clients receive their specially prescribed diets as indicated by the IPP and physician's orders. For Clients #3 and #5 all staff in the home and day program will be in-service on their diets as prescribed to include but not limited to portions, food consistency and caloric intake per diets, mealtime protocols, and Menu guidelines. Client #3 will receive meats that are finely chopped, and Client #5 will receive an extra portion of meats for all meals. The QP and/or the Nutritionist will provide in-service training to day program and group home staff on all clients' prescribed diets. The QP and program manager will monitor meals in the group home and day program weekly to ensure continued compliance.	7/2/22 7/2/22 7//2/22 7/2/22
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 reviews, and interviews, the facility failed to ensure 2 of 6 audit clients (#3 and #5) received their specially prescribed diet as indicated. The findings are: A. During observations in the day program on 5/2/22 at 11:30am, client #3 was observed eating lunch which included chicken nuggets, french fries, and vegetables. Client #3 was served and ate regular textured chicken nuggets. During observations in the home on 5/2/22 at 5:45pm, client #3 was observed eating dinner which consisted of a pork chop, corn, and cabbage. Client #3 was served and ate regular textured pork chop. At no time was his meats chopped.	W 460		

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W 460	Continued From page 12 During additional observations in the home on 5/3/22 at 7:30am, client #3 was observed eating breakfast which consisted of turkey bacon, oatmeal, English muffin, and fruit. Client #3 was served and ate regular textured turkey bacon. At no time was his meat chopped. Review on 5/2/22 of client #3's Individual Program Plan (IPP) dated 11/17/20 revealed a diet that consists of heart healthy, regular textured food. Review on 5/2/22 of the dietary guide dated 1/1/21 posted in the home revealed a diet that consisted of regular textured food with meats finely chopped. Review on 5/3/22 of client #3's nutritional evaluation dated 3/12/22 revealed a diet that consists of heart healthy, regular food with meats finely chopped. During interview on 5/3/22, Staff A stated that client #3 received a regular diet with regular meat texture. Interview on 5/3/22 with the Program Coordinator confirmed client #3 should have meats finely chopped. Interview on 5/3/22 with the ICF Program Director confirmed client #3 should have meats finely chopped. B. During observations in the home on 5/2/22 at 5:45pm, client #5 was observed eating dinner which consisted of one barbequed pork chop, corn, and cabbage. Client #5 was served and ate only one pork chop.	W 460		

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W 460	Continued From page 13 During additional observations in the home on 5/3/22 at 7:30am, client #5 was observed eating breakfast which consisted of one and a half pieces of turkey bacon, oatmeal, an English muffin and fruit. Client #5 was served and ate only one and a half pieces of turkey bacon. Review on 5/2/22 of client #5's IPP dated 10/13/20 revealed a diet that consists of heart healthy regular, low concentrated sweet, extra serving of meats at each meal. Review on 5/2/22 of client #5's nutrition evaluation dated 2/28/21 revealed a diet that consists of heart healthy regular, low concentrated sweets, extra serving of meats at all meals. Interview on 5/3/22 with the Program Coordinator confirmed client #5 should have received extra portions of meat at dinner and breakfast. Interview on 5/3/22 with the ICF Program Director confirmed client #5 should have received extra meat at dinner and breakfast as his diet order indicates.	W 460		
W 473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii) Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure all foods were served at an appropriate temperature. This potentially affected all clients residing in the home (#1, #2, #3, #4, #5 and #6). The finding is: During observations in the home on 5/3/22 at	W 473		

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W 473	Continued From page 14 6:30am, Staff D and client #6 were observed to remove a pan of English muffins from the stove and place them on the counter. Client #6 was observed to spread jelly on each of the English muffins and place them on a platter. Staff D placed a paper towel over the platter and sat it on the counter. At 6:48am, client #6 was observed to put bacon onto a platter and Staff D covered the platter with a paper towel. At 6:57am, the platter of English muffins and bacon were placed on the dining table. At 7:22am, client #6 was observed scooping oatmeal from a pot on the stove to a serving bowl. The oatmeal was then placed on the table. At 7:30am, clients #1, #2, #3, #4 and #5 were observed to begin eating breakfast. The English muffins had sat out for a total of 60 minutes and the bacon sat for a total of 42 minutes. At no time was the temperature of the English muffins or bacon checked and at no time were they reheated. Additional observations in the home on 5/3/22 at 7:47am revealed client #6 sitting down at the dining table to eat breakfast after his morning medication pass. Client #6 was served oatmeal, an English muffin, and bacon. The oatmeal had sat for a total of 25 minutes, the bacon had sat for a total of 59 minutes and the English muffin had sat for a total of 77 minutes. At no time was the temperature of client #6's food checked nor was the food reheated. Interview on 5/3/22 with the Program Coordinator revealed staff are to reheat food after it has sat for more than 15 minutes. Interview on 5/3/22 with the ICF Program Director revealed that the home is equipped with thermometers that staff should use to check the	W 473	The facility will ensure that all food is maintained at appropriate temperatures and served within 15 minutes or less to all individuals. The Program Manager and Habilitation Specialist will provide in-service training to all staff on the appropriate temperatures for hot and cold food items. The staff will be instructed to maintain food and liquids at appropriate temperatures and present the food or liquids to the individuals for consumption within 15 minutes or less. A thermometer will be secured and used to check food temperatures before presentation for client consumption. Staff will re-heat hot food as necessary to ensure presentation at appropriate food temperatures. The Program Manager and QP will monitor breakfast and dinner meals in the home weekly to ensure continued compliance.	7/2/22 7/2/22 7/2/22

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W 473	Continued From page 15 temperatures of food. The Program Director confirmed that staff are to use thermometers to check the temperature of the food and the food should have been reheated.	W 473		
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 16 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 17 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 18 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 COVID-19 vaccinations was documented for all employees. The finding is: Review on 5/2/22 and 5/3/22 of the facility's list of employees revealed where each staff on the list was vaccinated and/or had an exemption on file. Further review revealed no proof of COVID-19 vaccines cards and exemptions were available for review. Review on 5/2/22 of the facility's COVID-19 Vaccination Program policy (undated) revealed all staff must produce proof of vaccination or have an approved exemption on file. Interview on 5/3/22 with the ICF Program Director revealed the Director requested the surveyor call the facility's Human Resources (HR) representative to discuss the need to see vaccine cards and exemptions. After failing to contact the HR representative, the ICF Program Director confirmed the vaccine cards and exemptions were not available for immediate review.	W 508	The facility will ensure that all current staff are vaccinated and/or have an exemption on file. The facility will coordinate with Human Resources to ensure that upon request the immediate availability of documentation to support each staff's COVID vaccination status. The Regional Director will plan to have a copy of each staff's file regarding their COVID status in the Whiteville office and/or immediately available through direct contact with Human Resources. The QP and/or ICF Director will monitor monthly to ensure that the office maintains a copy of the COVID vaccination status for all active employees and/or consultants.	7/2/22 7/2/22 7/2/22