May 26, 2022

DHSR - Mental Health

JUN 1 2022

Lic. & Cert. Section

To: Lisa Jones
Facility Consultant I

Mental Health Licensure Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Dear Ms. Lisa Jones,

Enclosed you will find the Plan of Correction for the survey conducted on May 10-11, 2022. Please feel free to call me with any questions or concerns.

Sincerely,

Bridget Johnson, QIDP
Family Affair Care Group Management (Summerlyn Home)

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

PRINTED: 05/13/2022
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
	34G137	A. BUILDING ______ B. WING ______	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERLYN	6113 BLUE LANTERN ROAD GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.	W249	A TRASH CAN WITH A LID AND MOTIION DETECTOR WILL BE PURCHASED TO BETTER ASSIST CLIENTS IN TH DISPOSAL OF TRASH. THIS WILL ALSO PREVENT CLIENT #1 EASY ACCESS TO GOING INTO THE TRASHCAN TO REMOVE FOOD.	7/11/22
	This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure 1 of 3 sampled clients (#1) received a continuous active treatment program by failing to implement needed interventions and services as identified in the behavior support plan (BSP). The finding is:	w249	AN ADDEUM TO CLIENT #1 BEHAVIOR WILL DONE BY THE PSYCHOLOGIST TO INCLUDE EXAMBLES OF SUCH BEHAVIOR UNDER PROPERTY DESTRUCTION AND MISUSE. STAFF WILL RECEIVE A REFRESHER ON CLIENT'S BEHAVIOR SUPPORT PLAN ALONG WITH TARGET BEHAVIORS AND INTERVENTION TECHNIQUES REVIEWED FOR SUCH BEHAVIORS. MANAGER WILL MONITOR WEEKLY USING OBERVATION FORMS.	7/11/22
	Morning observations in the group home on 5/11/22 at 6:56 AM revealed client #1 to eat the breakfast meal which consisted of french toast, turkey bacon, apple juice and water. Continued observation at 7:07 AM revealed client #1 to finish breakfast meal and to take dishes to the kitchen. Further observation at 7:21 AM revealed client #1 to stand in the living room not engaged and for client #1 to go to an uncovered trash can in the kitchen to eat french toast out of the trash. Staff E attempted to check client #1's mouth for the item and tried to keep client #1 in the living room area.	W249	THE SPEECH PATHOLOGIST WILL CREAATE A VISUAL SCHEDULE OUTLINING THIS CLIENTS MORNING ROUTINE TO AID IN THE COMPREHENSION OF UPCOMING ACTIVITIES AND HOPEFULLY REDUCE ANXIETY, AS WELL AS ADD ADDITIONAL STRUCTURE TO DAILY ROUTINES. THIS SCHEDULE WILL SERVE AS A REMINDER TO STAFF TO INCLUDE NEW GOALS, AS WELL AS EXISTING ONES, ON A REGULAR BASIS.	7/11/22
	Subsequent observation at 7:36 AM revealed client #1 to enter the kitchen and eat bacon out of the uncovered trash can. Staff E removed the trash bag and took the trash bag to the outside trash can. Additional observation revealed staff F	w249	THE FOLLOWING WILL BE ADDED TO THE MORNING ROUTINE TO THE MORNING ROUTINE FOR CLIENT#1 1. A CAUSE AND EFFECT GOAL 2. A TURN TAKING GOAL MANAGEMENT WILL MONITOR WEEKLY ALONG WITH BEING MONITORED MONTHLY WITH PROGRESS NOTE BY SPEECH PATHOLOGIST.	7/11/22

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bridget Johnson QIDP 5/26/22 TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 249	Continued From page 1 to give staff E a blue pop up hand-held activity from the activity cabinet to offer to client #1. Review of records on 5/11/22 for client #1 revealed an individual habilitation plan (IHP) dated 9/25/21. Review of the IHP for client #1 revealed a diagnosis of profound intellectual disability and autistic disorder. Continued review of the IHP revealed a BSP dated 3/1/22. Review of the BSP revealed target behaviors to be self-injurious behaviors, aggression, and property destruction/misuse. Further review of client #1's BSP revealed that client #1 also displays behaviors of taking or attempting to take food and other items belonging to others and needs close supervision. Subsequent review of client #1's BSP revealed that client #1's daily routine should be as structured and consistent as possible to help decrease the client's behaviors. Interview on 5/11/22 with the qualified intellectual disabilities professional (QIDP) verified that client #1 will eat food from the trash if given the opportunity and that the trash can should have had a lid. In addition, as staff failed to structure the client's morning appropriately as recommended by the the client's BSP, the client was able to eat from the trash can on two separate occasions.	W 249	See Also page 1 for Response	7/11/22
W 508	COVID-19 Vaccination of Facility Staff CFR(s): 483.430(f)(1)-(3)(i)-(x) § 483.430 Condition of Participation: Facility staffing. (f) Standard: COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of	W 508	See Also page 3 for Response	7/11/22

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W 508	Continued From page 2 this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. (1) Regardless of clinical responsibility or client contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its clients: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its clients, under contract or by other arrangement. (2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with clients and other staff specified in paragraph (f)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with clients and other staff specified in paragraph (f)(1) of this section. (3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (f)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for	W 508	1. A POLICY WILL BE DEVELOPED FOR COVID-19 VACCINATION OF FACILITY STAFF WILL BE DEVELOPED TO PROVIDE PROCEDURES TO ENSURE ALL STAFF ARE FULLY VACCINATED AS ADDRESSED IN THE CMS GUIDELINESS FOR ICF/IID GROUP HOMES. THE POILCY WILL APPLY TO ALL STAFF THAT PROVIDE SERVICES TO THE CLIENTS IN THE FACILITY ETC. FACILITY, LICENSED PRACTIONERS, STUDENTS, TRAINEES, AND VOLUNTEERS ETC.	7/11/22
		W508 CONT.	2 .POLICY AND PROCEDURE WILL ALSO INCLUDE EXEMPTIONS FOR THOSE STAFF, SPECIFIED ABOVE WHO PROVIDE MEDICAL AND OR /PERSONAL DOCUMENATION ADDRESSING THE REASON TO DECLINE RECEIVING THE VACCINATIONS REQUIRED.THE POLICY WILL ALSO INCLUDE EXTRA PRECAUTIONS FOR THOSE EMPLOYESS THAT HAVE DOCUMENTATION AS TO WHY THEY DO NOT WANT TO GET THE VACCINE, AND WILL HAVE TO COMPLY WITH PROPER FACE COVERINGS AND WEEKLY TESTING AS STATED IN THE REVISED POLICY AND PROCEDURE MANUAL ALL STAFF WILL BE IN-SERVICED ON THE REVISED GUIDELINES FROM THE CDC/CMS AS IT RELATES TO ICF/IDD COVID-19 REQUIREMENTS WHICH WILL ALSO BE ADDED TO OUR COMPANIES POLICY AND PROCEDURES MANUAL.	7/11/22 7/11/22

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W 508	Continued From page 3 whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its clients; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (f)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all	W508	A COVID SHOT RECORD HAS BEEN CREATED TO PROVIDE COPIES OF ALL STAFF/PERSONELL VACCINATION CARD AND OR REQUIRED DOCUMENTATION OF LETTERS OF REASON AS TO WHY A STAFF HASN'T GOTTEN THE VACCINE AS APRROVED BY MANAGEMENT. ALL RERQUIRED DOCUMENTATION AND WEEKLY TESTING RESULTS WILL ALSO BE KEEP/LOGGED IN THIS BOOK. THIS WILL BE REVIEWED ON A WEEKLY BASIS BY OFFICE ASST. AND WILL BE UPDATED AS NEEDED WHEN NEW EMPLOYEES, TRAINEES, VOLUNTEERS ETC. ARE HIRED. THE QIDP WILL CHECK AT LEAST TWICE A MONTH FOR ANY UPDATES/REVISIONS FROM CDC AS IT RELATES TO ICF/IID THAT MAY OCCUR.	7/12/22

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W 508	Continued From page 4 applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: (ii) A process for ensuring that all staff specified in paragraph (f)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This STANDARD is not met as evidenced by: The facility failed to develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19 as evidenced	W 508	please See Also responses on pages 3-4	

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W 508	Continued From page 5 by observation, interview and record verification. The finding is: Record review on 5/10/22 revealed a list of staff who work at the group home along with photocopies of vaccination cards was reviewed. Further review of the staff information, substantiated by interview with the qualified intellectual disabilities professional (QIDP) revealed all but one staff person to be fully vaccinated as required. Further interview with the QIDP revealed the facility has been requiring all staff to be tested weekly to assure the clients were being protected from exposure from staff. Continued record review and interview with the QIDP revealed the facility was unaware of the existing staff vaccination requirements to establish policy and procedures regarding COVID-19 and therefore did not have staff vaccination policy and procedures developed to assure the one unvaccinated staff person was vaccinated or had an approved exemption. Observations during he 5/10-11/22 survey revealed staff to wear face masks while working in the group home appropriately and continue to do temperature checks upon entering the group home. Subsequent record review and interview with the QIDP however, revealed that although the facility has several systems in place to assure COVID-19 potential spread by staff is minimized, the facility has failed to develop any of the policy and procedures as required.	W 508	Please See Also responses on pages 3-4	