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

PRINTED: 05/18/2022
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
	34G272	A. BUILDING _____ B. WING _____	R-C 05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST ROAD GROUP HOME	114 GREENHOUSE LANE SOUTHERN PINES, NC 28387

(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 000}	INITIAL COMMENTS A revisit was conducted on 5/5/22 for all previous deficiencies cited on 2/14/22. The following deficiency was corrected W154. The facility remained out of compliance in W153, W286 and W508.	{W 000}		
{W 153}	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to immediately notify the administrator, law enforcement, department of social services (DSS) and the state agency, once discovering an injury of unknown origin. This affected 1 of 1 former clients (FC #1). The finding is: Review on 2/11/22 of a handwritten note written by the home manager (HM) on 12/21/21 regarding FC #1 revealed HM had transported him to the dentist. When they returned home on 12/21/21, she took FC #1 to the bathroom to be changed. The HM wrote that she noticed small blotches on FC #1's skin that were light color. A further review revealed on 12/23/21, the HM left a note for FC #1's guardian who was picking him up for an extended holiday visit. The note provided a list of injuries: small sores on arm, redness and peeling both knees and small dark spots on right hip, lower back and buttocks. The guardian signed and dated the injury report on	{W 153}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 8/24/22

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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(W 153)	Continued From page 1 12/23/21. Review on 2/14/22 of the facility's Consumer Incident Reporting 8/1/16 policy defined a Level II incident as: Those incidents which are not life threatening but are very serious and require swift investigation. If the incident results in injury, bruises, scrapes, serious unexplained injuries...or a complaint oversight agency. An incident review committee shall be convened as a subcommittee of the quality assurance committee. The purpose of this committee will be review and make recommendations for follow-up on all reported Level II incidents. Interview on 2/11/22 with the home manager (HM) revealed on 12/21/21, she took FC #1 to the restroom to change him and noticed small bruises on buttocks and right hip at the lower back. FC #1 was non-verbal and unable to tell her what happened. The HM revealed that she had witnessed FC #1 dropping to the floor before and that he would rest his buttocks on the heels of his shoes. The HM concluded that the bruises were caused by a self-injurious behavior (SIB) therefore she did not start an investigation. Interview on 2/11/22 with the qualified intellectual disabilities professional (QIDP) revealed she had no evidence that the incident report for FC #1 had been forwarded to her to start an investigation. Interview on 2/14/22 with the administrator revealed that incidents that results in bruises should be immediately reported. 1. According to a review with the QIDP on 5/5/22, there were no incidents or allegations of abuse in the past 3 months.	(W 153)	By 6-3-22 all staff will be inserviced on the reporting procedures of all incidents, discovery of bruises and accidents per agency policy. Daily monitoring will be documented by Home Manager, Hab Specialist, QIDP or Program Administrator designee. All trainings will be maintained.	6/3/22

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(W 153)	Continued From page 2 2. Based on the facility plan of correction, the facility listed they would train all staff on reporting abuse/neglect however all staff were not trained resulting in a recited deficiency. Interview on 5/5/22 with the QIDP revealed she did not retain training records for new staff and did not retain 3 months of monitoring records of abuse/neglect incident monitoring.	(W 153)		
(W 286)	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used for disciplinary purposes. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to prevent a restrictive technique to the manage the inappropriate behavior of 1 of 2 audit clients (#5). The finding is: Review on 2/11/22 of an incident report on Client #5 revealed on 12/6/21 at 4:30 PM, Client #5 would not follow instructions from Staff A. Staff A used a threat to remove a television from the room of Client #5 if he did not comply. Client #5 still ignored Staff A, who then went to remove the television from Client #5's bedroom. Client #5 responded by leaving the home and walking off the property. Staff B and Staff C had to follow Client #5 in their vehicles before the home manager (HM) could convince Client #5 to get in her vehicle. Interview on 2/11/22 with the HM revealed that she did not report the incident to the administrator	(W 286)	By 6-3-2022 all staff will be inserviced on each consumers BIP and techniques to manage inappropiate behavior. Implementation of appropiate management of inappropiate techniques will be monitored by Home Managers bimonthly by QIDP and Hab Specialist.	6/3/22

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{W 286}	Continued From page 3 for review. The HM confirmed that Client #5 was not on a behavior support plan (BSP). Interview on 2/11/22 with the qualified intellectual disabilities professional (QIDP) revealed that she was unaware of the incident and that Staff A should not remove the television from Client #5's room, because it would be a clients rights violation. Interview on 2/14/22 with the administrator revealed that staff cannot confiscate Client's personal property because it was a rights violation. During review on 5/5/22, the facility's client rights and behavior plan training were reviewed. According to the facility's records, there was no evidence that new staff had received training. There was no evidence of documentation for March 2022 for monitoring clients. On 4/6/22, 4/14/22, 4/17/22 and 4/27/22, management staff reportedly monitored inappropriate behaviors but there were no indicators which staff and clients were observed or if the behavior plan was followed correctly. Based on the facility's plan of correction, the facility listed they would train all staff on client behavior plans and client rights, however all staff were not trained resulting in a recited deficiency. Interview on 5/5/22 with the QIDP revealed she did not have documentation about the activities they observed for 3 months to ensure staff were following clients behaviors plans correctly.	{W 286}		
{W 508}	COVID-19 Vaccination of Facility Staff CFR(s): 483.430(f)(1)-(3)(i)-(x)	{W 508}		

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{W 508}	Continued From page 4 § 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 the facility setting and who do not have any direct contact with clients and other staff specified in paragraph (f)(1) of this section.	{W 508}		

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{W 508}	Continued From page 5 (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 COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized	{W 508}		

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{W 508}	Continued From page 6 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 vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those	{W 508}		

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{W 508}	Continued From page 7 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 that are based on Centers for Medicare and Medicaid Services (CMS) guidelines for staff who are not fully vaccinated for COVID-19. The findings are: Review on 2/14/22 of the facility's Mandatory Vaccination Policy, 2/9/21 revealed employees must be fully vaccinated no later than 4/9/22. Staff must obtain the first dose of a two dose vaccine no later than 3/5/22; and the second dose no later than 3/26/22 or obtain one dose of a single dose vaccine no later than 3/26/22. The facility will comply to determine each employee's vaccination status and require vaccinated employees to provide acceptable proof of vaccine. Interview on 2/14/22 with the qualified intellectual professional (QIDP) revealed the facility was not aware of the CMS employee vaccine requirement until learned of the new mandate through media sources. The QIDP had met with the Administrator last week, to work on a new vaccination policy. The QIDP acknowledged there was a typo on the original policy and it should read, effective 2/9/22. The facility planned to train their staff on 2/17/22 regarding the new interview on 2/14/22 with the Administrator revealed that a new policy was just developed and was going to be shared with employees on	{W 508}		

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{W 508}	Continued From page 8 2/17/22. The administrator did not have a full list of staff working with the clients and had not been doing vaccine tracking. The administrator acknowledged that there were 5 unvaccinated staff that work in the home; and she had not received requests for medical or religious exemptions approvals. The administrator's new policy planned to require staff to have their first COVID-19 vaccine by 3/9/22 and the second vaccine completed by 3/25/22. The administrator hoped to be fully compliant by 4/9/22. 1. According to the review on 5/5/22 of the facility's revised COVID-19 Vaccination Policy dated 2/18/21 was not specific to ICF staff vaccine requirements. Their policy highlighted that it was complying to Occupational Safety and Health Administration (OSHA)'s emergency temporary standard on vaccination and testing. 2. Review on 5/5/22 of the facility's revised COVID-19 Vaccination Policy dated 2/18/21 revealed that new employees must comply with their policy by being fully vaccinated within 90 days of start date of employment. Staff A was marked as a new employee and there was no proof of his vaccine status. Further, the facility did not have a record of Staff B, the nurse and the administrator's vaccine status. 3. Review on 5/5/22 of the facility's staff vaccine statuses revealed the home manager and Staff C and Staff D were identified as receiving approved religious exemption for the COVID-19 vaccine. A form titled "Coronavirus Vaccination Consent or Declination" was reviewed on 5/5/22. It revealed on 2/15/22 Staff D declined the vaccine and on 2/28/22 Staff C declined the vaccine. The form did not have any language that either Staff C or	{W 508}		

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{W 508}	Continued From page 9 Staff D declined the COVID-19 vaccine for religious exemptions. The facility did not have a record of the home manager's religious exemption. 4. Review on 5/5/22 of the Staff Vaccinations training conducted on 3/21/22 revealed that they required all non-vaccinated staff must provide a negative COVID-19 test on a weekly basis. The facility had no evidence non-vaccinated staff were reported results from weekly testing. 5. Based on the facility's plan of correction, the facility listed they would develop and implement a staff COVID-19 vaccination policy, however their efforts were not fully documented and achieved resulting in a recited deficiency. Interview on 5/5/22 with the qualified intellectual disabilities professional (QIDP) revealed she did not have copies of religious exemptions, weekly COVID-19 testing for unvaccinated staff, and was unable to gather from human resources proof that all of the vaccinated staff records were on file.	{W 508}	By 6-4-2022 all staff will be inserviced on the agency's policy for Covid-19 vaccination. The policy will contain Specifics for ICF facilities, agency requirements and procedures. All documentation (list of employees, trainings, policy and exemptions) will be maintained as well as current vaccinated employees.	6/4/22