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	34G278	A. BUILDING _____ B. WING _____	05/17/2022

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W 210	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the interdisciplinary team performed accurate assessments within 30 days after admission. This affected 1 of 1 newly admitted audit client (#6). The finding is: Review on 5/16/22 of client #6's individual program plan (IPP) dated 3/30/22 revealed he was admitted to the facility on 2/15/21. Further review of the IPP revealed assessments had been completed in: Nursing (dated 2/19/22), Psychology (4/15/22) and Occupational therapy (dated 6/26/21). There were not assessments in Speech, Physical Therapy or Habilitation. Interview on 5/17/22 with the qualified intellectual disabilities professional (QIDP) revealed these assessments had not been completed following client #6's admission on 2/15/21.	W 210		
W 242	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(iii) The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.	W 242		

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

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W 242	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure 1 of 4 audit clients (#1) was provided with training in the area of privacy. The finding is: During observations in the facility on 5/17/22 at 6:35am, staff I assisted client #1 out of his bedroom wearing only a towel from his waist to mid thigh. Client #1 walked with staff I from his bedroom through the dining room, hallway and to the bathroom. Following his shower, staff I again walked client #1 from the bathroom through the dining area and back to his bedroom. During this time, several clients were assisting with meal preparation and setting up the dining room for breakfast. Immediate interview on 5/17/22 with staff I revealed client #1 does not have a bathrobe, so he used a towel to escort client #1 to the shower. Review of client #1's individual program plan (IPP) dated 11/5/21 revealed no assessment of client #1's ability to protect his own privacy. Review on 5/17/22 of client #1's adaptive behavior inventory (ABI) dated 11/3/20 also did not assess client #1's ability to protect his own privacy during toileting, bathing and dressing. Interview on 5/17/22 with the qualified intellectual disabilities professional (QIDP) confirmed she could not confirm the interdisciplinary team had assessed client #1's ability to protect his privacy in his ABI or IPP. Further interview confirmed client #1 needs assistance from direct care staff to help him protect his privacy during bathing, dressing and toileting.	W 242		

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W 263	Continued From page 2	W 263		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) 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 1 of 4 audit clients (#6). The finding is: Review on 5/16/22 of client #6's record revealed he was admitted to the facility on 2/15/21. Review on 5/16/22 of client #6's individual program plan (IPP) dated 3/30/22 revealed client #6 has a behavior support program (BSP) dated 5/3/21 to address property destruction, physical aggression and taking food and beverages from others. This program incorporates the use of Zyprexa and Luvox. Additional review on 5/17/22 of client #6's IPP revealed he has been adjudicated incompetent and assigned a legal guardian. Further review on 5/17/22 of client #6's BSP revealed it was implemented on 5/3/21 and addresses property destruction, physical aggression and taking food and beverages from others. This program incorporates the use of Zyprexa and Luvox. Additional review of the consent page revealed the team obtained verbal consent from the guardian on 3/1/21. Interview on 5/17/22 with the qualified intellectual disabilities professional (QIDP) revealed the team	W 263		

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W 263	Continued From page 3 had not obtained written informed consent from client #6's guardian after obtaining verbal consent on 3/1/21.	W 263		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure nursing staff sufficiently trained direct care staff regarding appropriate nursing practices and protocols. This potentially affected 6 of 6 clients (#1, #2, #3, #4, #5 and #6). The finding is: During observations in the facility on 5/17/22 from 6:15am-8:15am, staff I was noted to wear a blue surgical mask while assisting clients with self help tasks, mealtime and meal clean up. During observations in the facility on 5/17/22 from 6:00am-8:15am staff H was observed to give medications, assist clients with self help tasks and helped prepare the clients to leave the facility to go to their vocational settings. Throughout observations from 6:00am-7:00am staff H did not wear a facial mask. During continued observations in the facility at 7:00am, staff H was noted to put on a blue facial mask. Review on 5/17/22 of North Carolina Department of Health and Human Services (NCDHHS) policy on Mask Guidance effective date 3/7/22 revealed,	W 340		

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W 340	Continued From page 4 "Masks are still required in places like health care and long term care. This is because of the setting or federal regulations." Review on 5/16/22 of the facility's list of employees who were granted religious exemptions from COVID-19 vaccination revealed staff I was not vaccinated but was granted a religious exemption by the human resources department. Review on 5/17/22 of the Covid-19 Vaccination Program compliance requirements revealed that staff who are approved for exemption should be subject to additional precautions intended to mitigate the transmission and spread of Covid-19 and must comply with all other applicable universal infection control precautions which may include wearing an N95 mask at all times while on CBC premises. Interview on 5/17/22 with the qualified intellectual disabilities professional (QIDP) revealed staff I should be wearing N-95 masks when working with clients and staff H should be wearing a facial mask in the facility per the facility policy.	W 340		
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	W 508		

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W 508	Continued From page 5	W 508		

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 whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have

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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 applicable State and local laws, and for further ensuring that such documentation contains:

(A) All information specifying which of the

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W 508	Continued From page 7 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: Based on observation, record review and interview the facility failed to develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. The finding is:	W 508		

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W 508	Continued From page 8 During observations in the facility on 5/17/22 from 6:00am-8:15am staff H was observed to give medications, assist clients with self help tasks and helped prepare the clients to leave the facility to go to their vocational settings. Throughout observations from 6:00am-7:00am staff H did not wear a facial mask. During continued observations in the facility at 7:00am, staff H was noted to put on a blue facial mask. Review on 5/17/22 of the facility's COVID-19 Vaccination Program revealed, "By no later than December 5, 2021, all staff must present proof of having received the one dose COVID-19 vaccine or the first dose of a multi-dose COVID-19 vaccine unless a vaccination exemption, or temporary delay as recommended by the Centers for Disease Control and Prevention (CDC) has been approved. By no later than January 4, 2022 all staff receiving a multi-dose COVID-19 vaccine must provide proof of having received all doses (e.g. second dose of a two dose vaccine)." Interview on 5/17/22 with the QIDP revealed she would contact the human resources department to get a copy of staff H's COVID-19 vaccination status. At the time of the exit, the QIDP did not have information available to clarify staff H's vaccination status.	W 508		