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	34G238	A. BUILDING _____ B. WING _____	08/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANTLE COURT GROUP HOME	4319 MANTLE COURT CHARLOTTE, NC 28205

(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. This STANDARD is not met as evidenced by: Based on observation, interviews and record review, the facility failed to ensure a continuous active treatment program consisting of needed interventions were implemented as identified in the individual support plan (ISP) for 1 sampled client (#1). The findings are: A. The facility failed to implement a training objective for client #1 relative to using a daily calendar. For example: Observations during the recertification survey on 8/29/22 from 4:00 PM - 5:45 PM revealed a daily wall calendar hanging on the wall in the dining room area of the facility. Observations revealed client #1 to remain in his room with the door closed for a significant amount of unstructured time. Continued observations revealed the wall calendar to have client #1's name on it, along with cue cards to include the weather, date and emojis relative to "how am I feeling today?". Further observations revealed the wall calendar to have Saturday, August 27 on the heading of the calendar. Additional observations at 5:00 PM revealed staff to prompt client #1 out of his room	W 249		

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

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W 249	Continued From page 1	W 249		

to wash his hands and prepare for the dinner meal. Observations at 5:15 PM revealed client #1 to complete the dinner meal, put his dishes in the kitchen and return to his room with the door closed. At no point during the observation was client #1 prompted to use the wall calendar.

Observations on 8/30/22 from 6:30 AM - 8:15 AM revealed client #1 to sit in the living room area, play with his iPad, participate in medication administration and participate in the breakfast meal. Observations at 8:15 AM revealed staff to prompt client #1 to use the wall calendar after this surveyor asked questions to staff relative to how often the client uses the calendar.

Review of the record on 8/30/22 for client #1 revealed an ISP dated 1/5/22. Continued review of the ISP revealed the following program goals: separate clean and dirty clothes, exercise goal, use a napkin to wipe hands, toothbrush goal, use IPad to choose an article, laundry goal, learn to tell time, privacy goal, dust bedroom and tv, use and refer to daily calendar, operate toaster and make toast and dining etiquette.

Interview with the home manager (HM) on 8/30/22 revealed client #1 is instructed to use the wall calendar to learn how to tell the date, day of the week, choose the weather and how he is feeling. Continued interview with the HM revealed client #1 has a formal program to use the calendar daily usually in the mornings before he goes to the day program.

Interview with the residential director (RD) revealed client #1's goals and interventions are current. It is important to mention that the qualified intellectual disabilities professional

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(QIDP) was not available to be interviewed during the survey. Continued interview with the RD revealed staff should run client #1's program goals as required.

B. The facility failed to implement a training objective for client #1 relative to preparing menu items. For example:

Morning observations in the facility on 8/30/22 from 6:30 AM - 8:15 AM revealed client #1 to sit in the living room area, play with his iPad, participate in medication administration and participate in the breakfast meal. Observations at 6:40 AM revealed a sealed container on the counter with toast and jelly already prepared. Continued observations at 7:20 AM revealed staff to prompt client #1 to take his toast to his plate. Observations at 7:35 AM revealed client #1 to participate in the breakfast meal. At no point during the observation was client #1 prompted to operate the toaster and make toast to prepare for the breakfast meal.

Review of the record for client #1 on 8/30/22 revealed an ISP dated 1/5/22. Continued review of the ISP revealed the following program goals: use a napkin to wipe hands, operate toaster and make toast, dining etiquette, separate clean and dirty clothes, exercise goal, toothbrush goal, use IPad to choose an article, laundry goal, learn to tell time, privacy goal, dust bedroom and tv and refer to a daily calendar.

Interview with the HM on 8/30/22 revealed staff should have prompted client #1 to use the toaster and make his toast with staff assistance as necessary. Interview with the RD on 8/30/22 revealed all of client #1's goals and interventions

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W 249	Continued From page 3 are current. The QIDP was not available to interview during the survey. Continued interview with the RD revealed staff should prompt client #1 to complete program goals and interventions as required.	W 249		
W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure food consistency was served in a form according to the clients' (#3, #4, #6) developmental level. The findings are: Afternoon observations in the group home on 8/29/22 at 4:45 PM revealed clients to wash hands and prepare for the dinner meal. The meal consisted of the following: fish bake, brown rice, gravy, southern green beans, cut up orange slices, 1% skim milk and sugar free beverage. Observations at 5:00 PM revealed clients #3, #4 and #6 to participate in the dinner meal. Observations did not reveal staff to prepare the clients' (#3, #4 and #6) meals at a mechanical soft consistency as prescribed. Morning observations at 7:25 AM revealed clients to sit at the dining table and participate in the breakfast meal. The breakfast consisted of scrambled eggs, toast with jelly, grits, turkey bacon, 1% milk and water. At no point during the observation was staff observed to prepare clients' (#3, #4 and #6) meals at a mechanical soft consistency as prescribed.	W 474		

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W 474	Continued From page 4 Review of the record on 8/30/22 for client #3 revealed an individual support plan (ISP) dated 9/29/21. Review of the nutritional assessment dated 9/30/21 revealed client should have a regular diet with mechanical soft consistency. Review of the record on 8/3/22 for client #4 revealed an ISP dated 8/10/22. Review of the nutritional assessment dated 7/28/22 revealed client #4 should have a 1500 calorie diet with mechanical soft consistency. Review of the record for client #6 revealed an ISP dated 10/22/21 which indicated client #6 should have altered food consistency chopped and mechanical soft. Review of the nutritional assessment dated 10/20/21 and physician's order dated 7/2022 revealed client #6 should have a regular, heart healthy diet with mechanical soft consistency. Interview with the home manager (HM) on 8/30/22 revealed client #3, #4 and #6 should have had food prepared at mechanical soft consistency as prescribed. The qualified intellectual disabilities professional (QIDP) was not available for interview during the survey. Interview with the residential director (RD) on 8/30/22 revealed she does not recall if the facility has a food processor in order to appropriately prepare food consistency for clients. Interview with the RD also revealed staff should follow all clients' physician's orders and nutritional assessments as prescribed. Continued interview with the RD verified all clients should have their food prepared according to their prescribed diet consistency.	W 474		

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W 508	Continued From page 5	W 508		
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) 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	W 508		

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W 508	Continued From page 6 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 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;	W 508		

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W 508	Continued From page 7 (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. 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	W 508		

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W 508	Continued From page 8 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 follow policies and procedures for COVID-19 relative to staff wearing mask. The finding is: Observation in the group home on 8/29/22 at 4:00 PM revealed staff A to open the front door of the home and to not wear a mask. Continued observation revealed staff A to not screen surveyors upon entering the group home. Further observation revealed staff C to walk through the dining room not wearing a mask. Subsequently, during observations staff A and staff C were asked by the surveyor to wear a mask. Review on 8/30/22 of the facility emergency preparedness and response plan dated 2/1/22 included policies and procedures for COVID-19 relative to face coverings. Continued review of the policies and procedures revealed that staff are required to wear a mask or face covering while on duty. Interview on 8/30/22 with the residential director (RD) revealed that staff should provide COVID-19 screening for visitors entering the group home. Continued interview with the RD verified that the facility requires all staff working in the group home to wear a mask as stated in the policy.	W 508		