STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G207	A. BUILDING _____ B. WING _____	09/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRTLEWOOD GROUP HOME	175 MYRTLEWOOD DRIVE MOUNT GILEAD, NC 27306

(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 131	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(8) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not compelled to perform services for the facility. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that 1 non-sampled client (#1) was not compelled to perform services for other clients in the facility. The finding is: Afternoon observations in the group home on 9/12/22 from 5:15 PM - 6:00 PM revealed client #1 to assist staff in cooking, meal preparation and clean up. Continued observations at 5:15 PM revealed client #1 to work in the kitchen with staff supervision and complete the meal preparation to include using the food processor to blend the food for another client. Further observations revealed client #1 to put the plate settings and cups on the table for the clients. Observations also revealed client #1 to also place the food on the table for the dinner meal without assistance. Additional observations at 5:40 PM revealed client #1 to place his dishes in the sink and immediately clean the kitchen and dishes of all clients. Morning observations in the group home on 9/13/22 from 6:30 AM - 8:00 AM revealed client #1 to assist staff in meal preparation and clean up. Continued observations revealed client #1 to use the food processor to blend the food items for two clients. Further observations at 7:00 AM revealed client #1 to be in the kitchen alone and to open and pour a liquid supplement into a cup for a client. Additional observations at 7:30 AM revealed client #1 to return to the kitchen, wash dishes, sweep the floor and wipe off the table	W 131		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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 131	Continued From page 1 without assistance from staff or peers. At no point during the observation were clients prompted to assist with meal preparation or clean up before and after mealtimes. Interview with staff on 9/13/22 revealed she allows client #1 to prepare the meals without prompting and considers him to be like a staff member in the kitchen. Interview with the qualified intellectual disabilities professional (QIDP) on 9/13/22 revealed that clients should assist with kitchen and cleaning duties with staff prompting and assistance before and after mealtimes. The QIDP also revealed no client should perform services for other clients in the facility.	W 131		
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 3 audit clients (#2). The finding is: Review on 9/12/22 of client #2's behavior support plan (BSP) dated 3/10/22 revealed target behaviors consisting of physical aggression, self-injurious behavior, inappropriate toileting, choking and successful communication. Further review of the BSP revealed verbal consent was obtained from the legal guardian on 5/26/22 but no written consent was obtained.	W 263		

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W 263	Continued From page 2 Interview on 9/13/22 with the qualified intellectual disabilities professional (QIDP) confirmed written informed consent has not been obtained by client #2's legal guardian.	W 263		
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 client's (#5) developmental level. The finding is: Afternoon observations in the group home on 9/12/22 at 5:25 PM revealed client #5 to wash hands and prepare for the dinner meal. The meal consisted of the following: meatloaf, sweet potato, mixed vegetables, pineapples, juice and water. Continued observations revealed staff to place a divided side dish in front of client #5 with meatloaf (ground), mixed vegetables (whole), cut up sweet potato and pineapple pieces. Further observation revealed staff C to spill client #5's drink and water which spilled into the client's plate. Observations revealed staff to continue to prompt client #5 to eat the whole pieces of vegetables mixed with water. At no point during the observation did staff prepare client #5's food into a mechanical soft consistency as prescribed. Review of the record on 9/13/22 for client #5 revealed a person-centered plan (PCP) dated 11/1/21. Review of the nutritional assessment dated 6/20/22 revealed client #5 should have a	W 474		

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W 474	Continued From page 3 1400 calorie diet with mechanical soft consistency. No celery, pretzels or chips. Interview with the qualified intellectual disabilities professional (QIDP) on 9/13/22 revealed client #5 should have had a new plate made for him at the mechanical soft consistency as prescribed. Continued interview with the QIDP revealed client #5's diet consistency is current according to the nutritional assessment. Further interview with the QIDP verified staff should follow all clients' physician's orders and nutritional assessments as prescribed.	W 474		
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	W 508		

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W 508	Continued From page 4 (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 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	W 508		

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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 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

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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 and interview, the facility failed to follow policies and procedures for COVID-19 relative to staff wearing mask and screening visit. The findings are:

A. During observation in the home on 9/12/22 at 11:30am, the home manager (HM) took the surveyors temperature upon entry into the home. At no time were the surveyors asked questions related to COVID-19 signs and symptoms.

Additional observations in the home on 9/12/22 at 5:00pm revealed the surveyors entering the home. At no time were the surveyors temperature taken nor were the surveyors asked questions related to COVID-19 signs and symptoms.

Further observations in the home on 9/13/22 at 6:30am revealed the surveyors entering the

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home. At no time were the surveyors temperature taken nor were the surveyors asked questions related to COVID-19 signs and symptoms.

Interview on 9/13/22 with the qualified intellectual disabilities professional (QIDP) confirmed the surveyors temperature should have been taken and they should have been asked questions regarding COVID-19 signs and symptoms per the facility policy.

B. During observations in the home on 9/13/22 at 6:30am, Staff F was observed to assist client #1 in the kitchen during meal preparation. During the observations, Staff F wore her mask below her chin.

During additional observations in the home on 9/13/22 at 7:46am, Staff B entered the home. Staff B walked into the living room, interacted with several of the clients and then proceeded to move a broken recliner out of the living room and outside of the home. At no time when he was in the home did Staff B wear a mask.

Interview on 9/13/22 with the QIDP confirmed staff are supposed to wear a mask that covers their mouth and nose at all times when working inside the home.