STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G078	A. BUILDING _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATSON'S GROUP HOME	1310 ELWELL AVENUE GREENSBORO, NC 27420

(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 sampled client (#1) and 1 client (#2) was not compelled to perform services for other clients in the facility. The findings are: A. The facility failed to ensure client #1 was not compelled to perform services for other clients in the facility. For example: Afternoon observations in the group home on 9/7/22 from 5:08 PM - 6:14 PM revealed client #1 to assist staff with cooking and meal preparation. Continued observations at 5:11 PM revealed client #1 to work in the kitchen with staff supervision and complete meal preparation to include placing frozen hamburger patties on a pan and placing them in the oven, pouring frozen corn into a pot and to pour a bag of salad into a bowl. Further observations revealed client #1 to set the table for all clients with a plate, napkin, fork, knife, spoon and 2 cups. Observations at 6:00 PM also revealed client #1 to remove all plates from the dining room table and place them on the counter and for client #1 to place all food items on the plates for all clients. Subsequent observations revealed client #1 to pour soda and water in cups for all clients. At no point during the observation were other clients prompted to assist with the meal preparation. Interview on 9/8/22 with the program director (PD) revealed that due to COVID-19 the facility will only allow one client to complete meal	W 131		

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

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W 131	Continued From page 1 preparation for sanitation reasons. Continued interview with the PD revealed that all clients are capable of making their own plates, choosing and pouring their drinks and participating in meal preparation with staff assistance as necessary. B. The facility failed to ensure client #2 was not compelled to perform services for other clients in the facility. For example: Morning observations in the group home on 9/8/22 from 6:20 AM - 6:38 AM revealed client #2 to assist staff with cooking and meal preparation. Continued observations at 6:20 AM revealed client #2 to place bowls with cereal on the dining room table for all clients. Further observation revealed client #2 to place toast in the toaster oven for all clients. Observations also revealed client #2 to pour milk, to pour juice and place toast on plates for all clients. At no point during the observation were other clients prompted to assist with the meal preparation. Interview on 9/8/22 with the program director (PD) revealed that due to COVID-19 the facility will only allow one client to complete meal preparation for sanitation reasons. Continued interview with the PD revealed that all clients are capable of making their own plates, choosing and pouring their drinks and participating in meal preparation with staff assistance as necessary.	W 131		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program.	W 288		

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W 288	Continued From page 2	W 288		

This STANDARD is not met as evidenced by:
Based on observations, record review, and interviews, the facility failed to ensure all techniques to manage inappropriate behavior were incorporated into an active treatment program for 2 of 3 sampled clients (#1, #5). The findings are:

A. The team failed to ensure formal interventions relative to restricting clothing items and toiletries from client #5's bedroom were approved and incorporated in the behavior support plan (BSP). For example:

Observations during the 9/7/22-9/8/22 survey period revealed client #5's toiletries to be stored in a caddy in the medication room. Continued observations revealed 3 pair of shoes and 1 pair of bedroom slippers to be stored on a bookshelf in the medication room. Further observations revealed client #5 to enter the medication room and pick up a pair of sneakers from the bookshelf to wear.

Review of the record on 9/8/22 for client #5 revealed an individual habilitation plan (IHP) dated 10/12/21. Continued review of the IHP revealed a BSP dated 2/28/21 including target behaviors such as agitation, self-injurious behaviors (SIBs) or suspected SIB. Review of the BSP did not reveal interventions relative to keeping client #5's shoes and toiletries on the shelf in the medication room. In addition, review of the record did not reveal core team meetings or evidence of approved interventions to keep client #5's shoes and toiletries outside of her bedroom.

Interview with staff G and staff H revealed client

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#5's shoes and toiletries have been stored in the medication room for several years. Continued interview with staff G and staff H revealed they could not recall the reasoning for the continued intervention to keep client #5's belongings in the medication room area.

Interview with the program director (PD) on 9/8/22 revealed client #5 used to throw away, misuse and/or destroy her toiletries and shoes. Continued interview with the PD revealed that although client #5's behaviors have improved over the years, the interventions to keep #5's belongings in the medication area have continued. Further interview with the PD could not locate evidence relative to implementation or continuance of the interventions to keep client #5's belongings in the medication area. Interview with the PD verified that formal interventions must be reviewed annually and verified in the BSP for client #5 relative to keeping belongings out of her bedroom.

B. The facility failed to ensure interventions relative to a transportation harness were approved and incorporated in client #1's BSP. For example:

Observations on 9/8/22 at 8:40 AM revealed the PD to escort client #1 to the van to prepare for transportation to school. Continued observations revealed the PD to attach a harness around client #1's shoulders and torso. Further observation revealed the PD to assist client #1 onto the facility van and attach the harness to the seatbelt.

Review of the record for client #1 revealed an IHP dated 4/28/22. Continued review of the record

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W 288	Continued From page 4 revealed a BSP dated 5/25/22 which included the following target behaviors: SIBs, property destruction, misuse, PICA and agitation. Review of an incident dated 3/25/22 revealed client #1 smashed the facility van window and the client was placed in a therapeutic hold until calm. Review of the record did not reveal an IRIS report relative to the need to utilize a restrictive intervention on client #1 on 3/25/22 until she remained calm. Review of the BSP did not include formal interventions relative to a safety harness to be used during transportation in the facility van. Additional review of the record did not reveal evidence of approved interventions or core team meetings to confirm the continued need for client #1 to wear a safety harness during transports in the facility van. Interview with the PD on 9/8/22 revealed client #1 is in need of the transportation harness to ensure her safety in the facility van. Continued interview with the PD revealed evidence of approved interventions were not found in the record during the survey. Further interview with the PD verified client #1 should have formal interventions incorporated in the BSP to include a safety harness during transportation in the facility van.	W 288		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide nursing services to 3 out of 6 clients (#3, #4, #5) relative to privacy during medication administration. The finding is:	W 331		

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Observations in the group home on 9/8/22 at 7:17 AM revealed staff G to prompt client #5 to enter the medication room for medication administration. Continued observations revealed client #5 to participate in medication administration as the door remained open. Further observations revealed staff H to enter the medication room and converse with staff G during the medication administration. Observations did not reveal staff to ensure client #4's privacy during medication administration.

Observations at 7:20 AM revealed staff G to call client #3 to the medication room to participate in medication administration. Continued observations revealed client #3 to participate in medication administration with the door open. Observations did not reveal staff to close the door during medication administration to ensure client #3's privacy.

Subsequent observations at 7:25 AM revealed staff G to prompt client #4 to enter the medication area for medication administration. Continued observations revealed client #4 to participate in medication administration with the door open as several clients passed by the medication room. Further observation revealed staff to continue medication observation with client #4 which could be heard from the kitchen area. Observations did not reveal staff to ensure client #4's privacy during the medication administration.

Interview with the program director (PD) on 9/8/22 revealed she attempts to keep all clients away from the medication area during medication administration. Continued interview with the PD revealed clients have a choice to keep the door open during medication administration. Further

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W 331	Continued From page 6 interview with the PD verified all clients should be offered privacy during medication administration.	W 331		
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	W 508		

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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 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

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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 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

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W 508	Continued From page 9 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 record review and interviews, the facility failed to develop policies and procedures for COVID-19. The finding is: Review on 9/7/22 of the facility employee COVID-19 vaccination cards revealed 18 out of 20 employees had completed a primary vaccination series for COVID-19 including a multidose vaccine. Continued review revealed 2 contractual employees to be unvaccinated with no exemption status in place at time of survey. Further observations revealed the facility did not have policies and procedures for COVID-19. Interview on 9/8/22 with the program director (PD) revealed the facility has not developed any written policies and procedures to ensure all staff are fully vaccinated for COVID-19. Continued interview with the PD revealed the facility was not aware of the CMS vaccine requirements including the need to develop policies and procedures for COVID-19. Further interview with the PD revealed that the facility does not require contractual employees to be vaccinated. It is the contractual staff choice and they have chosen to not be vaccinated.	W 508		