STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G140	A. BUILDING _____ B. WING _____	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEM ROAD HOME	**702 STEM ROAD CREEDMOOR, NC 27522**

(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 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure all medications were administered without error. This affected 1 of 4 audit clients (#2). The finding is: During afternoon medication observations in the home on 9/28/22 at 3:51pm, Staff C poured 15ml of Liquid Calcium Magnesium into a medicine cup with measurements at eye level, resting the cup on a shelf over the desk. Client #2 was instructed to digest the medication and drunk the contents, except for the liquid that stuck to the sides and bottom of the cup. Client #2 showed Staff C the cup then was allowed to toss it in the trash can. Record review on 9/29/22 of client #2's 4/11/22 signed Physician Orders revealed that client #2 should get 10ml of Liquid Calcium Magnesium daily. Interview on 9/29/22 with the nurse revealed Staff C should have made sure client #2 got all of the liquid medication.	W 368		
W 374	DRUG ADMINISTRATION CFR(s): 483.460(k)(7) The system for drug administration must assure that drugs used by clients while not under the direct care of the facility are packaged and labeled in accordance with State law. This STANDARD is not met as evidenced by: Based on observation, record review and	W 374		

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

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W 374	Continued From page 1 interviews, the facility failed to ensure all medications were packaged and labeled with the name of the person prescribed the medication, with instructions on how to administer the medication and instructions on how often to administer the medication. This affected 1 of 4 audit clients (#2). The finding is: During afternoon medication observations in the home on 9/28/22 at 3:51pm, Staff C removed a basket of medication belonging to client #2 from the medication closet. The bottle of Liquid Calcium Magnesium was not boxed in the original package, did not have a pharmacy label on it with instructions or client identification. Staff C was observed pouring 15ml of the medication into a medication cup, then gave it to client #2 to drink. Record review on 9/29/22 of client #2's 4/11/22 signed Physician Orders revealed that client #2 should get 10ml of Liquid Calcium Magnesium daily. Review on 9/29/22 of the facility's Storage of Medication Policy, October 2018 revealed "Medications are stored in the containers in which their original labeled container. Transfer between containers is performed only by the issuing pharmacy. Interview on 9/28/22 with Staff C revealed that client #2's father drops off some of his supplements that he arranged with the pharmacy. Staff C revealed the client #2's father had made arrangements with management to bring Liquid Calcium Magnesium to the group home and he did not have the box that it came in. Interview on 9/29/22 with the nurse	W 374		

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W 374	Continued From page 2 acknowledged she was aware client #2's father was bringing outside medication to the home from his pharmacy that staff were allowed to administer. The nurse offered no explanation for allowing medication to be administered without label, instruction or the client identified.	W 374		
W 378	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(1) The facility must store drugs under proper conditions of temperature. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure the medication for 1 of 4 audit clients (#2) was stored at the appropriate temperature as required. The finding is: During afternoon medication observations in the home on 9/28/22 at 3:51pm, Staff C removed a basket of medication belonging to client #2 from the medication closet. A bottle of Liquid Calcium Magnesium was in the basket and was used to pour medication into a medication cup. Client #2 was observed swallowing the poured contents of Liquid Calcium Magnesium that was at room temperature. The surveyor reviewed the bottle of Liquid Calcium Magnesium and it revealed instructions to keep it refrigerated after opening. Record review on 9/29/22 of the facility's Storage of Medication Policy, October 2018 revealed "Medications requiring refrigeration must be stored in the refrigerator in a locked container unless there is a refrigerator designmated for medication in a locked area. Interview on 9/29/22 with the nurse about the	W 378		

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W 378	Continued From page 3 medication practices for the home, the nurse revealed that she is not assigned to the home but she is familiar with the clients. The nurse offered no explanation when it was reported the Liquid Calcium Magnesium was given to client #2 at room temperature.	W 378		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure the medication room remained locked when not in use. The affected 2 of 4 audit clients (#2 and #5). The findings is: During afternoon medication observations in the home on 9/28/22 at 3:48pm, Staff C left the medication closet unlocked, walked out of the medication room leaving the door open, to instruct client #2 to pour a beverage from a pitcher left on the kitchen counter. Staff C remained in the kitchen until 3:50pm. During an additional observation on 9/28/22 at 3:53pm, revealed Staff C left the medication closet doors open as well as the door to the medication room for 3 minutes, assisting client #5 pour beverage from a pitcher on the kitchen counter. Another client #3 was observed pacing back in forth from the dining room to the kitchen, passing by the medication room during these observations. Record review on 9/29/22 of the facility's Storage	W 382		

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W 382	Continued From page 4 of Medication Policy, October 2018 revealed "All controlled drugs are stored double locked." Interview on 9/29/22 with the nurse revealed medications should be secured and locked in the medication closet at all times.	W 382		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the failed to furnish eyeglasses for 1 of 4 audit clients (#6). The finding is: During observations in the home and restaurant on 9/28/22-9/29/22, client #6 did not wear eyeglasses. Record review on 9/28/22 of client #6's Vision Assessment on 1/4/22 revealed he was prescribed eyeglasses. Record review on 9/28/22 of client #6's Behavior Support Plan (BSP) on 7/20/21 revealed he had a visual impairment and should be accommodated by allowing him to hold items that he is looking at so he can position them in such a manner that he can see them. Interview on 9/29/22 with the Home Manager (HM) revealed client #6 wore eyeglasses and had a new pair ordered that came in a week ago. The	W 436		

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W 436	Continued From page 5 HM stated the facility was unable to pick them up because the guardians purchased them. The HM offered no explanation why client #6 could not wear his intact old eyeglasses until the new eyewear was available.	W 436		
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	W 508		

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W 508	Continued From page 6 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 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;	W 508		

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W 508	Continued From page 7 (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 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.	W 508		

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W 508	Continued From page 8 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 observations, record review and interviews, the facility failed to implement their COVID-19 Vaccination Policy. The findings are: A. Observations on 9/28/22 at 9:35am, revealed the Administrator wearing a single face mask, applied over ear lobes that covered the nose and mouth. An additional observation on 9/29/22 at 8:45am, revealed the Administrator wearing a single face mask, applied over ear lobes that covered his nose and mouth. Record review on 9/29/22 of the Administrator's vaccine record revealed he received a religious exemption on 11/18/21 to not receive the COVID-19 vaccine. The exemption required unvaccinated staff to wear a double mask. Interview on 9/28/22 with the Administrator revealed he just returned to work after being out sick. An additional interview with the Administrator on 9/29/22 revealed that the face masks hurt his ear lobes and that he had a second face mask available that he could wear. The administrator asserted that he had to two face masks yesterday but because of the discomfort, he had the second mask tucked underneath the first mask.	W 508		

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W 508	Continued From page 9 Interview on 9/29/22 with the nurse revealed the proper way to wear the face mask was to pinch it across the nose and over the mouth, with both face masks looped over the earlobes, if unvaccinated. B. Record review on 9/29/22 of the facility's vaccine records revealed Staff E was hired on 8/19/22 and there was no record of a vaccine or approved religious exemption. Interview on 9/29/22 with the Human Resources Personnel (HRP) revealed she did not have a copy of Staff E's religious exemption. The HRP acknowledged Staff E had been allowed to work in the facility since hire date.	W 508		