STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G247	A. BUILDING _____ B. WING _____	10/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINOAK GROUP HOME	3175 BANK ROAD LINCOLNTON, NC 28092

(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 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation and interviews, the facility failed to include opportunities for client choice and self-management for 4 of 6 clients (#1, #2, #4, and #6) relative to medication administration. The finding is: Observation in the group home on 10/11/22 revealed the family-style breakfast meal to begin at approximately 7:05 AM. Observation at 7:07 AM revealed staff A to prompt client #2 to the medication room to receive their medications. Continued observation at 7:09 AM revealed staff A to prompt client #6 to the medication room to receive their medications. Continued observation at 7:22 AM revealed staff A to prompt client #1 to the medication room to receive their medications. Continued observation at 7:28 AM revealed staff A to prompt client #4 to the medication room to receive their medications. Subsequent observations revealed at no time during the breakfast meal were the clients asked or given a choice to interrupt their breakfast to participate in medication administration. Interview with staff A on 10/11/22 revealed it is routine to conduct medication administration during the breakfast meal due to the client's leaving for the day program between 8:10 AM - 8:30 AM. Interview with qualified intellectual disabilities professional (QIDP) on 10/11/22 verified the medication administration window is 7:00 AM - 9:00 AM. Further interview with the QIDP revealed if time is not a concern clients	W 247		

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

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W 247	Continued From page 1 should be provided the choice to leave the breakfast meal to participate medication administration.	W 247		
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, interview and record review, the facility failed to ensure a continuous active treatment program consisting of needed interventions were implemented as identified in the person-centered plan (PCP) for 1 sampled (#1) and 1 non-sampled client (#2). The findings are: A. The facility failed to implement monitoring guidelines for client #2 relative to entering others' rooms without permission. For example: Observations in the group home on 10/11/22 at 7:52 AM revealed client #2 to enter his room and his door alarm to chime. Continued observations at 7:55 AM revealed client #2 to exit his room and to enter client #6's room, the door chime to sound and the client to close the door behind him. Further observation at 8:00 AM revealed client #2 to exit client #6's room and return to his room and	W 249		

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W 249	Continued From page 2	W 249		

close the door behind him. Observations did not reveal staff to provide monitoring to client #2 as they were attending to other clients in the dining room.

Review of the record for client #2 on 10/11/22 revealed a PCP dated 7/25/22 which included the following program goals: fold underwear for storage, allow community partner to walk away, giving others privacy (knock on the bathroom door prior to entering), take out trash and work behaviors. Review of the behavior support plan (BSP) for client #2 dated 9/21/20 revealed the client has the following target behaviors: refusing habilitation activities, taking others belongings, inappropriate toileting events, property destruction, physical aggression and tantrum behavior. Continued review of the BSP revealed client #2 requires continuous monitoring when outside of his room. The bedroom door alert and visual monitoring will be monitored by the interdisciplinary team (IDT). Review of the record did not reveal program goals relative to entering others' bedrooms without permission.

Interview with the home manager (HM) on 10/11/22 revealed client #2 has not entered others' rooms without permission in several months. Interview with the qualified intellectual disabilities professional (QIDP) revealed client #2's program goals and interventions are current. Continued interview with the QIDP verified staff should monitor client #2 when he is not in his bedroom.

B. The facility failed to implement training objectives relative to meal preparation for client #1. For example:

Observation at the group home on 10/11/22 at

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W 249	Continued From page 3 6:30 AM revealed client #2 to sit the dining room table and all other residents in their bedroom or the bathroom completing morning routines. Continued observation at 6:35 AM and confirmed by staff D revealed the breakfast meal to be fully prepared and sitting on the kitchen counter covered in aluminum foil. Further observation at 7:18 AM revealed client #1 to enter the dining room, sit at the table and serve himself the breakfast meal which was already sitting on the table. Review of records for client #1 on 10/11/22 revealed a person-centered plan (PCP) dated 10/18/21. Review of the PCP indicated a training objective that client #1 will assist with preparing breakfast when asked, being 90% accurate for two consecutive program periods. Interview with staff D on 10/11/22 revealed they finished preparing the breakfast meal "a little after 6:00 AM" and further revealed it is their routine to cook the breakfast meal and have it ready for clients in the morning when they come to the table. Interview with staff A on 10/11/22 confirmed 3rd shift starts breakfast preparation because it makes it easier on staff in the morning and 1st shift usually finishes breakfast preparation while clients are finishing their morning hygiene. Interview with the qualified intellectual disabilities professional (QIDP) on 10/11/22 verified client #1's meal preparation goal is current and confirmed staff should implement client #1's training objectives as indicated in the PCP.	W 249		
W 473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii) Food must be served at appropriate temperature.	W 473		

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W 473	Continued From page 4 This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all foods were served at an appropriate temperature for 6 of 6 clients in the home (#1, #2, #3, #4, #5 and #6). The finding is: Observation at the group home on 10/11/22 at 6:35 AM and confirmed by staff D revealed the breakfast meal to be fully prepared and sitting on the kitchen counter covered in aluminum foil. Continued observation at 7:05 AM revealed the family-style breakfast meal to begin without any food being reheated. The breakfast meal consisted of pancakes and bacon. Further observation 7:09 AM revealed client #3 to request staff to warm up their breakfast. Subsequent observations revealed all other clients to participate in the breakfast meal without it being warmed up. Interview with staff D on 10/11/22 revealed they finished preparing the breakfast meal "a little after 6:00 AM" and further revealed it is their routine to cook the breakfast meal and have it ready for clients in the morning when they come to the table. Interview with the qualified intellectual disabilities professional (QIDP) on 10/11/22 confirmed staff should have warmed up the breakfast meal due it sitting for approximately one hour prior to being served.	W 473		
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	W 508		

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W 508	Continued From page 5 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 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	W 508		

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W 508	Continued From page 6 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; (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	W 508		

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W 508	Continued From page 7 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 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 interviews, the facility failed to ensure policies and	W 508		

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W 508	Continued From page 8	W 508		

procedures were implemented for 1of 3 sampled staff (#3) relative to assuring staff are fully vaccinated for COVID-19. The finding is:

Observations during the survey on 10/10/22-10/11/22 revealed the human resources (HR) manager to present the staff listing for the facility. Further observation revealed the HR manager to provide proof of vaccination and/or exemption status for 2 of 3 sampled staff (#1 & #2). Observations did not reveal vaccination or exemption status for staff #3 during the survey.

Record review on 10/11/22 revealed a staff listing consisting of staff that have direct contact with the clients within the facility. Review of staff vaccination and/or exemption status revealed one staff was fully vaccinated and one staff received religious exemption status. Review of staff vaccination status did not reveal vaccination or exemption status for staff #3 during the survey. Review of the COVID-19 vaccination policy revealed that current employees will be asked to sign a consent or declination form for the COVID-19 vaccination. The consent/declination form should be placed in the employee's health record. Once the employee receives the vaccination, a copy of the vaccination card or exemption status should be stored in the employee's health record.

Interview with the HR manager and qualified intellectual disabilities professional (QIDP) on 10/11/22 revealed the vaccination record for staff #3 could not be located in the staff personnel record at the time of the survey. Continued interview with the HR manager and facility administrator verified all staff should have a copy of the required vaccination card or exemption

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W 508	Continued From page 9 status stored in the employee's personnel record.	W 508		