STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G103	A. BUILDING _____ B. WING _____	11/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY PLACE	1050 HOGAN STREET FAYETTEVILLE, NC 28301

(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 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure privacy for 3 of 4 audit clients (#1, #4 and #5) residing in the home. The findings are: A. During observations in the home on 11/7/22 at 4:00pm, client #1 was seen in his bed with his disposable brief undone as his bedroom door was wide open. Further observations revealed at 4:01pm, a female client entered through the open door to empty the trash can that was in client #1's bedroom; as he was laying on his bed with his disposable brief undone. At 4:03pm, Staff C entered client #1's bedroom and turned him on his side with his disposable brief still undone while the female client was standing in his bedroom. During an interview on 11/7/22, Staff C revealed client #1 empties the trash around the house and once she begins she cannot be stopped. Staff C stated how the female client cannot be told "No" when it comes to her waiting to empty the trash. During an interview on 11/7/22, the Qualified Intellectual Disabilities Professional (QIDP) stated client #1 relies on staff to close his door for privacy. B. During observations in the home on 11/7/22 at 5:26pm, client #4 was observed taking a shower with the door wide open and the shower curtain not closed. At 5:33pm, Staff A went into the	W 130		

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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bathroom where client #4 was observed sitting on the toilet without any clothes on. Staff A asked client #4 "did you really take a shower; let me smell your armpits." The bathroom door remained open the entire time client #4 was taking her shower and getting dressed.

Review on 11/8/22 of client #4's Annual Comprehensive Functional Assessment dated 5/12/22 revealed she will close a door for privacy independently.

During an interview on 11/7/22, Staff A stated she always keeps the bathroom door open when client #4 takes a shower because she might fall.

During an interview on 11/8/22, the QIDP revealed the bathroom door should have been closed while client #4 was taking her shower.

C. During observations in the home on 11/7/22 at 5:27pm, client #5 was seen taking her shower with the door wide open, along with the shower curtain open. Further observations revealed while the door remained open, client #5's reflection was seen in the mirror as the surveyor walked past the open door. At 5:29pm, Staff A walked into the bathroom door while client #5 was taking her shower and then walked out, leaving the bathroom door open. The QIDP was observed pulling the bathroom door, but not closing it. Client #5 came out of the bathroom with a towel covering the front of her, while her backside was visible.

During an interview on 11/7/22, Staff A stated she always keeps the bathroom door open when client #5 takes a shower because she might fall.

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W 130	Continued From page 2 Review on 11/8/22 of client #5's Annual Comprehensive Functional Assessment dated 4/21/22 revealed she will close a door for privacy independently. During an interview on 11/8/22, the QIDP revealed the bathroom door should have been closed while client #5 was taking her shower.	W 130		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure 2 of 4 audit clients (#3 and #4) data for their goals was documented. The findings are: A. Review on 11/7/22 of client #3's goals: preparing a salad; walk for thirty minutes; independently wash hands for three consecutive months; wash dishes; count correct number of dollars; independently give herself medication and wash her hair revealed data was missing for the entire months of: June 2022, August 2022, September 2022 and October 2022. B. Review on 11/7/22 of client #4's goals: brush teeth and count one to twenty revealed data was missing for the entire months of: June 2022, August 2022, September 2022 and October 2022.	W 252		

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W 252	Continued From page 3 During an interview on 11/8/22, the Qualified Intellectual Disabilities Professional (QIDP) stated staff have been trained to ensure data is collected for clients #3 and #4.	W 252		
W 255	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(i) The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 2 of 4 audit clients (#3 and #4) objectives were reviewed and/or revised as needed including when the target date has passed. The findings are: A. Review on 11/7/22 of client #3's record revealed her prepare a salad goal was implemented on 4/1/22 and the completion date was on 9/1/22. Further review revealed client #3's walking goal was implemented on 9/23/20 and the completion date was on 9/1/22. Additional review revealed client #3's wash hands goal was implemented on 2/1/22 and the completion date was on 9/30/22. Further review revealed client #3's wash dishes goal was implemented on 3/5/21 and the completion date was on 10/1/22. Additional review revealed client #3's count the correct number of dollars was implemented on 3/5/21 and the completion date was on 9/1/22. Further review revealed client #3's give herself her medication was implemented on 3/5/21 and the completion date	W 255		

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W 255	Continued From page 4 was on 9/1/22. Further review revealed client #3's wash hair thoroughly was implemented on 4/1/22 and the completion date was on 9/1/22. Additional review revealed these seven goals were not replaced or revised with new ones. B. Review on 11/7/22 of client #4's record revealed her count to one to twenty goal was implemented on 9/23/20 and the completion date was on 9/1/22. Further review revealed client #4's brush teeth goal was implemented on 4/1/21 and the completion date was on 9/1/22. Additional review revealed client #4's recite the alphabet goal was implemented on 9/23/20 and the completion date was on 9/1/22. Additional review revealed these three goals were not replaced or revised with new ones. During an interview on 2/16/22, the Qualified Intellectual Disabilities Professional (QIDP) revealed he has not updated or revised the goals for clients #3 or client #4. Further interview revealed the company in which the QIDP works for acquired the group home in December 2021.	W 255		
W 258	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(iv) The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is being considered for training towards new objectives. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure training towards new objectives was considered in a timely manner for 1 of 4 audit clients (#1). The finding is:	W 258		

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W 258	Continued From page 5 Review on 11/7/22 of client #1's Individual Program Plan (IPP) revealed he only has one goal. Further review revealed the goal for client #1 is indicate choice. During an interview on 11/8/22, the Qualified Intellectual Disabilities Professional (QIDP) revealed he has not implemented any new goals for client #1. Further interview revealed the company in which the QIDP works for acquired the group home in December 2021.	W 258		
W 260	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to update the Individual Program Plan (IPP) annually for 2 of 4 audit clients (#1 and #4). The findings are: A. Review on 11/7/22 of client #1's record revealed an IPP dated 8/1/21. Additional review of client #1's record revealed no updated IPP since 8/1/21. B. Review on 11/7/22 of client #4's record revealed an IPP dated 8/6/21. Additional review of client #4's record revealed no updated IPP since 8/6/21. During an interview on 11/8/22, the Qualified Intellectual Disabilities Professional (QIDP) confirmed clients #1 and #4 IPP's have not been updated.	W 260		

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W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure each client received a nourishing, well balanced diet including modified and specially prescribed diet as prescribed. This affected 2 of 4 audit clients (#3 and #4). The findings are: A. During evening observations in the home on 11/7/22 at 6:01pm, client #4 began eating a bowl with three pears that were cut in half. Further observations revealed client #4 consuming the pear halves. Additional observations revealed the pear halves were not cut. Review on 11/7/22 of the facility's diet list dated 9/26/22 for client #4 stated, "Cut all foods bite size." During an interview on 11/2/22, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4's pears should have been cut into bite sized pieces. B. During breakfast observations on 11/8/22 at 7:04am, client #3 asked for a second helping of oatmeal. Further observations revealed Staff B let client #3 get a second helping of the oatmeal. During an interview on 11/8/22, Staff A stated client #3 should not have been allowed a second helping of oatmeal.	W 460		

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W 460	Continued From page 7 Review on 11/7/22 of client #3's Nutritional Evaluation dated 6/27/22 indicated, "Diet:...Seconds of one fruit or vegetable only". Review on 11/7/22 of the facility's diet list dated 9/26/22 for client #3 stated, "May have seconds of one fruit or vegetable only." During an interview on 11/8/22, the QIDP stated client #3 should only get seconds of fruits or vegetables. Further interview revealed client #3 should not have received the second helping of the oatmeal.	W 460		
W 481	MENUS CFR(s): 483.480(c)(2) Menus for food actually served must be kept on file for 30 days. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure food substitutions were documented. The finding is: During review on 11/7/22 of a goal for client #3 which states, "...[Client #3] will prepare a salad...." Further review of the documentation revealed client #3 made a salad on the following days 5/19/22; 7/5/22; 7/7/22; 7/12/22; 7/14/22; 7/19/22; 7/21/22; 7/26/22 and 7/29/22. During review on 11/7/22 of the menu book revealed there was no documentation indicating a salad was used as a substitute during any of client #3's meals. During an interview on 11/7/22, the Qualified Intellectual Disabilities Professional (QIDP)	W 481		

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W 481	Continued From page 8 confirmed there was no documentation indicating a salad was used as a substitute for client #3.	W 481		
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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W 508	Continued From page 9 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	W 508		

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W 508	Continued From page 10	W 508		

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 11 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 ensure that 100 percent of their staff have been vaccinated or had an approved exemption against COVID-19. The finding is: During review on 11/8/22 of the facility's COVID-19 vaccination information, it was discovered that one staff had not been vaccinated or approved for an exemption. During an interview on 11/8/22, the Qualified Intellectual Disabilities Professional (QIDP) stated there was one staff who did not provide the paperwork for an exemption from the COVID-19 vaccination.	W 508		