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RAVENDALE DRIVE GROUP HOME	1123 RAVENDALE DRIVE CHARLOTTE, NC 28216

(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 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to assure the individual support plan (ISP) included interventions for client #5 relative to respecting boundaries, privacy and leaving the area without permission. The findings are: A. The facility failed to provide support to client #5 relative to respecting boundaries, personal space and privacy. For example: Afternoon observations in the group home on 12/19/22 at 4:10 PM revealed client #5 to pace in the living room area. Continued observations revealed client #5 to hug a female staff member. Further observations at 4:30 PM revealed client #5 to hug a surveyor. At no point during the observation did staff prompt the client to refrain from having contact with females. Morning observations in the group home on 12/20/22 at 6:51 AM revealed client #5 to enter bathroom #1 without knocking while another client was toileting. Observations reveled client #5 to turn around and exit the bathroom leaving the bathroom door open while the other client was toileting. Continued observations at 7:12 AM revealed client #5 to enter bathroom #2 while another client was toileting. Observations revealed client #5 to again exit the bathroom without closing the door while another client was toileting.	W 227		

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

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W 227	Continued From page 1 Review of the record for client #5 on 12/20/22 revealed an ISP dated 10/24/22 which indicated the following program goals: safety, relationship building, make choices and self-management, community inclusion and health/wellness goals. Review of the behavior support plan (BSP) dated 10/24/22 revealed the following target behaviors: agitation/anxiety, inappropriate social behaviors and verbal aggression. Continued review of the record for client #5 did not include program goals and/or interventions relative to respecting boundaries and personal space and respecting the privacy of others. Interview with the residential services director (RSD) on 12/20/22 revealed client was admitted to the facility on 10/24/22 and the staff and management are still getting to know the client. Continued interview with the RSD revealed all of client #5's goals and interventions are current. Further interview with the RSD revealed client #5 could benefit from program goals relative to respecting boundaries, personal space and privacy. B. The facility failed to provide support to ensure client #5 would not leave his assigned area without permission. For example: Observations in the group home on 12/20/22 at 6:30 AM revealed client #5 to answer the door for the surveyors without staff presence. Continued observations revealed client #5 to pace around the group home at various times throughout the morning. Further observations from 7:20 AM to 7:45 AM revealed client #5 to go outside the front door and pace outside without staff permission. Observations at 7:45 AM revealed staff to	W 227		

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W 227	Continued From page 2 acknowledge client #5 was outside and went outside to accompany him. At no point during the observation did staff prompt client #5 to not go outside without permission or supervision. Review of the record for client #5 on 12/20/22 revealed an ISP dated 10/24/22. Continued review of the record for client #5 revealed a BSP dated 10/24/22 which indicated the following target behaviors: agitation/anxiety, inappropriate social behaviors and verbal aggression. Continued review of the record for client #5 did not include program goals and interventions relative to leaving his area without permission. Interview with the RSD on 12/20/22 revealed client #5 was admitted to the facility on 10/24/22 and the staff and management are still getting to know the client's behaviors. Continued interview with the RSD revealed all of client #5's goals and interventions are current. Further interview with the RSD revealed client #5 could benefit from goals and/or interventions relative to leaving his area without permission.	W 227		
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 assure all drugs were administered as prescribed for 1 client (#2) observed during medication administration. The finding is: Observation in the group home on 12/20/22 at	W 368		

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W 368	Continued From page 3 6:52 AM revealed staff D to pre-punch medications into a medicine cup for medication administration. Continued observation revealed staff D to administer client #2 prescribed nasal spray with 1 spray in each nostril. Further observation revealed staff D to give the client 7 pills in a medicine cup to take whole with water. Subsequent observation revealed staff D to provide surveyor medication packets for medications administered. Review of records for client #2 on 12/20/22 revealed physician orders dated 10/1/22. Review of the 10/1/22 physician orders revealed medications to administer at 7:00 AM to be the following: fexofenadine 180 mg tab, fluoxetine 40 mg cap, memantine 5 mg tab, multi-vitamins tab, omeprazole 40 mg cap DR, vitamin D3 1000u (25mcg) tab, vitamin D3 400 units tab with quantity (2), and dymista nasal spray. During the survey observation, staff D was not observed to administer vitamin D3 1000u (25mcg). Interview with the facility nurse on 12/20/22 verified the physician orders dated 10/1/22 to be current. Continued Interview with the nurse confirmed that staff should have administered the client #2's prescribed medication. Further interview with the facility nurse revealed she did not receive any calls from staff D regarding vitamin D3 1000u (25mcg) being unavailable to administer to the client.	W 368		
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.	W 382		

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W 382	Continued From page 4 This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to assure all medications were secured appropriately as required. The finding is: Observations in the group home on 12/20/22 at 6:59 AM revealed staff D to pre-punch 12 prescribed medications for client #4 into a medicine cup and document on an IPAD. Continued observations revealed staff D to exit the medication room leaving the medication closet unlocked and door to medication room open with medications sitting on desk. Further observations revealed staff D to enter the kitchen for keys to the supply closet, open the supply closet and walk into living to escort client #4 to the medication room. Subsequent observations at 7:26 AM revealed staff D to pre-punch medications and pour medication into medicine cup and exit the medication room leaving the medication closet unlocked. Continued observations revealed staff D to retrieve client #6 from bedroom and return to medication room. Additionally, staff D exits the medication room leaving client #6 with medications on the desk and obtain the milk pitcher from the refrigerator in the kitchen. Interview with the facility nurse on 12/20/22 revealed that staff D should have secured the medication closet and medications should have not been left unattended in the medicaiton room with the client. Continued interview with the facility nurse revealed that staff D did not follow medication administration and all clients should be present before beginning medication administration.	W 382		

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W 454	Continued From page 5	W 454		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the potential for cross-contamination was prevented relative to 6 out of 6 clients (#1, #2, #3, #4, #5 and #6). The finding is: Observations in the group home on 12/20/22 from 6:30 AM - 7:45 AM revealed all clients to use both bathrooms in the facility with no toilet paper. Continued observations at 6:45 AM revealed client #2 to enter the bathroom and use the toilet with the door open. Observations revealed client #2 to pull up his pants and leave out of the bathroom without wiping or washing his hands. Observations also revealed feces droppings and urine to remain on the toilet seat and the floor. Additional observations at 7:12 AM revealed client #2 to return to the bathroom and sit on the soiled toilet seat. Observations revealed client #2 to again leave the bathroom without wiping and washing his hands. Observations at 6:55 AM revealed client #6 to enter the same bathroom and sit on the soiled toilet seat with the door open. Observations revealed staff E to enter the bathroom, check on client #6 and exit the bathroom leaving the door open and not refilling the toilet paper. Observations also reveal client #6 to stand up from the toilet, pull up his pants and exit the bathroom without wiping and washing his hands.	W 454		

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W 454	Continued From page 6 Subsequent observations at 7:05 AM revealed client #4 to enter the bathroom and sit on the soiled toilet seat with the door open. Observations revealed client #4 to stand up from the toilet and pull up his pants without wiping. Continued observations revealed client #4 to wash his hands and exit the bathroom. Observations at 7:15 AM revealed this surveyor to request toilet paper for both bathrooms and make staff aware of the feces droppings. Additional observations revealed staff E to clean the bathroom toilet and floor and refill toilet paper in both bathrooms. Interview with the Residential Services Director (RSD) on 12/20/22 revealed staff should have checked all bathrooms to ensure cleanliness to prevent potential cross-contamination and refill paper products as necessary. Continued interview with the RSD revealed staff should have monitored the clients going to the bathroom. Further interview revealed staff are responsible for ensuring clients receive assistance in the bathroom as necessary.	W 454		
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observations, and interviews, the facility failed to implement an active program for the prevention and control of infection and communicable diseases. The finding is: Observation upon entry into the group home on	W 455		

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W 455	Continued From page 7 12/19/22 at 4:00 PM revealed staff C to meet surveyors at the front door with client #5 and staff A to prepare the dinner meal in the kitchen. Continued observations revealed both staff to be without a face mask or face covering. Further observations at 4:09 PM revealed the home manager (HM) to enter the group home and not wear a mask which is a current requirement by the Centers for Medicare and Medicaid Services (CMS) to limit the spread of the COVID-19 virus. Subsequent observations revealed all staff and HM to put on a face mask upon surveyor speaking to HM regarding mask requirements at approximately 4:35PM. Interview on 12/20/22 with the facility nurse verified that all staff working in the group home should be wearing a face mask. Continued interview with the facility nurse confirmed that all staff received an in-service training on 10/18/22 that the current policy is for all staff and visitors to wear masks in the group homes.	W 455		
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 clients' (#1, #2) developmental level. The findings are: A. The facility failed to ensure client #1's diet consistency was implemented as prescribed. For example:	W 474		

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W 474	Continued From page 8	W 474		

Afternoon observations in the group home on 12/19/22 at 4:55 PM revealed client #1 to sit at the dining table to prepare for the dinner meal. The dinner meal consisted of the following: chicken alfredo, tossed salad, dressing, garlic toast, cupcakes, water and milk. Continued observations revealed client #1 to sit at the table with his plate already prepared by staff. Further observations revealed staff to cut client #1's chicken alfredo and salad with scissors into bite size pieces. Additional observations at 5:15 PM revealed staff to give client #1 a whole cupcake which had not been cut according to the client's mechanical soft diet. At no point during the observation was client #1's food processed into a mechanical soft diet as prescribed.

Review of the record for client #1 on 12/20/22 revealed an individual support plan (ISP) dated 8/12/22. Continued review of the record for client #1 revealed an annual nutritional assessment dated 7/29/22 which indicated client #1 should have the following diet: 1800 calorie, low cholesterol and mechanical soft diet.

Interview with the Residential Services Director (RSD) on 12/20/22 revealed client #1's diet plan and consistency are current. Continued interview with the RSD revealed staff should implement client #1's diet consistency as prescribed.

B. The facility failed to ensure client #2's diet consistency was implemented as prescribed. For example:

Afternoon observations in the group home on 12/19/22 at 4:50 PM revealed client #2 to sit at the dining table to prepare for the dinner meal. The dinner meal consisted of the following:

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W 474	Continued From page 9 chicken alfredo, tossed salad, dressing, garlic toast, cupcakes, water and milk. Continued observations revealed staff to cut client #2's chicken alfredo and salad with scissors into bite size pieces. Additional observations at 5:05 PM revealed staff to give client #2 a whole cupcake for dessert. At no point during the observation was client #2's food processed into a mechanical soft diet as prescribed. Morning observations in the group home at 6:35 AM revealed staff to prepare client #2's plate for the breakfast meal. The breakfast meal consisted of the following: 2 hard boiled eggs, whole wheat toast, margarine, jelly, water and milk. Continued observations revealed client #2's plate to have 2 hard boiled eggs cut in half size pieces and a whole piece of toast. At no point during the observation did staff process client #2's food into a mechanical soft diet as prescribed. Review of the record for client #2 on 12/20/22 revealed an individual support plan (ISP) dated 3/19/22. Continued review of the record for client #2 revealed a nutritional assessment dated 3/12/22 which indicated client #2 should have the following diet: 1800 calorie, mechanical soft diet. Interview with the residential services director (RSD) on 12/20/22 revealed client #2's diet plan and consistency are current. Continued interview with the RSD revealed staff should implement client #2's diet consistency 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	W 508		

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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 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:

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W 508	Continued From page 11 (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 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	W 508		

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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 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

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RAVENDALE DRIVE GROUP HOME	1123 RAVENDALE DRIVE CHARLOTTE, NC 28216

(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 508	Continued From page 13 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 follow developed policies and procedures for COVID-19. The finding is: Review on 12/19/22 of the facility employee COVID-19 vaccinations and exemption information revealed the home manager (HM) had not completed primary vaccination series for COVID-19 including a multi-dose vaccine and no request for exemption approved. The employee while present in the group home on 12/19/22 confirmed with surveyor regarding unvaccinated status. Review of the facility COVID-19 vaccination policy for staff (dated 1/25/22) on 12/20/22 revealed that all ICF employees shall be fully vaccinated for the COVID-19 virus. Continued review of the policy revealed that employees who fail to comply with the vaccine policy are subject to disciplinary action, including termination. Interview on 12/20/22 with the residential services director (RSD) verified the facility has written policies and procedures to ensure all staff are fully vaccinated for COVID-19. Continued interview with the residential services director verified that the HM is currently unvaccinated and does not have an approved exemption.	W 508		