STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G294	A. BUILDING _____ B. WING _____	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KONNOAK GROUP HOME	2901 KONNOAK DRIVE WINSTON SALEM, NC 27127

(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 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 observations, record reviews and interviews, the facility failed to ensure 4 of 6 audit clients (#2, #3, #4 and #5) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Support Plan (ISP) in the areas of leisure and opportunities for choice and self management. The findings are: A. During observations throughout the survey on 1/30/23 from 4:30pm until 6:04pm on 1/31/23 from 6:00am until 7:00am, client #3 was observed sitting at a table, coloring in a book. At no time during the observations was client #3 prompted to do anything other than eat dinner on 1/30/23 and breakfast on 1/31/23. Review on 1/31/23 of client #3's ISP revealed training in the areas of participating in household chores, participate in appropriate toileting, participate in appropriate personal space, participate in medication administration, and participate in activities. Interview on 1/31/23 with the qualified intellectual	W 249		

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

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W 249	Continued From page 1 disabilities professional (QIDP) confirmed client #3 should have been prompted and engaged in other activies than coloring. B. During observations in the home on 1/31/23 from 6:00am until 7:00am, Staff C was observed to prepare the breakfast meal and wash dishes. At no time during the observation was any client prompted to assist with meal prep and clean up. Review on 1/30/23 of client #5's ISP dated 7/5/22 revealed a training objective to prepare a simple meal. Review on 1/31/23 of client #2 ISP dated 1/4/23 revealed a training objective to prepare his lunch or meal. Review on 1/31/23 of client #4's ISP dated 4/29/22 revealed a training objective to cook a meal. Interview on 1/31/23 with the QIDP confirmed staff should have prompted and engaged clients in the meal preparation and clean up.	W 249		
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the restrictive behavior techniques for 1 of 6 audit clients (#5) was reviewed and monitored by the human rights	W 262		

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W 262	Continued From page 2 committee (HRC). The findings is: Review on 1/30/23 of client #5's behavior support plan (BSP) dated 7/11/22 revealed target behaviors consisting of cooperation disturbance. Further review of the BSP revealed medications consisting of Paxil for depression and Ativan for anxiety. Continued review of the BSP revealed the Human Rights Committee (HRC) had not reviewed or consented to the BSP since 7/8/19. Interview on 1/31/23 with the qualified intellectual disabilities professional (QIDP) confirmed client #5's BSP was not reviewed or consented to by the HRC.	W 262		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 1 of 1 of 6 audit clients (#5). The finding is: Review on 1/30/23 of client #5's behavior support plan (BSP) dated 7/11/22 revealed target behaviors consisting of cooperation disturbance. Further review of the BSP revealed medications consisting of Paxil for depression and Ativan for anxiety. Continued review of the BSP revealed no guardian consent was obtained. Interview on 1/31/23 with the qualified intellectual	W 263		

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W 263	Continued From page 3 disabilities professional (QIDP) confirmed written informed consent has not been obtained from the legal guardian.	W 263		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure all medications were administered without error. This affected 1 of 2 clients (#6) observed receiving medications. The findings are: During observations in the home at 7:00am, client #6 was observed eating breakfast. At 7:12am, client #6 was observed taking his medication. Client #6 ingested one Calcium 60mg tablet; one Losartin 50mg tablet; one Metformin 1000mg tablet; one Vitamin D3 2000iu capsule; one Januvia 100mg tablet; one Montelukast 10mg tablet; and one Alendronate 70mg. Review on 1/31/23 of client #6's physician's orders dated 10/1/22 revealed an order for Januvia 100mg, "take 1 tablet by mouth one daily before breakfast," and an order for Alendronate 70mg, "take on an empty stomach." Interview on 1/31/23 with the qualified intellectual disabilities professional (QIDP) confirmed client #6's medications should have been administered according to physician's orders.	W 369		
W 508	COVID-19 Vaccination of Facility Staff CFR(s): 483.430(f)(1)-(3)(i)-(x)	W 508		

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W 508	Continued From page 4 § 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 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	W 508		

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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 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

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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 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

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W 508	Continued From page 7 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 follow policies and procedures for COVID-19 vaccinations. The finding is: Review on 1/31/23 of the facility employee COVID-19 vaccination cards revealed 1 out of 14 employees had completed exemptions or a primary vaccination series for COVID-19 including a multidose vaccine. Continued review revealed that staff G completed 1 dose of a multidose vaccine and no evidence of a final dose. Interview on 1/31/23 with human resource confirmed that the facility did not have documentation or proof that staff G was fully vaccinated. Continued interview with human resource confirmed that the facility has developed written policies and procedures to ensure all staff are fully vaccinated for COVID-19.	W 508		