STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G024	A. BUILDING _____ B. WING _____	09/20/2022

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W 226	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to implement a person-centered plan within 30 days of admission for 1 of 5 clients (#4). The finding is: Review of record for client #4 on 9/20/22 revealed an admission date of 6/7/22. Continued review revealed a person-centered plan for client #4 with an implementation date of 8/6/22. Interview with the qualified intellectual disabilities professional (QIDP) on 9/20/22 confirmed person-centered plan meeting for client #4 was held on 8/6/22. Further interview with the QIDP confirmed client #4's person-centered plan should have been completed within thirty days of the client's admission.	W 226	**W 226** VP of Operations LTSS will in-service all Residential Team Leads (RTLs) under her supervision on the Discharge and Transfer P&P and Active Treatment, Admission, Discharge, Individual Program Plan P&P by 11/20/2022.	11/20/2022
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, record review and	W 249		

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Louise Winstead, RN, Compliance Specialist — 10/03/2022

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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W 249	Continued From page 1 interview the facility failed to implement the person-centered plan (PCP) for 2 of 5 clients (#2 and #5) relative to using prescribed gait belts. The findings are: A. The facility failed to use prescribed gait belt for client #2. For example: Observation in the group home on 9/20/22 at 6:50 AM revealed client #2 to exit the bathroom dressed and not wearing a gait belt. Continued observation revealed client #2 to enter the bedroom and ambulate around bedroom and to open dresser drawers. Further observation at 7:00 AM revealed client #2 to exit the bedroom not wearing gait belt and ambulate without assistance to the dining room table. Subsequent observation at 7:08 AM revealed staff E to walk into client #2's bedroom and return to dining room with a gait belt to place on the client. Review of record on 9/20/22 for client #2 revealed a PCP dated 8/1/22. Review of PCP revealed client #2 to have a diagnosis of profound intellectual disabilities, neurogenerative disease, seizure disorder, hypothyroidism, apraxia, macular hypoplasia, bilateral ocular albinism and ventricular septal defect. Continued review of client #2's PCP revealed client to be prescribed a gait belt at home and a wheelchair when assessing the community. Further review of PCP revealed client has had some previous injuries including broken ribs and collar bone and uses a bed alarm at night to alert staff. Interview with the qualified intellectual disabilities professional (QIDP) verified the PCP dated 8/1/22 for client #2 was current. Continued interview with the QIDP confirmed that staff	W 249	**W 249** RTL and/or Residential Manager (RM) will in-service staff on Client #2 and Client #5's PCP relative to using prescribed gait belts. RM and/or Designee will monitor a minimum of weekly for 3 months to ensure staff are following plans as written. This will be documented on an observation form.	11/20/2022 To start no later than 11/20/22 and continue 3 months

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W 249	Continued From page 2 should be using client #2's adaptive equipment as prescribed. B. The facility failed to use prescribed gait belt for client #5. For example: Observation in the group home on 9/20/22 at 7:50 AM revealed client #5 to ambulate around the living room in a wheelchair. Continued observation revealed staff C to assist client #5 to the dining room area. Further observation at 7:59 AM revealed staff C to lock the wheels on client #5's wheelchair and to assist the client to walk to the dining room table while not wearing a gait belt and to sit the client into a chair. Subsequent observation revealed staff A to look in the client's wheelchair and locate the gait belt to place on the client. Review of record on 9/20/22 for client #5 revealed a PCP dated 9/1/21. Review of PCP revealed client #5 to have a diagnosis of profound intellectual disabilities, hydrocephalus and seizure disorder. Continued review of client #5's PCP revealed the client over the last year to be severely unsteady resulting in multiple falls and injuries. Further review of record revealed a physician order dated 3/18/21 for client #5's prescribed gait belt. Interview with the qualified intellectual disabilities professional (QIDP) verified the PCP dated 9/1/21 for client #5 was current. Continued interview with the QIDP confirmed that staff should be using client #5's adaptive equipment as prescribed.	W 249	This Page Intentionally Left Blank	
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i)	W 340		

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W 340	Continued From page 3 Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure staff were adequately trained to ensure privacy during medicaion administration for 3 of 5 clients (#1, #2 and #5). The finding is: Observation in the group home on 9/20/22 at 7:35 AM revealed staff E to administer medications to client #2 and allow the client to remain in the medication room to finish fiber drink while staff E assisted client #5 into the medication room. Continued observation at 7:37 AM revealed staff E to administer medications to client #5 with the medication room door open and client #2 remaining in the medication room. Further observation at 7:38 AM revealed staff E to assist client #5 to exit the medication room and client #1 to enter the medication room while client #2 remained in medication room and for staff E to administer medications to client #1 with the door open. Staff A entered the medication room and assisted client #2 to the dining room table to finish fiber drink. Subsequent observation at 7:47 AM revealed client #1 to exit the medication room and enter the kitchen to place an empty cup in the sink. Interview with the facility nurse on 9/20/22 confirmed that the staff should be administering medications one client at a time. Continued interview with the facility nurse revealed that the staff should provide privacy during medication	W 340	**W 340** LTSS Nurse and/or Designee will in-service staff on Medication Administration P&P with emphasis on privacy. RM and/or Designee will monitor a minimum of 2 medication passes weekly for 3 months to ensure privacy is being maintained for the individuals and documented on the Medication Observations form.	11/20/2022 To start no later than 11/20/22 and continue 3 months

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W 340	Continued From page 4 administration.	W 340	This Page Intentionally Left Blank	
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 facility that are performed exclusively outside of	W 508		

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W 508	Continued From page 5 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 has granted, an exemption from the staff	W 508	This Page Intentionally Left Blank	

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W 508	Continued From page 6 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 paragraph (f)(1) of this section are fully	W 508	This Page Intentionally Left Blank	

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W 508	Continued From page 7 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 interview, the facility failed to follow policies and procedures for COVID-19 relative to staff wearing mask and screening protocol. The finding is: Upon arrival on 9/19/22 at 11:00 AM revealed staff A and staff B to work in the group home not wearing a mask. Continued observation revealed an outside contractor to enter the home wearing a mask and no screening performed. At no point during survey on 9/19 - 9/20/22 did staff working in the group home screen the surveyor. Review of staff COVID-19 vaccinations on 9/19/22 revealed 15 out of 16 employees to be fully vaccinated. Continued review revealed staff A to be unvaccinated with an approved exemption. Review of policy and procedure manual on 9/20/22 revealed a mask/PPE COVID-19 guideline for all locations dated 5/3/22. Continue review of the guidelines revealed all staff are required to wear mask. Further review of the policies and procedures dated 8/2/22 revealed the facility will follow all CMS mandates and requirements as it pertains to COVID-19 vaccination for all required sites. Interview on 9/20/22 with the facility nurse revealed that staff are to wear mask while	W 508	**W 508** RTL and/or RM will in-service staff on Mask/PPE Covid-19 Guidelines and After Covid-19 Residential Plan Update 03.03.2022 RTL and/or RM will monitor that required PPE is being worn properly and will document this on Mask Observation Form. This monitoring will be conducted a minimum of weekly for 3 months (or less if the mask restriction is lifted).	11/20/2022 Will start by 11/20/22 and continue for 3 months (or less if mask restriction is listed)

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W 508	Continued From page 8 working in close contact with individuals in the group home and staff do not have to wear mask all the time. Continue interview with the nurse revealed staff should screen all visitors entering the group home. The nurse was not clear on the facilities policy and procedures regarding staff wearing mask.	W 508	This Page Intentionally Left Blank	