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	34G222	A. BUILDING _____ B. WING _____	10/20/2022

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JADE TREE	6501 JADE TREE LANE RALEIGH, NC 27615

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W 120	SERVICES PROVIDED WITH OUTSIDE SOURCES CFR(s): 483.410(d)(3) The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure outside services were coordinated to meet the needs of clients. This affected 4 of 4 audited clients in the home (#1, #2, #3 and #6). The findings are: A. Record review on 10/19/22 at the vocational center revealed there were no copy of the individual program plan (IPP) and behavior support plan (BSP) for client #1 provided to the staff. B. Record review on 10/19/22 at the vocational center revealed there were no copy of the individual program plan (IPP) and behavior support plan (BSP) for client #2 provided to the staff. C. Record review on 10/19/22 at the vocational center revealed there were no copy of the individual program plan (IPP) and behavior support plan (BSP) for client #3 provided to the staff. D. Record review on 10/19/22 at the vocational center revealed there were no copy of the individual program plan (IPP) and behavior support plan (BSP) for client #6 provided to the staff. Interview on 10/19/22 with the qualified intellectual disabilities professional (VC-QIDP) for the clients at the vocational center revealed that	W 120	During our annual survey, a systems review revealed an area of needed improvement which included ensuring consistent and open communication with all treatment team members. While we work closely with our consumer treatment team members, this communication was disrupted during the coronavirus pandemic as we attempted to navigate new means of communicating and sharing information. It was later found that the information regarding the injured participant was indeed communicated with the staff members who received the consumers on the morning that he was dropped off at the day program. Despite this information, we will provide all treatment team members with a copy of all program documents necessary to ensure coordination of care. To monitor this, a record of all shared documentation will be maintained by the QP and reviewed at least annually.	Within 60 days

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary S. Haven, QP | TITLE: Clinical Director | (X6) DATE: 1/17/2023

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 120	Continued From page 1 she did not have any copies of the BSP and IPP. The VC-QIDP revealed that client #2 missed work for three days and the facility did not communicate why. When client #2 appeared at the vocational center today, staff noticed that he had stitches on lip and swelling around his eye. The vocational center thought that perhaps he had been involved in an incident at the home but was not certain. Interview on 10/20/22 with the QIDP at the group home revealed that on 10/16/22, client #3 fell on his face while standing and sustained facial injuries. Client #3 was sent to the emergency room to rule out new seizure activity. The home kept client #2 home to monitor his condition. The QIDP acknowledged that they fell to communicate this to the day program before 10/19/22. The QIDP also stated that they should send the vocational center copies of the clients IPP and BSP but during the pandemic, it fell through the cracks.	W 120		
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 interview, the facility failed to provide privacy for 2 of 2 clients (#1 and #3) observed during medication administration. The findings are: A. During medication administration observed in the home on 10/19/22 between 4:07pm-4:10pm, client #3 stood in the hallway, near the medication closet when client #1 received her medication.	W 130		

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W 130	Continued From page 2 In addition, during medication administration observation in the home on 10/20/22 from 6:55am-6:58am, Client #3 stood in the hallway, near the medication closet when client #1 received her medication. B. During medication administration observed in the home on 10/20/22 between 7:10am-7:13am, Staff D escorted clients #4 and #6 to the hallway near the medication closet, to stand holding their cups of water, waiting for their turns. Staff C proceeded to lift client #3's shirt to give him an insulin injection in his stomach, in front of clients #4 and #6. Review on 10/19/22 of a sign posted inside the medication closet stated: One client allowed at closet at a time. Interview on 10/20/22 with the qualified intellectual disabilities professional (QIDP) revealed that she had observed client #3 standing in the hallway during client #1's medication administration on 10/19/22 and redirected him to wait in another area. The QIDP acknowledged that clients were supposed to be ensured privacy during medications.	W 130	A systems review during our annual survey identified the need to implement additional training measures for our staff to ensure consumer privacy during medication administration. As a result, we will retrain staff on the medication administration right to privacy. Additionally, we will implement a medication observation record that will require a manager or higher level administrator to observe medication administration on various shifts at least 3 times weekly. The QP and/or her designee will review this on at least a monthly basis until it has been determined that staff are in compliance with the requirement. Furthermore, this observation will continue to be conducted at random to ensure continued compliance.	Within 60 days
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.	W 252		

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W 252	Continued From page 3 This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure all data relative to targeted behaviors in the behavior support plan (BSP) were documented for 2 of 4 audit clients (#2 and #3). The findings are: A. Review on 10/20/22 of client #2's behavior data log for October 2022 omitted targeted behaviors present or not displayed, on every shift, as required in the BSP. B. Review on 10/20/22 of client #3's behavior data log from 10/9/22-10/16/22 did not indicate any recorded data of skin picking. There was no data from 10/17/22-10/19/22. Interview on 10/20/22 with the qualified intellectual disabilities professional (QIDP) revealed that behavior data should be completed on the data log as indicated in the BSP.	W 252	During our annual survey review, it was revealed the need to add additional training for staff on how to properly document consumer behaviors. We will increase our training and immediately conduct an inservice with staff on how and when to document consumer behaviors. In conjunction with the agency Psychologist, the QP will review the behavior documentation at least monthly to ensure that documentation is completed accurately.	Within 60 days
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 staff interview, the facility failed to ensure a restrictive Behavior Support Plan (BSP) device was conducted with the written consent of the guardian. This affected 1 of 4 audit clients (#3). The finding is: Review on 10/20/22 of client #3's BSP summary dated 3/14/22 stated target behaviors included self-injurious behaviors (SIB). SIB was defined as	W 263		

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W 263	Continued From page 4 any scratching, poking, or picking at the skin that result in scratches, bleeding, roughened, or reddened skin. Interventions for SIB stated if client #3 was observed picking at his skin he should be told to stop and redirected to an area where staff can observe him. If client #3 does not respond to redirection, neoprene gloves should be applied for a maximum of 30 minutes. Released when behavior stops, or maximum time is reached. Review on 10/20/22 of client #3's BSP consent signed by the guardian on 3/1/22 did not include using neoprene gloves to prevent injuries during skin picking. Interview on 10/20/22 with the qualified intellectual disabilities professional (QIDP) revealed that they did not include neoprene gloves on the BSP consent form.	W 263	During the annual survey review, a review of systems revealed that although a behavior consent was completed, the consent did not include the restrictive intervention as outlined in the consumer's BSP. As a result, the consumer's BSP consent will be reviewed for accuracy and resubmitted to the guardian for approval and signature. The QP will ensure that all BSP consents are accurate prior to submitting to the guardian for review and signature at the annual renewal.	Within 60 days
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	W 508		

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W 508	Continued From page 5 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 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;	W 508	A review of systems during our annual survey identified the need to increase oversight of required employee documentation including vaccination cards. This information is obtained by our Human Resources department. To remedy this, we will train our Human Resources staff on the importance of gathering this information and following-up with staff to obtain required documentation *within 5 days of requesting*. HR will maintain a record of all required employee vaccinations which will be reviewed at random by the Executive Director and/or her designee.	Within 60 days

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W 508	Continued From page 6 (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 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	W 508		

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W 508	Continued From page 7 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 record review and interviews, the facility failed to implement their COVID-19 Vaccination Policy for unvaccinated staff. The finding is: Review on 10/20/22 of the facility's COVID-19 Vaccination Policy dated January 2022 revealed: All staff required to have COVID-19 vaccine unless exempted under religious/medical policies. Before beginning work at the facility, all new hires must have at least the first dose of Center for Disease Control (CDC) approved vaccine.	W 508		

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W 508	Continued From page 8 Exempted employees must submit to weekly testing, any positive test will result in staff being removed from work schedule until an acceptable time has elapsed as outlined by the CDC. Review on 10/20/22 of the employee's vaccine statuses revealed Staff E, a new hire did not have evidence of a COVID-19 vaccine or approved religious or medical exemption. Interview on 10/20/22 with the qualified intellectual disabilities professional (QIDP) revealed that Staff E worked on 10/16/22. The QIDP was unaware of Staff E's vaccine status. Interview on 10/20/22 with the Program Director (PD) revealed Staff E was hired about three weeks ago and it was the responsibility of the hiring manager to obtain the vaccine card or arrange the exemption. The PD acknowledged that she could not find a record that Staff E had received the COVID-19 vaccine and did not have a vaccine exemption on file.	W 508		