STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G146	A. BUILDING _____ B. WING _____	10/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXTRA SPECIAL CARE	6214 KILMORY DRIVE FAYETTEVILLE, NC 28304

(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
E 004	Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency	E 004	DHSR - Mental Health NOV 21 2022 Lic. & Cert. Section	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dana Dawson | TITLE: QP | (X6) DATE: 11/14/22

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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E 004	Continued From page 1 Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the emergency plan was reviewed and updated biannually. This potentially affected all clients (#1, #2, #3, #4, #5, and #6) living in the home. Review on 10/24/22 of the emergency preparedness plan revealed 9/14/20 as the most recent date of review and update. Interview on 10/25/22 with the Qualified Intellectual Disabilities Professional (QIDP) revealed that she was unable to locate an updated emergency plan following 9/14/20.	E 004	E004: The facility will ensure the emergency preparedness plan is reviewed and updated at least every two years. The QP will monitor monthly.	12/25/2022
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:	E 039		

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E 039	Continued From page 2 (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:	E 039		

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E 039	Continued From page 3 (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or	E 039		

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E 039	Continued From page 4 man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next	E 039		

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E 039	Continued From page 5 required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency	E 039		

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E 039	Continued From page 6 event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise	E 039		

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E 039	Continued From page 7 following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based	E 039		

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E 039	Continued From page 8 functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or	E 039		

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E 039	Continued From page 9 (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:	E 039		

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E 039	Continued From page 10 (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to conduct exercise to test the emergency preparedness plan. This potentially affected all clients (#1, #2, #3, #4, #5, and #6) living in the home. Review on 10/24/22 of the emergency preparedness plan, dated 9/14/20, revealed that neither a tabletop activity, nor a full-scale, community-based activity could be located. Interview on 10/25/22 with the Qualified Intellectual Disabilities Professional (QIDP) revealed that she was unable to locate either a tabletop activity, or a full-scale, community-based activity.	E 039	E039: The facility will ensure to maintain documentation for all drills, tabletops exercises and emergency event and revised the emergency plan as needed. The QP will monitor monthly.	12/25/2022
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 meet the needs of each client through consistent	W 120	W120: The facility will ensure outside side service meet the needs of each client through consistent implementation across settings of behaviors management strategies, identified in the Behavior Support Plan and Dietary guideline. QP will provide each BIP and Dietary Guidelines to each teacher of the clients. QP will monitor as needed.	12/25/2022

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W 120	Continued From page 11 implementation across settings of behavior management strategies, identified in the Behavior Support Plan (BIP), and dietary guidelines, identified in the Individual Program Plan. This affected 1 of 4 audit clients (#6). The findings are: Review on 10/24/22 of client #6 IPP, dated 8/19/22, revealed a prescribed regular diet, with seconds if desired, using soy milk instead of regular milk. All food should be pre-cut into bite-sized pieces before serving. Client #6 should use a plate guard at each meal. The IPP included regurgitation as a target behavior for client #6 and stated that his BIP addressed the behavior. Review on 10/24/22 of client #6's Behavior Intervention Plan (BIP), dated 1/13/22, revealed a target behavior of regurgitation with an intervention requiring liquids to be served before serving meals. The BIP states that client #6 should be given his meal after he consumes his liquid. The BIP further states that staff should encourage client #6 to drink his liquid while telling him that he will receive his meal afterwards. Review on 10/25/22 of physician orders, dated 9/30/22 for client #6 revealed a prescribed regular diet, pre-cut and pre-plated to bite-sized pieces with the use of soy milk only. In addition, the orders included the use of a plate guard. Interview on 10/24/22 with client #6's high school teacher revealed that client #6's food is brought from the cafeteria on a regular tray without a plate guard. The teacher stated that all food was served to client #6 whole. When asked if he is served liquids before meals or encouraged to drink before eating, the teacher stated that client #6 was food and beverages together without	W 120		

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W 120	Continued From page 12 reference to liquids first. Interview on 10/25/22 with the residential manager revealed that facility members had attended client #6's Individual Education Plan (IEP) meetings and was aware of information about client #6. When asked if the school had a copy of the client #6's BIP, the residential manager stated that the school chose to develop their own BIP instead of using the facility BIP.	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 interviews with staff, the facility failed to provide privacy to 2 of 4 audit clients (#3 and #5) during personal care. The findings are: A. During observations in the facility on 10/24/22 at 4:22pm, staff B assisted client #3 to the bathroom next to the kitchen with her towel and grooming kit. Staff B had client #3 undress and get into the shower while the door was open revealing client #3 undressed with the door open. Client #3 continued to shower with the door open and staff B standing at the doorway. Client #3 was cued to close the bathroom door as she got dressed after getting out of the shower. Review on 10/25/22 of client #3's adaptive behavior Inventory (ABI) dated 1/25/22 revealed she is independent in closing the bathroom door for privacy during bathing. Interview with the qualified intellectual disabilities	W 130	W130: The facility will ensure all staff are trained on privacy of each client during personal care and making sure all privacy of each client is met. Home Manager will monitor daily and QP will monitor monthly.	12/25/2022

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W 130	Continued From page 13 professional (QIDP) revealed staff should close the bathroom door for privacy to protect client #3's privacy during personal care. B. During observations in the facility on 10/25/22 at 5:40am client #5 went into the bathroom to use the toilet with the door open. There were two staff working in the facility. The bathroom is adjacent to clients #3 and #4 who were in their bedroom with the door open. Staff B walked down the hallway and did not cue client #5 to close the bathroom door. Client #5 also was not cued to wash his hands after toileting. Review on 10/25/22 of client #5's ABI dated 1/20/22 that client #5 is independent in closing the door for privacy and washing his hands after toileting. Interview on 10/25/22 with the QIDP revealed staff should close the bathroom door for privacy to protect client #5's privacy during personal care.	W 130		
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 review, and	W 249		

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W 249	Continued From page 14 interviews, the facility failed to ensure clients received a continuous active treatment program consisting of needed interventions and services to support the achievement of objectives identified in the Individual Program Plan (IPP) in the areas of dietary guidelines. This affected 1 of 4 audit clients (#6). The findings are: Observations in the dining room on 10/24/22 to 10/25/22 revealed client #6 served beverages with his food. On 10/24/22, at 4:49pm, the residential manager (RM) told staff to make sure they gave client #6 liquids before food. At 4:54pm, during snack time, Staff B assisted client #6 to pour soy milk in a glass. He was then served his pretzel snack with his beverage. Client #6 did not have his beverage before eating. During dinner, at 6:01pm, client #6 was served pre-cut beef stew, vegetables, mashed potatoes, and bread with soy milk and water. On 10/25/22, at 5:45am, Staff E served client #6 cereal and soy milk with juice. Review on 10/24/22 of client #6 IPP, dated 8/19/22, revealed a prescribed regular diet, with seconds if desired, using soy milk instead of regular milk. All food should be pre-cut into bite-sized pieces before serving. The IPP stated that client #6 had a history of regurgitation as a target behavior. Review on 10/24/22 of client #6's Behavior Intervention Plan (BIP), dated 1/13/22, revealed a target behavior of regurgitation with an intervention requiring liquids to be served before serving meals. The BIP states that client #6 should be given his meal after he consumes his liquid. The BIP further states that staff should encourage client #6 to drink his liquid while telling	W 249	W249: The facility will ensure all clients received a continuous active treatment program consisting of needed interventions and services to support the achievement of objectives identified in the Individual Program Plan in the areas of dietary guidelines. The facility will ensure all staff will be trained on active treatment. QP will monitor monthly. Home Manager will monitor daily.	12/25/2022

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W 249	Continued From page 15 him that he will receive his meal afterwards. Interview on 10/25/22 with Staff E revealed client #6 needs prompting to eat. When asked if client #6 should have liquids before his meal, Staff E stated, "I think he had liquid when she gave him meds." Interview on 10/25/22 with the residential manager revealed that client #6 had a history of projectile vomiting but did not "vomit like he use to anymore." The residential manager stated that client #6's guidelines include food being pre-cut before serving with beverages being served first. When asked if client #6 should drink before eating, the residential manager referred to the BIP and stated that client #6 is to be served liquids before meals.	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 confirmed by interviews with staff, the facility failed to obtain approval for 2 of 4 audit clients (#2 and #5) restrictive behavior support programs (BSP) from the human rights committee (HRC). The findings are: A. Review on 10/24/22 of client #2's BSP dated 7/12/21 revealed his BSP addressed the target behaviors of: non-compliance, self- injurious behavior, attention seeking, severe disruptive	W 262	W262: The facility will ensure to obtained approval for all restrictive behavior intervention programs (BIP) from the human rights committee (HRC). QP will monitor as needed.	12/25/2022

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W 262	Continued From page 16 behaviors, physical aggression, AWOL, PICA and crying. Further review of this BSP revealed it incorporated the use of Clonidine, Risperdal, Focalin and Guanfacine. Further review of this BSP revealed no consent from the HRC. B. Review on 10/25/22 of client #5's behavior support program (BSP) dated 2/20/22 which addressed target behaviors of PICA, begging for food, inappropriate toileting, stealing and physical aggression included the use of Olanzapine and Clonidine. Further review of this program revealed there was not approval from the HRC. Interview on 10/25/22 with the qualified intellectual disabilities professional (QIDP) revealed there was not HRC written or verbal approval for clients #2 and #5's BSPs.	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 obtain written informed consent for 2 of 4 audit clients (#2 and #3) restrictive behavior support programs (BSP). The findings are: A. Review on 10/24/22 of client #2's BSP dated 7/12/21 revealed his BSP addressed the target behaviors of: non-compliance, self- injurious behavior, attention seeking, severe disruptive behaviors, physical aggression, AWOL, PICA and crying. Further review of this BSP revealed it incorporated the use of Clonidine, Risperdal,	W 263	W263: The facility will ensure all clients obtain written informed consent for Restrictive Behavior plan support programs. QP will monitor monthly.	12/25/2022

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W 263	Continued From page 17 Focalin and Guanfacine. Additional review of this BSP revealed the last written informed consent from the legal guardian for client #2 was dated 7/20/21 and the consent indicated it would be effective for one year after the program was signed. Additional review revealed no subsequent written informed consent from the guardian since 7/20/21. Interview on 10/25/22 with the qualified intellectual disabilities professional (QIDP) revealed there was not current written informed consent from #2's legal guardian since 7/20/21. B. Review on 10/24/22 of client #3's BSP dated 2/15/22 revealed her BSP addressed the target behaviors of: non-compliance, physical aggression, self-injurious behavior, property destruction physical aggression and stealing. Further review of this BSP revealed this program incorporated the use of Clonidine and Aripiprazole. Additional review of this program revealed the last consent for client #3's BSP was for her previous program dated 8/21/21. The consent dated 8/21/21 revealed the written informed consent was only valid for one year. There was not any written informed consent from client #'s legal guardian for the new BSP dated 2/15/22. Interview on 10/25/22 with the qualified intellectual disabilities professional (QIDP) revealed there was not current written informed consent from #3's legal guardian since 8/21/21.	W 263		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure	W 369		

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W 369	Continued From page 18 that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, record review and confirmed by interviews with staff, the facility failed to ensure all medications were administered to 1 of 4 audit clients (#2) without error. The finding is: During observations of the medication administration pass on 10/25/22 at 5:59am, staff D administered the following medications to client #2: Cetirizine 5ml., Clonidine 0.1mg, Guanfacine 2 mg., Risperdal .25mg., Focalin 15mg., Pediasure (1) and Miralax 17 grams. Review of the physician orders dated 7/14/22 revealed the following medications were ordered at 6am: Cetirizine 5ml., Clonidine 0.1mg, Guanfacine 2 mg., Risperdal .25mg., Pediasure (1) and Miralax 17 grams. Further review of physician orders dated 10/31/21 and the medication administration record for October 2022 revealed Focalin 15 mg. was ordered by the physician to be administered at 8 am. Interview on 10/25/22 with the qualified intellectual disabilities professional (QIDP) revealed medications can be administered an hour before or an hour after the prescribed time indicated by the physician to be administered without error.	W 369	W369: The facility will ensure all medication administered to the client during the appropriate time provided by physician. QP will monitor as needed.	12/25/2022
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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W 508	Continued From page 19 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:	W 508		

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W 508	Continued From page 20 (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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W 508	Continued From page 21 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	W 508		

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W 508	Continued From page 22 CDC, due to clinical precautions and considerations; This STANDARD is not met as evidenced by: Based on record review and confirmed by interviews with staff, the facility did not have a system for recording staff COVID-19 vaccination and/or approved exemption status as required. This affected all clients in the facility (#1, #2, #3, #4, #5 and #6). The finding is: Review on 10/25/22 of the list for staff COVID-19 vaccinations and/or religious and medical exemptions revealed there was confirmation for the administrator, qualified intellectual disabilities professional (QIDP) and the human resource director. The facility was unable to provide any other confirmations for the residential staff and professional contractors that worked with the clients in the facility. Interview on 10/25/22 with the QIDP and Administrator confirmed there was not currently a system to provide documentation for staff vaccination and/or medical or religious exemptions.	W 508	W508: The facility will ensure to have a system for recording staff COVID-19 vaccination and/or approved exemption status as required. HR will monitor as new staff hired and QP will monitor weekly to make sure previous staff is vaccinated.	12/25/2022