STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G151	A. BUILDING _____ B. WING _____	06/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NO PLACE LIKE HOME	4309 NC HWY 87 SOUTH FAYETTEVILLE, NC 28306

(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 218	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include sensorimotor development. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #1 was assessed for his use of an adaptive bowl. This affected 1 of 3 audit clients. The finding is: During lunch and dinner observations in the home on 6/5/23, client #1 utilized an extra large bowl to consume his meals. He consumed the meals with very minimal spillage. During breakfast observations in the home on 6/6/23, client #1 utilized a low sectioned plate. He consumed his breakfast meal with very minimal spillage. Interview on 6/5/23 with Staff A revealed client #1 uses the large bowl due to excess spillage at meals. Review on 6/5/23 of client #1's Individual Program Plan (IPP) dated 2/16/23 noted, "He is independent at feeding himself but needs prompts for manners...Because of excessive spillage he uses a high sided plate/bowl." Additional review of an Occupational Therapy evaluation dated 7/18/13 revealed no assessment of his dining skills and noted "N/A" under adaptive equipment. Interview on 6/6/23 with the Qualified Intellectual Disabilities Professional (QIDP) indicated client #1 was admitted to the facility with an adaptive bowl several years ago. The QIDP acknowledged the client needs to be reassessed for the appropriate adaptive dining equipment necessary at meals.	W 218		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Assistant Director	6/15/23

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G151	A. BUILDING _____ B. WING _____	06/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NO PLACE LIKE HOME	4309 NC HWY 87 SOUTH FAYETTEVILLE, NC 28306

(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 231	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4)(iii) The objectives of the individual program plan must be expressed in behavioral terms that provide measurable indices of performance. This STANDARD is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure the Individual Program Plan (IPP) included goals which were expressed in behavioral terms that provide measurable indices of performance for 3 of 3 audit clients (#1, #2, and #5). The findings are: A. Review on 6/5/23 of client #1's IPP dated 2/16/23 revealed the following objectives with no measurable criteria for completion: - "I will allow staff to brush my teeth with manual toothbrush while sitting in a chair with my headback." - "I will ID a penny independently." - "I will bring my clothing basket to the laundry room." - "I will greet people entering the home." - "I will wipe after BMs independently." B. Review on 6/5/23 of client #2's IPP dated 2/25/23 revealed the following objectives with no measurable criteria for completion: - "I will do voice exercises two times weekly to increase my speech volume." - "I will wipe down the stove, microwave and counters after meals." - "I will mop the kitchen floor independently." - "I will independently keep pants and underwear adjusted properly (pull up)." - "I will independently counts coins to equal $1.00."	W 231		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G151	A. BUILDING _____ B. WING _____	06/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NO PLACE LIKE HOME	4309 NC HWY 87 SOUTH FAYETTEVILLE, NC 28306

(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 231	Continued From page 2 C. Review on 6/5/23 of client #5's IPP dated 2/23/23 revealed the following objectives with no measurable criteria for completion: - "I will vacuum the dining room independently after each meal." - "I will ID a quarter independently." - "I will improve social skills by not interrupting when talking to others." - "I will clean the bathroom independently by checking the schedule." Interview on 6/6/23 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the objectives do not have a measurable criteria.	W 231		
W 255	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(i) The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the Individual Program Plan (IPP) for 2 of 3 audit clients (#1 and #2) was reviewed and/or revised after the clients had successfully completed objectives. The findings are: A. Review on 6/5/23 of client #1's Behavior Intervention Plan (BIP) dated 4/10/22 revealed objectives to decrease hand mouthing to 5 or fewer incidents for 10 out of 12 consecutive months and to decrease self-injurious behaviors	W 255		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G151	A. BUILDING _____ B. WING _____	06/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NO PLACE LIKE HOME	4309 NC HWY 87 SOUTH FAYETTEVILLE, NC 28306

(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 255	Continued From page 3 to 3 or fewer for 10 out of 12 consecutive months. Additional review of the client's behavior progress notes and data sheets for April '22 - May '23 revealed two documented self-injurious behaviors. No other self-injurious behaviors were documented over 13 months. Interview on 6/6/23 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the behavior objective had been completed and needed to be revised. B. Review on 6/5/23 of client #2's BIP updated 2/25/23 revealed objectives to decrease noncompliance to 4 incidents or fewer for 10 out of 12 consecutive months, to decrease physical aggression to 1 incident or fewer for 10 out of 12 consecutive months and to decrease verbal aggression to 6 or fewer per month for 10 out of 12 consecutive months. Additional review of the client's behavior progress notes and data sheets for April '22 - May '23 revealed one incident of physical aggression. No other incidents of physical aggression were documented over 13 months. Interview on 6/6/23 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the behavior objective had been completed and needed to be revised.	W 255		
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:	W 263		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G151	A. BUILDING _____ B. WING _____	06/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NO PLACE LIKE HOME	4309 NC HWY 87 SOUTH FAYETTEVILLE, NC 28306

(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 263	Continued From page 4 Based on record review and interview, the facility failed to ensure written informed consent was obtained from both of client #5's guardians for his restrictive Behavior Intervention Plan (BIP). This affected 1 of 3 audit clients. The finding is: Review on 6/5/23 of client #5's BIP dated 10/20/21 revealed an objective to decrease noncompliance to 0 incidents for 10 out of 12 consecutive months and to decrease physical aggression to 0 incidents for 10 out of 12 consecutive months. Additional review of the client's physician's orders dated 5/3/23 revealed the use of Risperdal, Cogentin, Clonazepam and Hydroxyz HCL to address his inappropriate behaviors. Further review of the record indicated only one of two guardian's for client #5 had given their written informed consent for the BIP on 3/12/23. Interview on 6/6/23 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #5 has two guardians and only one guardian had given their written informed consent for the BIP.	W 263		
W 312	DRUG USAGE CFR(s): 483.450(e)(2) be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure medications used to address client #5's inappropriate behaviors were included in a formal active treatment plan. This affected 1 of 3 audit clients. The finding is:	W 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G151	A. BUILDING _____ B. WING _____	06/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NO PLACE LIKE HOME	4309 NC HWY 87 SOUTH FAYETTEVILLE, NC 28306

(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 312	Continued From page 5 Review on 6/5/23 of client #5's BIP dated 10/20/21 revealed an objective to decrease noncompliance to 0 incidents for 10 out of 12 consecutive months and to decrease physical aggression to 0 incidents for 10 out of 12 consecutive months. Additional review of the client's physician's orders dated 5/3/23 revealed the use of Risperdal, Cogentin, Clonazepam and Hydroxyz HCL to address his inappropriate behaviors. Further review of client #5's BIP did not identify the use of medications used to address his inappropriate behaviors. Interview on 6/6/23 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #5 ingests medications to address inappropriate behaviors, however, the behavior medications are not included in a formal behavior plan.	W 312		
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 interviews, the facility failed to ensure all medications were administered in accordance with physician's orders. This affected 1 of 4 clients (#1) observed receiving medications. The finding is: During morning observations in the home on 6/6/23 at 7:36am, client #1 received one drop of Genteal tear solution in both eyes. Immediate interview with the medication	W 368		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G151	A. BUILDING _____ B. WING _____	06/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NO PLACE LIKE HOME	4309 NC HWY 87 SOUTH FAYETTEVILLE, NC 28306

(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 368	Continued From page 6 technician confirmed one drop was administered in both of client #1's eyes and this is done twice per day. Review on 6/6/23 of client #1's physician's orders dated 5/3/23 revealed an order for Genteal Tear Solution, "Apply 2 drops in each eye twice daily." Interview on 6/6/23 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #1 should have received two drops of the solution in both eyes.	W 368		
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	W 508		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G151	A. BUILDING _____ B. WING _____	06/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NO PLACE LIKE HOME	4309 NC HWY 87 SOUTH FAYETTEVILLE, NC 28306

(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 7 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; (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;	W 508		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G151	A. BUILDING _____ B. WING _____	06/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NO PLACE LIKE HOME	4309 NC HWY 87 SOUTH FAYETTEVILLE, NC 28306

(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 8 (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 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	W 508		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G151	A. BUILDING _____ B. WING _____	06/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NO PLACE LIKE HOME	4309 NC HWY 87 SOUTH FAYETTEVILLE, NC 28306

(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 9 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 interview, the facility failed to develop policies and procedures which include a contingency plan for staff who are not fully vaccinated against COVID-19. The finding is: Review on 6/5/23 of the facility's COVID-19 vaccination policy for employees (revised 1/21/22) did not include a contingency plan for staff that are not fully vaccinated. Interview on 6/6/23 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the facility's current COVID-19 vaccination policy for employees did not include a contingency plan for unvaccinated staff.	W 508		

No Place Like Home
Plan of Correction

W218 On or before August 5, 2023 the QP will review all Individual Plans and Comprehensive Functional Assessment and update them. Any clients to include client #1 who needs an Occupational Therapy Assessment on their dining skills will be assessed by an Occupational Therapist. The facility will then follow any and all recommendations given. QP will in-service staff on any OT recommendations. QP will monitor monthy or more frequently as needed.

W231 On or before August 5, 2023 the QP will review and revise the Individual Program Plans for consumers #1, #2, #5 and all others to ensure that the objectives are expressed in behavioral terms that provide measureable indicators of performance. The QP will re-train staff on each objective for all consumers. The QP will monitor bimonthly to ensure the staff is following the objectives of the Individual Program Plan.

W255 On or before August 5, 2023 the QP will review and revise the Behavior Intervention Plans for client #1 and #2 and any other clients where needed. In circumstances including but not limited to situations where the client has successfully completed objectives in the individual program the QP will revise the plan to indicate that the objective has been completed. Staff will be re-inserviced. QP will monitor bimonthly.

W263 On or before August 5, 2023 the QP will ensure that written informed consent is obtained from both of the clients' guardians for his restrictive Behavior Plan. The QP will review and revise the BIP for client #5 and ensure that both guardians give written informed consent. The QP will also review the Behavior Intervention Plans for all consumers and revise if necessary. QP will monitor quarterly.

W312 On or before August 5, 2023 the QP will review and revise client #5 and all other clients' Individual Program Plan to ensure medications used to address inappropriate behavior are included in the plan. The QP will monitor this quarterly or more frequently if needed.

W368 Before August 5, 2023 the RN will re-train the staff on Medication Administration in order to correctly carry out physician orders as written. The RN will monitor on a weekly basis.

W508 On or before August 5, 2023 the facility will develop policies and procedures, including a contingency plan for staff who are not fully vaccinated against Covid 19. Once the policy is developed QP will monitor every 90 days or more frequently if needed to ensure those that are not vaccinated are protected. The Covid 19 plan will be developed per NCDHHS Covid guidelines, and CDC Covid guidelines.

Assistant Director
4/15/23