	-	ID HUMAN SERVICES				FO	RM APPROVED	
	<u>S FOR MEDICARE & </u> DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI		E CONSTRUCTION		IO. 0938-0391 TE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			· /			COMPLETED		
34G297			B. WING			0	3/27/2018	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
ROANOKE PLACE					704 CAROLINA AVENUE AHOSKIE, NC 27910			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH			PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
E 006	CFR(s): 483.475(a)(1		E	006				
	[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]							
	facility-based and cor	include a documented, nmunity-based risk an all-hazards approach.*						
	on and include a docu community-based risk	§483.73(a)(1):] (1) Be based umented, facility-based and assessment, utilizing an , including missing residents.						
	and include a docume community-based risk	3.475(a)(1):] (1) Be based on ented, facility-based and < assessment, utilizing an , including missing clients.						
	(2) Include strategies events identified by the	s for addressing emergency ne risk assessment.						
	strategies for address identified by the risk a management of the c failures, natural disas that would affect the h care.	18.113(a)(2):] (2) Include sing emergency events assessment, including the onsequences of power ters, and other emergencies nospice's ability to provide						
	Based on record revi failed to develop an e (EP) plan including th							

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 04/02/2018

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.

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/02/2018 APPROVED 0. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G297	B. WING			03/2	27/2018	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE			
ROANOKE	PLACE			704 CAROLINA AVENUE AHOSKIE, NC 27910				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
E 006	based upon risk asses Review on 3/26/18 of revealed the plan did information in regards of the facility and the of in the risk assessmen approach. Interview on 3/26/18 v disabilities professiona not aware of this spect included in the EP plat this information on to Development of EP PC CFR(s): 483.475(b) (b) Policies and proced develop and implement policies and procedure plan set forth in parage assessment at parager and the communication this section. The polic reviewed and updated *Additional Requirement Facilities: *[For PACE at §460.8 procedures. The PAC	ve an emergency plan ssments. the facility's current EP plan not provide specific to the geographic location clients' needs of the facility at, utilizing an all-hazards with the qualified intellectual al (QIDP) revealed she was cific information was to be an; however, she would pass her manager. tolicies and Procedures edures. [Facilities] must nt emergency preparedness res, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must be d at least annually. ents for PACE and ESRD	EO	06	DEFICIENCY)			
	policies and procedure plan set forth in parage assessment at parager and the communication	res, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must						

Facility ID: 944506

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DATE	0. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	3	· · ·	LETED
34G297		B. WING		03/	27/2018	
AME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
ROANOKE PLACE				704 CAROLINA AVENUE AHOSKIE, NC 27910		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
E 013	Continued From page	e 2	E 01	13		
		t of medical and nonmedical				
		ng, but not limited to: Fire;				
		water failure; care-related				
		tural disasters likely to r safety of the participants,				
		ne policies and procedures				
	must be reviewed an	d updated at least annually.				
	-	at §494.62(b):] Policies and ysis facility must develop and				
		y preparedness policies and				
		n the emergency plan set				
	forth in paragraph (a)					
		raph (a)(1) of this section,				
		on plan at paragraph (c) of cies and procedures must be				
		d at least annually. These				
		, but are not limited to, fire,				
	equipment or power f					
	÷	supply interruption, and				
		y to occur in the facility's				
	geographic area.	not met as evidenced by:				
		the facility failed to develop				
		procedures to address				
		ness, considering risk				
		r communication plan in y evacuation of the clients in				
	the facility. The finding					
	During an interview o	n 3/26/18, gualified				
	intellectual disabilities	•				
	revealed they did not	have policies procedures for				
-	the emergency prepa					
E 032	-	ans for Communication	E 03	32		
	CFR(s): 483.475(c)(3	3)				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 04/02/2018 // APPROVED). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
34G297			B. WING			_	03/	27/2018
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
ROANOKE	E PLACE				704 CAROLINA AVENUE AHOSKIE, NC 27910			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRE) CROSS-REFERE	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 032 E 037	that complies with Fer and must be reviewed annually.] The commu- all of the following: (3) Primary and alterr communicating with the (i) [Facility] staff. (ii) Federal, State, trib emergency managem *[For ICF/IIDs at §483 alternate means for co- ICF/IID's staff, Federal local emergency man This STANDARD is r Based on documenta facility failed to develor communicating with fa- local governments dur finding is: The facility failed to de for communicating with governments during a Review on 3/26/18 of preparedness (EP) di information regarding communication. During an interview of intellectual disabilities	hess communication plan deral, State and local laws d and updated at least unication plan must include hate means for he following: val, regional, and local hent agencies. 3.475(c):] (3) Primary and ommunicating with the al, State, tribal, regional, and agement agencies. hot met as evidenced by: ation and interviews, the op an alternate means for acility staff, regional and ring an emergency. The evelop an alternate means th staff, regional and local an emergency. the facility's emergency d not include any alternate means of n 3/26/18, the qualified s professional (QIDP) he phone and cell service not another way to		03				
,								

Facility ID: 944506

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/02/2018 MAPPROVED D. 0938-0391	
· · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G297	B. WING			03/	27/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
ROANOKE	E PLACE				704 CAROLINA AVENUE AHOSKIE, NC 27910			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
E 037	ASCs, PACE organiza and dialysis facilities] (i) Initial training in empolicies and procedur staff, individuals provia arrangement, and vol expected role. (ii) Provide emergence least annually. (iii) Maintain documer (iv) Demonstrate staff procedures. *[For Hospitals at §48 at §491.12:] (1) Trainio or RHC/FQHC] must (i) Initial training in empolicies and procedur staff, individuals provia arrangement, and vol expected roles. (ii) Provide emergence least annually. (iii) Maintain documer (iv) Demonstrate staff procedures. *[For Hospices at §41 hospice must do all of (i) Initial training in empolicies and procedur staff, individuals provia arrangement, and vol expected roles. (ii) Provide emergence least annually. (iii) Maintain documer (iv) Demonstrate staff procedures.) The [facility, except CAHs, ations, PRTFs, Hospices, must do all of the following: hergency preparedness es to all new and existing ding services under unteers, consistent with their y preparedness training at htation of the training. 'knowledge of emergency 2.15(d) and RHCs/FQHCs ng program. The [Hospital do all of the following: hergency preparedness es to all new and existing ding on-site services under unteers, consistent with their y preparedness training at htation of the training. 'knowledge of emergency 8.113(d):] (1) Training. The f the following: hergency preparedness es to all new and existing ind individuals providing yement, consistent with their	E	037				
	policies and procedur staff, individuals provi arrangement, and vol expected role. (ii) Provide emergenc least annually. (iii) Maintain documer (iv) Demonstrate staff procedures. *[For Hospitals at §48 at §491.12:] (1) Traini or RHC/FQHC] must (i) Initial training in em policies and procedur staff, individuals provi arrangement, and vol expected roles. (ii) Provide emergenc least annually. (iii) Maintain documer (iv) Demonstrate staff procedures. *[For Hospices at §41 hospice must do all of (i) Initial training in em policies and procedur hospice employees, a services under arrang expected roles.	es to all new and existing ding services under unteers, consistent with their y preparedness training at ntation of the training. knowledge of emergency 2.15(d) and RHCs/FQHCs ng program. The [Hospital do all of the following: nergency preparedness es to all new and existing ding on-site services under unteers, consistent with their y preparedness training at ntation of the training. knowledge of emergency 8.113(d):] (1) Training. The f the following: nergency preparedness es to all new and existing unteers, consistent with their						

Facility ID: 944506

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 04/02/2018 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION		(X3) DATE : COMPL	SURVEY
		34G297	B. WING		_	03/2	27/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
ROANOKE PLACE				704 CAROLINA AVENUE AHOSKIE, NC 27910			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 037	procedures. (iii) Provide emergence least annually. (iv) Periodically review emergency preparedre employees (including special emphasis place procedures necessary others. *[For PRTFs at §441. program. The PRTF ne (i) Initial training in emplicies and procedure staff, individuals provi- arrangement, and vol- expected roles. (ii) After initial training preparedness training preparedness training (iii) Demonstrate staff procedures. (iv) Maintain document preparedness training *[For PACE at §460.8 organization must do (i) Initial training in emplicies and procedure staff, individuals provi- arrangement, contract volunteers, consistent (ii) Provide emergence least annually. (iii) Demonstrate staff procedures, including	cy preparedness training at w and rehearse its hess plan with hospice nonemployee staff), with ced on carrying out the y to protect patients and 184(d):] (1) Training must do all of the following: hergency preparedness res to all new and existing iding services under unteers, consistent with their y, provide emergency at least annually. knowledge of emergency thation of all emergency c. 44(d):] (1) The PACE all of the following: hergency preparedness res to all new and existing iding on-site services under tors, participants, and t with their expected roles. y preparedness training at f knowledge of emergency informing participants of go, and whom to contact in y.	E 037	7			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/02/2018 MAPPROVED). 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		_	(X3) DATE SURVE COMPLETED		
1		34G297	B. WING			03/2	27/2018	
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE			
ROANOKE	E PLACE			04 CAROLINA AVENUE NOSKIE, NC 27910				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
E 037	CORF must do all of t (i) Provide initial traini preparedness policies and existing staff, indi	.68(d):](1) Training. The the following: ing in emergency s and procedures to all new ividuals providing services	E 037					
	with their expected ro (ii) Provide emergence least annually. (iii) Maintain documer (iv) Demonstrate staff procedures. All new p and assigned specific the CORF's emergence their first workday. The include instruction in t alarm systems and sign equipment.	ey preparedness training at ntation of the training. f knowledge of emergency personnel must be oriented e responsibilities regarding cy plan within 2 weeks of he training program must the location and use of gnals and firefighting						
	The CAH must do all (i) Initial training in empolicies and procedur reporting and extingui and where necessary personnel, and guests cooperation with firefin authorities, to all new individuals providing s and volunteers, consis- roles. (ii) Provide emergence least annually. (iii) Maintain documer	nergency preparedness res, including prompt ishing of fires, protection, v, evacuation of patients, s, fire prevention, and ghting and disaster and existing staff, services under arrangement, stent with their expected by preparedness training at						

Facility ID: 944506

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 04/02/2018 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G297	B. WING				03/	27/2018
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STAT	TE, ZIP CODE		
ROANOK	E PLACE				704 CAROLINA AVENUE AHOSKIE, NC 27910			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
E 037	CMHC must provide i preparedness policies and existing staff, ind under arrangement, a with their expected ro documentation of the demonstrate staff kno procedures. Thereaffd emergency preparedr annually. This STANDARD is r Based on interview a failed to ensure direct trained on the facility's finding is: Staff had not received plan (EP). Review on 3/26/18 of no documented speci staff in regards to the Staff interviews (2) or been trained regardin drills; however, the st details regarding the Interview on 3/26/18 disabilities profession care staff had been tr and disaster drills. Ho any training provided INITIAL COMMENTS	 920(d):] (1) Training. The nitial training in emergency is and procedures to all new ividuals providing services and volunteers, consistent les, and maintain training. The CMHC must evelope of emergency er, the CMHC must provide hess training at least not met as evidenced by: and record review, the facility is emergency plan (EP). The emergency plan (EP). The emergency facility documents revealed fic training for direct care EP. n 3/26/18 revealed they have g fire drills and disaster aff could not provide specific facility's EP program. with the qualified intellectual al (QIDP) revealed direct ained regarding fire drills wever, there had not been concerning the new EP. 		037				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/02/2018 APPROVED). 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G297	B. WING			03/	27/2018	
NAME OF P	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE			
ROANOK	E PLACE				04 CAROLINA AVENUE HOSKIE, NC 27910			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
W 000	of participation for interpretence of persons with mental r	ermediate care facilities for retardation found at 42 CFR and 42 CFR 483.480		000				

Facility ID: 944506

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