STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G175	A. BUILDING _____ B. WING _____	04/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHWAY 117 GROUP HOME	3801 US 117 NORTH GOLDSBORO, NC 27530

(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 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) [(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:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop an emergency preparedness (EP) plan including the geographic location of the facility and the clients' needs of the facility in the risk assessment, utilizing an all-hazards approach. The finding is:	E 006		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 006	Continued From page 1 The facility did not have an emergency plan based upon risk assessments. Review on 4/2/18 of the facility's current EP plan revealed the plan did not provide specific information in regards to the geographic location of the facility and the clients' needs of the facility in the risk assessment, utilizing an all-hazards approach. Interview on 4/2/18 with the qualified intellectual disabilities professional (QIDP) revealed she was not aware of this specific information was to be included in the EP plan.	E 006		
E 013	Development of EP Policies and Procedures CFR(s): 483.475(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical	E 013		

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E 013	Continued From page 2 emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This STANDARD is not met as evidenced by: Based on interview, the facility failed to develop specific policies and procedures to address emergency preparedness, considering risk assessment and their communication plan in case of an emergency evacuation of the clients in the facility. The finding is: During an interview on 4/2/18, with management revealed they did not have policies and procedures specifically for the emergency preparedness plan.	E 013		
E 032	Primary/Alternate Means for Communication CFR(s): 483.475(c)(3) [(c) The [facility] must develop and maintain an emergency preparedness communication plan	E 032		

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E 032	Continued From page 3 that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This STANDARD is not met as evidenced by: Based on documentation and interviews, the facility failed to develop an alternate means for communicating with facility staff, regional and local governments during an emergency. The finding is: The facility failed to develop an alternate means for communicating with staff, regional and local governments during an emergency. Review on 4/2/18 of the facility's emergency preparedness (EP) did not include any information regarding alternate means of communication. During an interview on 4/2/18, management revealed if the land line phone and cell service were down there was not another way to communicate during an emergency.	E 032		
E 037	EP Training Program CFR(s): 483.475(d)(1)	E 037		

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E 037	Continued From page 4 (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at	E 037		

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E 037	Continued From page 5	E 037		

least annually.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.

*[For CORFs at §485.68(d):](1) Training. The

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E 037	Continued From page 6 CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency	E 037		

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E 037	Continued From page 7 preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure direct care staff were sufficiently trained on the facility's emergency plan (EP). The finding is: Staff had not received training on the emergency plan (EP). Review on 4/2/18 of facility documents revealed no documented specific training for direct care staff in regards to the EP. Staff interviews (2) on 4/3/18 revealed they have been trained regarding fire drills and disaster drills; however, the staff could not provide specific details regarding the facility's EP program. Interview on 4/2/18 with the qualified intellectual disabilities professional (QIDP) revealed direct care staff had been trained regarding fire drills and disaster drills. However, there had not been any formal training provided concerning the new EP.	E 037		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged	W 154		

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W 154	Continued From page 8 violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and document reviews the facility neglected to conduct a thorough investigations of an incident of unknown origin involving client (#1). The finding is: Client #1's injury of unknown origin was not investigated. Review on 4/2/18 of an incident report dated 12/9/17 involving client #1, revealed the following: "While [Client #1] was taking a shower I went to check on him. When I walked in his forehead above his left brow was bleeding. I asked him what happened and he said that he didn't know."Further review of the incident report revealed; " Approx. 1" cut above left eyebrow noted. Area cleaned and steri-strips applied. Consumer stated he didn't know how it happened." During an interview on 4/2/18 and 4/3/18, management confirmed the investigation was not conducted because client #1 had been having some issues with stability, however no documentation was available to support this could have been the cause of the incident. The qualified intellectual disabilities professional (QIDP) confirmed she understood why the incident should have been investigated.	W 154		