	-	D HUMAN SERVICES					MAPPROVED		
	<u>S FOR MEDICARE &amp;</u>		(22) MUU				D. 0938-0391		
-	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •				(X3) DATE SURVEY COMPLETED		
		34G175	B. WING			04	/03/2018		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•			
HIGHWAY	117 GROUP HOME				801 US 117 NORTH				
				G	GOLDSBORO, NC 27530		1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE		
E 006	Plan Based on All Ha CFR(s): 483.475(a)(1	zards Risk Assessment )-(2)	E	006					
	<ul> <li>[(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:]</li> <li>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*</li> </ul>								
	on and include a docu community-based risl	§483.73(a)(1):] (1) Be based umented, facility-based and c assessment, utilizing an , including missing residents.							
	and include a docume community-based risl	8.475(a)(1):] (1) Be based on ented, facility-based and c assessment, utilizing an , including missing clients.							
	(2) Include strategies events identified by the	o 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 l care. This STANDARD is r Based on record revi failed to develop an e (EP) plan including th	18.113(a)(2):] (2) Include sing emergency events assessment, including the onsequences of power ters, and other emergencies nospice's ability to provide not met as evidenced by: ew and interview, the facility mergency preparedness e geographic location of the ' needs of the facility in the zing an all-hazards							

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

TITLE

(X6) DATE

PRINTED: 04/05/2018

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	): 04/05/2018 APPROVED	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		34G175	B. WING			04/	03/2018	
NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
HIGHWAY 117 GROUP HOME					301 US 117 NORTH OLDSBORO, NC 27530			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
E 006	based upon risk asses Review on 4/2/18 of the revealed the plan did information in regards of the facility and the of in the risk assessment approach. Interview on 4/2/18 wid disabilities profession not aware of this spect included in the EP plat Development of EP P 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 develop and implement policies and procedure plan set forth in parager assessment at parager and the communication the policies and procedure plan set forth in parager assessment at parager and the communication	ve an emergency plan ssments. he facility's current EP plan not provide specific to the geographic location clients' needs of the facility it, utilizing an all-hazards ith the qualified intellectual al (QIDP) revealed she was cific information was to be an. volicies 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 d at least annually. ents for PACE and ESRD H4(b):] Policies and E organization must nt emergency preparedness res, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, prisk raph (a)(1) of this section, risk raph (a)(2)	EC		DEFICIENCY)			
	assessment at paragr and the communication this section. The polic	raph (a)(1) of this section,						

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		IO. 0938-039 TE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	· /		CON	MPLETED		
		34G175	B. WING		04/03/2018			
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE		i		
HIGHWAY 117 GROUP HOME				3801 US 117 NORTH GOLDSBORO, NC 27530				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION ) CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
E 013	equipment, power, or emergencies; and nat threaten the health or staff, or the public. The must be reviewed and *[For ESRD Facilities procedures. The dialy implement emergence procedures, based or forth in paragraph (a) assessment at paragraph and the communication this section. The polic reviewed and updated emergencies include, equipment or power f emergencies, water so natural disasters likely geographic area. This STANDARD is n Based on interview, for specific policies and p emergency prepared assessment and their case of an emergency the facility. The findir	ng, but not limited to: Fire; water failure; care-related tural disasters likely to safety of the participants, ne policies and procedures d updated at least annually. at §494.62(b):] Policies and visis facility must develop and y preparedness policies and n the emergency plan set 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. These but are not limited to, fire, ailures, care-related upply interruption, and y to occur in the facility's 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 ng is: n 4/2/18, with management	E 013	3				
E 032	procedures specifical preparedness plan. Primary/Alternate Me CFR(s): 483.475(c)(3	ans for Communication	E 032	2				
		develop and maintain an ness communication plan						

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## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 34G175 B. WING 04/03/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3801 US 117 NORTH **HIGHWAY 117 GROUP HOME** GOLDSBORO, NC 27530 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 3 E 032 E 032 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 037 **EP** Training Program E 037 CFR(s): 483.475(d)(1)

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 04/05/2018

	MENT OF HEALTH AN	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/05/2018 / APPROVED ). 0938-0391
STATEMENT (	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		(X3) DATE SURVEY COMPLETED		
		34G175	B. WING			04/	03/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHWAY	117 GROUP HOME				801 US 117 NORTH OLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
E 037	<ul> <li>(1) Training program. ASCs, PACE organiza and dialysis facilities]</li> <li>(i) Initial training in empolicies and procedur staff, individuals provi arrangement, and volue expected role.</li> <li>(ii) Provide emergence least annually.</li> <li>(iii) Maintain documer</li> <li>(iv) Demonstrate staff procedures.</li> <li>*[For Hospitals at §48 at §491.12:] (1) Traini or RHC/FQHC] must of (i) Initial training in empolicies and procedures.</li> <li>(ii) Provide emergence least annually.</li> <li>(iii) Naintain documer</li> <li>(ii) Initial training in empolicies and procedures.</li> <li>(ii) Provide emergence least annually.</li> <li>(iii) Maintain documer</li> <li>(iv) Demonstrate staff procedures.</li> <li>*[For Hospices at §41 hospice must do all of (i) Initial training in empolicies and procedures.</li> <li>*[For Hospices at §41 hospice must do all of (i) Initial training in empolicies and procedures.</li> <li>*[For Hospices at §41 hospice employees, a services under arrang expected roles.</li> <li>(ii) Demonstrate staff procedures.</li> </ul>	The [facility, except CAHs, ations, PRTFs, Hospices, must do all of the following: nergency preparedness res to all new and existing iding services under functeers, consistent with their by preparedness training at ntation of the training. f knowledge of emergency B2.15(d) and RHCs/FQHCs ing program. The [Hospital do all of the following: nergency preparedness res to all new and existing iding on-site services under functeers, consistent with their expreparedness training at mation of the training. f knowledge of emergency lineteers, consistent with their expreparedness training at mation of the training. f knowledge of emergency lineteers (1) Training. The	EC	037			

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	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	: 04/05/2018 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	(X3) DATE SURVEY COMPLETED			
		34G175	B. WING		_	04/0	03/2018
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
HIGHWAY 117 GROUP HOME				801 US 117 NORTH GOLDSBORO, NC 2753	30		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 037	least annually. (iv) Periodically review emergency preparedr employees (including special emphasis place procedures necessary others. *[For PRTFs at §441.1] program. The PRTF m (i) Initial training in em- policies and procedure staff, individuals provi- arrangement, and volte expected roles. (ii) After initial training preparedness training (iii) Demonstrate staff procedures. (iv) Maintain documer preparedness training *[For PACE at §460.8] organization must do (i) Initial training in em- policies and procedures staff, individuals provi- arrangement, contract volunteers, consistent (ii) Provide emergency least annually. (iii) Demonstrate staff procedures, including what to do, where to g case of an emergency (iv) Maintain documer	v and rehearse its hess plan with hospice nonemployee staff), with ced on carrying out the v to protect patients and 184(d):] (1) Training hust do all of the following: hergency preparedness es to all new and existing ding services under unteers, consistent with their , provide emergency at least annually. knowledge of emergency tation of all emergency 4(d):] (1) The PACE all of the following: hergency preparedness es to all new and existing ding on-site services under tors, participants, and with their expected roles. y preparedness training at knowledge of emergency informing participants of go, and whom to contact in <i>r</i> .	E 037				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CON	STRUCTION		NO. 0938-039	
ND PLAN OF CORRECTION		. ,	A. BUILDING			COMPLETED		
		34G175	B. WING				4/03/2018	
NAME OF PI	ROVIDER OR SUPPLIER	•		STREE	T ADDRESS, CITY, STATE, ZIP CODE	1		
HIGHWAY 117 GROUP HOME					IS 117 NORTH ISBORO, NC 27530			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
E 037	Continued From page	ge 6	É O	37				
	CORF must do all o	-						
	(i) Provide initial trai	ning in emergency						
		es and procedures to all new						
	-	dividuals providing services and volunteers, consistent						
	with their expected							
		ncy preparedness training at						
	least annually.	entetion of the two in in a						
		entation of the training. aff knowledge of emergency						
		personnel must be oriented						
	<b>.</b> .	fic responsibilities regarding						
		ency plan within 2 weeks of						
		The training program must In the location and use of						
		signals and firefighting						
	equipment.							
		.625(d):] (1) Training program.						
	The CAH must do a	5						
		emergency preparedness ures, including prompt						
		uishing of fires, protection,						
		ry, evacuation of patients,						
		sts, fire prevention, and						
		fighting and disaster w and existing staff,						
		g services under arrangement,						
		sistent with their expected						
	roles.							
	least annually.	ncy preparedness training at						
		entation of the training.						
	(iv) Demonstrate sta procedures.	aff knowledge of emergency						
	*[For CMHCs at §48	35.920(d):] (1) Training. The						

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-		D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/05/2018 / APPROVED ). 0938-0391
STATEMENT OF DEFICIEN AND PLAN OF CORRECTION	CIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		34G175	B. WING			04/	03/2018
NAME OF PROVIDER OF	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHWAY 117 GROU	IP HOME				8801 US 117 NORTH GOLDSBORO, NC 27530		
	ACH 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 E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
prepared and exis under ar with thei documen demonst procedun emerger annually This ST/ Based of failed to trained of finding is Staff had plan (EP Review of no docun staff in re Staff inte been tra drills; ho details re Interview disabilitie care staf and disa any form EP. W 154 STAFF T CFR(s):	ting staff, ind rangement, a r expected ro nation of the rate staff kno res. Thereafte icy preparedr NDARD is r on interview a ensure direct in the facility's anot received ). on 4/2/18 of fi- mented speci- egards to the erviews (2) or ined regardin wever, the st egarding the fa- erviews (2) or ined regardin wever, the st egarding the fa- ster drills. Ho is profession f had been tr ster drills. Ho is training pro- REATMENT 483.420(d)(3	a and procedures to all new ividuals providing services and volunteers, consistent les, and maintain training. The CMHC must weledge of emergency er, the CMHC must provide ness training at least not met as evidenced by: and record review, the facility care staff were sufficiently s emergency plan (EP). The d training on the emergency acility documents revealed fic training for direct care EP. a 4/3/18 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 ovided concerning the new OF CLIENTS		037			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/05/2018 1 APPROVED 0. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G175	B. WING		_	04/	03/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-		
HIGHWAY 117 GROUP HOME				8801 US 117 NORTH GOLDSBORO, NC 2753	0			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
W 154			W 154					
	facility neglected to co investigations of an in involving client (#1).	onduct a thorough icident of unknown origin The finding is:						
	Client #1's injury of ur investigated.	nknown origin was not						
	12/9/17 involving clier "While [Client #1] was check on him. When I above his left brow wa what happened and h know."Further review revealed; " Approx. 1'	of the incident report ' cut above left eyebrow and steri-strips applied.						
	conducted because c some issues with stat documentation was a	ed the investigation was not lient #1 had been having bility, however no vailable to support this could of the incident. The qualified professional (QIDP) stood why the incident						

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