

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/09/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G115		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2018	
NAME OF PROVIDER OR SUPPLIER DARTMOUTH ROAD GROUP HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 210 DARTMOUTH ROAD RALEIGH, NC 27606			
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E 020	<p>Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.475(b)(3)</p> <p>[(b) Policies and procedures. The [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. At a minimum, the policies and procedures must address the following:]</p> <p>Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.</p> <p>*[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance.</p> <p>* [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical</p>		E 020				

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 020	<p>Continued From page 1</p> <p>Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients.</p> <p>* [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This STANDARD is not met as evidenced by: Based on record review and interviews with staff, the facility failed to develop specific policies and procedures to address emergency preparedness, considering risk assessment and alternate placement and communication plan in case of an emergency evacuation of the clients in the facility. The findings include:</p> <p>The facility did not include a specific detailed alternate placement and communication plan within their emergency preparedness plan.</p> <p>Review on 4/3/18 of the facility policy on Emergency Plans and Sheltering out of home revealed relocation may be necessary for the safety of the individuals. And if the communication systems are working then staff in charge will contact management and discuss relocating the individuals. If communication system failure prevents this, the staff in charge should prepare to evacuate to a safe area. However, there was no information to indicate how communication would be relayed to other staff, guardians and/or authorities. The plan did not include specifics about relocation site(s) of the clients nor the communication between staff, guardians or any other the entity.</p> <p>During an interview on 4/3/18, a staff confirmed they were unsure as to where they would relocate</p>	E 020			

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E 020	Continued From page 2 if they had to relocate. The staff further confirmed they had not discussed neither had been presented with nor tested on any emergency preparedness information. During an interview on 4/3/18, the home manager confirmed they were unsure as to where they would relocate if they had to relocate. The facility is still in the process of identifying alternate shelter(s). Further interview confirmed they had not presented, discussed nor tested the staff on any emergency preparedness information nor shared any of the information with the guardians. During an interview on 4/3/18, management acknowledged they are still working on their plans and would have to look into means identifying alternate relocation shelter(s) and alternate means of communication.	E 020			
E 037	EP Training Program CFR(s): 483.475(d)(1) (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	E 037			

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E 037	<p>Continued From page 3</p> <p>or RHC/FQHC] must do all of the following:</p> <p>(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.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:</p> <p>(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.</p> <p>(ii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iii) Provide emergency preparedness training at least annually.</p> <p>(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.</p> <p>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:</p> <p>(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.</p> <p>(ii) After initial training, provide emergency</p>	E 037			

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E 037	<p>Continued From page 4</p> <p>preparedness training at least annually.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iv) Maintain documentation of all emergency preparedness training.</p> <p>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:</p> <p>(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.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(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.</p> <p>(iv) Maintain documentation of all training.</p> <p>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:</p> <p>(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.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of the training.</p> <p>(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</p>	E 037			

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E 037	<p>Continued From page 5 equipment.</p> <p>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:</p> <ul style="list-style-type: none"> (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. <p>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must 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, 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.</p> <p>This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to assure direct care staff were adequately trained on the facility's emergency preparedness policies and procedures. The finding is:</p>	E 037			

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E 037	Continued From page 6 Staff were not trained on the facility's emergency preparedness plans. During an interview on 4/3/18, staff revealed they had not received any training on the facility's emergency preparedness plans. The staff further stated they had recently received information about the emergency preparedness plans and had not read over the information in detail. During an interview on 4/3/18, management acknowledged they are still working on their emergency preparedness plans. Review on 4/3/18 of facility's emergency preparedness plans revealed no staff had received training on the facility's emergency preparedness plans. There was no documentation available for review to indicate the facility had conducted any emergency preparedness training.	E 037			
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to assure co-guardians signed all documents jointly. This affected 1 of 3 audit client (#3). The finding is: Client #3's consents were signed by only one of two guardians.	W 125			

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W 125	Continued From page 7			W 125			
	Review on 4/3/18 of client #3's guardianship papers revealed co-guardians.						
	Review on 4/3/18 of client #3's behavior support plan (BSP) consent dated 2/22/18 revealed only one guardian's signature.						
	During an interview on 4/3/18, the home manager confirmed client #3 currently has co-guardians.						
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7)			W 130			
	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 observation and interview, the facility failed to assure the privacy for 1 of 3 audit clients (#2) during toileting. The finding is:						
	Client #2 was not provided privacy while using the toilet.						
	During observations in the home on 4/2/18, client #4 went into the bathroom located near her bedroom and the kitchen. Staff was in the bathroom while client #2 was preparing for her shower. Client #2 had removed all of her clothing and was totally naked seated on the toilet. The staff exited the bathroom, leaving the bathroom door wide opened exposing client #2 seated on the toilet. The staff went over into the kitchen and carried on a conversation with the staff working in the kitchen. The door remained wide opened while client #2 was still seated on the toilet. The						

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W 130	Continued From page 8 staff returned to the bathroom, leaving the bathroom door wide opened, put something down near the shower then came back and closed the bathroom door. Client #2 was not prompted to close the door nor was the door closed for her. During an interview on 4/2/18, staff stated they should have closed the door and they do not normally leave the doors open when the clients are in the bathroom. During an interview on 4/2/18, the qualified intellectual disabilities professional (QIDP) stated staff should not have left the door open while client #2 used the bathroom.	W 130			
W 248	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(7) A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on reviews and interviews the facility failed to assure outside services had access to relevant parts of each person's individual program plan. This affected 2 of 3 audit clients (#2 and #6). The findings are: Clients #2 and #6 did not have current behavior support plans (BSP) available at the day program. a. Review on 4/2/18 at the day program of client #2's record revealed a BSP dated 3/14/17. The	W 248			

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W 248	Continued From page 9 day program was not provided with a current 2018 BSP. Review on 4/3/18 of client #2's record in the home revealed a BSP dated 3/22/18. b. Review on 4/2/18 at the day program of client #5's record revealed a BSP dated 3/13/17. The day program was not provided with a current 2018 BSP. Review on 4/3/18 of client #6's record in the home revealed a BSP dated 3/1/18. During an interview on 4/3/18, the qualified intellectual disabilities professional (QIDP) revealed they had just submitted (4/3/18) the BSP's for client #2 and #6 to the day program.	W 248			
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, interviews and record review, the facility failed to assure each client received a continuous active treatment plan consisting of needed interventions and services as identified in their individual program plan (IPP) in the area of meal preparation participation. This affected 2 of 3 audit clients (#2 and #6). The findings are:	W 249			

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W 249	<p>Continued From page 10</p> <p>1. Clients #2 and #6 were not consistently encouraged to participate in the dinner meal preparation.</p> <p>During observations of the dinner meal preparations on 4/2/17, the meal were prepared by staff. During the dinner meal preparation clients #2 and #6 were not prompted/encouraged to participate in preparing any of the food items. The staff preparing the foods only encouraged client #2 to obtain and discard items (used paper towels and used gloves) which was used by the staff. Clients #2 and #6 did not participate in the actual meal preparation. The dinner menu consisted of: Brussel sprouts, pork loin, brown rice and fruit cocktail.</p> <p>a. Review on 4/3/18 of client #2's IPP dated 3/22/18 revealed, "INTERESTS/NON-NEGOTIABLES Enjoys cooking."</p> <p>Review on 4/3/18 of client #2's community/home life assessment dated 3/14/18 revealed physical assistance is required when: "Makes food with no cooking. 3. Makes food with cooking but with no mixing. 4. Makes food with cooking and mixing....Uses Kitchen Appliances/Utensils....4. Stove/oven."</p> <p>b. Review on 4/3/18 of client #6's IPP dated 3/1/18 revealed, "INTERESTS/NON-NEGOTIABLES Enjoys cooking."</p> <p>Review on 4/3/18 of client #6's community/home life assessment dated 3/14/18 revealed physical assistance is required when: "Makes food with no cooking. 3. Makes food with cooking but with no</p>	W 249			

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W 249	Continued From page 11 mixing. 4. Makes food with cooking and mixing....Uses Kitchen Appliances/Utensils....4. Stove/oven." During an interview on 4/4/18, the qualified intellectual disabilities professional (QIDP) confirmed staff are to encourage the clients' to participate with all meal preparations including the use of the stove as the clients' abilities allow them to. 2. Client #2 was not afforded the opportunity to consistently cut her meat. During observations of the dinner meal in the home on 4/2/17, a staff obtained then meat for client #2, cut it into bite sized pieces while client #2 looked on. the staff used a rocker knife to perform this task. Client #2 was not prompted nor offered to independently cut her meat. Review on 4/3/18 of client #2's IPP dated 3/22/18 revealed a strength, "Participates in family style dining." Review on 4/3/18 of client #2's community/home life assessment dated 3/14/18 revealed independence in the area of using a knife and eats family style.	W 249			
W 322	PHYSICIAN SERVICES CFR(s): 483.460(a)(3) The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by:	W 322			

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(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 322	<p>Continued From page 12</p> <p>Based on record reviews and interviews, the facility failed to assure 3 of 3 female audit clients (#2, #3 and #6) obtained a pap smears. The findings are:</p> <p>Clients #2, #3 and #6 did not receive their annual pap smears.</p> <p>Review on 4/3/18 of client #2's record did not reveal information for a current gynecology (GYN) evaluation. Review of client #2's physical examination dated 6/8/17 revealed, "Pelvic Exam...01/15 NL (-) - 2020." The home manager revealed the physician stated client #2 was not to receive a PAP until the year 2020. However, the was no information from the physician as to the reason for the delay nor was there any current team meeting information to indicate the teams discussion about the delay.</p> <p>Review on 4/3/18 of client #3's record did not reveal information for a current gynecology (GYN) evaluation. Review on 4/3/18 of client #3's GYN report dated 10/26/17 did not reveal any information to indicate a GYN assessment was completed. The home manager revealed client #3 was not assessed during the 10/2617 visit, the physician only obtained information about the new birth control medication she was receiving.</p> <p>Review on 4/3/18 of client #6's record did not reveal information for a current gynecology (GYN) evaluation. Client #6's last PAP/pelvic examination was dated 1/31/17. Review on 4/3/18 of client #6's physical examination dated 9/14/17 revealed, "Genito - Urinary N/A....Sees OB/GYN."</p> <p>During an interview on 4/3/18, the home manager</p>	W 322			

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W 322	Continued From page 13 revealed the the qualified intellectual disabilities professional (QIDP) was to write a note about the pap smears and no information could be located to indicate any meeting were held to discuss the clients and their pap smears. She further stated she thought it was to be completed yearly or as ordered by the physician.	W 322			
W 323	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(i) The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to assure each client received adequate annual physical examination which included a visual evaluation. This affected 1 of 3 audit clients (#3). The finding is: Client #3 did not receive an adequate annual physical to include a visual evaluation. Review on 4/3/18 of client #3's physical evaluation dated 3/14/18 revealed her vision was not assessed. Further review of the physical evaluation form revealed, "REFERRAL/FOLLOW UP: ...Vision." The current information available for review did not reveal a complete 2018 physical evaluation, which included a visual assessment was completed. During an interview on 4/3/18, the home manager confirmed client #3's vision was not assessed during her annual physical and the physician referred her out to have her eyes assessed.	W 323			

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W 323	Continued From page 14 Further interview confirmed client #3 was in need of having her eyes assessed.	W 323			