STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G026	A. BUILDING _____ B. WING _____	04/10/2018

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NEW RIVER COTTAGE INC	82 DAVIS LANE SPARTA, NC 28675

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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 interview and record review, the facility failed to develop specific facility-based communication strategies as part of their emergency plan (EP). The finding is: Review of the facility's EP revealed the EP to contain a thorough risk assessment and	E 006		

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

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E 006	Continued From page 1 community-based strategies. However, further review of the EP, substantiated by interview with the qualified intellectual disability professional (QIDP), revealed additional facility-based information needed to be developed to address the specific needs of the clients in the group home. Continued review of the EP, verified by interview with the QIDP, revealed information regarding the residents of the group home had not been developed to address the specific needs of the 5 residents of the group home to assist anyone unfamiliar with the residents working with them in an emergency situation.	E 006		
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 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.	E 037		

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E 037	Continued From page 2 (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 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.	E 037		

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E 037	Continued From page 3 *[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 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	E 037		

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E 037	Continued From page 4 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 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 show evidence direct care staff in the home were adequately trained on the facility's emergency plan (EP). The finding is: Review of the facility's EP, verified by interview with the qualified intellectual disability professional (QIDP), revealed no training records to show direct care staff had been trained in the use of the EP were available for review. Continued interview with the QIDP revealed staff are trained in implementing disaster drills but no	E 037		

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E 037	Continued From page 5 training has been done specifically for the use of the EP for the specific group home. Therefore, the facility has failed to provide sufficient staff training in implementing the facility EP.	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: The facility failed to promote the rights of 1 of 3 sampled clients (client #4) by failing to show evidence legal guardianship had been obtained in order to legally advocate for the client's rights relative to treatment as evidenced by interviews and review of records. The finding is: Review of the records for client #1 revealed the client is 31 years old with a diagnoses of profound intellectual functioning with Autism, a history of seizures who was admitted to the facility on 9/26/16. Continued review of the records revealed an individual program plan dated 10/19/17 which included a behavior support plan (BSP) to reduce disruptive and aggressive behaviors. Continued review of the BSP, substantiated by interviews with the qualified intellectual disability professional (QIDP), revealed the client is receiving Zyprexa and Trazodone to assist in controlling the inappropriate behaviors. However, additional review of the records, verified by interview with the QIDP revealed no	W 125		

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W 125	Continued From page 6 documentation is present in the records adjudicating the client as incompetent or appointing anyone as the client's legal guardian. Continued interview with the QIDP revealed he has attempted to get the mother to get the paperwork appointing her as the client's legal guardian but she has not done so as of the 4/9-4/10/18 survey. This is a delay of approximately 18 months in obtaining legal guardianship from the time the client was admitted to the facility. Therefore, the facility has failed to show evidence of attempting to ensure legal guardianship has been obtained for client #1 in order to legally advocate for the client's rights.	W 125		
W 256	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(ii) The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is regressing or losing skills already gained. This STANDARD is not met as evidenced by: The team failed to ensure 4 of 6 skill acquisition objectives to be trained in the home listed on the individual program plan (IPP) for 1 of 3 sampled clients (#4) were revised when regression occurred as evidenced by interview and review of the records. The findings are: A. Review of the 8/17/17 IPP for client #4 revealed an objective to exercise with 100% accuracy for 3 consecutive months. Review of the objective data revealed the client was	W 256		

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W 256	Continued From page 7 functioning at the 97% level in 7/17. Continued review of the data revealed the client to function at 91% in 8/17, 91% in 9/17, 90% in 10/17, 95% in 11/17, 96% in 12/17, 86% in 1/18, 80% in 2/18 and 90% in 3/18. Continued review of this data revealed at no time did the client achieve the 97% level achieved in 7/17 but regressed 7% after 8 months of training. Additional review of the objective, verified by interview with the qualified intellectual disability professional (QIDP) revealed no revisions has been made to this objective. B. Review of the 8/17/17 IPP for client #4 revealed an objective to increase table etiquette to 100% accuracy for 3 consecutive months. Review of the objective data revealed the client was functioning at the 87% level in 7/17. Continued review of the data revealed the client to function at 86% in 8/17, 84% in 9/17, 76% in 10/17, 77% in 11/17, 87% in 12/17, 84% in 1/18, 75% in 2/18 and 76% in 3/18. Continued review of this data revealed only 1 time did the client achieve the 87% level achieved in 7/17 but regressed 11% after 8 months of training. Additional review of the objective, verified by interview with the QIDP revealed no revisions has been made to this objective. C. Review of the 8/17/17 IPP for client #4 revealed an objective to complete cleaning bedroom 90% of the time for 3 consecutive months. Review of the objective data revealed the client was functioning at the 71% level in 8/17. Continued review of the data revealed the client to function at 63% in 9/17, 50% in 10/17, 60% in 11/17, 55% in 12/17, 55% in 1/18, 40% in 2/18 and 59% in 3/18. Continued review of this data revealed did the client did not achieve the 71% level achieved in 8/17 but regressed 12% after 7	W 256		

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W 256	Continued From page 8 months of training. Additional review of the objective, verified by interview with the QIDP revealed no revisions has been made to this objective. D. Review of the 8/17/17 IPP for client #4 revealed an objective to complete bathroom procedures 90% of the time for 3 consecutive months. Review of the objective data revealed the client was functioning at the 65% level in 8/17. Continued review of the data revealed the client to function at 63% in 9/17, 61% in 10/17, 60% in 11/17, 61% in 12/17, 63% in 1/18, 48% in 2/18 and 50% in 3/18. Continued review of this data revealed did the client did not achieve the 68% level achieved in 8/17 but regressed 18% after 7 months of training. Additional review of the objective, verified by interview with the QIDP revealed no revisions has been made to this objective.	W 256		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: The facility failed to ensure a required hearing aide was furnished or repaired in a timely manner for 1 of 3 sampled clients (#4) as evidenced by observations, interview and review of records. The finding is:	W 436		

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W 436	Continued From page 9 Review of the records for client #4 revealed a individual program plan (IPP) dated 8/17/17 which included an objective to keep hearing aide in room when not in use 100% time for 3 consecutive months. Review of the objective data revealed no data had been recorded since 6/17. The data sheets from 7/17 to 3/17 for this objective were marked as N/A. Interview with the qualified intellectual disability professional (QIDP) revealed the client's hearing aide has been lost for about a year (9 months). Continued interview with the QIDP revealed the client will "fiddle" with the hearing aide and tear it up. Further interview with the QIDP revealed the doctor had given an estimate for a new one of approximately $2800.00 but the mother does not want to spend that much money when the client will tear it up. Additional interview with the QIDP, verified by review of record, revealed no aggressive action in trying to replace client #4's hearing aide has been taken since 6/17. Therefore, the facility has failed to show evidence of aggressively attempting to replace needed adaptive equipment identified in the IPP (hearing aide) in a timely manner.	W 436		