

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2018
NAME OF PROVIDER OR SUPPLIER HOLLY STREET HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 HOLLY STREET GOLDSBORO, NC 27530		
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E 006	<p>Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2)</p> <p>[(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:]</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*</p> <p>*[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.</p> <p>*[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.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>* [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.</p> <p>This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to develop an emergency preparedness (EP) plan to include the geographic location for the facility and the clients' specific needs in the risk assessment, utilizing an all-hazards approach. The finding is:</p>	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 4/10/18 of the facility's current EP plan revealed the plan did not provide specific information in regards to the geographical location of the facility and the clients' specific needs in the risk assessment, utilizing an all-hazards approach. During an interview on 4/9/18, the program director confirmed their EP plan was not complete and they are still working on their plans.	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 emergencies, including, but not limited to: Fire;	E 013			

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E 013	<p>Continued From page 2</p> <p>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.</p> <p>*[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.</p> <p>This STANDARD is not met as evidenced by: Based on interview, the facility failed to develop specific policies and procedures to address management of medical and nonmedical emergencies, including, but not limited to: power failure with the need for alternate power usage, water failure, care-related emergencies; and natural disasters likely to threaten the health or safety of the clients and staff in the event of an emergency and a evacuation from the facility is needed. The finding is:</p> <p>During an interview on 4/9/18, program director revealed they are still working on their emergency preparedness plans. Further interview confirmed some policies will have to be revised to include other emergencies and disaster which would require the need for alternate power and other natural disasters for the area which the homes</p>	E 013			

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E 013	Continued From page 3 are located (Air Force Base). During an interview on 4/9/18, staff revealed they had not received any documented information nor training on the facility's emergency preparedness plans. The staff further stated they had recently had a meeting about the emergency preparedness plans and more information about it will be coming soon.	E 013			
E 020	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.475(b)(3) [(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:] 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. *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCl or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s).	E 020			

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E 020	<p>Continued From page 4</p> <p>(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 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 4/9/18 of the facility's Emergency Plans 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 should</p>	E 020			

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E 020	Continued From page 5 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. During an interview on 4/9/18, the home manager confirmed they had not discussed and was not presented with any documentation nor information on the emergency preparedness to discuss with any of the staff and the guardians. During an interview on 4/10/18, program director confirmed they are still working on their plans and would have to look into means identifying alternate relocation shelter(s) and alternate means of communication. The plans did not include all of the components outlined in the emergency preparedness plan.	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.	E 037			

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E 037	<p>Continued From page 6</p> <p>*[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:</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</p>	E 037			

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E 037	<p>Continued From page 7</p> <p>expected roles.</p> <p>(ii) After initial training, provide emergency 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</p>	E 037			

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E 037	<p>Continued From page 8</p> <p>include instruction in the location and use of alarm systems and signals and firefighting equipment.</p> <p>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:</p> <p>(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.</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 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</p>	E 037			

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E 037	<p>Continued From page 9 finding is:</p> <p>Staff were not trained on the facility's emergency preparedness plans.</p> <p>During an interview on 4/9/18, staff revealed they had not received any training on the facility's emergency preparedness plans. The staff further stated they had recently had a meeting about the emergency preparedness plans and more information about it will be coming soon.</p> <p>During an interview on 4/9/18, program director revealed they are still working on their emergency preparedness plans and some policies will have to be revised to be more specific.</p> <p>Review on 4/10/18 of facility's Emergency Preparedness plans revealed staff had not 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.</p>	E 037			