STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G177	A. BUILDING _____ B. WING _____	04/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARTER CLINIC RESIDENTIAL HOME	235 KINLAW RD FAYETTEVILLE, NC 28301

(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 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 [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. * [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	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	Continued From page 1 Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [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 in case of an emergency evacuation of the clients in the facility. The findings include: Management staff failed to develop a comprehensive plan to safely evacuate should an emergency necessitate leaving the facility. Review on 4/25/18 of the facility's emergency management plan revealed if necessary staff would implement, "General evacuation procedures within the facility doing head counts and ensuring all exits are clearly marked." There was no additional information regarding under what conditions direct care staff would consider leaving the facility or what locations to which they would consider evacuating. Interview on 4/24/18 with management staff revealed there was no list or contract with an alternate location that could be utilized as a shelter for the facility's clients if evacuation from the facility became necessary.	E 020		
E 032	Primary/Alternate Means for Communication CFR(s): 483.475(c)(3) [(c) The [facility] must develop and maintain an	E 032		

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E 032	Continued From page 2	E 032		

emergency preparedness communication plan 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 record review 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:

Management staff failed to develop an alternate means of communicating with facility staff, guardians and local emergency management officials in the event of an emergency.

Review of the faclity's emergency management plan revealed there were contact numbers for local agencies and facility staff listed in the plan. Further review revealed however, there was no alternate means of contacting management or direct care staff if primary communications were unavailable.

During observations in the facility on 4/24/18 direct care staff indicated the facility had walkie talkies to utilize if needed.

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E 032	Continued From page 3 Interview with the residential manager confirmed staff had not been trained to use the walkie talkies. Additional interview revealed the walkie talkies necessitated triple A batteries. Staff confirmed there were no triple A batteries available for the walkie talkies. Interview on 4/25/18 with the qualified intellectual disabilities professional (QIDP) confirmed there is no alternate location identified for evacuation of the clients in the facility and that a comprehensive communication plan to contact staff and guardians of the clients in an emergency has not been developed.	E 032		
E 036	EP Training and Testing CFR(s): 483.475(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and	E 036		

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E 036	Continued From page 4	E 036		

testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h).

*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually.
This STANDARD is not met as evidenced by:
Based on record review and interviews, the facility failed to develop an emergency preparedness (EP) training and testing program. The finding is:

Management staff failed to develop a comprehensive training program for direct care staff on the facility's emergency management plan.

Review on 4/24/18 of the facility's emergency management plan revealed no training of direct care staff on the facility's emergency management plan.

Interview with three direct care staff on 4/24/18 revealed they had not been trained on the facility's emergency management plan. Further interview revealed staff were not aware of any alternate locations to which the clients may be evacuated. Staff were also unaware of any

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E 036	Continued From page 5 alternate communication plan. Staff were able to identify there were walkie talkies in the facility. Staff stated they had not been trained to use them. Staff also confirmed there were not triple A batteries available for their use. Interview on 4/25/18 with the facility's qualified intellectual disabilities professional (QIDP) revealed the facility had not provided facility wide training on the emergency management plan developed by management.	E 036		
W 126	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(4) The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 2 of 3 audit clients (#1, #5) were taught money management skills to the extent of their capabilities. The findings are: The facility did not develop training for clients #1, #5 to address their money management needs. Review on 4/25/18 of client #5's individual program plan (IPP) dated 3/6/18 revealed a need under the area of community living skills to develop money recognition values. Further review of the IPP revealed no training in the area of money management. Review on 4/25/18 of client #5's adaptive behavior inventory (ABI) dated 3/24/18 revealed	W 126		

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W 126	Continued From page 6 he has no independence counting money values from 25 cents, 50 cents and one dollar denominations. Further review revealed he has no independence identifying amounts from one dollar to five dollars. Review on 4/25/18 of client #1's ABI dated 3/10/18 revealed he can count denominations of 25 cents to one dollar with assistance. Further review revealed he can count denominations from one dollar to five dollars with partial assistance. Review on 4/25/18 of client #1's IPP dated 3/9/18 revealed no current training in the area of money management. Interview on 4/25/18 with the Qualified Intellectual Disabilities Professional (QIDP) revealed clients #1, #5 have no current training in the area of money management.	W 126		
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, record review and staff interview, the facility failed to ensure a pattern of interactions supported the active treatment plans	W 249		

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for 2 of 3 audit clients (#1, #5), specific to integrating strengths identified in the area of meal preparation. The findings are:

Direct Care staff failed to integrate identified meal preparation strengths for clients #1, #5.

During observations on 4/24/18 at 5:55pm, staff opened a container of macaroni and put it into a pot of boiling water. Staff stirred the macaroni, drained the noodles, opened a packet of cheese and emptied it into a bowl. Staff took frozen biscuits, put them on aluminum foil and put them into the oven. Client #5 was nearby and available to assist.

Interview on 4/24/18 with direct care staff revealed client #5 was identified to assist with meal preparation for supper that evening.

During observations on 4/25/18 at 6:00am direct care staff took eggs out of the refrigerator, cracked several eggs and stirred them in a bowl. Staff poured the eggs into a skillet. Staff took ham out of the refrigerator and put into a skillet. Client #1 was available in the kitchen to assist.

Interview with direct care staff on 4/25/18 revealed client #1 was to assist with meal preparation.

Review on 4/25/18 of client #1's IPP dated 3/9/18 revealed he has a strength to assist with meal preparation.

Review on 4/25/18 of client #1's adaptive behavior inventory (ABI) dated 3/10/18 revealed he can assist with preparing meat in the microwave with assistance, prepare food in the

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W 249	Continued From page 8 oven independently, prepare supper independently. Review on 4/25/18 of client #5's IPP dated 3/6/18 revealed he has needs to prepare a meal using a recipe and develop cooking skills. Review on 4/25/18 of client #5's ABI revealed he can prepare breakfast, meat dishes in microwave and oven with assistance. Interview with the qualified intellectual disabilities professional (QIDP) on 4/25/18 revealed clients #1, #5 can assist with several aspects of meal preparation. Further interview confirmed direct care staff should encourage clients to assist with additional aspects of meal preparation.	W 249		