STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G313	A. BUILDING _____ B. WING _____	04/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK DRIVE GROUP HOME	1305 PARK DRIVE MOUNT AIRY, NC 27030

(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 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 record review and interview, the facility failed to develop specific facility-based strategies as part of their emergency plan. The finding is: Review of the facility Emergency Plan (EP), conducted on 4/16/18 revealed the EP to contain a thorough risk assessment and community	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G313	A. BUILDING _____ B. WING _____	04/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK DRIVE GROUP HOME	1305 PARK DRIVE MOUNT AIRY, NC 27030

(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 006	Continued From page 1 based strategies. However, further review the EP revealed that while the EP addressed the identified needs of the group home, it failed to address the specific needs of the clients residing in the group home. For example: A. Review of the EP revealed one of the highest potential emergency disasters identified by the group home to include severe weather and power outage. Observations conducted in the group home substantiated by interview with the group home manager revealed an inadequate supply of water and food designated for use by clients and staff was available to meet subsistence needs during severe inclement weather/power outage in the group home. These supplies were being stored elsewhere and where not currently available on the group home premises. B. Review of the EP revealed information regarding residents of the group home was limited to the general information included on the face sheet informational sheet. Interview the facility QIDP revealed the facility was working on compiling comprehensive specific information to assist anyone unfamiliar with the client working with the clients in an emergency situation, however this information not currently available.	E 006		
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide opportunities for choice and self-management for 1 of 6 clients (#6) residing in	W 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G313	A. BUILDING _____ B. WING _____	04/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK DRIVE GROUP HOME	1305 PARK DRIVE MOUNT AIRY, NC 27030

(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 247	Continued From page 2 the home relative to bathroom choice. The finding is: Observation in the group home on 4/17/18 at 8:35 AM revealed client #6 to walk to a hallway of the group home and attempt to enter a bathroom. Staff was observed to immediately intervene with the client by stating "No, you know you don't use that bathroom" and redirected client #6 to a different bathroom in the same hallway. Client #6 was noted to respond with a loud vocalization at staff's redirection and walked to the bathroom staff directed the client to. Interview with staff revealed the initial bathroom client #6 was observed to try to use is a "staff bathroom." Staff further indicated clients should not be using the staff bathroom unless the other bathrooms are occupied. Interview with staff further revealed client #6 has a history of urinary tract infections and more cleaning of the staff bathroom would be needed if client #6 used it. Interview with the facility qualified intellectual disability professional revealed all clients should have access to all bathrooms of the group home. Further interview with the QIDP verified client choice of a bathroom should not be limited by staff convenience.	W 247		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by:	W 288		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G313	A. BUILDING _____ B. WING _____	04/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK DRIVE GROUP HOME	1305 PARK DRIVE MOUNT AIRY, NC 27030

(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 288	Continued From page 3	W 288		

Based on observations, record review and interviews, the team failed to assure techniques to manage inappropriate behavior were not used as a substitute for active treatment for 1 of 3 sampled clients (#6) relative to locked beverages. The finding is:

Observation in the group home on 4/17/18 at 9:25 AM revealed client #6 to enter the kitchen and attempt to access a cup from the cabinet. Staff was observed to assist client #6 by asking what the client wanted and then staff was noted to walk away from the client, enter the office of the group home and return with a soda for the client. Client #6 was observed to drink a soda and then load the facility van for the day program. Interview with staff revealed sodas in the home are locked in the staff office area due to client #6 stealing them from the fridge and drinking them excessively.

Review of records on 4/17/18 for client #6 revealed a plan of care dated 3/8/18 with no training objective relative to restricting soda access. Further record review revealed a behavior intervention plan (BIP) revised 12/12/17 for target behaviors of non-compliance, verbal aggression, physical aggression to include "aggressive liquid seeking" when staff must intervene to prevent drinking related to polydipsia and wandering/AWOL behavior. Continued review of client #6's BIP revealed no prevention technique relative to locking sodas away from the client.

Interview with the facility qualified intellectual disabilities professional (QIDP) revealed locking sodas in the group home is a technique used for client #6 to address inappropriate drinking of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G313	A. BUILDING _____ B. WING _____	04/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK DRIVE GROUP HOME	1305 PARK DRIVE MOUNT AIRY, NC 27030

(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 288	Continued From page 4 soda. Further interview with the QIDP verified the behavior and intervention should be identified in the client's BIP.	W 288		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to hold evacuation drills at least quarterly for the third shift of personnel. The finding is: Review of the facility's fire evacuation drill reports for the past year on 4/16/18 revealed evacuation drills were conducted during third shift on 12/18/17 at 5:20 AM. Further review of the facility's fire drill records revealed fire evacuations drills were conducted on 6/20/17 at 2:07 PM, on 9/17/17 at 8:25 PM, and on 3/17/18 at 9:45 PM which were all documented as third shift drills. Interview with the staff and the qualified intellectual disabilities professional (QIDP) revealed third shift starts at 11:00 PM and ends at 7:00AM and 3rd shift drills should be held for the third shift of personnel beginning at 11:00 PM and ending at 7:00 AM. Further interviews with the QIDP confirmed fire evacuation drills should be held for the third shift personnel during the hours of third shift on a quarterly basis. Therefore, the facility failed to conducted evacuation drills during the hours 11:00 PM-7:00 AM for the third shift of personnel for a period of over 8 months.	W 440		